# Administrative support: Ingredients necessary to implement the Clinical Nurse Specialist role in Oncology

By Carolyn Ingram and Dauna Crooks

## Abstract

*In this article on issues pertaining to the Clinical Nurse Specialist (CNS), the area of administrative support for the role is explored. Issues are organized under the headings of: Reasons for hiring and selection, methods of hiring and support, position description and work plan, reporting relationships, and structural elements. The issues addressed include: Organizational experience with the role, attitudes regarding the CNS's credentials, need for involvement of stakeholders in planning and interviewing, methods of operationalizing support, identification of the referral base, effects of organizational placement, and need for adequate resources. The issues are explored from the vantage point of current findings in the literature as well as the authors' personal experiences.*

In this article, issues pertaining to administrative support for the Clinical Nurse Specialist (CNS) will be discussed from the vantage point of both current literature in the field, and analysis of personal experience. Administrative support will be defined as elements of the relationship between the CNS and his or her superiors in the organization. The major administrative support issues have been organized and analyzed according to the following framework: Reasons for hiring and selection, methods of hiring and support (including planning), position description and work plans, reporting relationships and structural elements.

Carolyn Ingram

Dauna Crooks

## Reasons for hiring and selection

All relationships undergo a "honeymoon" phase in which expectations are high and both parties are at their best. The relationship between the CNS applicant and the prospective employer is no different. Each seeks to put his or her best foot forward, yet, even this very early stage can lay the groundwork for misunderstandings if the involved parties are not open and well informed, and the purpose for hiring the CNS is not clear.

Although the CNS role is still evolving, Walker (1986) demonstrated that most nurse administrators view the CNS role as beneficial to an organization, and that those who do not employ a CNS would do so if funds were available. As Baird (1985) notes, however, administrations which are rooted in the traditional values of order and predictability may accept the CNS in theory, but have trouble supporting the role in practice. One might expect the strength of nursing administrative support to match the financial commitment and rigorous justification required to establish the position. Unfortunately this is not always the case. Baird believes this is, at least in part, due to the fact that the success of the CNS relies heavily on a good match between organization and incumbent, and that the CNS's impact is much harder to predict than the impact of nurses in traditional, more clearly defined roles. To avoid unpleasant surprises for either party, it is to the advantage of both to spell out the mutual role expectations as clearly and frankly as possible during the interview stage.

## LE SOUTIEN ADMINISTRATIF: LES INGRÉDIENTS NÉCESSAIRES À L'IMPLANTATION D'UNE INFIRMIÈRE CLINICIENNE SPÉCIALISTE EN ONCOLOGIE

## ABRÉGÉ

Les auteures se sont penchés sur le soutien administratif de l'Infirmière Clinicienne Spécialiste en Oncologie. Les sujets traités sont organisés de la façon suivante: raisons de l'embauche et de la sélection, méthodes d'embauche et de soutien, description de l'emploi et plan de travail, rapports au niveau des responsabilités et éléments structurels. Les auteures s'intéressent aux questions suivantes: expérience administrative du rôle, attitudes au sujet de la qualification l'Infirmière Clinicienne Spécialiste en Oncologie besoin qu'il y a de faire participer aux stades de la planification et de l'entrevue tous ceux qui sont intéressés par la situation, méthodes visant à rendre le soutien opérationnel, description de la base de reférence, effets du placement administratif et enfin, besoin de ressources adéquates. Cette exploration des questions y est faite du point de vue des derniers résultats de la recherche et aussi du point de vue de l'expérience personnelle des auteures.

Carolyn Ingram, RN, MScN is a lecturer at the McMaster University School of Nursing in Hamilton, Ontario. Dauna Crooks, RN, MScN, doctoral candidate, is an assistant professor with the same faculty. Both authors held positions as Clinical Nurse Specialists in Oncology prior to joining McMaster.

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The likelihood of an applicant seeking a CNS position in an organization unfamiliar with the role is apt to be greater in Canada than the U.S. As Montemuro (1987) points out, the role has developed similarly but much more slowly in Canada than the U.S., and so, these positions are not as common. The desires of the inexperienced organization seeking to hire a CNS may centre on specific needs or projects which are not appropriate to the CNS role as it is commonly defined. For example, the staff of specialized oncology units are often trained in accessing and maintaining central venous access devices, and in administration of chemotherapeutic agents below the drip chamber of an intravenous infusion. Maintenance of continuous, patient-controlled analgesic infusions is another specialized skill which oncology nurses may perform. Although the CNS may consult with or assist staff with the skills common to his or her area, assigning the CNS the overall responsibility to organize and run certification programs will contribute to confused perceptions of the role among staff, and eat away at the CNS's availability for clinical practice, consultation and research. The latter three sub-roles are those which distinguish the CNS from a clinical educator, and if they are emphasized rather than minimized, the institution is more likely to achieve the maximum benefit of having both CNS's and clinical educators on board.

