Impact of the North Carolina Board of Nursing Regulation Change on Clinical Nurse Specialist Practice

Amelia G. Ross

East Carolina University

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Abstract

Entry level preparation for the clinical nurse specialist (CNS) role is completion of a graduate degree or post-master's certificate in nursing, with clinical specialization and preparation for expanded role functioning. However, nurses without CNS education fulfill CNS positions in a number of healthcare organizations in North Carolina (NC). The NC Board of Nursing (NCBON) implemented a regulation change for mandatory recognition to practice as a CNS. The purpose of this scholarly project was to explore the impact of the regulation relevant to job title and description changes; thus, access to CNS care. A non-experimental, descriptive project was conducted through an internet survey on a convenience sample of 11,478 master's or higher degree prepared nurses. A majority (88.5%) of the sample size (n = 218) reported sustainment of their CNS job title; while 13% reported a job title change. Of those with a job title change, 6% reported a job description change and 12% were uncertain of changes in job performance. There was no significant association ($p < .05$) between changes in job title, job description or performance of responsibilities with reason for portfolio submission. Accurate data analysis of CNSs in NC was tenuous due to the self-report nature prior to regulation. The findings suggest CNSs engaged in policy advocacy for their title and role at the organizational level. The NCBON improved the CNS practice by the regulation change; still, for those who submitted a portfolio and/or reported changes in job titles and job descriptions, compels reevaluation to ensure the regulation is upheld for recognition in order to practice at an advanced practice level. Further education is necessary on the distinct four APRN roles. The results of this project

warrant further investigation on the long-term effect of CNS practice at the individual, organizational and community level.

DEDICATION

In loving memory of my mother and father, Marilyn James Ross and Kenneth Malcolm Ross, without your love, support and guidance, I would not be who I am today. Mama, your loving, giving, caring, and compassionate nature molded me to be all that I am. Thank you "Capsule". I love you and miss you very much. Daddy, from your example, you instilled in me a strong work ethic and to always put forth my very best to get the job done. This has given me the strength to persevere to get this job done. Thank you "Squirrel". I love and miss you very much.

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Chapter 1: Introduction

Health policy, policy advocacy and politics are integral components of nursing practice. The National Council of State Boards of Nursing (NCSBN) released the Consensus Model for Advanced Practice Registered Nurse (APRN) regulation in 2008 which includes the components of licensure, accreditation, certification, and education to ensure protection of the public through uniformity in APRN education and regulation (APRN Consensus Work Group & National Council of State Boards of Nursing APRN Advisory Committee, 2008). Disparate state regulation fails to fully utilize the competencies of APRNs, creating role confusion, limitations to professional autonomy and barriers for consumers accessing APRN services (Lyon & Minarik, 2001b). Regulatory disparities create confusion that is amplified in the recognition and implementation of the CNS role while creating public safety issues in disparate entry requirements for safe, effective care for consumers. Nowhere has this been more evident than in the regulation of the clinical nurse specialist (CNS). The Consensus Model addresses these issues by providing evidence-based, standardized regulation that will be the model of the future.

Clinical Nurse Specialists (CNSs) in North Carolina (NC) do not have statutory title protection by the Nurse Practice Act and prior to the revised regulation were not regulated by the North Carolina Board of Nursing (NCBON) beyond the level of the registered nurse (RN) license (Kugler, Burhans, & George, 2011). The NCBON, in fostering the implementation of the provisions of the Consensus Model, introduced an administrative regulatory rule change for CNS practice (21 NCAC 36 .0228) effective July 1, 2015. The rule provides regulation of CNS practice and moves voluntary recognition to mandatory recognition as a requirement to practice as a CNS; thus ensures consistency in entry level to CNS practice (North Carolina Board of Nursing [NCBON], 2015c). In anticipation of these changes, CNS practice has already sustained

a loss of CNS titled positions in order to maintain CNSs without formal education and advanced practice certification. Although the regulation was warranted and generally supported, there was concern regarding its impact on CNS practice positions, access to CNS delivered care and effect on patient outcomes. With the regulation in place, CNSs in NC must effectively advocate for their role and title with organizational policy makers.

Background and Significance

The APRN Consensus Model includes the components of licensure, accreditation, certification, and education (LACE) (APRN Consensus Work Group & National Council of State Boards of Nursing APRN Advisory Committee [NSCBN], 2008). Licensure refers to the granting of authority to practice. Accreditation is the formal review and approval recognition of the educational program by a recognized accrediting agency. Certification is the formal recognition of knowledge and skills of the individual APRN through the achievement of demonstrated standards identified at an advanced practice level. Education refers to the formal APRN preparation at a graduate-degree or post-graduate certificate program. The model requires the recognition of all four APRN roles: certified registered nurse anesthetist, certified nurse midwife, nurse practitioner, and clinical nurse specialist. In addition to role recognition, major components of title, licensure, education, certification, independent practice, and independent prescribing are also included in the model. The overall goal is for all state boards of nursing (BONs) to align their APRN regulation with the major components of the APRN model by 2015 (NCSBN, 2008).

The role of regulation is to oversee and ensure the safe practice of nursing to protect the public's health and welfare (NCSBN, 2015). It is the mission of the NCBON to protect the public by regulating the practice of nursing (NCBON, 2015b). Statutes, rules, policies,

guidelines, and position statements are terms to describe the level of statutory authority applied by various boards of nursing to regulate nursing practice (Hudspeth, 2009). The BON in each state has the authority to develop these rules or regulations to clarify or make the law more specific to ensure the safety and competency of nursing practice (Hudspeth, 2009; Russell, 2012).

After the release of the Consensus Model, the NCBON established an APRN Advisory Committee in 2010 with representatives from each APRN role in practice and education settings, employers and the public. The purpose of the committee was to assist and support the board in issues related to APRN practice and regulation, consensus model, and administrative rules. The committee studied the state's APRN licensure, accreditation, certification, and education models; identified gaps with the Consensus Model and made recommendations to the board (Kugler et al., 2011).

The analysis identified that CNSs were not recognized as an APRN beyond the definition for the elected representative board seat. Although the regulation provided qualifications for recognition, the process was strictly on a voluntary basis and not required to practice as a CNS. The regulation of CNS practice was as a RN and not at an advanced practice level. In addition, there was no title protection by the Nurse Practice Act and CNSs did not have prescriptive authority in the state (The APRN Advisory Committee, 2011).

In a final report to the NCBON, recommendations regarding CNS regulation and practice were to maintain regulation by the NCBON, establish role recognition and regulation, title protection, prescriptive privileges, and to provide a grandfathering provision (The APRN Advisory Committee, 2011). In 2012, the administrative rule (21 NCAC 36.0120) defining

APRN was clarified from APRN roles defined for the elected board seat to expressly define and list the four distinct roles consistent with the national nomenclature (NCBON, 2012).

The NCBON began further exploration of CNS practice through presentations by and discussions with CNSs on issues of practice components, certification, and educational requirements. A CNS advisory group was established to work with the NCBON on the revision of 21 NCAC 36 .0228 to begin regulation of nurses who practice at the APRN level in the CNS role in order to meet standardized qualifications consistent with the Consensus Model for APRN Regulation. The rule was approved on December 17, 2014 (NCBON, 2014).

Statement of the Problem

The Consensus Model was endorsed by over 48 national nursing organizations, including the National Association of Clinical Nurse Specialists (NACNS). As the only association specifically representing CNS practice, NACNS endorsed the Consensus Model despite the multiplicity of challenges including, but not limited to, the variability of state role recognition and title protection of the CNS, lack of regulatory approach to grandfathering, and limited CNS certification exams (National Association of Clinical Nurse Specialists [NACNS], 2012). Even before the release of the Consensus Model, NACNS recommended regulation of CNS practice for both title protection in statute and scope of practice regulation to include role recognition and accountability for nursing at an advanced practice level (NACNS, 2004; (Goudreau et al., 2007).

With the release of the APRN Consensus Model, CNSs across the nation reported to NACNS a negative impact in lost jobs due to employer misperceptions of the model (NACNS, 2012). For example, CNSs without APRN certification were eliminated from their jobs despite the unavailability of certifications (NACNS, 2012). In anticipation of these changes, some employers in NC have implemented changes that directly impacted CNS practice in the reported

loss of CNS titled positions. The reason for this is so facilities can maintain CNSs without formal education and advanced practice certification (C. Horne, personal communication, December 6, 2014). In addition, CNS positions that previously had not been filled or had become vacant have been eliminated (C. Horne, personal communication, December 6, 2014). These preemptive actions by employers were taken before regulatory changes, grandfathering or equivalency provisions were implemented.

