HEALTH POLICY AND SYSTEMS

National Validation of the NACNS Clinical Nurse Specialist Core Competencies

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Abstract

Purpose: To validate the 75 core National Association of Clinical Nurse Specialists' (NACNS) clinical nurse specialist (CNS) competencies among practicing CNSs. Specific aims were to (a) determine the extent to which 75 core CNS competencies were used in current CNS practice, (b) determine the importance of those competencies to practicing CNSs, and (c) identify gaps between CNS core competencies and role expectations in current practice.

Design: A survey design was used with both paper-and-pencil and online instruments. The survey included 150 items and three open-ended questions.

Methods: A convenience sampling method was used, which targeted practicing CNSs.

Findings: Respondents ($N=505$) were practicing CNSs who entered the field as RNs between 1956 and 2006. The survey had a high degree of internal consistency reliability (0.967%) between the subscales. The 75 NACNS core competencies were found to be useful and important for CNSs. A few gaps were identified between CNS core competencies and CNS role expectations in current practice.

Conclusions: No one method for validating competencies will be satisfactory for all situations; however, the processes and methods used in this study were well suited to accomplish the goal of validating CNS core competencies. The process described here may be instructive to leaders of other national and international professional organizations interested in developing and evaluating competencies. Core competencies are useful and important to currently practicing CNSs.

Clinical Relevance: The CNS role is growing internationally. Core CNS competencies can be a framework for CNS role development, education, and practice. As described here, a competency validation survey is one way to assure that CNSs are meeting healthcare needs.

Articulating core competencies for a particular professional role can clarify what essential skills, knowledge, and personal characteristics are needed for successful performance (Lucia & Lepsinger, 1999). Core competencies should be robust, clear about technical knowledge and

skills, and written in behavioral terms (Green, 1999). Those who follow a competency-based curriculum can guide educators and address consumer expectations for clear program outcomes (Davis, Stullenbarger, Dearman, & Kelly, 2005). Also, elucidation and validation of core

competencies can help members of certification bodies to match the skills and knowledge of professionals to the testing of competencies. In the United States (US), because of the lack of core competencies for Clinical Nurse Specialists (CNSs), national credentialing for many CNSs was limited.

As advanced practice nurses (APNs), CNSs have responsibility and accountability to recipients of their care and to healthcare communities. Thus, core competencies for the CNS APN role are a critical element of education and practice. It was not until 1995 that the first CNS core competencies were developed and not until 2005 that the core competencies underwent validation study.

Shortly after being formed in 1995, the National Association of Clinical Nurse Specialists (NACNS) began to develop core competencies for CNS practice. In addition to being designed to articulate the underpinning of CNS practice, these common core CNS-specific competencies were also designed to differentiate the CNS role from other APN roles. The process used to develop the NACNS core competencies conformed to the process used by other U.S. national nursing groups developing competencies in 1995. The process included: (a) initial identification of competencies by experts in the role; (b) first-tier corroboration by experts followed by revision; (c) second-tier corroboration by additional experts and stakeholders followed by revision; (d) broad review by members of the representative group followed by revision; (e) general release of the information about competencies for feedback and public comment; and (f) development of a final version with publication of competencies (Baldwin et al., 2007).

Information about the competencies was initially published in the first edition of the NACNS Statement on CNS Education and Practice (Statement) in 1998 (NACNS, 1998). These were reviewed and revised to reflect practice changes before publication of the second edition in 2004 (NACNS, 2004). More than 8,000 copies of the statement were disseminated to practicing CNSs, graduate CNS students, schools of nursing, employers, state boards of nursing, and various national groups.

In 2005, NACNS leaders authorized a research study to validate the core competencies in the 2004 statement. The study was conducted by members of the NACNS board of directors. In this article, we report the results of that study.