Poteet and Branyon (1986) observe that all persons with graduate degrees in nursing are not suitable to assume a CNS role. They stress the need for specific qualities, such as extensive experience in the specialty, intellectual ability, interpersonal skill, and extraordinary energy. In Canada, some problems exist in hiring suitable applicants due to the scarcity of clinically focused graduate nursing programs and the relatively small pool of qualified clinicians. The Canadian move to university education in nursing has lagged behind the U.S., and graduate programs continue to be harder to access (Montemuro, 1987). Many who seek to further their education do so after establishing homes and families, which may lead nurses to pursue graduate degrees outside of nursing for very practical reasons.

Administrators seeking to hire a CNS may, therefore, find themselves faced with the dilemma of hiring an applicant with many but not all of the desired requirements. Examples of this dilemma might include the case of an applicant with a Masters degree in another field, a baccalaureate nursing degree but no Masters, or a lack of recent clinical experience, say within the last two to three years. The administrator may not realize that the contributions of a baccalaureate in nursing or Masters preparation in another field will be different from those of the MScN. Experts on the role (ANA, 1980; RNAO, 1990) have clearly asserted that the CNS should be an expert practitioner of the chosen specialty who is educated at the Masters or Doctoral level in nursing. To avoid role confusion and difficulties in establishing credibility, it is recommended that, if compromises are necessary in hiring, the issue of the Masters preparation in nursing be least negotiable. In considering such compromises the applicant and administrator should, ideally, discuss the candidate's limitations openly and honestly, and communicate clearly to all stakeholders the specific rationale for selecting the applicant in spite of any limitations. An action plan for remediation of the deficient areas may be negotiated as a condition of employment, and should not be viewed by either party as a mark of personal or professional inadequacy. For example, if a candidate is chosen who has the appropriate educational clinical background but has not had recent, patient-centred clinical practice in the specialty, the negotiation of a refresher period as part of the appointment is entirely appropriate. In the case of the non-Masters prepared applicant, or an applicant with a Masters degree in another field, the pursuit of the MScN could be made a condition of employment, along with an offer of administrative support in obtaining the degree.

Adherence to the MScN requirement is important to CNS credibility, particularly given the assertion (ONS, 1985; Welch-McCaffrey, 1986) that the CNS should be expected to spend at least 50% of his or her time in patient-centred clinical practice. Administrators who hire inappropriately prepared individuals for the CNS role may find them developing into physicians' assistants, instructor/clinicians, full-time researchers, or research assistants.

## Methods of hiring and support

It is helpful to conduct a comprehensive needs assessment involving all stakeholders within the organization prior to initiating the search for a CNS. The nursing staff and other health care providers who will interact with the CNS are especially important in this process. While some input may be biased by individual needs or educational background, or hampered by lack of experience in needs assessment; an honest effort to include as many perspectives as possible is worthwhile. The purpose of such an assessment process is not so much to decide the needs or projects to be handled by the CNS but, in fact, to determine priorities regarding the type of resource person that is actually needed and desired. For example, if the nursing staff feel that they are perpetually short-handed, or that their nurse manager is overwhelmed by his or her workload, it is unlikely that a CNS will be accepted unless attention is first directed to easing the staffing difficulties, or to the possibility of hiring an assistant for the nurse manager. If such "felt" needs are ignored or incompletely addressed, the stage may be set for widespread resentment and resistance toward the CNS. Alternatively, the pressure of unmet needs can eventually force the CNS to assume inappropriate administrative or clinical functions in an effort to reduce the resistance and antagonism.

The involvement of all levels of staff in the process of hiring a CNS ideally extends to the interview phase. If all possible levels and disciplines are involved in the interviews, it is more likely that

ownership and responsibility for success of the chosen applicant will be shared. Welch-McCaffrey (1986) further notes that the CNS should not expect to be viewed as a leader until acceptance by the nursing staff is achieved. To be accepted, the specialized knowledge and skills inherent in the role must be understood. Harrell and McCulloch (1986) note that if the CNS is viewed by nursing staff as a critic of their care, rivalry and conflict will result. A particular effort to include the nursing staff in the interview process ensures that their interests are clearly represented.

Once the CNS is hired, a number of additional administrative support mechanisms are crucial to the success or failure of the role. Several authors (Baird, 1985; Shaefer, 1973) assert that the most important factor related to job satisfaction and consequent success of the CNS is the positive attitude and support of nursing administration. Shaefer (1973) states that administrative support for the CNS should be made tangible as the vesting of authority for important projects and aspects of care, willingness to support new ideas and projects, and a salary reflective of the high level of expertise the CNS brings to the organization. To this list, Harrell and McCulloch (1986) add the need to chair and sit on key committees, and to be publicly sought out for advice by nursing administration. Examples of committees on which the oncology CNS might be especially useful include: Nursing practice, palliative care, nursing research, ethics, infection control, medical advisory and/or pharmacy and therapeutics, to name a few. If specialized multidisciplinary teams such as those for nutritional support or skin care exist in the institution, the oncology CNS can be a valuable asset and should be expected to participate.

