

**Clinical Nurse Specialist (CNS) & Nurse Practitioner (NP)
Advanced Practice Nurse
Survey**

1. Name _____
2. Preferred Mailing Address _____

3. Phone Number:
Office _____ Unit _____
Fax _____ Home _____
4. Email Address _____
5. Your Current Job Title (*indicate all that apply*)
 a. Clinical Nurse Specialist (CNS) c. Advanced Practice Nurse (APN)
 b. Nurse Practitioner (NP) d. Other (*specify*) _____
6. Institution/Unit (*or Service*) _____
7. Medical Director (*Unit/Service*) _____
8. Work Address _____

9. Hospital demographics (*indicate all that apply*)
 a. University affiliated
 b. Community
 c. Children's hospital
10. Number of Hospital Beds _____
11. Number of ICU Beds in your Unit _____
12. Number of "Step Down" Beds in your Unit _____
13. Number of Intensivists _____

14. **Number of Critical Care Fellows** _____
15. **Number of Residents/Month for ICU** _____
16. **Number of Critical Care Physician Assistants** _____
17. **Number Critical Care Staff Nurses (Full Time Equivalent -FTE's)** _____
18. **Number of Critical Care Clinical Nurse Specialists** _____
19. **Number of Critical Care Nurse Practitioners** _____
20. **Number of Critical Care Nurse Educators** _____
21. **Patient Population within Your Unit/Service (indicate % for all that apply)**
- a. Cardiothoracic Surgery _____ f. Oncology _____ k. Transplant _____
- b. Neurology/Neurosurgery _____ g. Pulmonary _____ l. Cardiology _____
- c. General Surgical _____ h. Orthopedics _____ m. Endocrine _____
- d. General Medical _____ i. Renal _____ n. Pain _____
- e. Gastroenterology _____ j. Trauma/Burns _____ o. Other specify _____
22. **Education - Degree (indicate all that apply to you)**
- a. Bachelor's in Nursing c. Post Master's e. Diploma
- b. Master's in Nursing d. PhD f. ADN
- g. Other (*please specify*) _____
23. **Education – Type/Specialty (indicate all that apply to you)**
- a. Pediatric NP-Acute/Critical Care e. Adult NP-Acute/Critical Care
- b. Pediatric NP-Primary Care f. Adult NP-Primary Care
- c. CNS-Pediatric Acute/Critical Care g. CNS-Adult Acute/Critical Care
- d. Family Nurse Practitioner h. Other (*specify*) _____

24. **School/University you received your APN training** (*include year completed*)

25. **Organization(s) which have certified you as an APN** (*indicate all that apply*)?

- a. ANCC (CS) c. AACN(CCNS)
- b. NCBPNP/N; "NAPNAP" (CPNP) d. Other(*specify*) _____

26. **Certification Specialty** (*indicate all that apply*)

- a. Pediatric Nurse Practitioner d. Family Practice
- b. General Medical-Surgical Nurse Practitioner e. Clinical Nurse Specialist
- c. Acute Care Nurse Practitioner f. Other (*specify*) _____

27. **Total Years in Nursing** _____

28. **Total Years in Critical Care** (*in any nursing position*) _____

29. **Years as a Staff Nurse – Pediatric Critical Care** _____

30. **Years as a Staff Nurse – General Pediatric** _____

31. **Years as a Staff Nurse - Neonatal** _____

32. **Years as an Advanced Practice Nurse:** CNS _____ NP _____

33. **Years as an APN in Pediatric Critical Care** _____

34. **Your Direct Supervisor** (*indicate all that apply*)

- a. Nursing Director d. Administrator (not physician/nurse)
- b. Unit Nurse Manager e. Staff Physician
- c. Medical Director f. Advanced Practice Nurse
- g. Other (*please specify*) _____

35. **Person responsible for Annual Performance Evaluation** (*indicate all that apply*)

- a. Nursing Director d. Administrator (non-physician/nurse)

- b. Unit Nurse Manager e. Staff Physician
- c. Medical Director f. Advanced Practice Nurse
- g. Other (*please specify*) _____

36. Annual Income (\$)

- a. <35,000 f. 50,001-55,000 k. 70,001-75,000
- b. 35,001-40,000 g. 55,001-60,000 l. 75,001-80,000
- c. 40,001-45,000 h. 60,001-65,000 m. 80,001-85,000
- d. 45,001-50,000 i. 65,001-70,000 n. >85,001

37. How are you Paid (*indicate all that apply*)?

- a. Salary c. Reimbursed directly via Medicaid/Private Insurance
- b. Hourly d. Combination of above (*describe*) _____