The NCBON has initiated the process to begin alignment of CNS practice with regulatory recommendations. The issue at large for all CNSs in NC is competency in advocating for role and title protection and for access to CNS services for clients and consumers with organizational policy stakeholders.

Purpose of the Scholarly Project

The purpose of this scholarly project is to explore the impact of the NCBON regulation change on CNS practice related to role viability, job description and/or title change, as well as, access to CNS services. The impact of 21 NCAC 36 .0228 on CNS practice must be clarified for full utilization of the CNS role within clinical practice areas. This project will inform organizational leaders and policy makers about the impact of this regulation.

Conceptual and Theoretical Frameworks

Health Policy

Health policy refers to decisions, plans, and actions that are undertaken to achieve specific health care goals within a society (World Health Organization [WHO], 2014). An explicit health policy can define a vision for the future, outline priorities and expected roles of different groups, build consensus, and inform people (WHO, 2014). In order to engage in, advocate for, or effect change in a policy, it is necessary to understand the complexities of the

policy process, how the policy came into existence, where the opportunity for change exists, and the source of origin (Taft & Nanna, 2008). The identified major sources of health policy that influence nursing practice are organizational, public, and professional (Fawcett & Russell, 2001; Russell & Fawcett, 2005).

Various types of policies exist. Organizational policies are developed by healthcare institutions to govern work places, direct behaviors and fulfill organizational roles. Public policies are authoritative in the form of laws, rules, and judicial decisions pertaining to health and its components, and are developed by government (federal, state, local) to direct or influence the actions, behaviors, or decisions of others. Professional policies are developed by professional associations (discipline or multidisciplinary specific) that establish standards, guidelines, and evidence-based practice recommendations to guide providers and healthcare delivery systems about the profession (Fawcett & Russell, 2001; Russell & Fawcett, 2005).

Organizational policies governing title, job description, responsibilities, and qualifications are of interest to the CNS. When a change in organizational policy occurs related to the role, the CNS must be able to advocate for the most qualified person to fulfill the role and ultimately maintain the responsibilities and title of a CNS.

Policy Advocacy

Advocacy is defined as the act or process of supporting a cause or proposal (Advocacy, 2014). Advocacy is well established in nursing practice as accountability or a moral or philosophical value (Hanks, 2008; Spenceley, Reutter, & Allen, 2006). Advocacy is interceding on behalf of a vulnerable patient or population in protection of the patient's health, safety and rights (Day, 2006). Patient advocacy attributes may be summarized as "valuing, apprising, interceding, and inherent in each is the nurse who is proactive as well as reactive" (Baldwin,

2003, p. 35). Advocacy at the health policy level by nurses has been conceptualized as a reasonable extension of patient advocacy, but has remained essentially invisible (Spenceley et al., 2006).

Policy advocacy is defined as knowledge-based action intended to improve health by influencing system-level decisions (Spenceley et al., 2006). The involvement in policy advocacy by nurses requires an outward shift in focus from the nurse-patient relationship to a systems-level approach in political astuteness and competence (Taft & Nanna, 2008).

Political astuteness includes awareness of policy issues including understanding of the complexities of the policy process, how, why and where the policy originated, and opportunities for change of the policy (Taft & Nanna, 2008). It is also important to know whom the policy makers are and how to communicate with them (Primomo, 2007). Political competence involves nursing expertise of assessment of the issues, problem solving, networking, interpersonal relationships aimed to influence policy makers, consensus building and strategic planning (Primomo, 2007; Warner, 2003). Effective advocacy demands power, will, time, and energy, along with the necessary political skills to bring about policy change (Abood, 2007). Inherent in the success of a policy is the degree of value placed by the intended recipient to justify participation in the policy making process (Smart, 2013). Perhaps at the core of the matter is the inherent caring principal of nursing conflicting with the seemingly uncaring act of policy development and politics that results in the lack of participation in advocacy. This may also contribute to disconnection of how policy affects nursing practice at the point of interaction with the patient. Despite the numerous barriers, the challenge before CNSs in NC is to intercede and advocate on their own behalf.

Emancipatory Knowing

Emancipatory knowing served as the nursing theory for this project. Emancipatory knowing was founded upon critical theory that reveals the origins and consequences of social inequities and injustices (Chinn & Kramer, 2011). Critical social theory asserts that knowledge is practical and linked to action; its purpose is emancipatory and can free the knower from oppression (Kagan, Smith, Cowling, & Chinn, 2010). Emancipatory knowing provides a foundation for all nursing knowledge and surrounds both the original patterns of knowing in nursing (ethical, empirical, personal, and aesthetic) identified by Carper and White's sociopolitical knowing (Chinn & Kramer, 2011).

The patterns of knowing recognize that experience develops knowledge beyond the empirical and serves as a framework for various types of nursing knowledge that can guide actions needed in policy advocacy (Carper, 1978). Ethical knowing involves the moral component of nursing practice. Empirical knowing concerns the science of nursing. Personal knowing entails the interpersonal relationships and experiences that define the self. Aesthetic knowing embraces the art of nursing (Carper, 1978). Sociopolitical knowing moves the nurse from an environment of introspection and places nursing within the larger context where nursing and health care take place (White, 1995). Sociopolitical knowing serves as a "means to understand sociopolitical and cultural contexts that influence perceptions of health and illness, identity, language, and relationship with society" (Snyder, 2014, p. 66). To broaden the scope of sociopolitical knowing, emancipatory knowing was proposed to reveal how the factors of history, society, politics, and culture can suppress human potential (Chinn & Kramer, 2011). Sociopolitical and emancipatory knowing explore ontological questions of being (Bonis, 2009). Each pattern of knowing is a basic component of the integrated knowledge base for professional

practice which is framed by emancipatory knowing as the foundation of all nursing knowledge that shapes nursing practice (Chinn & Kramer, 2011; Fawcett, Watson, Neuman, Walker, & Fitzpatrick, 2001).

Emancipatory knowing is the "human capacity to be aware of and to critically reflect upon the social, cultural, and political status quo and to figure out how and why it came to be that way" (Chinn & Kramer, 2011, p. 5). Emancipatory knowing calls for action to reduce or eliminate inequality and injustice within social and political environments that support advantage for some and disadvantage for others (Chinn & Kramer, 2011). It asks the critical questions of who benefits, what is wrong with this picture, what are the barriers to freedom, and what changes are needed (Chinn & Kramer, 2011).

Application of Conceptual and Theoretical Frameworks

Health policy and policy advocacy are integral components of nursing practice. Nursing practice is based on theory. Emancipatory knowing serves as the foundation of nursing knowledge and surrounds the patterns of knowing. Emancipatory knowing calls for action to reveal and address sociopolitical inequalities and injustices (Figure 1). As a knowledgeable APRN, the CNS must demonstrate a commitment to action through participation in important decisions that ensure the delivery of quality health care (Milstead, 2013).

Disparities in equality and social injustice exist for CNSs in NC as seen by the lack of role protection by the NCBON compared to the other APRN roles. This lack of regulation has resulted in the misuse of the title and role within some organizations by hiring those without the proper graduate preparation as a CNS and lending to a misrepresentation of CNSs to the public. In anticipation of an emerging new CNS rule change, some employers in the state have eliminated the CNS positions by either not rehiring into the role or revising the title of the job

description while maintaining the same CNS responsibilities and accountabilities in order to keep non-CNS educated employees in these roles. This practice supports an advantage for those not educated as a CNS and a disadvantage for educated CNSs that ultimately affects public access to this type of advanced practice care.

CNSs, especially those in NC, have not participated in policy advocacy despite education in health policy and systems thinking in CNS curriculum and core practice competencies related to health policy and advocacy (NACNS, 2008). This is a significant problem as CNS advocacy for health policy surrounding regulation and viability of the role and practice is crucial including, competency to influence policy and to maneuver within the political environment of the workplace, ensuring access to CNS care. If CNSs are unable to advocate for themselves and continue to accept the status quo, the continued negative consequences in the loss of CNS titled roles will deprive consumers, their families, and employers of full access to CNS services resulting in poor public policy and a social injustice (Lyon & Minarik, 2001a).