The first step in realizing the necessary level of support is for nursing administration to prepare the organization for the CNS's arrival. This may be accomplished in a number of ways. The Oncology Nursing Society (ONS, 1985) describes a number of key features of visible preparatory support, including incorporating the role into the agency and departmental mission statement and philosophy, integrating the role into the functions of appropriate management systems, giving the CNS background about the organizational climate and potential role conflicts, introducing the CNS to key people and facilitating ongoing relationships with them, providing for easy access to senior management, and providing a comprehensive orientation.

Baird (1985) summarized the importance of active and visible preparatory support in outlining three particularly difficult issues: The CNS role is still evolving, and is not operationalized in the same way from agency to agency; the CNS is likely to invade professional territory which has belonged to other health care providers, thus increasing the risk of "turf wars"; and the increased autonomy and authority for clinical decisions embodied in the CNS role often makes other practitioners feel displaced and anxious. Some examples of practitioners within an oncology service who may experience role overlap with the CNS are physicians, social workers, clinical educators, clinical trials nurses, psychologists, palliative care practitioners, physicians' assistants, nutritionists and clinical pharmacists.

A final word with respect to the hiring and support process relates to the documentation of agreements. Details may be forgotten in the excitement surrounding the CNS's hiring. It is advisable for both parties to keep notes on mutual expectations discussed and agreements negotiated, including the agreed upon reporting relationship, office arrangements and role expectations. The gist of these discussions may be summarized in the appointment letter. This document can then be used as a basis to renegotiate expectations at a later time, or to clarify expectations, in the case of changes in administration.

## Position description and work plan

Development of a general position description customarily precedes the hiring of the CNS, so that both the applicant and administrator are clear on the purpose of the role within the organization. The role will be implemented differently from agency to agency, however, and it is best if the initial description is written at a general level to allow for the individual strengths and interests of the chosen applicant (ONS, 1985). The ONS further recommends that the nursing administrator and the CNS negotiate an annual work plan, which is reviewed quarterly, is based on mutual goals, and specifically outlines intra and inter-departmental role relationships. Through this document, administration provides visible support for the CNS's role definition. It also helps to limit expectations of the CNS, particularly in the probationary period, when the needs of the organization seem endless. According to the ONS, it is advisable for the administrator to actively assist the CNS in setting realistic limits and priorities for the initial work plan. Even the experienced CNS assumes the role of apprentice or beginner for up to one year, to allow for realistic assessment and prioritization of needs and issues.

Another key area of administrative support is clarity of the administrator's stand on the relationship of the CNS vis-a-vis other nurses with similar functions such as instructor/clinicians, physicians' assistants, clinical trials nurses or program coordinators. The problems in this area are typified by assigning the title of "CNS" to nurses in other expanded roles, regardless of education. Another variant is physician's hiring of nurses who are called "CNS" for expanded roles in their practices, without regard to education. The problem is compounded by the willingness of nurses to accept these quasi-CNS roles without considering the implications in terms of the role confusion it creates.

It is vital to the success of the qualified CNS, particularly one who is the first and only clinician of this type in the organization, that the nursing administrator publicly support the need for graduate level preparation in nursing to function as a CNS (ANA, 1980; Fox, 1982). This support may take the form of verbalizing his or her beliefs, and of challenging the use of the title for clinicians hired by physicians.

Perhaps even more important is the administrator's verbalization and enforcement of the belief that the CNS's practice is the umbrella, or framework, within which the practice of other, related nursing clinicians should fit. This stance is best enforced when administration takes an active part in discussions about role definition involving all clinicians affected. It is important that, while a firm stand is taken, an honest effort is also made to create role definitions which are collaborative and mutually satisfying to all.

Related to the referral base of the CNS is the observation by Montemuro (1987) that, while the role developed in large teaching institutions, there has been an increase in CNS roles in smaller community hospitals over the past few years. In order to justify the expense of the CNS's salary within these smaller budgets, the geographic area to be serviced is often so large as to negate the term "specialist". Even specialties with a clear focus, such as oncology, may require the CNS to serve as an expert on so many subjects that the title "generalist" is far more appropriate. While it may be necessary for the CNS to serve as a resource on a wide variety of subjects, it is also important that he or she be allowed to establish credibility as a specialist by defining and developing at least one area of specialization. Examples of specialty areas which may prove mutually beneficial for both organization and the oncology CNS might include wound and skin care, stress management, management of treatment side effects, pain control, body image and sexuality concerns, and cancer rehabilitation, to name a few. Other approaches to defining a "specialty" within the more general role are to focus on specific disease entities (eg. haematologic malignancies), treatment modalities (eg. chemotherapy), or age groups (eg. pediatric, geriatric) within the cancer population at large.

