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Clarifying Clinical Nurse Consultant work in Australia: A phenomenological study

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Summary The Clinical Nurse Consultant role in Australia is an Advanced Practice Registered Nurse Role (APRN). This role has been conceptualized from the discrete pillars of research, education, practice, system support and leadership, articulated in the Strong Model of Advanced Practice. This conceptualization has been manifested in job descriptions, workforce planning and course design. This paper explored whether there was a more refined way of conceptualizing the unique 'value add' of the role. A hermeneutic phenomenological approach was employed to explore the lived experience of the role. It was identified that the pillars of education, practice, leadership and research are interconnected and expressed in the system work of the Clinical Nurse Consultant. The findings have implications for education and workforce planning.

1. Introduction

Clinical Nurse Consultants (CNCs) are a type of advanced practice nurse in the Registered Nurse scope in the state of New South Wales (NSW), Australia (NSW Health, 2011a). The CNC position was introduced into the NSW state award structure in 1986 (O'Baugh, Wilkes, Vaughan, & O'Donohue,

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2007), and was modeled on the Clinical Nurse Specialist (CNS) role in the UK and USA (Baldwin et al., 2013). The role was created to provide a career pathway for experienced nurses who wished to maintain a clinical role, rather than moving into administration or education (Elsom, Happell, & Manias, 2006). Similar roles exist in other Australian states and territories, but some have different position titles. At the most general level, a NSW CNC is a Registered Nurse who possesses at least five years full-time equivalent post registration experience, and who, in addition, has attained approved post-registration nursing/midwifery qualifications relevant to the specialty field in which he or she is appointed (NSW Health, 2011b). Over the years, there has been significant confusion and debate about the CNC role, and how these professionals contribute to improved service delivery (Baldwin et al., 2013; Fry et al., 2013; Wilkes, Cummings, & McKay, 2013). There are three grades of CNC in NSW. While job description varies between grades, and corresponding remuneration, there has often been arbitrary application of grade to positions informed in many cases more by budgetary constraints as opposed to rational service planning across NSW. This is one component of the confusion referred to above (Chiarella, Hardford, & Lau, 2007). The three grades are embedded in the industrial award and are paid at different rates ranging from CNC one at the lowest end to CNC three at the highest end. The focus of the grade varies from unit based expectation for a CNC level one to a state level focus for CNC level three. The different levels should require different academic preparation, but at present in NSW formal qualifications are only listed as desirable elements at the time of recruitment as opposed to mandatory.

In attempting to identify the unique elements of CNC practice, and the 'value add' (Mundinger, Cook, et al., 2000; Mundinger, Kane, et al., 2000) of these positions, researchers have often relied upon what is termed the ''Strong Model'' of advanced practice (Ackerman, Norsen, Martin, Wiedrich, & Kitzman, 1996; Mick & Ackerman, 2000). The Strong Model was developed by Ackerman and co-workers in the mid-1990s, in an attempt to characterize the unique nature of the acute care nurse practitioner role in the United States (Ackerman et al., 1996). The model defines five areas of practice which together comprise the advanced nursing role, namely direct comprehensive clinical care (patient-focused activities); support of systems (which include professional contributions to improve nursing practice within the health care institution); education (of staff, clients, carers, and members of the public); research (including the incorporation of findings from evidence-based practice to improve patient care); and professional leadership (which may include publication of findings beyond the immediate practice setting) (Ackerman et al., 1996). The five components of the Strong Model may be referred to as the ''domains'' or ''pillars'' of advanced practice (Barton, Bevan, & Mooney, 2012; NSW Health, 2011a). Common ''conceptual strands'' cutting across each domain, namely empowerment; collaboration; and scholarship were also identified.

Since publication, the Strong Model, or models very similar to this, have been widely employed by nursing researchers. It has been used to characterize a number of different advanced nursing roles, beyond Nurse Practitioners, such as the role of the Clinical Nurse Specialist or Clinical Nurse Consultant (Bahadori & Fitzpatrick, 2009; Chang, Gardner, Duffield, & Ramis, 2010; Maloney & Volpe, 2005; Stewart, McNulty, Griffin, & Fitzpatrick, 2010). Additionally, the model has been applied to characterize advanced nursing roles beyond the original American context, in places such as the United Kingdom and Australia, and in specialties other than acute care, such as psychiatry and endocrinology (Bahadori & Fitzpatrick, 2009; Harwood, Wilson, Heidenheim, & Lindsay, 2004; Ridley, Harwood, Lawrence-Murphy, Locking-Cusolito, & Wilson, 2000).

Internationally, aspects of the Strong Model have been used by policy makers and health service planners in creating position descriptions for advanced nursing roles. For example, in both Wales and Scotland, advanced practice is conceptualized around four ''pillars'', namely clinical, education, research, and management/leadership. With the exception of systems support, these reflect the pillars of the Strong Model (National Leadership and Innovation Agency for Healthcare, 2011; NHS Scotland, 2008). The current NSW CNC position description also appears to have been based on the Strong Model and its pillars, although this is not explicitly acknowledged in the documentation (NSW Health, 2011a). In this position description, the domains of clinical service and consultancy; leadership; research; education; and planning and management, are listed as being central to the CNC role, and bear clear similarities to the five pillars of the Strong Model (NSW Health, 2011a).

However, at this stage, the question arises as to whether the Strong Model does in fact provide an accurate conceptualization of the CNC role and other Australian advanced nursing positions. As explained previously, the model was originally developed as a means of conceptualizing the role of an acute care nurse practitioner in the United States, a role which differs from that of the NSW CNC in important ways. Second, the Strong Model was developed in the mid-1990s, almost 20 years previously, and as Lowe and colleagues correctly suggested, advanced practice nursing roles are not static (Lowe, Plummer, O'Brien, & Boyd, 2012). Rather, as the health care system changes, such roles tend to evolve, and consequently, a model of practice which was appropriate years ago may not be appropriate now, and may require updating to better reflect contemporary practice.

A number of Australian researchers have investigated CNC practice, however, there are several weaknesses associated with these studies. First, apart from one study by Chiarella and colleagues, which examined CNC roles across NSW (Chiarella et al., 2007), the research has tended to be small in scale, and concentrate on single sites or health services. For example, Dawson and Benson examined the CNC role in Wentworth Area Health Service, where a total of 13 CNCs were employed (Dawson & Benson, 1997), whilst McIntyre and colleagues' more recent paper looked at ward nurses' attitudes to intensive care unit CNCs at a single health service (McIntyre et al., 2012). Similarly, Santiano and co-authors' paper on the work of after-hours CNCs at a metropolitan hospital focused on only two participants (Santiano et al., 2009). Whilst small scale studies provide a