

**Society of Trauma Nurses
Position Statement on The Role of the Clinical Nurse Specialist in Trauma
(2008, Revised 2023)**

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INTRODUCTION

The Clinical Nurse Specialist (CNS) is a licensed registered nurse who, through advanced education at a graduate level and through clinical experience, is recognized as an expert practitioner within a specialty population (American Nurses Association [ANA], 2017). The CNS is included in the collective term Advanced Practice Registered Nurse (APRN), which also includes the certified registered nurse anesthetist (CRNA), nurse practitioner (NP), and certified nurse midwife (CNM) (National Association of Clinical Nurse Specialists [NACNS], 2019). Three spheres of influence are recognized in CNS practice: the patient, nurse, and system (NACNS, 2019). Traditionally, CNS practice is broadly focused on the provision of direct and indirect care, staff education, consultation, research, and system change. The CNS demonstrates clinical nursing expertise in diagnosing and treating patients with complex conditions. The CNS also advances the practice of nursing by designing innovative evidence-based interventions, influencing the practice of other nurses, and influencing the healthcare system environment to support autonomous nursing practice (NACNS, 2019). A primary goal of the CNS includes continuous improvement of patient outcomes and nursing care (APRN Consensus Work Group & National Council of State Boards of Nursing [NCSBN] APRN Advisory Committee, 2008).

HISTORY OF THE CNS AS AN APRN

Advanced practice roles for nurses have existed for well over one hundred years as documented by nurse-administered anesthesia in the late nineteenth century (Ray, 2016). The nurse clinician role was conceptualized in the 1940s as an expert practitioner educated at the graduate level. However, the exact year the CNS title was introduced is uncertain. The CNS role was the first APRN role to adopt graduate preparation; the first master's program was established for psychiatric nurses by Peplau in 1954 (Keeling, 2005). Clinical nurse specialization greatly expanded in the 1960s, spawned by the enactment of the Nurse Training Act and other legislation. New areas of CNS specialization developed, and as such, the American Nurses Association (ANA) officially recognized the CNS role and developed specialty certification (Fulton, 2020; ANA 2017). The number of CNS specialties eligible to certify has increased. For the past 50 years, the CNS has been identified as an advanced practice nurse in the literature and educational programs (Hamric et al., 2013).

EDUCATION, CERTIFICATION, LICENSURE & CREDENTIALING

CNS practice is primarily defined by educational preparation, certification, and state licensure. The CNS completes a graduate program, master's, or doctoral level at a nationally accredited program. The program prepares the clinical nurse specialist and provides eligibility to sit for national certification. The curriculum includes didactic courses such as health assessment, advanced pathophysiology, pharmacology, and clinical experiences within the specialty. APRNs are educated from wellness to acute care in one of six population foci: family/individual across the lifespan, adult-gerontology, pediatrics, neonatal, women's health/gender related, or psych/mental health (APRN Consensus Work Group & NCSBN APRN Advisory Committee, 2008). Further clinical specialization, for example trauma, provides a depth of practice within the broad population focus (Fulton, 2020).

National certification, a requirement to practice in the advanced role in the majority of states, aligns with requirements of the APRN Consensus Model (2008) and meets the National Council of State Boards of Nursing (NCSBN) for APRN Certification Programs. Furthermore, the consensus model recognizes specialty certification and preparation as optional, but recommended, and should follow the ANA Criteria for Recognition as a Nursing Specialty (APRN Consensus Work Group & NCSBN APRN Advisory Committee, 2008; NCSBN, 2023).

License to practice as a CNS is defined and authorized by individual states (Hartigan, 2011). Despite the release of the APRN consensus model in 2008, there remains no uniform model of regulation of APRNs or CNS practice across the states (NCSBN, 2023). According to the role mapping by the National Council of State Boards of Nursing, APRNs are not licensed in every state; some states use terms such as "authority to practice, certificate, or recognition." The final decision on scope of practice is held with state licensing boards, which are governed by individual state regulation and statute (APRN Consensus Work Group & NCSBN APRN Advisory Committee, 2008).

The CNS is considered an independent practitioner in most US states and territories (20). Independent APRN practice is defined as "no requirement for a written collaborative agreement, no supervision, no conditions for practice, and may follow a statutorily required period of practice under a collaborative/supervisory agreement" by the NCSBN (2023). Authority to practice beyond the scope of the RN license as a CNS with prescriptive authority is often role dependent. Independent or collaborative prescriptive authority is also state regulated. CNSs often have the same requirements as NPs in states which sanction prescriptive authority.

Beyond the regulatory requirements for licensure, the need for credentialing and privileging of the CNS is defined by individual organizations and may affect the scope of practice of the individual practitioner. Not all organizations credential and privilege the CNS; it is largely defined by medical and professional staff rules and regulations. The purpose of credentialing and privileging is to ensure competence to practice within the advanced role. The privileging process builds on the credentialing application and allows the CNS to request privileges to perform advanced skills in the institution. The request must be consistent with the state-defined scope of practice for the CNS. Typically, to obtain the privilege to perform a specific skill, the CNS must first document educational qualifications. The process may further require demonstrating the skill under supervision in an animal lab or clinical situation.