## Reporting relationships

It has been asserted that placement within the organizational structure is a major factor in the job satisfaction and effectiveness of the CNS. Werner, Buman and O'Brian (1988), and Lucas (1988) conclude that there is no consensus regarding the preferred placement of the CNS on the organizational chart. Lucas did identify a preference among CNSs for a participative style of management, and a significant correlation between CNS job satisfaction and participative supervisory style. Lucas' findings imply that the level of the supervisor and the CNS's placement in the organization are less important than the degree of support received from the supervisor and the clarification

of role expectations. Despite these findings, there is a preponderance of anecdotal reports in the literature (Arford and Olson, 1988; Fox, 1982; Werner, Buman and O'Brian; 1988) which recommend some form of matrix or "specialized staff" relationship for the CNS. In this model the CNS is at the level of the directors of nursing service, and reports to the chief nursing administrator. The CNS's services cross divisional lines in a horizontal manner, rather than focusing on one line or nursing division. This model offers several advantages which are worth noting.

The main advantage is that the specialized knowledge and skills of the CNS are available throughout the organization as they are needed, rather than being seen as the "property" of one particular group. This can be significant when, for example, the staff of a general medical or surgical unit must cope on its own with unfamiliar problems related to an off-service oncology patient. It stands to reason that, on such occasions, these nurses may find a nurse specialist even more beneficial than the staff of a unit in the CNS's own specialty area. Fox (1982) recommends that written guidelines for CNS utilization be made available in such a system, to clarify the roles which a CNS may fulfill and the method for making referrals.

A second important advantage of the matrix arrangement is that the CNS's "staff" relationship is preserved. It precludes the possibility of the CNS being drawn away from his or her key functions by administrative duties, which would take priority in a line position.

Fox (1982) points out that, by enlarging the territory which the CNS may access, the matrix model enlarges his or her opportunities for patient-centred care, and his or her network of staff and other professionals, both of which contribute to greater effectiveness in the long run. Arford and Olson (1988) also point out that the CNS in a staff position, who is attached to one bureaucratic line in a traditional, organizational chart, is depicted, and often treated, as if his or her work is outside of the main thrust of the department's work. They caution, however, that a CNS who is placed in a reporting relationship with a program manager, such as a physician or director of educational services, will lose all formal channels of influence and communication with the nursing department.

## Structural elements

A key principle to be agreed upon by the CNS and nursing administrator is that of autonomy in the role. The CNS, by definition, should function with a high degree of self-direction. The ability to work independently and set priorities is a criterion for CNS selection. If the administrator holds other expectations of a more traditional nature, for example that the CNS wear a uniform, attend change of shift reports or share daily schedules with the supervisor, it is useful to share these expectations and renegotiate, if necessary, during the hiring process rather than after-the-fact.

A willingness to afford the CNS the resources necessary to do an effective job is another hallmark of good administrative support. Not the least of these is proper office space. Baird (1985) notes that if the specialty is based in a particular area of the institution, office space in this area should be allocated in advance of the CNS's arrival. Two poor alternatives are allocation of office space distant from the CNS's clinical area, or reallocation of space after the CNS starts in the role. The latter scenario is especially damaging because it gives the impression that the CNS has "taken space" away from his or her colleagues, and sets the stage for resistance and resentment.

Other material resources to negotiate prior to hiring, and to review with the annual work plan, include clerical support, protected time for research and professional development, and financial support for continuing education. Baird (1985) notes that the CNS is more likely than most other nurses to have educational needs which cannot be met through in-house offerings, and that administration might expect the CNS to spend a proportionately greater amount of the conference budget than other levels of nursing staff.

Closely related to support for continuing education is the issue of support for networking. This is an especially vital issue if the CNS is the only one in the agency or the only one for a given specialty. If one is new to the role, a further note of urgency is added. Welch-McCaffrey (1986) notes that the "lone" CNS needs a supportive peer network with which to sort out specialty and role related issues. The supportive supervisor willingly hears and considers ideas which the CNS develops on the basis of interaction with peers, and does not expect the CNS to work in isolation.

## Conclusion

Many of the crucial issues regarding administrative support for the CNS centre around the themes of: Reasons for hiring and selection, methods of hiring and support, position description and work plan, reporting relationships, and structural elements. Few will argue that administrative support is critical to the success or failure of the CNS. This article has focused on methods to effectively operationalize administrative support, which have been drawn from both current literature and personal experience related to the five themes identified. It is the authors' hope that, by sharing these findings and experiences, the process of successful CNS selection and retention will be facilitated for administrators, as well as potential and experienced CNSs.

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