Summary

As regulation of CNS practice in NC emerges in alignment with the Consensus Model, organizational policy will change as a response. It is imperative for CNSs to engage in policy advocacy. Emancipatory knowing can be used as a framework for CNS advocacy to question inequality and injustices that create advantages for some and disadvantages for others. Advocacy challenges the political status quo to actively protect or change policies, ensuring the viability of the CNS role, title protection and consumer access to CNS delivered services.

Chapter 2: Review of the Literature

The purpose of this scholarly project is to examine the impact of mandatory recognition regulation on CNS practice related to CNS titled positions and job description responsibilities. This chapter is a review of the literature relevant to CNS regulation.

A literature review using the key words: advanced practice nurses AND health policy advocacy, ("Health Policy"[MAJR]) AND "Nurse Clinicians"[MeSH Terms], and ("Health Policy"[MAJR]) AND clinical nurse specialists; ((MH "Politics") OR (MH "Political Participation")) AND (MH "Clinical Nurse Specialists"), (MH "Clinical Nurse Specialists") AND (MH "Health Policy"), (MH "Clinical Nurse Specialists") AND ("policy advocacy" OR (MH "Health Policy")), "professional regulation" OR (MH "Rules and Regulations") AND (MH "Clinical Nurse Specialists"), (patterns of knowing), (Carper's fundamental patterns of knowing), (sociopolitical knowing), (emancipatory knowing), and "health policy advocacy clinical nurse specialists professional regulation" was conducted using the PubMed, Cumulative Index to Nursing and Allied Health Literature (CINAHL), and ProQuest Nursing & Allied Health Source databases. A total of 1,800 potentially relevant articles were obtained. Duplicates, comments, and editorials were eliminated. Emphasis was placed on articles from the past five years. There were 60 articles used for the literature review.

Regulation of Clinical Nurse Specialist Practice

The practice environment for CNSs is changing. The mandates of advanced nursing practice through statutory, regulatory, credentialing and/or certification requirements are crucial elements of the practice environment and are critical to the safety of the public by ensuring competent healthcare providers (Lyon & Minarik, 2001a; Lyon & Minarik, 2001b).

The issue of regulation either through second licensure and/or certification for APRNs, inclusive of the CNS, has long been an issue for the nursing profession (Lyon & Minarik,

2001a). In 1992, the NCSBN recommended regulation of APRNs through licensure to the state boards of nursing (Sechrist & Berlin, 1998). In 1994 in a position statement on certification and regulation of APRNs, the American Association of Colleges of Nursing (AACN) reported on the lack of standardization in educational preparation and certification that has prompted nurses without graduate education and certification to function in advanced practice roles (American Association of Colleges of Nursing [AACN], 1996). As one of the APRN roles, the CNS should hold a graduate degree in nursing and an advanced practice certification (AACN, 1996).

Since its establishment in 1995, the mission of NACNS (2012) has been to represent CNS practice, education, regulation, and certification interests. NACNS has consistently maintained model regulatory language to guide CNSs, state nursing associations and boards of nursing to promote consumer access to CNS delivered services (Lyon & Minarik, 2001a; Lyon & Legislative/Regulatory Committee, 2000; NACNS, 2003, 2004a). The model regulatory language by NACNS includes provisions for title protection, definition and scope of practice of the CNS as an APRN, educational level, practice standards, recognition requirements to practice, continuing recognition requirements to practice through certification, prescriptive authority, and disciplinary action (Lyon & Minarik, 2001a; Lyon & Legislative/Regulatory Committee, 2000; NACNS, 2003, 2004a). These regulatory elements are congruent with the APRN Consensus Model recommendations set forth by the NCSBN (NCBSN, 2008).

The NCBON regulation (21 NCAC 36 .0228) on CNS practice begins the alignment of CNS practice with the recommendations of the Consensus Model and that of NACNS related to recognition, qualifications and advanced scope of practice. The regulation does not include pharmacologic prescriptive authority or title protection. The regulation components include mandatory recognition by the board as a CNS in order to practice. The qualifications for

recognition require the completion of a master's or higher degree program accredited by an approved nursing accrediting body and CNS certification by an approved national credentialing body. The regulation provides for portfolio equivalency if there is no CNS certification available in the specialty. The scope of practice incorporates the understanding and application of nursing principles at an advanced practice level in the area of specialization for which the CNS is educationally prepared and competency has been maintained (NCBON, 2015c).

Synthesis of the Body of Evidence

Nursing involvement in health policy and policy advocacy reported in the literature is elusive, especially in regards to the CNS. What is known in the literature focuses primarily on barriers to policy advocacy and ways to foster policy advocacy.

Barriers to policy advocacy include low efficacy to influence policy, lack of opportunity, resources, absence of support, role models, time constraints, gender issues, lack of involvement in nursing organizations and the fear of retaliation if involved. (Kunaviktikul et al., 2010; Primomo, 2007; Primomo & Björling, 2013; Shariff, 2014; Vandenhouten, Malakar, Kubsch, Block, & Gallagher-Lepak, 2011). Despite these barriers, policy advocacy can be fostered in the nurse's knowledge and behavior.

Advocacy is entrenched in the specific knowledge held by nurses. The AACN (AACN 1996, 2006, 2008, 2011) published essential health policy and advocacy competencies for nursing education. Yet, nurses continue to report feeling not adequately prepared to impact local, state or national government policy decisions (Vandenhouten et al., 2011). There is also a belief that nursing input in policy is discounted and even those active in policy roles do not identify themselves as nurses for fear their input will be discredited even further (Gebbie,

Wakefield, & Kerfoot, 2000). Moreover, nurses that do not value advocating for themselves or their colleagues weaken collective advocacy power (Gebbie et al., 2000).

Policy advocacy can be fostered through advocacy practices, experiences, and education (formal, professional and community). These experiences shape sociopolitical socialization as shown in a qualitative study by MacDonnell (2009) on the relationship between nurses and policy in ten nurse activists (inclusive of CNSs). Vandenhouten et al. (2011) used a descriptive, predictive study of a convenience sample of registered nurses (N = 468) to see how nurses felt they impact policy from at a local, state or national level. The authors found that 40% felt they could impact local policy decisions and even fewer (32%) felt they could impact state or national government decisions. A majority of these nurses (80%) also felt their curricula did not adequately prepare them to participate in political activities (Vandenhouten et al., 2011).

Academic preparation of nurses in health policy has expanded to include opportunities for experiential learning in sociopolitical activities. Several studies have shown a statistically significant increase in political astuteness after completion of a health policy course and after participation in a nurse legislative day (Primomo & Björling, 2013). The possession of knowledge and skills along with opportunities to participate in health policy activities stimulate a desire for involvement in policy advocacy (Shariff, 2014).

A secondary analysis of an internet survey of APRNs (N = 884) in Florida examined factors related to advocacy in resolving practice barriers (Kung & Lugo, 2014). APRNs who were more politically active were those who recognized barriers to practice, were over 50 years of age, had a doctorate, belonged to a professional organization, and had more years of APRN

experience (Kung & Lugo, 2014). It is important to note that less than one percent of the survey participants were CNSs (Kung & Lugo, 2014).

There is a lack of information in the literature that describes the concept of Emancipatory Knowing related to the regulation of CNS practice. Descriptive literature on the experiences and processes of various state APRN and CNS groups regarding implementation of CNS regulation is beginning to emerge (Davidson et al., 2001; Duffy, 2008; Mathews, Boland, & Stanton, 2010; Thurman, 2015). It is important to study this area within CNS practice due to the changes with implementation of the APRN Consensus Model. There were no quantitative studies identified that lend to the body of knowledge related to CNS practice regulation and Emancipatory knowing.

Project Inquiry Question

The specific question that will be addressed in this project is:

What is the impact of the regulation change on CNS practice in the state of North Carolina related to changes in job title and/or job description responsibilities?

Definition of Terms

For the purposes of this project the following terms are conceptually defined as:

Regulation is the CNS administrative rule, 21 NCAC 36 .0228, as approved on December 17, 2014 by the NCBON to be effective on July 1, 2015.

Clinical Nurse Specialist is any master's or higher degree prepared RN who has defined themselves as a CNS prior to the NCBON regulation rule change.

Practice is the work performed by a CNS who has the job title and job responsibilities of a CNS given to them by the employer regardless of credentialing or education.