38. If you are responsible for Night/Weekend "Call" are you paid extra ?

- a. Yes b. No c. N/A

39. Salary Paid by (*indicate % for all that apply*)

- a. Physician Practice Plan (e.g. Pediatrics, Anesthesia) _____
- b. Hospital - Physician Budget Line _____
- c. Hospital - Nursing Budget Line _____
- d. Grant Funding _____
- e. Other (please specify) _____

40. Type of Orientation to Current Position (*indicate all that apply*)

- a. Formal/Structured Program f. APN Preceptor
- b. Informal (as needed) Training g. Attending Preceptor

- c. Lectures with Resident/Fellow h. Supervised by Fellow
- d. Lectures designed for APNs i. Supervised by Resident Staff
- e. Specific Procedure Training j. Rotations with other Services
- k. Other (*please specify*) _____

41. **Approximate Length of Orientation period** (*in years/months*) _____

42. **Approximate Length of Time before you were fully functional in your APN role.**
(*in months/years*) _____

43. **Your Work Schedule** (*actual hours worked*) **in a Typical Week**
Indicate **START TIME** and **STOP TIME** (*Circle or Bold Text*)

- a. Sun. 1am 2 3 4 5 6 7 8 9 10 11 12n 1pm 2 3 4 5 6 7 8 9 10 11 12mn
- b. Mon. 1am 2 3 4 5 6 7 8 9 10 11 12n 1pm 2 3 4 5 6 7 8 9 10 11 12mn
- c. Tues. 1am 2 3 4 5 6 7 8 9 10 11 12n 1pm 2 3 4 5 6 7 8 9 10 11 12mn
- d. Wed. 1am 2 3 4 5 6 7 8 9 10 11 12n 1pm 2 3 4 5 6 7 8 9 10 11 12mn
- e. Thurs. 1am 2 3 4 5 6 7 8 9 10 11 12n 1pm 2 3 4 5 6 7 8 9 10 11 12mn
- d. Friday 1am 2 3 4 5 6 7 8 9 10 11 12n 1pm 2 3 4 5 6 7 8 9 10 11 12mn
- e. Sat. 1am 2 3 4 5 6 7 8 9 10 11 12n 1pm 2 3 4 5 6 7 8 9 10 11 12mn

44. **In a Typical Week, how many Nights/Week do you provide Coverage?** _____

45. **If Night Coverage is provided, is this “In-house” Coverage?**

- a. Yes c. N/A
- b. No

46. **If “In-house” Night Coverage is provided, which Physicians are also present “In-house”?** (*indicate all that apply*)

- a. Resident c. Attending Physician
- b. Fellow d. N/A

47. In a Typical Month, how many Weekends “in-house” do you Work?

Saturday _____ Sunday _____

48. In a Typical Month, how many Weekends “on call” from home do you Work?

Saturday _____ Sunday _____

49. If applicable, how many In-Patients/Day (on average) do you manage? _____

50. If applicable, does Acuity or Type of Patient play a part in assignment of Patients?

a. Yes (*describe*) _____ c. N/A

b. No

51. Do you have responsibility for patients outside the ICU?

a. Yes (*describe*) _____ c. N/A

b. No

52. If applicable, how many Out-Patients/Day (*on average*) do you manage? _____

53. Do you have Scheduled Work Time for Activities outside of Patient Care?

(*For example, Research, Professional Development, Teaching, Unit Leadership*)

a. Yes (*describe*) _____

b. No

54. Indicate Activities you perform in Practice (*approximate % time/week to equal 100%*)

a. Direct Patient Management (physical assessment, interpret findings, treatment, rounds, patient/family education)
 Inpatient _____%

Outpatient _____%

c. Coordination of Patient Care (inpatient services, referrals, identify resources, discharge planning, team meetings) _____%

<input type="checkbox"/> d. Patient Care (as bedside/staff nurse)	_____%
<input type="checkbox"/> e. Nursing Education (formal & informal)	_____%
<input type="checkbox"/> f. Medical Education (formal & informal)	_____%
<input type="checkbox"/> g. Consultation to other services/units/other facilities	_____%
<input type="checkbox"/> h. Research	_____%
<input type="checkbox"/> i. Support of Systems (participate in unit planning, leadership in programs/projects)	_____%
TOTAL	100%

55. Use the Scale to Indicate your assessment of the Degree of Skill you bring to each Activity. Mark N/A for those Activities that are not an expectation in your practice. (*circle or bold text*)

