CNS Competency Feedback Forum

4:30-7:00pm April 2, 2014
Arbutus Room, 4th Floor, Central City
13450 – 102nd Avenue Surrey, BC

ATTENDED
Patty Roy, CNS Older Adult, FH
Karen LeComte, CNS Heart Centre Adult Congenital Heart, SPH
Rosella McCarthy, CNS, Critical Care, BC Children's
Trudy Robertson, CNS, Fraser Health, Neurosurgery
Sara Kaufman, CNS Maternal, Infant, Child, Youth program, FH
Lori Hughes, CNS, Surgery, FH
Pamela Thorsteinsson, Director of Professional Practice, Nursing, FH
Julie Fraser, CNS Home Health, Maple Ridge, FH
Susan Brown, CNS Home Health, FH
Dale Affleck, MSN Student, UBC
Maylene Fong, Manager, Home Health, FH
Bonnie Caitlin, CNS Cardiac Services of BC, PHSA,
Susanne Burns, CNS, Cardiac Services, FH
Neleena Popatia, CNS, VCH
S Secord, CNS, FH
Marcia Car, CNS Medicine
Sherri Kensall, CNS Medicine
Carolyn Hammond, University of Victoria
Rosalie Starzomski, University of Victoria

Compiled information on the feedback forum CNSABC hosted on April 2nd (catering sponsored by University of Victoria. The 19 in attendance provided feedback on the different sections of the competency document. In the first section one of the attendees has offered her suggestions for wording in relation to the introduction and assumptions section. Following this is the feedback from the group under the sections of:

- Introduction
- Assumptions
- Clinical Care
- Systems Leadership
- Advancement of Nursing Practice
- Evaluation and Research

Suggestion for rewording of section for Introduction and Assumptions:

Practice Environments - suggestions
CNS practice is diverse and can vary within the same institution, across programs and across jurisdictions. The CNS roles varies dependent upon a variety of often competing priorities, such as the health care funding body, institutional administrative focus, client populations, individual unit/service, and nursing staff. The CNS practices very differently from one organization to the next and his or her function may change over time. Despite these differences, all CNS work is aimed at raising the quality of care.

Assumptions
Familiarity with the assumptions used to develop the core competencies is essential to the understanding of how these competencies may be applied to the CNS practice in all roles and settings, not only those specific to a particular client population or practice environment. In developing the core competencies listed in this document, the following assumptions were made.

1. CNS practice encompasses and builds on the professional role and scope of practice of the registered nurse to assess and manage complex health care issues and support innovation to improve the delivery of nursing and health care. Graduate nursing education is essential for operationalizing all areas of CNS practice across diverse practice settings and client populations.

2. The integration of the CNS role in the health delivery system is essential for the development and evolution of professional practice environments that support quality nursing care by: improving quality of care, achieving better health outcomes, avoiding unnecessary costs through prevention of adverse events and complications and reducing acute health-care costs through more efficient models of delivery.

3. The CNS is an autonomous practitioner who collaborates with clients, their family and/or caregivers, and other health providers as a member of the interprofessional/intersectoral healthcare team to deliver quality client care. Direct and indirect care delivery is core to CNS practice grounded in patient-centered care.

4. The CNS uses systematic approaches to retrieve, critically appraise, apply and translate research knowledge into practical information for clients, family members, nurses, other health-care providers, health-care decision-makers and policy-makers.

5. The CNS identifies, initiates and leads clinical therapeutic and health service interventions that result in beneficial short, intermediate and/or long term outcomes for clients and family members, nurses and other providers, organizations and the healthcare system.

6. The CNS understands provincial/territorial, federal and socio-political issues and the impact of these issues on health services and healthy public policy.

INTRODUCTION

- The first sentence is incorrect, advance nursing practice is an old term→must be changed to Advance Practice Nursing (MUST)
- Research too narrow, consider Quality Improvement Initiatives. Need to ensure that language is consistent from between the domains
- Replace CNS interventions to CNS practice (stronger statement)
- Is there some merit to the new competencies developed through inspirenet (may connect with Noreen Frisch (can view website at www.inspirenet.com)
- 3rd paragraph after 1st section. Suggestion is to: introduce the concept of 4 buckets of competencies in introductory area
- Missing priorities of health care funding body, admin institution focus, client needs, individual service, nursing staff
- Support notion of co-management of health
- Role of the CNS in educating other CNSs, and patient education
- What happens when the CNS disagrees with the prevailing political process or views? It is that ethical leadership piece and attention to the moral distress of nurses and other staff that is not as evident as it could be, as Rosalie mentioned.

ASSUMPTIONS

- Translating Research knowledge → suggest use evidence informed
- Should we ensure it notes in the body of the text that Client-centred is inclusive of the family. Should this be Person-centred?
- Can we include a definition of health under the assumptions (which guides all other competencies) within this document and does this include co-management and self-management support.
- Why does the survey focus on how frequently we do specific aspects? This is actually not a relevant question and may be misleading. We need to demonstrate specific competencies (may not be very often).
- Should Nurse Sensitive Adverse Events be in this document?
- CNS role extends beyond standard RN competencies
- Can we highlight family and relational practice in the competencies.

CLINICAL CARE

- When we start at the beginning at the 1st set of competencies, there is no reference to CNS as a leader in ethical practice in helping to decrease moral distress
- #5 (change remedial to appropriate) ie: recommends appropriate actions
- Consultation re: service delivery model development
- #15 – in the context of care transitions we look at all populations – not just highly complex and unpredictable situations.
- Promotes ethical nursing practice through the development of strong moral climates in the practice setting.

SYSTEM LEADERSHIP

- Can we reduce the number of competencies? Concern expressed that this appears to be goals of an expert CNS competencies, not entry level.
- Lead the development and implementation of system change in collaboration with...operations leaders, professional practice, Doctors, Quality Improvement
- Can we build in interprofessional language throughout?
- Systems leadership: #3 “Critically analyzes socio-political, demographic and economic issues, trends and policies to optimize health outcomes” is contributing to the political process to influence change, so why be redundant?
- Advocates for and implements change to create safe and healthy ADD (and ethical) workplace environments.

ADVANCEMENT OF NURSING PRACTICE

- Changing #3 to advocates and implements changes that optimize the professional development of nurses in their chosen field of practice.
- #4 change benchmarks to competencies
- #12 add clinical, nursing and organizational outcomes
- Advancement of Nursing practice: #8 do all CNSs advance practice at the national level (as well as local and regional) as a competency?
- Again, build in interprofessional practice language

EVALUATION AND RESEARCH

- Beyond Nurse sensitive indicators include evaluate patient outcomes
- #12 Lead and participate in research initiatives that facilitate the generation of new evidence
- #11-stronger word than encourage—coach? facilitates?
- Note: systems section had more focus on research than this section.