Purpose

In 2005, a national validation study was conducted for the CNS core competencies included in the NACNS 2004 statement. The purpose of this study was to validate 75 core CNS competencies (**Table 1**) among practicing CNSs. Specific aims were to (a) determine the extent to which the 75 core CNS competencies were used in current CNS practice, (b) determine the importance of those competencies to practicing CNSs, and (c) identify gaps between CNS core competencies and CNS role expectations in current practice. Human subject approval for the study was obtained from a research-intensive university.

Design and Instrument Development

A survey design was used to obtain self-reported data from CNSs. Three doctorally prepared faculty members of the NACNS Board developed the initial survey. The 75 core competencies were listed in a column. Based on feedback from expert reviewers, two parallel columns were added to the list of 75 core competencies for respondents to rate the "use" and "importance" of the individual competencies. The "use" scoring scale was headed by the question, "Do you use this competency in your current role?" A 5-point Likert-type scale from rarely to all the time was used for rating responses. The "importance" scoring scale was headed by the question, "If yes, how important is each competency to attaining expected outcomes in your current practice-role?" Respondents were asked to answer the question by selecting their responses on a 3-point Likert-type rating scale ranging from not important to very important. Extensive demographic data were also requested.

Separating "use" and "importance" scoring for each competency doubled the number of items on the instrument from 75 to 150. The 2004 Statement showed the core competencies by domains, called spheres of influence. Following this precedent, the instrument was formatted into three sections—Patient-Client, Nursing Practice, and Organization-Systems with corresponding competencies listed by domain. Because of the anticipated time required to respond to 150 items, the decision was made to limit the number of demographic items collected, thus decreasing the burden of completing the survey in an attempt to increase participation and sample size.

The instrument was feasibility tested using a convenience sample of 39 CNSs. To obtain geographic and specialty practice variability, the feasibility sample was obtained from among CNSs attending several different state and national nursing meetings. Findings from instrument feasibility testing indicated that competency "use" and "importance" were independent constructs. Respondents noted that while a competency might not be used frequently in practice, it nonetheless could be important for practice. It was also noted that the use