Summary

The NCBON implemented regulation on CNS practice to begin alignment with the Consensus Model. NACNS, as the national organization representing the interests of the CNS has been a proponent of recognition and regulation of CNS practice. There is a dearth of literature on nursing policy advocacy and Emancipatory Knowing as it relates to the CNS. What is known in the literature reports on barriers in fostering policy advocacy. Descriptive literature on the regulation process of CNS practice is beginning to emerge; however, there were no quantitative studies identified that lend to the body of knowledge related to CNS practice and supporting conceptual frameworks.

Chapter 3: Methodology

The purpose of this project is to explore the impact of a regulation change on CNS practice in the state of North Carolina. This chapter will discuss sample, setting, survey instrument and implementation, and procedure for data collection and data analysis.

Needs Assessment

In working with the NCBON to identify how to align CNS practice and regulation with the APRN Consensus Model it became apparent that the impact on the current generation of CNSs was not known. The need to explore the impact was also identified through personal experience and hearing of other CNSs losing titled positions in anticipation of regulation, yet without changes in job description responsibilities.

Sample and Setting

The sample included master's prepared registered nurses (RNs) from a purchased database from the NCBON who are self-identified as having practiced as a CNS within the last

eight years. This time frame coincides with the emergence of information regarding the Consensus Model.

The setting for the participants was an internet survey related to their practice setting environment. Internet or web-based surveys are a convenient method for conducting surveys targeted to specific populations, such as professionals, especially when there are comprehensive lists containing email addresses (Dillman, Smyth, & Christian, 2014). The potential advantages of internet surveys are lower costs, higher percent of questions answered correctly and accurately, faster distribution of the survey, shorter data entry time with lower errors compared to manual entry (Dillman et al., 2014; Dykema, Jones, Piche, & Stevenson, 2013).

Project Design

A non-experimental, descriptive design project was conducted through an internet survey using Qualtrics® (2015), a web-based, research survey software licensed by East Carolina University. A convenience sample of master's prepared registered nurses (RNs) were sent an electronic mail (E-mail) invitation to voluntarily participate in the survey. Participants who self-identified as having practiced as a CNS within the last eight years were eligible to participate in the survey. Descriptive statistical analysis using IBM® SPSS® Statistics, Version 20 software was conducted. The project received exempt status approval from the University and Medical Center Institutional Review Board (UMCIRB) at East Carolina University on April 15, 2015 (see Appendix A).

Data Collection Survey Tool

A 29-item survey was developed from a selection of unpublished survey questions on CNS practice (Horne et al., 2011) with additional questions developed by the researcher (see Appendix B). The questions consisted of current job title, job description, employment status,

work setting, voluntary recognition status, planned method for mandatory recognition and rationale, education, concentration of program, certification, years practicing as a CNS, and work location zip code. Some of the questions were designed based on conditional response logic. General demographic questions consisted of age, sex and ethnicity. An open-ended comment statement on the survey in regards to CNS practice in NC was available.

The initial survey was emailed to ten CNSs practicing across the state of North Carolina for content validity and flow of the survey. The response rate was 100% and the feedback was reviewed and incorporated in the final survey.

Procedure

The NCBON provides a service for the purchase of licensure data of nurses. An application for purchase was required including a description of how the information would be used. The application was submitted after UMCIRB approval was received. The data was received as a Comma Separated Variable (CSV) file capable of manipulation by Microsoft Excel® software. The data was current as of the time the data request was completed by the NCBON. The licensees were responsible for updating their information and thus, the accuracy of the data on record was not guaranteed by NCBON.

There were 124,333 RNs in the database. The data was sorted according to reported educational level of master's or higher degree and available E-mail address. The file was exported to Qualtrics® software (2015). The survey instrument was administered using Qualtrics®. A request to participate in the project survey was emailed to 11,478 RNs with an individual, anonymous embedded link for participants to access the survey. Participants were informed of the purpose of the survey, participation was anonymous and voluntary, and there was no penalty for not taking part in the survey. Informed consent was implied by completion of

the survey. A reminder email and survey link was sent to the participants who had not completed or were in progress of completing the survey weekly in an effort to maximize the response rate. The survey remained open for 23 days. All data and responses were saved according to the UMCIRB data storage requirements. The data was downloaded into a .csv file, coded and loaded into IBM® SPSS® Statistics, Version 20 software for descriptive statistical analysis.

Three hundred six emails were returned as undeliverable (2.36%), resulting in 11,176 in the project. There were 3,662 total participants who started the survey and 2,780 who completed the survey yielding an overall 25% response rate. The average response rate for internet surveys is 26% (Dillman et al., 2014).

Three thousand sixty five (84%) responded they had not practiced as a CNS in NC within the last eight years, which excluded them from continuing with the survey. Five hundred eighty seven (16%) responded they had practiced as a CNS to continue with the survey. There were 387 participants excluded from the analysis with missing data required for specific analysis, and comments that they were not a CNS, reported zero years of practice as a CNS, retired, and/or out of state work location zip codes; yielding 218 participants in the sample for data analysis.

The dissemination of findings will be conducted through abstract submissions for presentations to the state and national CNS organizations and submission for journal publication. The findings will also be disseminated to the NCBON.

Resources

Primary resources used for this project were library databases, internet search engines, and the knowledge and expertise of CNSs practicing in the state. The purchase cost of the

NCBON RN database was $430.00. Funding of the purchase cost was sought through scholarship applications.

Summary

This chapter described the research design, sample, setting, instruments, data collection, human protection measures, and data analysis plan completed in this project. An internet based survey was distributed to 11,478 master's or higher degree prepared RNs identified from a purchased database from the NCBON. The survey remained open for 23 days with weekly reminders sent to those who had not completed the survey or were in progress. An overall response rate of 25% (n = 2,780) was obtained from those completing the survey. After exclusion of participants who reported not practiced as a CNS in NC, missing data required for specific analysis, commented not a CNS, reported zero years of practice as a CNS, retired, and/or work location zip codes out of state, there were 218 participants included in the descriptive data analysis.

Chapter 4: Results

This chapter contains the descriptive statistics of the sample population and major findings related to the project inquiry question. After a descriptive analysis of the sample, the data were explored regarding the impact of the regulation change on actual or potential changes in job title and job description responsibilities.

Sample Characteristics

The demographics of the project sample are found in Table 1. The majority of the respondents were female and Caucasian, 78.4% and 84.9%, respectively. The mean age was 54.54 years with a SD of 9.10 years, range of 35-75 years. There was a mean of 15 years of practice as a CNS.

Major Findings

The educational preparation and characteristics of the degree program concentration of the sample are found in Table 2. Fifty percent of the respondents reported their concentration of their graduate degree program was that of a CNS and 5.5% were of a combined CNS and nurse practitioner program. Almost 75% of the respondents reported having a master's degree in nursing as their highest degree held, while nearly 8% held a doctorate in nursing.

The respondents practice in a variety of settings; however, the majority works in a hospital setting (39%) and is employed full-time (69.7%) while 12.8% are part-time. Of those who responded they were not employed as a CNS, 5% reported the facility in which they are employed does not utilize the CNS role, 1.4% reported there were no open positions or they did not meet the facility's requirements, and 2.3% reported they function as a CNS but do not hold the job title. Thirty five percent of the respondents reported their current job title as a CNS (See Table 3).

Table 4 describes the CNS recognition characteristics of the sample. Thirty seven percent of the respondents reported voluntary recognition as a CNS by the NCBON. Sixty two percent intended to apply for mandatory recognition through the standard application process as they felt they met the NCBON recognition requirements, yet only 36% reported having an advanced practice certification from either the American Nurses Credentialing Center (ANCC) or the American Association of Critical Care Nurses (AACN). Of those who intended to apply for mandatory recognition through portfolio (33.5%), the primary reason was they did not have an advanced practice certification (20.2%).

Project inquiry question. What is the impact of the regulation change on CNS practice in the state of North Carolina related to change in job title and job description responsibilities?

The CNS job title and job description changes related to mandatory regulation are found in Table 5. An overwhelming majority (88.5%) responded they had not sustained a job title change; whereas, 12.8% reported a job title or impending job title change. Respondents reported job title changes from CNS to nursing practice specialist, clinical practice specialist, clinical nurse program coordinator, and program coordinator. Of those who reported a job title change, only 5.5% reported a change or impending change in their job description responsibilities. Less than 2% of these reported they would perform the job responsibilities the same; whereas, 12% were uncertain of job performance changes at the time of the survey.