THE CLINICAL NURSE SPECIALIST IN TRAUMA

The trauma CNS assumes the traditional roles of CNS practice including expert practitioner, educator, consultant, and researcher. Implementation of the CNS role in a particular trauma program, however, will be dictated by the needs of the organization. As a result, the priority placed, and proportion of time spent in each role may vary.

Clinical Expertise

The work of the CNS includes, but is not limited to, diagnosis and treatment of acute or chronic illness in an identified population (NACNS, 2019). Because of training and education in advanced pathophysiology, assessment and pharmacology, a CNS for the trauma population may have substantial impact on a patient's clinical course of care, whether through direct physical presence or indirectly through consultation as a clinical expert on program or organizational initiatives. CNSs have the unique ability and training to identify processes that can be enhanced to improve the outcomes, whether for a single patient at the point of care or system wide. Management of the injured patient can be challenging to staff that do not have the experience or education to care for this patient population, subsequently rapid identification of clinical concerns and management can be overwhelming. The trauma CNS is familiar with the patient population and can impact these processes with their expertise clinically, as well as to navigate patient, unit, and organizational level barriers to facilitate optimal care.

With bedside clinical expertise as a cornerstone for the CNS role, collaboration and effective communication with staff are important. In the setting of direct care, CNSs can bridge the gap between direct patient care as an advanced practice provider as well as design clinical processes. Classic examples of CNS involvement within the trauma population may include

assessment and prescribing, active participation in daily multi-disciplinary rounding, providing insight into patient care opportunities as a consultant, and exploring alternatives to the current care delivery model. Outside of physical presence, the CNS has trained to collaborate with other clinical teams to identify opportunities to drive evidence-based practice (EBP) changes to achieve best patient outcomes. While initiatives may arise from care of the trauma patient, these can often inform adoption of strategies across multiple populations.

Performance Improvement and Patient Safety

All trauma centers that are verified by the American College of Surgeons or hold a state level trauma designation should have a Performance Improvement and Patient Safety program (PIPS) and must demonstrate a continuous process of monitoring, assessment and management directed at improving care (ACS COT, 2022). A successful PIPS program includes a process of event identification, corrective action plans, methods of monitoring reevaluation, benchmarking and achieving event resolution (Pidgeon, 2015). The CNS is in a unique position to assume a leadership role with the PIPS process to improve care for the trauma population, often positively impacting patients in other care settings. When applying CNS core competencies, the CNS acts as a change agent to make improvements leading to enhanced safety and quality in the care of patients (Reimers & Miller, 2014).

Involving a CNS in performance improvement (PI) can help maintain trauma center standards as well as elevate the standard of care. PI is a daily focus for the CNS who utilizes clinical expertise to focus on clinical aspects of trauma nursing and an understanding of evidence-based practice and facilitation of complex PI initiatives. These fundamental competencies make the CNS instrumental in the development of performance improvement measures that are meaningful and impactful to the organization and patient population (Forst, Stafos, Barbay, & Henderson, 2019). CNSs are acknowledged as being “essential partners due to their focus on the spheres of nursing and their ability to work across disciplines and bring everyone together” (Adams, et al., 2015, p. 36). They can identify and track trends as well as performance/system issues. This insight allows them to resolve issues while improving outcomes. The CNS can partner with RNs in a PI role to investigate trends within injury patterns in order to develop and implement evidence-based solutions.

Trauma Research and Scholarship

An integral part of any trauma program, and a key component to Level I Trauma Center verification/designation, is research and scholarship. They exist together with clinical expertise,

performance and quality improvement, and education and outreach; each aspect feeds the others. PI concerns may spark clinical inquiry and quality improvement projects or original research that can be disseminated beyond the local trauma team, often informing clinical practice through local, regional, and national conference opportunities.

The CNS is uniquely qualified to coordinate research and scholarship efforts in the trauma system. A core component of the CNS curriculum is interpreting evidence and translating that evidence into practice (NACNS, 2019). Interpretation of original research, systematic reviews, case reports, and best practice guidelines can help ensure that evidence-based practice is built upon a solid foundation. The understanding of the research process and practical applications of research findings helps the CNS develop policies and protocols within the trauma program that are scientifically sound and based on proven research.