	Novice		Proficient		Expert	N/A
	1	2	3	4	5	<input type="checkbox"/>
Clinical Practice						
<input type="checkbox"/> History/Physical Exam	1	2	3	4	5	<input type="checkbox"/>
<input type="checkbox"/> Venipuncture - Blood Draw	1	2	3	4	5	<input type="checkbox"/>
<input type="checkbox"/> Insert Intravenous Lines	1	2	3	4	5	<input type="checkbox"/>
<input type="checkbox"/> Initiate/Adjust IV Fluids	1	2	3	4	5	<input type="checkbox"/>
<input type="checkbox"/> Insert PICC lines	1	2	3	4	5	<input type="checkbox"/>
<input type="checkbox"/> Place Central Lines	1	2	3	4	5	<input type="checkbox"/>
<input type="checkbox"/> Place Arterial Catheters	1	2	3	4	5	<input type="checkbox"/>
<input type="checkbox"/> Place Umbilical Lines	1	2	3	4	5	<input type="checkbox"/>
<input type="checkbox"/> Remove Intracardiac Lines	1	2	3	4	5	<input type="checkbox"/>
<input type="checkbox"/> Suture Wounds	1	2	3	4	5	<input type="checkbox"/>
<input type="checkbox"/> Suture Lines in Place	1	2	3	4	5	<input type="checkbox"/>
<input type="checkbox"/> Suture Removal	1	2	3	4	5	<input type="checkbox"/>
<input type="checkbox"/> Initiate/Titrate Vasoactive Drugs	1	2	3	4	5	<input type="checkbox"/>
<input type="checkbox"/> Adjust Oxygen Therapy	1	2	3	4	5	<input type="checkbox"/>
<input type="checkbox"/> Endotracheal Intubation	1	2	3	4	5	<input type="checkbox"/>
<input type="checkbox"/> Initiate/Adjust Mech. Ventilation	1	2	3	4	5	<input type="checkbox"/>
<input type="checkbox"/> Document on Progress Notes	1	2	3	4	5	<input type="checkbox"/>
<input type="checkbox"/> Chest Tube (CT) Removal	1	2	3	4	5	<input type="checkbox"/>
<input type="checkbox"/> Needle Thoracentesis/CT placement	1	2	3	4	5	<input type="checkbox"/>

<input type="checkbox"/> Insert Gastro./Intestinal Feeding Tube	1	2	3	4	5	<input type="checkbox"/>
<input type="checkbox"/> Initiate/Adjust Nutrition Support	1	2	3	4	5	<input type="checkbox"/>
<input type="checkbox"/> Order Common Lab./Diagnostic Tests	1	2	3	4	5	<input type="checkbox"/>
<input type="checkbox"/> Interpret Common Lab./Diagnostic Tests	1	2	3	4	5	<input type="checkbox"/>
<input type="checkbox"/> Interpret Common Radiologic Tests	1	2	3	4	5	<input type="checkbox"/>
<input type="checkbox"/> Interpret ECG	1	2	3	4	5	<input type="checkbox"/>
<input type="checkbox"/> Order Medications	1	2	3	4	5	<input type="checkbox"/>
<input type="checkbox"/> Order Blood Therapy	1	2	3	4	5	<input type="checkbox"/>
<input type="checkbox"/> Other_____	1	2	3	4	5	<input type="checkbox"/>
Caring Practices	Novice		Proficient		Expert	N/A
<input type="checkbox"/> Administer Sedation –Procedures	1	2	3	4	5	<input type="checkbox"/>
<input type="checkbox"/> Administer Local Anesthesia	1	2	3	4	5	<input type="checkbox"/>
<input type="checkbox"/> Other_____	1	2	3	4	5	<input type="checkbox"/>
Respond to Diversity						
<input type="checkbox"/> Facilitate Team Meetings	1	2	3	4	5	<input type="checkbox"/>
<input type="checkbox"/> Other_____	1	2	3	4	5	<input type="checkbox"/>
Collaboration						
<input type="checkbox"/> Participate in Medical Rounds	1	2	3	4	5	<input type="checkbox"/>
<input type="checkbox"/> Participate in Nursing Rounds	1	2	3	4	5	<input type="checkbox"/>
<input type="checkbox"/> Contribute Nurse Staff Evals.	1	2	3	4	5	<input type="checkbox"/>
<input type="checkbox"/> Contribute Medical Staff Evals.	1	2	3	4	5	<input type="checkbox"/>
<input type="checkbox"/> Other_____	1	2	3	4	5	<input type="checkbox"/>
Systems Thinking						
<input type="checkbox"/> Initiate/Plan Patient Discharge	1	2	3	4	5	<input type="checkbox"/>
<input type="checkbox"/> Coordinate Patient Care/Services	1	2	3	4	5	<input type="checkbox"/>
<input type="checkbox"/> Other_____	1	2	3	4	5	<input type="checkbox"/>
Advocacy/Moral Agency						
<input type="checkbox"/> Discuss Care with Families	1	2	3	4	5	<input type="checkbox"/>
<input type="checkbox"/> Initiate Ethics Consultation	1	2	3	4	5	<input type="checkbox"/>
<input type="checkbox"/> Other_____	1	2	3	4	5	<input type="checkbox"/>
Clinical Inquiry						
<input type="checkbox"/> Develop Standards/Pathways	1	2	3	4	5	<input type="checkbox"/>
<input type="checkbox"/> Participate in Quality Improvement	1	2	3	4	5	<input type="checkbox"/>
<input type="checkbox"/> Disseminate Research	1	2	3	4	5	<input type="checkbox"/>
<input type="checkbox"/> Participate in Research	1	2	3	4	5	<input type="checkbox"/>
<input type="checkbox"/> Initiate Research	1	2	3	4	5	<input type="checkbox"/>
<input type="checkbox"/> Other_____	1	2	3	4	5	<input type="checkbox"/>
Facilitator of Learning						
<input type="checkbox"/> Patient/Family Education	1	2	3	4	5	<input type="checkbox"/>