Statistical analysis was performed to discern if there was an association between reported changes in job title, job description and performance of job responsibilities with the reason for portfolio method of application for recognition. The rationale for portfolio method of application included not holding a degree from a CNS program, had less than 500 clinical practicum hours, do not have a CNS certification from an approved credentialing body, or other reason. A Chi-square test for independence (with Yates Continuity Correction) indicated no significant association between job title change with reason for portfolio method of application for mandatory recognition, χ^2 (3, n = 70) = .51, p_{exact} = 1.00, V = .06; impending job title change, χ^2 (3, n = 64) = 2.27, p_{exact} = .27, V = .20; job description change, χ^2 (2, n = 8) = 1.60, p_{exact} = 1.00, V = .45; impending job description change, χ^2 (3, n = 70) = .73, p_{exact} = .79, V = .20; perform job description responsibilities the same as the previous job description, χ^2 (3, n = 3) = 3.00, p_{exact} = .33, V = -1.00; and perform impending job description responsibilities the same as the previous job description, χ^2 (6, n = 71) = 3.02, p_{exact} = .66, V = .16. An alpha level of .05 was used for all statistical tests.

Summary

This chapter described the characteristics of the sample and major findings related to the project inquiry question. The sample was primarily female, Caucasian, average age of 54 years, and 15 years of practice as a CNS. The respondents primarily work in a hospital setting, full-time, and with a current job title of CNS. The principal intended method of application for mandatory recognition to practice was standard as they met the NCBON requirements. A third of the respondents intended to apply through portfolio, as they did not have an advanced practice certification. A majority of the sample responded they had not sustained a job title change; whereas, 12.8% reported a job title or impending job title change with only 5.5% resulting in a change or impending change in their job description responsibilities. A small percentage (1.4) reported they will perform the job responsibilities the same, but 12% were uncertain. A cross tabulation showed there was no significant association between job title change, job description change and performance of job description responsibilities the same as in their previous job description with the reason for portfolio submission as mandatory recognition.

Chapter 5: Discussion

The primary goal of this project was to evaluate the impact of the NCBON regulation change from voluntary to mandatory recognition on CNS practice. The secondary goal of the project was to evaluate the impact of the regulation on access to CNS delivered services to the population of NC. This chapter presents implications of the major findings of the project, application of the theoretical framework, strengths and limitations of the project, recommendations, and implications for nursing practice.

Implication of Findings

As CNSs have not been consistently licensed or recognized by statute or regulation in all states, inclusion in national or state data analyses has been challenging as nurses may refer to themselves as CNSs without regulatory authority. Many CNSs do not have national provider identifier numbers resulting in data too small to be considered representative of the population and therefore not included in analysis (Skillman et al., 2012). In addition, CNSs are included in the RN occupation code (29-1141) for national employment and wage statistics unlike the other APRN roles that each has a separate occupation code (U.S. Department of Labor & Bureau of Labor Statistics, 2014).

In 2013, NACNS reported there were 72,000 CNSs in the United States (NACNS, 2013). According to the NCBON licensure statistics, there are 1,028 clinical specialists (NCBON, 2015a). It is important to note the NCBON data is based upon self-report of employment position at the time of licensure renewal and not verified by education, certification or voluntary recognition status.

Characteristics of NACNS study sample. The NACNS conducted a web-based survey in 2014 in an effort to provide a baseline understanding of the role of the CNS and how they are meeting the health care needs of the nation. The survey was completed by nurses (n = 3,370) who had completed or were enrolled in a CNS education program (NACNS, 2015a). The sample was predominantly Caucasian (88.43%) and female (94.9%) (NACNS, 2015b). The national data is consistent with this project sample of primarily female (78.4%) and Caucasian (84.9%). Although the national census did not report on age, the mean age of this study's sample was 54.4 years, which is higher than the national RN workforce average age of 44.6 years (U. S.

Department of Health and Human Services, Health Resources and Services Administration, Bureau of Health Professions, & National Center for Health Workforce Analysis, 2013).

The NACNS census reported 78% held a master's (MSN or MS) as the highest nursing degree; while 13.73 % held a doctorate in nursing (PhD, DNP, DNS, DNSc, or ND). CNSs work in a variety of settings, but primarily work in a hospital setting (59.45%); 85.38% work full-time while 11.29% work part-time (NACNS, 2015b). This project reflects the national statistics for both education level and employment status. The sample for this project showed 75% of the respondents had a master's (MSN or MS) as the highest nursing degree held, while nearly 8% held a doctorate in nursing. CNSs in NC are also employed in a variety of settings with a majority in a hospital setting (39%) and employed full-time (69.7%) while 12.8% are part-time.

Impact of regulation on CNS practice. Thirty-five percent of the respondents reported their job title was as a CNS. A majority (88.5%) of the sample responded they had not sustained a job title change; whereas, 12.8% reported a job title or impending job title change. Of those who reported a job title change, only 1.4% reported they had a change or impending change in their job description responsibilities. A concern of compliance to the regulation may be in those who reported a job title and job description change, yet may continue to perform the job responsibilities the same or are uncertain if they will continue to perform the job the same.

During cross tabulation, the effect size was small for job title change and impending job title change in their current role to submission of portfolio to the NCBON; although several of the table cells had less than the expected count. In looking at the change in job description from their current role with portfolio submission, the statistics suggested a large effect size; however, the sample was too small (*n = 8)* and cell size less than expected to draw conclusions. The

effect size for impending job description change with portfolio submission was small with a less than expected cell size taken into consideration. The effect size for whether those with a job description change perform their job responsibilities the same as their previous job description with submission of the portfolio was small; however with a small sample (n = 3) and a less than expected cell size, the results are unreliable. For performance of the impending job description responsibilities the same as the previous job description, the effect size was also small; however, there was a less than expected cell size for a reliable conclusion.

Theoretical Framework

Emancipatory knowing served as the theoretical framework for the project. The theory provides a foundation for all nursing knowledge and surrounds the patterns of nursing knowledge of ethical, empirical, personal, aesthetic and sociopolitical knowing. Emancipatory knowing calls for action to challenge societal, cultural and political status quos that enable advantages and disadvantages of others; in other words, to advocate. Advocacy is entrenched in nursing knowledge, philosophical and moral values.

With the lack of CNS role regulation by the NCBON, inequality and social injustice existed for CNSs in NC, resulting in the misuse of the title and role through hiring practices of some organizations. Some organizations changed the title of CNS positions prior to mandatory regulation, so advocacy by CNSs for policy associated with regulation of the role and practice was crucial to ensure continued access to CNS care. The loss of CNS positions in the wake of mandatory recognition would deprive all consumers to full access of CNS services. This project suggests that a number of CNSs were able to effectively employ characteristics of emancipatory knowing in advocating for their role and title in their organizational systems.

Strengths and Limitations of the Project

There are a couple of identified strengths of this project. The project provides baseline data for where CNS practice stands prior to full implementation of regulation on October 1, 2015. Another strength is that this project may also guide the NCBON in setting limits of new regulation.

There are several limitations in this project. The self-report nature of the respondents using an on-line survey is a significant limitation. Another limitation was the evident challenge the respondents had in their uncertainty, misunderstanding or lack of knowledge as to whether they were actually a CNS or not with some thinking that they were a CNS when in fact they reported they were a certified registered nurse anesthetist (CRNA) or other APRN.

The sample size was small in comparison to number of self-identified clinical specialists report by the board of nursing. Incomplete data sets had a significant effect on analysis of the data. Furthermore, the findings from this project are not generalizable to CNSs in other states.

A major limitation was the inability to correlate data of recognition status reported by the NCBON with the project sample. Although the regulation was effective July 1, 2015, there were delays in the NCBON application process that conflicted with the project timeline (See Appendix C). As a result, survey questions related to NCBON recognition status were unable to be included. In addition, the lack of comparison of role delineation and competencies in job description changes to CNS core competencies was another limitation of the project.

Recommendations

Further investigation on the impact after the notification of recognition status by October 1, 2015 of portfolio candidates is warranted. The NCBON improved CNS practice by changing regulation; still, for those who submitted a portfolio and/or reported change in job title and job

description, this compels reevaluation to ensure the regulation is upheld for recognition in order to practice at an advanced level and to comply with LACE recommendations.

As a result of mandatory recognition status, the NCBON will be able to accurately include CNSs in the licensure statistics and the APRN database which will enable further examination on policy advocacy and political astuteness of recognized CNSs. Moreover, a change in the state nursing practice act with continued push toward full implementation of the Consensus Model is needed.