Table 1. 75 NACNS Core Competencies

Patient/client sphere

1. Conducts comprehensive, holistic wellness and illness assessments using known or innovative evidence-based techniques, tools, and methods.
2. Obtains data about context, such as disease, culture, and age-related factors, along with data related to etiologies (including both nondisease and disease-related factors) necessary to formulate differential diagnoses.
3. Identifies the need for new or modified assessment methods or instruments within a specialty area.
4. Before designing new programs, identifies, collects, and analyzes appropriate data on the target population that serve as the basis for demonstrating CNS impact on program outcomes.
5. Synthesizes assessment data and develops differential diagnoses of illness problems.
6. Draws conclusions about individual or aggregate patient problems with etiologies amenable to nursing interventions.
7. Describes problems in context, including variation in normal and abnormal symptoms, functional problems, or risk behaviors inherent in disease, illness, or developmental processes.
8. Plans for systematic investigations of patient problems needing clinical inquiry, including etiologies of problem, needs for interventions, outcomes of current practice, and costs associated with care.
9. Predicts outcomes of interventions relative to prevention, remediation, modification, and/or resolution of problems.
10. Anticipates ethical conflicts that may arise in the healthcare environment and plans for resolution.
11. Selects evidence-based nursing intervention for patients/clients that target the etiologies of illness or risk behaviors.
12. Develops interventions that enhance the attainment of predicted outcomes while minimizing unintended consequences.
13. Implements interventions that integrate the unique needs of individuals, families, groups, and communities.
14. Collaborates with multidisciplinary professionals to integrate nursing interventions into a comprehensive plan of care to enhance patient outcomes.
15. Incorporates evidence-based research into nursing interventions within a specialty population.
16. Selects, develops, and/or applies methods to evaluate outcomes of nursing interventions.
17. Evaluates effects of nursing interventions for individual and populations of patients/clients for clinical effectiveness, patient response, efficiency, cost-effectiveness, consumer satisfaction, and ethical considerations.
18. Collaborates with patients/clients and other healthcare professionals, as appropriate, to monitor progress toward outcomes and modifications as needed
19. Evaluates the impact of nursing interventions on fiscal and human resources.
20. Documents outcomes in a reportable manner.
21. Disseminates the results of innovative care.
22. Uses/designs methods and instruments to assess patterns of outcomes related to nursing practice within and across units of care.
23. Uses/designs appropriate methods and instruments to assess knowledge, skills, and practice competencies of nurses and nursing personnel to advance the practice of nursing.
24. Identifies, in collaboration with nursing personnel and other healthcare providers, needed changes in equipment or other products based on evidence, clinical outcomes, and cost-effectiveness.
25. Gathers and analyzes data to substantiate desirable and undesirable patient outcomes linked to nursing practice.
26. Identifies interpersonal, technological, environmental, or system facilitators and barriers to implementing nursing practices that influence nurse-sensitive outcomes.
27. Collaborates with nurses to assess the processes within and across units that contribute to barriers in changing nursing practices.
28. Draws conclusions about the evidence base and outcomes of nursing practice that require change, enhancement, or maintenance.
29. Identifies desired outcomes of continuing or changing nursing practice.
30. Anticipates both intended and unintended consequences of change.
31. Incorporates clinical and fiscal considerations in the planning process for product and device evaluation.
32. Plans for achieving intended and avoiding unintended consequences.
33. Plans for using facilitators and overcoming barriers for changing nursing practice and incorporating new products and devices.
34. Considers resource management needs when weighing the benefits of changing practice.
35. Anchors nursing practice to evidence-based information to achieve nurse-sensitive outcomes.
36. Mentors nurses to critique and apply research evidence to nursing practice.
37. Works collaboratively with nursing personnel to implement innovations that improve outcomes.
38. Implements interventions that are effective and appropriate to the complexity of patient care problems and the resources of the system.
39. Develops and implements educational programs that target the needs of staff to improve nursing practice and patient outcomes.
40. Assists staff in the developmen5t of innovative, cost-effective patient/client programs of care.
41. Mentors nurses to acquire new skill and develop their careers.
42. Creates an environment that stimulates self-learning and reflective practice.
43. Evaluates the ability of nurses and nursing personnel to implement changes in nursing practice, with individual patients/clients and populations
44. Evaluates the effect of change on clinical outcomes, nurse satisfaction, and collaboration with other multidisciplinary healthcare providers.

Table 1. (Continued)

45. Documents outcomes in a reportable manner.
46. Disseminates results of changes to stakeholders.
47. Uses/designs system level assessment methods and instruments to identify organization structures and functions that impact nursing practice and nurse-sensitive patient care outcomes.
48. Assesses the professional climate and multidisciplinary collaboration within and across units for their impact on nursing practice and outcomes.
49. Assesses targeted system level variables, such as culture, finances, regulatory requirements, and external demands that influence nursing practice and outcomes.
50. Identifies relationships within and external to the organization/system that are facilitators or barriers to nursing practice and any proposed change.