The CNS is also a key member of any implementation team for changing practices throughout the healthcare system. Understanding team dynamics, interprofessional patient care, and having practical experience with bedside patient care helps the CNS guide healthcare professionals through practice changes. The CNS understands that the act of conducting research on its own does not guarantee a meaningful transition to practice (Duffy et al., 2016). The full scope of CNS practice is used to bring an evidence-based practice change from idea and research to implementation and dissemination. The CNS identifies gaps in knowledge or risks to quality and safe patient care, works within and across departments to meet clinical needs and identifies quality data sources, understands statistical analyses, and develops research plans. As a leader, the CNS has effective strategies to influence clinical practice, foster a spirit of clinical inquiry, and lead organizational change (Duffy et al., 2016). As a change agent, the CNS develops the need for change (or research in this case), finds and addresses systems issues that may impede research, establishes research as an intent for practice change and translates that change into action, and hardwires that change into practice. Ultimately, this stabilizes the adoption of research and evidence-based practice and builds the spirit of clinical inquiry in a trauma department (Rogers, 2003).

The verification of trauma centers by the ACS COT or state designation is an important milestone for trauma programs. For Level I trauma centers designated by state or verified by the ACS COT, well-developed research programs are frequently required (ACS COT, 2022). Research is required not only by the trauma surgeons on staff, but also from other members of the interprofessional trauma team at Level I trauma centers. Scholarly activities such as research in

basic sciences, translational sciences, systematic reviews, or quality improvement and patient safety initiatives coincide with the requirements for research and scholarly activity (ACS COT, 2022). The CNS is an ideal member of the non-physician faculty for residency programs to guide the trauma team through the research process and encourage interprofessional education and scholarship. Educating members of the interprofessional healthcare team shifts away from siloed, profession specific models of care delivery towards a culture that engages in cooperation, shared skills and knowledge, respect, and collaborative care delivery placing evidence-based practice and the patient in the center of care (Duffy, Dresser, & Fulton, 2016).

Education, Outreach, and Injury Prevention

In addition to previously outlined trauma program elements, education, outreach, and injury prevention initiatives are foundational elements to improve outcomes for the trauma-injured patient. There is often significant overlap between these efforts and the CNS can augment many of these endeavors, providing clinical expertise based on current science and recommendations to connect resources.

Public and professional education and outreach are core components of a trauma program (ACS COT, 2022). Through the performance improvement process and ongoing program needs assessment, education is often a key focus area. Building on a core competency and their advanced educational preparation, the CNS can identify or create high quality programs based on current science both within the hospital setting and the community. If a program has an existing outreach coordinator, the CNS can partner with this person in program development and dissemination plan, also identifying ways to evaluate programs for future improvements or research initiatives. If this role does not exist, a CNS can augment some of these gaps. Within the hospital, programs can be developed for nursing and ancillary staff aimed to increase the knowledge base for the trauma-injured patient. For existing curriculums, the CNS can provide additional lecture support for advanced trauma training courses or certification preparatory classes. Outside of the hospital setting, the educational collaboration with a CNS can be seen in the partnership with EMS. Frequently, EMS opportunities for improved care center around lack of advanced knowledge of pathophysiology or pharmacology. Utilizing the CNSs clinical expertise, an educational program can be developed to highlight the physiologic implications of injuries and how EMS can provide interventions in the field with positive implications for long-term outcomes. Additionally, education and outreach are key with regional referring facilities, leaning on the clinical expertise and evidence-based framework of the CNS role to collaborate in developing and education on

regional clinical protocols and standards of care for the trauma-injured patient.

Another principal component to a trauma center is having an organized and effective approach to injury prevention (ACS COT, 2022). Working with program staff to identify community injury pattern trends via internal trauma facility data or Trauma Quality Improvement Program (TQIP) data, the CNS can identify targeted evidence-based interventions to collaborate on the design and implementation of injury prevention programs. If the gap is not informed by current literature, the CNS can partner to lead a research initiative in developing and studying a new injury prevention program.

SUMMARY

Trauma centers are increasingly challenged by high volumes of complex patients coupled with the economic pressures of caring for those patients with dwindling resources. It is incumbent on the CNS to define and measure outcomes to show the impact on the trauma services department within the organization. Measuring CNS outcomes may involve examining complications and length of stay, measuring compliance with protocols achieved through education, or the value of original publications and research. The trauma CNS is well prepared to support quality multidisciplinary trauma care and to affect organizational change to better serve the trauma population. As an Advanced Practice Registered Nurse, the CNS is able to identify current practice gaps in caring for the trauma-injured patient, implement evidence-based practice changes, as well as augment other program roles.

The Society of Trauma Nurses:

1. Recognizes the Clinical Nurse Specialist as an Advanced Practice Registered Nurse.
2. Values the clinical expertise and leadership demonstrated by the Clinical Nurse Specialist.
3. Supports the utilization of the CNS as an expert practitioner, educator, consultant, leader, and researcher in trauma programs.
4. Recognizes the CNS as an integral member of the multidisciplinary team which strives to achieve desired outcomes and prevent complications through evidence-based trauma care.
5. Acknowledges that the CNS must meet specific state requirements to practice as an APRN.
6. Supports the National Council on State Boards of Nursing recommendation that all CNSs be certified per the APRN Consensus Model.

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