As evident in the role confusion of the respondents, further education on the distinct four APRN roles is necessary not only in the academic setting, but also in the public and practice settings. The results of this project merit further investigation on the long-term effect of CNS practice at the individual, organizational and community level.

Implications for Nursing Practice

Clinical Nurse Specialists are distinctively prepared to meet the high demand for health care and ensure the provision of quality care for optimal patient outcomes. CNS practice is distinguished from other APRNs in the incorporation of core competencies of leadership, collaboration, coaching, consultation, clinical expertise, and ethical decision making. These competencies influence patient care through innovative evidence-based interventions, the practice of nurses, and the organizational environment to support and improve nursing practice (NACNS, 2004b). CNS practice has long been in alignment with the Institute for Healthcare Improvement (IHI) triple aim goals to improve the health care system.

The IHI triple aim goals are improving the experience of care, improving the health of populations, and reducing per capita costs of health care (Berwick, Nolan, & Whittington, 2008). CNSs have demonstrated a rich history as leaders and interprofessional partners with other health

care providers in the implementation of evidence-based quality improvement interventions, care coordination and transitions of care that have decreased health care costs related to hospital length of stay, readmissions, and hospital-acquired conditions; including, but not limited to, providing prenatal care, preventive and wellness care, behavioral health care and care to those with chronic conditions (NACNS, 2013). As pressure mounts for accountability in delivery of affordable, safe, quality health care, CNSs are pivotal in the development and implementation of performance improvement strategies to assist organizations in meeting these demands.

The largest implication of this project is the need for further investigation on the actual impact of regulation of CNS practice in NC. The results of this project merit further analysis on the long-term effect of CNS practice at the individual, organizational and community level.

Conclusion

This project provides information on the impact of regulation of CNS practice in NC using Emancipatory Knowing as the theoretical framework. Although accurate data analysis of CNSs in NC is challenging due to the self-report nature prior to regulation, the overall sustainment of CNS job titles suggests CNSs engaged in policy advocacy for their title and role at the organizational level. As health policies continue to emerge to align CNS practice with the Consensus Model, changes will occur in response. The engagement of CNSs in political advocacy related to regulation and viability of practice is imperative to ensure continued access to CNS delivered care.

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Table 1

Sample Demographics (n =218)

Characteristic	Frequency (%)	Mean (SD) Range
Age in years	196 (89.6)	54.54 (9.101) 31-75
Missing	22 (10.1)	
Total	218 (100)	
Gender		
Female	185 (84.9)	
Male	11 (5)	
Missing	22 (10.1)	
Total	218 (100)	
Ethnicity		
American Indian / Alaska Native	2 (.9)	
Asian	3 (1.4)	
Black / African American	17 (7.8)	
Caucasian / White	171 (78.4)	
Hispanic / Latino	2 (.9)	
Decline to Answer	2 (.9)	
Missing	21 (9.6)	
Total	218 (100)	
Total Years Practicing as a CNS	193 (88.5)	15.34 (10.076) 1-45
Missing	25 (11.5)	
Total	218 (100)	

Note. CNS = Clinical Nurse Specialist

Table 2

Educational Preparation and Program Characteristics (n = 218)

Characteristic	Frequency (%)
Program Concentration	
Clinical Nurse Specialist	110 (50.5)
Nursing Education	34 (15.6)
Nursing Administration / Leadership	16 (7.3)
Nurse Practitioner	4 (1.8)
Nursing Informatics	2 (.9)
Both CNS / NP	12 (5.5)
Other	17 (7.8)
Missing	23 (10.6)
Total	218 (100)
Clinical Practicum Hours Required	
Yes	168 (76.1)
No	18 (8.3)
Uncertain	6 (2.8)
Missing	28 (12.8)
Total	218 (100)
Number of Clinical Practicum Hours Required	
Less than 300	52 (23.9)
300 - 399	38 (17.4)
400 - 499	16 (7.3)
500 or greater	68 (31.2)
Missing	44 (20.2)
Total	218 (100)
Program Required 3 Ps	
Yes	82 (37.6)
No	65 (29.8)
Content Integrated	39 (17.9)
Missing	32 (14.7)
Total	218 (100)
Program Accredited CCNE or NLN	
Yes	141 (64.7)
No	13 (6)
Uncertain	37 (17)

Table 2 *(continued*)

Missing	27 (12.4)
Total	218 (100)
Graduate Degree(s) Held	
MSN	163 (74.8)
MSN & Practice Doctorate in Nursing	6 (2.8)
MSN & Practice Doctorate in Other Field	4 (1.8)
MSN & PhD in Nursing	11 (5)
MSN & PhD in Other Field	1 (.5)
MSN & Additional Graduate Degrees	14 (6.4)
Master in Other Field	1 (.5)
Master in Health Related Field	2 (.9)
Missing	16 (7.3)
Total	218 (100)

Note. 3 Ps = Advanced Pharmacology, Advanced Health / Physical Assessment, Advanced Physiology / Pathophysiology. CCNE = Commission on Collegiate Nursing Education. NLN CNEA = National League for Nursing Commission for Nursing Education Accreditation. MSN = Master of Science in Nursing. PhD = Doctor of Philosophy.

Table 3

Employment Status (n = 218)

Characteristic	Frequency (%)
Current Job Title	
Clinical Nurse Specialist	77 (35.3)
Clinical Practice Specialist	3 (1.4)
Educator	37 (17.0)
Case Manager	4 (1.8)
Nurse Researcher	1 (.5)
Administrator / Director / Manager / Coordinator	30 (24.8)
Nurse Practitioner	5 (2.3)
NP / CNS Blended Role	12 (5.5)
Staff Nurse / Nurse Clinician	10 (4.6)
Other	36 (16.5)
Missing	3 (1.4)
Total	218 (100)
Present Employment Arrangement	
Full-time with CNS Job Title	90 (41.3)
Part-time with CNS Job Title	16 (7.3)
PRN with CNS Job Title	1 (.5)
Full-time without CNS Job Title	62 (28.4)
Part-time without CNS Job Title	12 (5.5)
Not Employed as CNS	33 (15.1)
Missing	4 (1.8)
Total	218 (100)
Current Work Setting	
Hospital Inpatient	85 (39)
Outpatient	31 (14.2)
Medical Office Practice	11 (5)
Home Care	6 (2.8)
Extended Care	5 (2.3)
School of Nursing	30 (13.8)
Corporate / Industry	7 (3.2)
Self-employed	16 (7.3)
Other	24 (11)
Missing	3 (1.4)
Total	218 (100)

Table 3 *(continued)*

Reason not practicing as a CNS	
No open or available positions at facility of employment	2 (.9)
Facility does not utilize role	11 (5)
Do not meet facility's requirements (e.g., certification, degree)	1 (.5)
Function as CNS without Title	5 (2.3)
Missing	186 (85.3)
Total	218 (100)

Note. NP = Nurse Practitioner. CNS = Clinical Nurse Specialist.

Table 4

Certification and Recognition Status (n = 218)

Characteristic	Frequency (%)
Advanced Practice Certification from ANCC or AACN	
Yes	78 (35.8)
No	113 (51.8)
Other Certifying Body	10 (4.6)
Missing	17 (7.8)
Total	218 (100)
Application Method for Mandatory Recognition	
Standard (Meets NCBON Requirements)	135 (61.9)
Portfolio	73 (33.5)
Do not intend to apply	1 (.5)
Missing	9 (4.1)
Total	218 (100)
Reason for Portfolio Application	
Not educated as a CNS	16 (7.3)
Degree program had less than 500 clinical practicum hours	2 (.9)
Do not have advanced practice (CNS) certification	44 (20.2)
Other	10 (4.6)
Missing	146 (67)
Total	218 (100)
Voluntarily Recognized as CNS	
Yes	81 (37.2)
No	91 (41.7)
Unaware of requirements	43 (19.7)
Missing	3 (1.4)
Total	218 (100)

Note. ANCC = American Nurses Credentialing Center. AACN = American Association of Critical Care Nurses. NCBON = North Carolina Board of Nursing. CNS = Clinical Nurse Specialist. Missing data may be related to skip pattern (not directed to respond to question) or chose not to respond to question.

