EVALUATING THE CLINICAL NURSE SPECIALIST ROLE IN CHILD HEALTH

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IMPLICATIONS FOR PRACTICE

- Listening to children, young people and their families and acting on the results should be built into evaluation of the service.
- Audit provides a vehicle for practitioners to evaluate their services.
- Clinical nurse specialists provide information, education and a service that is accessible to children, young people and their families.
- Service evaluation can, in itself, be a learning experience for practitioners.

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The clinical nurse specialist (CNS) role aims to improve patient care and develop services. Gaining the views of service users is a vital part of the role. This study aimed to evaluate CNS services provided to children and their families. The inclusion of children and young people is imperative in paediatric trust. A group of CNSs in a surgical directorate undertook an audit.

Parents, children and young people reported high levels of satisfaction with the nurses. Parents highlighted their good communication skills and high level of professionalism. Those areas identified less positively by parents and children included accessibility, equity of service provision and variable information resources. This audit showed that one-to-one contact between children, families and the nurses was considered by service users to be the most valuable part of CNS work.

INTRODUCTION

The clinical nurse specialist (CNS) role focuses on improving patient care and developing clinical services, often within specialist areas. CNS roles demonstrate a high degree of professional competence, skill and teamwork in both generalist and specialist areas of practice. Many CNSs are considered leaders within their own specialties, initiating care and making treatment decisions (Raja-Jones, 2002).

Although a concise and legislative agreement of the CNS role does not exist, several key areas are identified in the literature. These include: expert clinical competence; education; research; critical thinking skills; and resource and time management expertise (Henderson, 2004; Raja-Jones, 2002). A pivotal part of the CNS role is to seek service users’ views. In our evaluation we explored the views of children, young people and parents across the surgical directorate.

BACKGROUND TO THE STUDY

In 2007 a group of clinical nurse specialists based in the surgical directorate of a paediatric trust undertook an audit to evaluate the services they provided to children and their families. The inclusion of children and young people is imperative in service evaluation and design. We recognise and value the families’ keen awareness of their healthcare needs. Informal discussions also highlighted the interest and enthusiasm parents and children had about being involved in the evaluation.

METHOD

Clinical nurse specialists representing a diverse surgical patient workload meet monthly to discuss ways of advancing their roles and improving services. Nine specialties are represented at the meetings.

It was during these meetings that an audit was suggested and we agreed to proceed with the project.

We reviewed questionnaires available for this type of audit. The Commission for Health Improvement (now the Healthcare Commission) had produced The Experience of Service Questionnaire Handbook (2000). The Experience of Service Questionnaire (EoS) is a 15-item self-completion questionnaire that assesses users’ views of services in terms of accessibility, humanity of care, organisation of care and the environment. The commission introduced it as a method to assess child and adolescent mental health services (CAMHS) as part of a clinical governance review.

The hospital’s psychology department was involved in piloting the work and continues to use it to evaluate its service. The CAMHS questionnaire comprised three distinct components: parent/carer; young people aged 11–15; and young people aged 16–18.

For our project, we adapted the age ranges in line with the work already undertaken by our psychology department. This resulted in a wider age range of children being included in the study (9–11 years, over 12 years and parents/carers). Stamped, self-addressed envelopes were supplied with each questionnaire, which were returned to the audit department.

The trust’s patient and service-user group oversaw the process. This group ensures that any survey undertaken within the trust involving patients and/or families is methodologically sound and does not replicate existing work. It also ensures that outcome data is acted on.

Patient selection

Patient selection for the audit proved to be difficult. Following discussion, we decided that each specialty would nominate the previous 50 children and/or families...
they had seen over the last six months. This ensured the families had recent contact with the service and that possible bias in selection was avoided. These lists were then sent to the coordinator within the group.

Some families were seen by more than one service due to the complexity of their needs and some children had died. We carried out cross-referencing of all names submitted to ensure that we did not send out questionnaires which would be duplicated or cause distress.

Each one was modified accordingly for the population we were seeking views from. However, once the final list had been compiled a final number was not noted, which meant that we could not calculate the response rate. This omission was only noticed once the forms had been sent out.

The closed responses (yes, sometimes, no, don’t know) from the 15 questions were subjected to simple descriptive statistical analysis. The section of the questionnaire that allowed free text was explored thematically.

RESULTS
Parents reported satisfaction >90% with nurses’ knowledge, skills and multidisciplinary working, while children and young people reported 83–97% satisfaction. For a summary of the results, see nursingtimes.net.

The number of questionnaires received in each group was as follows:
- Parents/carers = 115
- Children aged 9–11 years = 12
- Young people aged 12 and over = 29

Those aged 9–11 years: This group found the nurses’ care effective and accessible, and the nurses were available. Comments from participants included: ‘I was spoken to as a young adult’ and ‘When I needed help it was always there, even if I just phone for help.’

Those aged 12 and over: This group found the nurses explained things, listened and related to their problems. They were also good at problem-solving, helpful and friendly, and involved the young people in aspects of their care.

Comments from participants included: ‘I was given a choice in the care I got, my views were listened to and taken into account’ and ‘Sometimes I was unable to see or speak to the nurse when I need to because she was busy.’

In accordance with recent studies, the clinical nurse specialists in our audit appeared to be considered as ‘good nurses’ (Brady, 2008). They possessed skills and demonstrated all the characteristics suggested by Brady (2008), which included good communication skills, knowledge, trustworthiness, awareness of safety, humour and professionalism.

Parents/carers: This group found there were many aspects to the care provided by the CNS, which we have ranked in order of priority. Communication, professionalism, being approachable, knowledgeable and understanding/helpful were the top five.

Other comments from parents and carers included the following: ‘Always felt the team was available for us outside clinic hours – nurses used a range of incentives to motivate… to make their treatment more bearable’ and ‘It has been consistent, supportive and informative through a very difficult time in our lives.’

DISCUSSION
Many lessons were learnt from the project. Parents and children reported high levels of satisfaction with CNS services. However, they identified the following areas less positively – accessibility, equity of service provision, variable information resources and administrative issues. These will be examined by individual services and the group to see how best to address them.

Changes that have already been put in place range from simple ones, such as producing uniform business cards, to setting up transitional clinics, improving care by using pathways and updating information. We also felt that involvement of some families would help us in implementing change and ensure that developments remain focused on their needs.

After completing the audit, the group met to discuss problems that had arisen during the process. As the audit is to be a regular event we explored how the tool, recruitment, evaluation and dissemination of findings should be addressed and improved on. We also discussed how we could improve the audit process following implementation of changes to practice. Issues identified were:
- Stricter control on documenting numbers of questionnaires sent out;
- It would have been helpful to find out how many of each group were involved in the audit;
- Involvement of patients and their families in the design of the questionnaire, as we felt some questions were too similar in nature and the format was not very child-friendly.

On the issue of frequency of repeat audits, the group decided that a re-audit should take place every 3–4 years. This is because it will take some time for changes to filter down to children and their families.

CONCLUSION
All those who took part in the audit felt it was an ambitious project but recognised the importance of having their services evaluated by families who used them. This audit showed that the most important part of our work – one-to-one contact between children, families and clinical nurse specialists – was considered by service users to be the most valuable. These nurses are a valuable resource delivering high-quality care and are important members of the healthcare team in our trust.

REFERENCES