Organization/Systems sphere

51. Identifies effects of organizational culture on departments, teams, and/or groups within an organization.
52. Monitors legislative and regulatory health policy that may impact nursing practice and/or CNS practice for the specialty area/population.
53. Diagnoses facilitators and barriers to achieving desired outcomes of integrated programs of care across the continuum and at points of service.
54. Diagnoses variation in organizational culture (i.e., values, beliefs, or attitudes) that can positively or negatively affect outcomes.
55. Draws conclusions about the effects of variance across the organization that influences outcomes of nursing practice.
56. Plans for achieving intended system-wide outcomes, while avoiding or minimizing unintended consequences.
57. Draws conclusions about the impact of legislative and regulatory policies as they apply to nursing practice and outcomes for specialty populations.
58. Develops innovative solutions that can be generalized across differing units, populations, or specialties.
59. Leads nursing and multidisciplinary groups in implementing innovative patient care programs that address issues across the full continuum of care for different population groups and/or different specialties.
60. Contributes to the development of multidisciplinary standards of practice and evidence-based guidelines for care, such as pathways, care maps, and benchmarks.
61. Solidifies relationships and multidisciplinary linkages that foster the adoption of innovations.
62. Develops or influences system-level policies that will affect innovation and programs of care.
63. Targets and reduces system-level barriers to proposed changes in nursing practice and programs of care.
64. Facilitates factors to effect program-level change.
65. Designs methods/strategies to sustain and spread change and innovation.
66. Implements methods and processes to sustain evidence-based changes in nursing practice, programs of care, and clinical innovation.
67. Provides leadership for legislative and regulatory initiatives to advance the health of the public with a focus on the specialty practice area/population.
68. Mobilizes professional and public resources to support legislative and regulatory issues that advance the health of the public.
69. Selects evaluation methods and instruments to identify system-level outcomes of programs of care.
70. Evaluates system-level clinical and fiscal outcomes of products, devices, and patient care processes using performance methods.
71. Uses organizational structure and processes to provide feedback regarding effectiveness of nursing practices, multidisciplinary relationships in meeting identified outcomes of programs of care.
72. Evaluates organizational policies for their ability to support and sustain outcomes of programs of care.
73. Evaluates and documents the impact of CNS practice on the organization.
74. Documents all outcomes in a reportable manner.
75. Disseminates outcomes of system-wide changes, impact of nursing practices, and CNS work to stakeholders.

NACNS, 2004.

and importance of different competencies vary across time and practice settings. As a result, the "importance" question on the final survey was changed to "How important is this competency?"

Final Survey Instrument

The final survey included two subscales: (a) competency use in practice and (b) competency importance for attaining expected outcomes in current practice or role. Each subscale contained the 75 core competencies as items. The items within each subscale were divided into three domains: patient-client, nursing practice, and organization-system.

The patient-client domain consisted of 21 competencies. Use of the competency in clinical practice was scored on a 5-point Likert-type scale from 0 (*never*) to 4 (*all the time*), yielding a potential range of total scores from 0 to 84. Importance of the item for achieving desired practice outcomes was scored on a 3-point Likert-type scale from 0 (*not important*) to 2 (*very important*), for a potential range of total scores from 0 to 42. The nursing

practice domain consisted of 25 competency items; thus the potential range for total "use" scores was from 0 to 100 and the potential range for total "importance" scores was from 0 to 50. The organization-system domain consisted of 29 competency items. Thus, the potential range for total "use" scores was from 0 to 116; for total "importance" scores from 0 to 58.

An open-ended response section was added to the survey to help in identifying additional information about competencies from respondents. Three open-ended questions were added at the end of the instrument. In addition, an open-ended comment section was added. Limited demographic data were collected. Participants were asked to provide number of years in nursing, number of years as a CNS, type of initial preparation in nursing, focus of master's education, and highest degree earned.

Methods

A convenience sampling method was used, which targeted practicing CNSs in any specialty. The instrument was distributed in paper-and-pencil format at the 2005 NACNS Convention in Salt Lake City, Utah. To increase return rates and increase variability, an online format was developed using Survey Monkey™. A link to the online instrument was posted on the NACNS Website. All CNSs, regardless of NACNS membership status, were encouraged to complete the instrument. The NACNS Website indicated encouragement to respondents to invite CNS colleagues to participate in the online survey. Invitations to participate were sent via e-mail to NACNS local affiliates (chapters) and to national nursing organizations with CNS members. American Nurses Association (ANA) leaders agreed to put a link to the study's invitation on their Website. Finally, NACNS leaders discussed the study at various national meetings and invited CNSs in attendance to participate in the online survey.