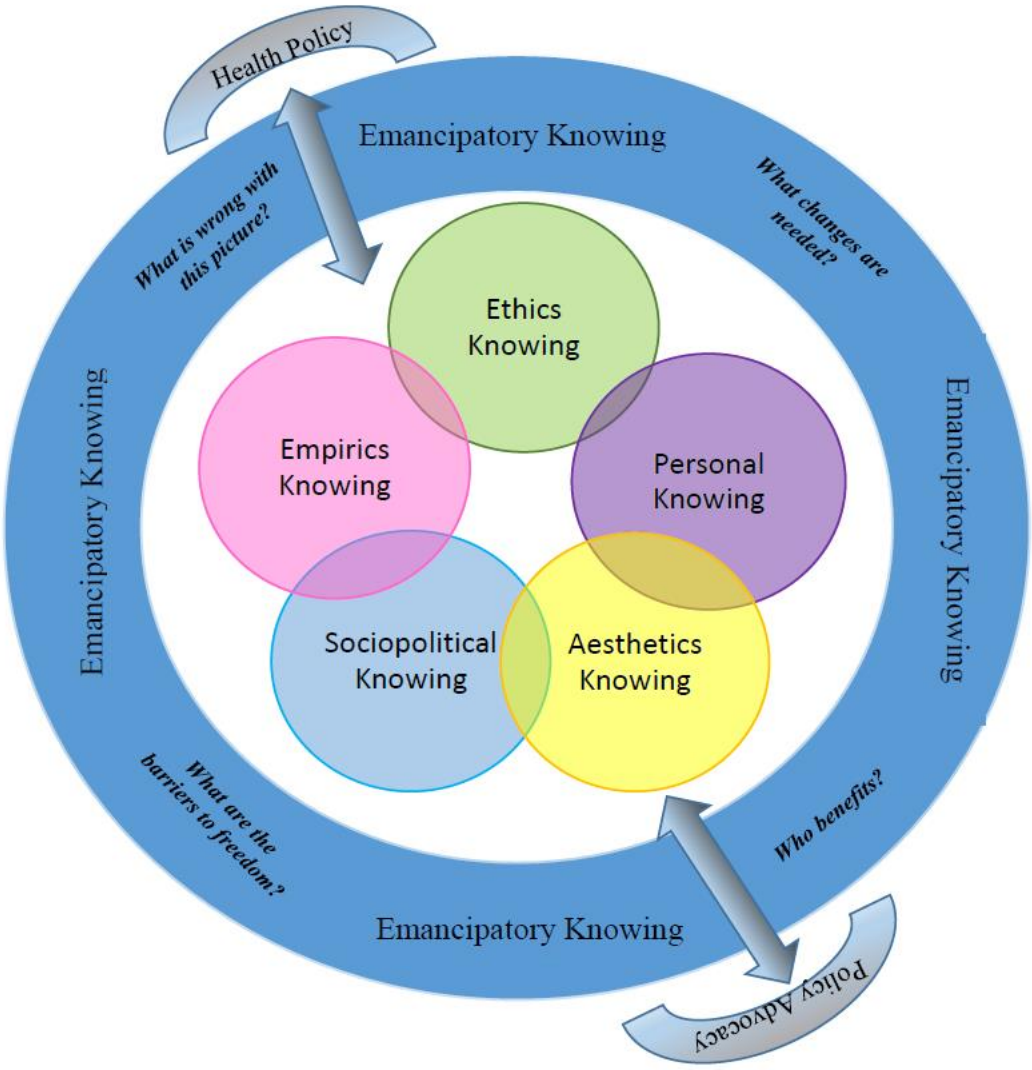
Table 5

Job Title and Job Description Change Related to Regulation (n = 218)

Characteristic	Frequency (%)
Job title change	
Yes	12 (5.5)
No	193 (88.5)
Missing	13 (6)
Total	218 (100)
Impending job title change	
Yes	16 (7.3)
No	179 (82.1)
Missing	23 (10.6)
Total	218 (100)
Job description change	
Yes	3 (1.4)
No	8 (3.7)
Missing	207 (95)
Total	218 (100)
Perform job description same as previous	
Yes	3 (1.4)
No	2 (.9)
Missing	213 (97.7)
Total	218 (100)
Impending job description change	
Yes	9 (4.1)
No	191 (87.6)
Missing	18 (8.3)
Total	218 (100)
Perform impending job description change the same	
Yes	164 (75.2)
No	12 (5.5)
Uncertain	27 (12.4)
Missing	15 (6.9)
Total	218 (100)

Note. Missing data may be related to skip pattern (not directed to respond to question) or chose not to respond to question.

Figure 1. Conceptual Model of Emancipatory Knowing



Appendix A

Institutional Review Board Approval Letter

EAST CAROLINA UNIVERSITY
University & Medical Center Institutional Review Board Office
4N-70 Brody Medical Sciences Building· Mail Stop 682
600 Moye Boulevard · Greenville, NC 27834
Office **252-744-2914** · Fax **252-744-2284** · **www.ecu.edu/irb**

Notification of Exempt Certification

From:	Social/Behavioral IRB
To:	Amelia Ross
CC:	Bobby Lowery
Date:	4/15/2015
Re:	UMCIRB 15-000339 Impact of NCBON Regulation on CNS Practice

I am pleased to inform you that your research submission has been certified as exempt on 4/15/2015. This study is eligible for Exempt Certification under category #2.

It is your responsibility to ensure that this research is conducted in the manner reported in your application and/or protocol, as well as being consistent with the ethical principles of the Belmont Report and your profession.

This research study does not require any additional interaction with the UMCIRB unless there are proposed changes to this study. Any change, prior to implementing that change, must be submitted to the UMCIRB for review and approval. The UMCIRB will determine if the change impacts the eligibility of the research for exempt status. If more substantive review is required, you will be notified within five business days.

The UMCIRB office will hold your exemption application for a period of five years from the date of this letter. If you wish to continue this protocol beyond this period, you will need to submit an Exemption Certification request at least 30 days before the end of the five year period.

The Chairperson (or designee) does not have a potential for conflict of interest on this study.

Appendix B

Data Collection Clinical Nurse Specialist Survey Tool on Regulation Change

Dear Colleague:

You are being invited to participate in a **research** study titled *"Impact of the North Carolina Board of Nursing Regulation Change on Clinical Nurse Specialist Practice"* being conducted by Amelia Ross, MSN, RN, APRN,CCNS, a Doctor of Nursing Practice student at East Carolina University in the College of Nursing, Graduate department. The goal is to survey a maximum of 150 master's prepared registered nurses in North Carolina. The survey will take approximately 10 minutes to complete. It is hoped that this information will assist me to better understand the impact of the regulation change on clinical nurse specialist practice related to possible changes in job titles, roles and responsibilities, and job descriptions. The survey is **anonymous**. Your participation in the research is **voluntary**. You may choose not to answer any or all questions, and you may stop at any time. Completion of the survey implies consent. There is **no penalty for not taking part** in this research study. Please call Amelia Ross at 252-753-3795 for any research related questions or the Office of Research Integrity & Compliance (ORIC) at 252-744-2914 for questions about your rights as a research participant.

Survey Starts Here:
Please answer the following questions:

1. Do you currently practice or have you practiced as a Clinical Nurse Specialist within the past eight (8) years in the state of North Carolina (NC)?

    - Yes (Skip logic to 3)
    - No

2. I am sorry, based on your response indicating that you have not practiced as a CNS in the state of NC in the last 8 years, you do not meet the eligibility criteria for this survey. Thank you for your time. (Skip logic to end of survey)

3. What is your current title? PRIMARY POSITION (Select one)

    - Clinical Nurse Specialist
    - Clinical Practice Specialist
    - Academic Educator
    - Case Manager
    - Research Nurse
    - Consultant
    - Director/Manager/Coordinator
    - Genetic Counselor
    - Medical Science Liaison
    - Nurse Practitioner
    - Nurse Practitioner in blended CNS Role
    - Nurse Scientist/Researcher
    - Patient Educator
    - Pharmaceutical Representative
    - Staff Educator
    - Staff Nurse/Nurse Clinician
    - VP/CNO/COO
    - Other (please list): _____

4. Which of the following best describes your present employment arrangement? (Select one)

    - Employed full time with a CNS job title
    - Employed part time with a CNS job title
    - Employed PRN with a CNS job title
    - Employed full time without a CNS job title
    - Employed part time without a CNS job title
    - Employed part time without a CNS job title
    - Not employed as a CNS (skip logic to 5)

5. Which statement best describes why you are not practicing as a CNS? (Select all that apply)

    - No available or open position as a CNS at the facility in which I work or have applied
    - Facility does not utilize the CNS role
    - Do not meet the facility's requirements for a CNS position (e.g. advanced certification, degree)