Inclusion criteria were CNSs currently practicing in a CNS role, in any specialty area, holding a master's degree in nursing from a program that prepared graduates for the CNS role. Exclusion criteria were CNS students, nurses without graduate degrees in nursing, and nurses not educated as CNSs. The inclusion criteria were explained in person at conferences and posted on the NACNS Web site along with the invitation to complete the survey. Data were collected over 18 months to assure a large sample. Nursing leaders had verbally stated that a sample of at least 500 should be obtained.

Data Analysis

Quantitative data were analyzed using SPSS statistical software version 12.0. Demographic data were analyzed using descriptive statistics. Data on the use and importance of the competencies were analyzed using both descriptive statistics and analysis of variance (ANOVA). Additionally, internal consistency reliability of the "use" and "importance" items was assessed using Cronbach's alpha. Qualitative data from the open-ended questions were analyzed by grouping themes.

One-way ANOVA was used to compare the mean scores of use and importance by specialty for the top five specialties: Medical Surgical-Adult Health, Critical Care-Acute Care, Families-Maternal Child Health, Psychiatric-Mental Health, and Cardiac-Cardiovascular. The Bonferroni post hoc test was used to assess for statistical differences between groups.

Findings

In all, 874 people responded. Respondent data were excluded if respondents reported that they: (a) were not educated as a CNS, (b) were a CNS student, or (c) did not answer any of the survey questions, as was seen when a respondent returned a blank paper survey or failed to continue after logging into the survey via Survey Monkey™. A total of 369 (42%) of surveys were excluded from analysis for not meeting inclusion criteria. A final sample size of 505 surveys (75 paper-and-pencil and 429 online surveys) were included in the analysis. Respondents represented CNSs who entered the field as RNs between 1956 and 2006. The survey results showed a high degree of internal consistency reliability (0.967%) between the scales.

For their basic education in nursing, over half reported having a baccalaureate degree, over one fourth reported being prepared at the associate-degree level, and the rest reported being prepared at the diploma level. About two-thirds reported having a master's degree and the remaining one third, post-master's education. All but five of the respondents reported a CNS major at the master's level. The five respondents who were not prepared as a CNS at the master's level had obtained post-master's certificates as CNSs.

Respondents listed 33 specialties; five specialty groups, Medical Surgical-Adult Health, Critical Care-Acute Care, Families-Maternal Child Health, Psychiatric-Mental Health (PMH), and Cardiac-Cardiovascular, accounted for 63.1% of the respondents. These specialties each had more than 35 respondents. Medical Surgical-Adult Health was the most represented with Critical Care-Acute Care, second. Many subspecialties were only represented by one or two people. Participants had been practicing as CNSs from less than 1 year to 40 years. About two-thirds had been working 10 or fewer years, another one-fourth

Table 2. Demographic Findings

Characteristics	Results
Years in nursing	Mean: 26.35
	Mode: 26 years
	Range: 1–40
Years as CNS	Mean: 9.13
	Mode: 1 year
	Range: <1 year-40 years
Initial nursing preparation	Diploma: 83 (16.4%)
	Associate: 133 (26.3%)
	Bachelor: 283 (56%)
	Other: 6 (1.2%)
Focus of MSN education	CNS: 500 (99.0%)
	Other: 5 (1.0%)
Highest degree earned	Masters in Nursing: 320 (63.4%)
	Doctorate in Nursing: 74 (14.7%)
	Post-Masters Certificate
	(as CNS or other): 104 (20.6%)
	Doctoral candidate: 2 (0.4%)
	Post Doc: 1 (0.2%)
	No selection: 4 (0.8%%)