- Function as a CNS however, do not have a CNS title
- Other:_____

6. How would you describe your current work setting?

   - Hospital Inpatient
   - Hospital Outpatient
   - Medical Office Practice
   - Home Care
   - Health Department Clinic(s)
   - Extended Care Facility
   - School of Nursing
   - Corporate or Industry
   - School System
   - Self-employed
   - Other (please list): _____

7. Are you currently **voluntarily** recognized by the NCBON as a CNS?

   - Yes
   - No
   - Unaware of the voluntary recognition status requirements

8. To apply for **mandatory** recognition to practice as a CNS, which application method will you select?

   - Standard application, I meet the mandatory requirements (Skip logic to 10)
   - Application through portfolio

9. Select the statement(s) that best describes why you applied through portfolio (select all that apply):

   - Do not hold a Master's, Post-Master's, or Doctorate degree from a program that prepared graduates with clinical nurse specialist practice competencies
   - CNS program had less than 500 hours of clinical practicum
   - Do not hold a certification as a CNS from a national credentialing body approved by the NCBON
   - Other (please list): _____

10. Have you had a change in your job title as a result of the regulation change?

    - Yes
    - No (Skip logic to 14)

11. Please provide your new job title. _____

12. Have you had a change in your job description responsibilities as a result of the CNS regulation change?

    - Yes
    - No (Skip logic to 17)

13. Do you continue to perform your responsibilities the same way as you did in your previous job description?

    - Yes
    - No

14. Do you have an impending change in your job title as a result of the CNS regulation change?
    - Yes
    - No (Skip logic to 17)

15. Do you have an impending change in your job description responsibilities as a result of the CNS regulation change?

    - Yes
    - No

16. Will you continue to perform your responsibilities in the same way as you did in your previous job description?

    - Yes
    - No
    - Uncertain

17. Do you hold an advanced practice certification as a CNS from ANCC or AACN?

    - Yes
    - No
    - Certification is from a certifying body other than ANCC or AACN Please provide name of certification: _____

18. Select all graduate degrees held:

    - Master's in Nursing (MSN, MS, MN, MA)

    Select the concentration of your degree program:

    - Clinical Nurse Specialist
    - Nurse Educator
    - Nurse Administrator

- Nurse Practitioner
- Nursing Informatics
- Other (please list) _____

- Master's in other discipline (please specify) _____
- Practice doctorate in nursing (DNP, ND)
- Practice doctorate in other discipline (e.g. EdD, DrPH)
- Doctor of Philosophy in nursing (PhD, DNS, DNSc, DSN)
- Doctor of Philosophy in other discipline

19. Was your graduate CNS program an accredited (CCNE, NLN-AC) program?

    - Yes
    - No
    - Uncertain

20. Did your graduate program require the completion of the 3 P's (Advanced Pharmacology, Advanced Health/Physical Assessment and Advanced Physiology/Pathophysiology) as separate courses?

    - Yes
    - No, the program did not include these courses
    - Content was integrated into the overall program

21. Did your graduate program require clinical practicum hours for degree completion? Clinical practicum hours are defined as direct clinical practice in the CNS role with a specific client and/or population focus.

    - Yes
    - No
    - Uncertain

22. How many clinical practicum hours did your program require?

    - Less than 300
    - 300-399
    - 400-499
    - 500 or greater

24. Please provide age rounded up to the next year _____

25. What is your ethnicity?

    - American Indian/Alaska Native
    - Asian
    - Black/African American
    - Caucasian/White

- Hispanic/Latino
- Mixed Race
- Decline to answer
- Other race not listed: _____

26. Gender:

    - Male
    - Female
    - Transgender

27. Total years practicing as a CNS (please list): _____

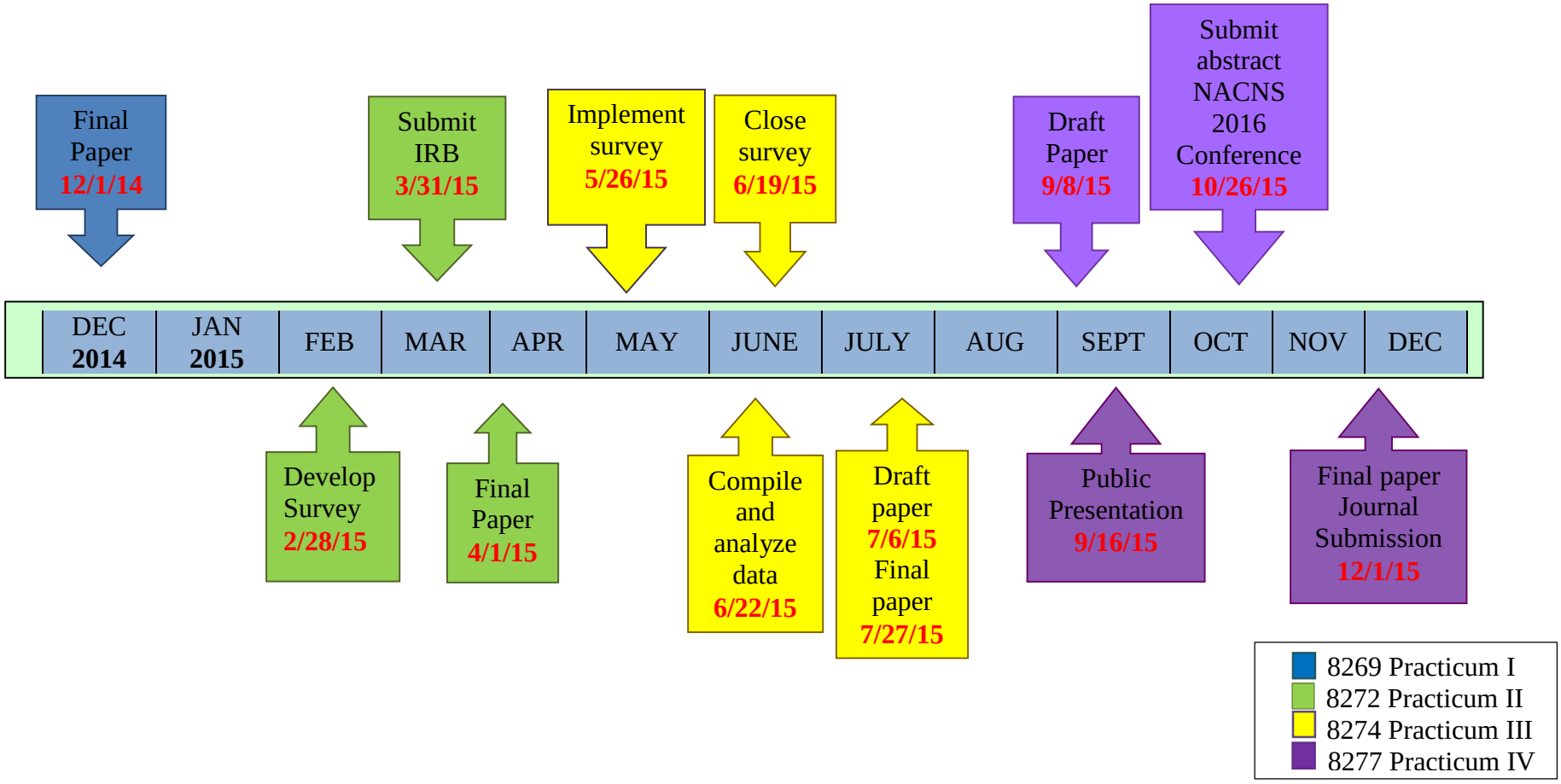
28. Please list the five (5) digit zip code for your current practice location: _____

29. Please provide any further comments regarding this survey or the CNS role in NC below: _____

Thank you for participating in this survey!

Appendix C

Scholarly Project Timeline



Appendix D

Final Scholarly Project Approval Form

East Carolina University
College of Nursing
Doctor of Nursing Practice
Final Scholarly Project Approval

Student Name: Amelia Ross

Project Title: Impact of the North Carolina Board of Nursing Regulation Change on Clinical Nurse Specialist Practice

Private Defense Completed on 9/9/2015

Public Defense Completed on 9/16/2015

Final Project/Final Paper Approval:

As the Chair of this student's Doctor of Nursing Practice Scholarly Project Committee, I have reviewed and approved this student's project and final paper and agree that he/she has met the project expectations, including the DNP Essentials, and has completed the project.

DNP Committee Chair Signature: Bobby Lou PhD Date 9/16/15

06/2015 cak