Table 3. Specialty Practice Areas Reported by Validation Study Participants

Specialty reported	N (%)
Medical-surgical/adult health	164 (32.5%)
Critical care	78 (15.4%)
Childbearing families/maternal child	40 (7.9%)
Psych–mental health	37 (7.3%)
Cardiovascular	28 (5.5%)
Pediatrics	27 (5.3%)
Gerontology	26 (5.1%)
Community health	19 (3.8%)
Oncology/adult health oncology	16 (3.2%)
Emergency/trauma	14 (2.8%)
Adult acute care	8 (6%)
Rehabilitation	5 (1%)
Education	5 (1%)
Perioperative	3 (0.6%)
Neurosciences; diabetes education; family; women's health	2 in each role (0.4% each)
Public health; orthopedics; chronic illness; home health; palliative care; pulmonary; nutritional support; integrated health practices; spheres of influence; forensic nursing; health and wellness; high risk obstetrics; urology; administration; none	1 in each role (0.2% each)
No response	8 (6%)
TOTAL	505 (100%)

had worked from 10 to 20 years; the remaining had worked more than 20 years. **Tables 2** and **3** show participants' characteristics.

Specific aims of this study were to (a) determine the extent to which the 75 core CNS competencies were used in current CNS practice, (b) determine the importance of those competencies to practicing CNSs, and (c) identify gaps between CNS core competencies and CNS role expectations in current practice. Only two "use" competencies fell below the midpoint, both were related to legislative-regulatory activities. However, "importance" scores for both competencies indicated they were important to CNS practice because scores were above the midpoint. **Figures 1** and **2** show graphs of the means and midpoints for the 75 "use" and 75 "importance" competencies.

Using one-way ANOVA, the only significant difference between these major groupings of CNSs was found in the use of competencies in the Nurses-Nursing Practice group. Post-hoc tests indicated the PMH group differed significantly from all other groups in use of competencies in nursing practice. **Table 4** shows the ANOVA results. None of the other specialty groups differed significantly from one another on this measure.

Open-Ended Questions

For the first question we asked participants to make recommendations about other core competencies that they believed should be included in future revisions; 65 participants responded. The most frequent response was

that no change was needed in the existing core competencies. Competencies related to prescriptive authority was one of the two second most common recommendations. The other was to expand competencies in scholarship and professional involvement. Other suggestions about new competencies were related to the diversity of CNS practice; the validation of worth including financial impact; leadership; ethics; change theory; health promotion and accountability; differentiation between core competencies for novices and experts; nurse-run clinics; private practice; integrating technology; business development and strategic planning; and including more items about independent practice competencies.

For the second question we asked participants to provide comments indicating how well they believed the core competencies covered important aspects of their practice-role; 119 participants responded. The majority of respondents (83.8%) believed that the competencies fit either very well, well, or adequately with their clinical roles.

For the third question, we asked participants if they or their employers used the core competencies to write or rewrite their job descriptions; 113 participants responded. About the same number of respondents indicated the competencies were used in developing their job descriptions (41.6%) as those who stated the competencies were
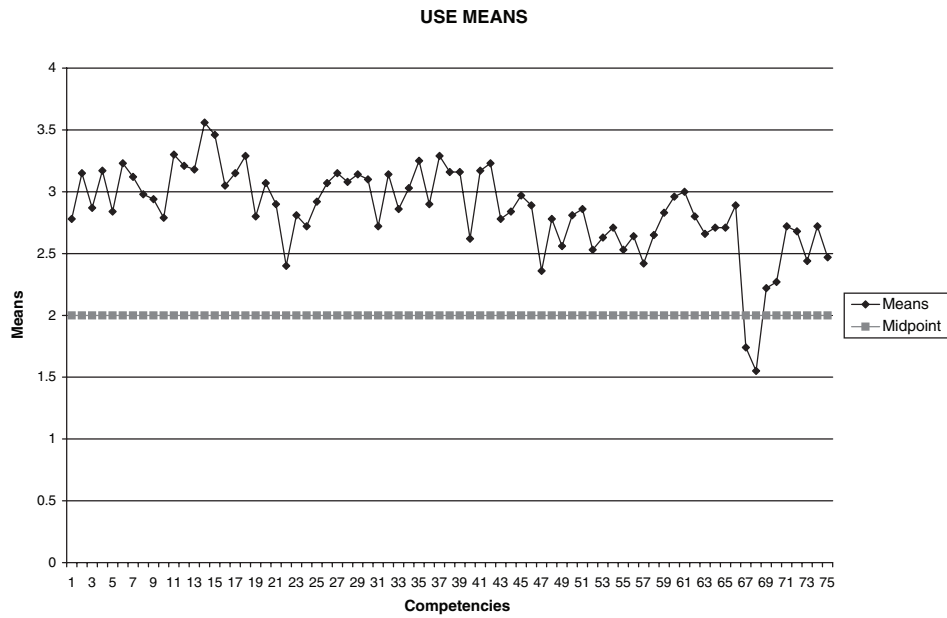
USE MEANS

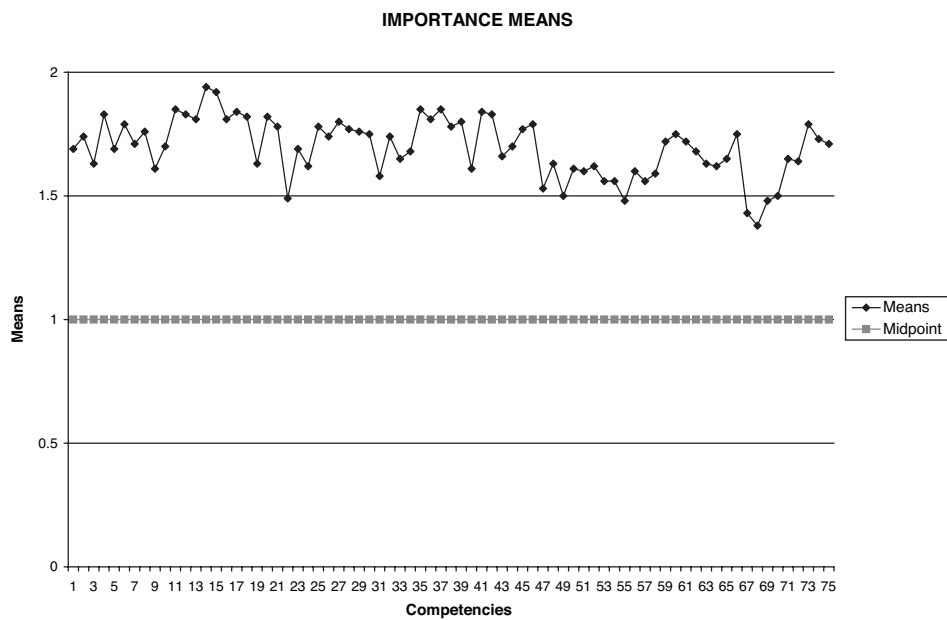**Figure 1.** Graph of overall use means and midpoints

IMPORTANCE MEANS

Figure 2. Graph of overall importance means and midpoints

Table 4. ANOVA Results of the Top Five Specialties

| Domain | Patient/client | | | | Nurses/nursing practice | | | | Organization/system | | | |
| | Use | | Import | | Use | | Import | | Use | | Import | |
	F	Sig	F	Sig	F	Sig	F	Sig	F	Sig	F	Sig
ANOVA results	0.179	0.949	1.771	0.134	4.31	0.002*	1.42	0.229	1.950	0/102	0.350	0.844

*$p<0.05$.

not used in developing their job descriptions (44.2%). Additionally, 10.6% indicated that leaders in their organizations were considering use of core competencies to rewrite job descriptions.

A limited number of additional comments were made by respondents. Practice issues and comments critiquing the survey instrument were the most frequent focus of the comments.

Discussion

Results of this national validation study show that NACNS core competencies are valid from the perceptions of practicing CNSs. In addition, the core competencies accurately reflect the current role of CNSs. The competencies are used in current practice and considered important by practicing CNSs.

The only significant finding in the ANOVA of the five top groups was that PMH CNSs differed from those in the other top five CNS specialties in use of the nurses-nursing practice competencies. A reason for this may be that many PMH CNSs counsel individual clients in independent practice settings. These settings may result in little interaction with other nursing-care providers. None of the other top five specialty groups differed significantly concerning use of these competencies. This finding may also reflect the practice sites for these roles, which are often in acute-care facilities.

Three limitations of the study were noted. First, a convenience sample used might have introduced bias into the study results. For example, a relatively high number of CNSs with doctoral degrees responded and their preference for more complex core competencies may have skewed some results.

A second limitation of the study was that a significant number of surveys ($n=369$, 42%) were not useable for data analysis. The overall length of the survey was believed to be the primary reason for this. Future work on the survey might indicate redundancies allowing for eliminating some items and shortening the survey. Another reason for the low number of useable surveys may have been that the inclusion criteria set prior to data collection specified that only those respondents educated as CNSs and practicing in the role would be included in the study. Because some states do not provide title protection for CNSs, the CNS role is the only APN role in which nurses educated in another nursing major are permitted to practice. Therefore, nurses were practicing as CNSs who did not meet the education inclusion criteria and their surveys were excluded from the data analysis.

Although nurse practitioners have been known to work in the CNS role in states without title protection and this was validated in the study, a surprising finding

was that one nurse midwife also reported working in the CNS role. Computer problems and problems using Survey Monkey^{TM} might also have diminished the number of useable surveys.

A third limitation was the amount of missing data. The overall length of the survey was thought to be the major reason for missing data. This was confirmed in the comments about the questionnaire. The Flesch-Kincaid Grade Level of the survey was grade 12. Although this might have affected the amount of missing data, the targeted audience of the survey was master's prepared nurses. The 18-month length of time to collect data was necessary to assure a sample size of at least 500.

Only two "use" competency scores were below the mean and both were related to legislative-regulatory issues. Importance scores for these two competencies were above the mean. This finding may reflect the general lack of political activism existing in nursing. During the current healthcare crisis it is increasingly important for nurses to become politically active.

Qualitative data indicated that the 75 competencies reflected current CNS practice. About half of the respondents reported that the competencies are used as a basis for their job descriptions. The need for prescriptive authority seems to be increasing among CNSs. At this time prescriptive authority remains an optional skill for CNSs. In the future, all CNSs may need to prescribe. Comments about other needed core competencies reflect the breadth and depth of the CNS role. As NACNS prepares to revise the 2004 statement and core competency descriptions, the comments from the open-ended questions will be reviewed for inclusion.

Clinical Relevance

The CNS core-competency descriptions are a framework for role development for practicing CNSs. For example, they have been used to develop job descriptions and professional evaluation tools for practicing CNSs. The competencies are specific enough to facilitate an understanding of the role by nursing leaders who are not CNSs yet who are responsible for evaluating CNS practice within an organization. In addition, the findings from this validation study are being used by the American Nurses Credentialing Center (ANCC) as part of a needs assessment for a new core CNS exam currently being developed.

Conclusions

The process used by NACNS to develop the CNS core competencies was patterned after processes used by other

professional nursing organizations for the developing competencies and standards (Baldwin et al., 2007; Davis et al., 2005). The competency validation process was shown to be effective for validating competencies. This process may also be useful for revising and updating existing competencies in a timely manner. To help assure "transparency" of the process, leaders of professional organizations should publish information about the methods used to create, validate, and assure the quality of competencies and standards. Perhaps no one method will ever be satisfactory for all situations; however, the processes and methods used by NACNS were well suited for accomplishing the goal of validating CNS core competencies. This review may be instructive to leaders of other national and international professional organizations interested in developing and evaluating competencies and standards. A national survey to validate that a professional practice organization's core competencies are those that allow practitioners to meet the needs of patients and the priorities of healthcare organizations is a way to assure that advanced-practice roles are relevant and necessary.

Acknowledgements

Clinical Resource

- National Association of Clinical Nurse Specialists: www.nacns.org

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