<input type="checkbox"/> Nursing Education (formal/informal)	1	2	3	4	5	<input type="checkbox"/>
<input type="checkbox"/> Physician Education (formal/informal)	1	2	3	4	5	<input type="checkbox"/>
<input type="checkbox"/> Precept Students	1	2	3	4	5	<input type="checkbox"/>

56. Use the Scale to Indicate your assessment of the Degree of Supervision you require for each activity (*Circle or Bold text*).

1= Always Directly Supervised	4= Supervision without Direct Presence
2= Usually Directly Supervised	5= No Supervision Required
3= Occasional Direct Supervision	N/A= Not Applicable

Clinical Practice						N/A
<input type="checkbox"/> History/Physical Exam	1	2	3	4	5	<input type="checkbox"/>
<input type="checkbox"/> Venipuncture - Blood Draw	1	2	3	4	5	<input type="checkbox"/>
<input type="checkbox"/> Insert Intravenous Lines	1	2	3	4	5	<input type="checkbox"/>
<input type="checkbox"/> Initiate/Adjust IV Fluids	1	2	3	4	5	<input type="checkbox"/>
<input type="checkbox"/> Insert PICC lines	1	2	3	4	5	<input type="checkbox"/>
<input type="checkbox"/> Place Central Lines	1	2	3	4	5	<input type="checkbox"/>
<input type="checkbox"/> Place Arterial Catheters	1	2	3	4	5	<input type="checkbox"/>
<input type="checkbox"/> Place Umbilical Lines	1	2	3	4	5	<input type="checkbox"/>
<input type="checkbox"/> Remove Intracardiac Lines	1	2	3	4	5	<input type="checkbox"/>
<input type="checkbox"/> Suture Wounds	1	2	3	4	5	<input type="checkbox"/>
<input type="checkbox"/> Suture Lines in Place	1	2	3	4	5	<input type="checkbox"/>
<input type="checkbox"/> Suture Removal	1	2	3	4	5	<input type="checkbox"/>
<input type="checkbox"/> Initiate/Titrate Vasoactive Drugs	1	2	3	4	5	<input type="checkbox"/>
<input type="checkbox"/> Adjust Oxygen Therapy	1	2	3	4	5	<input type="checkbox"/>
<input type="checkbox"/> Endotracheal Intubation	1	2	3	4	5	<input type="checkbox"/>
<input type="checkbox"/> Initiate/Adjust Mechanical Ventilation	1	2	3	4	5	<input type="checkbox"/>
<input type="checkbox"/> Document on Progress Notes	1	2	3	4	5	<input type="checkbox"/>
<input type="checkbox"/> Removal of Chest Tube (CT)	1	2	3	4	5	<input type="checkbox"/>
<input type="checkbox"/> CT placement/thoracentesis	1	2	3	4	5	<input type="checkbox"/>
<input type="checkbox"/> Insert Gastro./Intestinal Feed Tube	1	2	3	4	5	<input type="checkbox"/>
<input type="checkbox"/> Initiate/Adjust Nutrition Support	1	2	3	4	5	<input type="checkbox"/>
<input type="checkbox"/> Order Common Lab./Diagnostic Tests	1	2	3	4	5	<input type="checkbox"/>
<input type="checkbox"/> Interpret Common Lab./Diagnostic Tests	1	2	3	4	5	<input type="checkbox"/>
<input type="checkbox"/> Interpret Common Radiologic Tests	1	2	3	4	5	<input type="checkbox"/>
<input type="checkbox"/> Interpret ECG	1	2	3	4	5	<input type="checkbox"/>
<input type="checkbox"/> Order Medications	1	2	3	4	5	<input type="checkbox"/>
<input type="checkbox"/> Order Blood Therapy	1	2	3	4	5	<input type="checkbox"/>

<input type="checkbox"/> Other_____	1	2	3	4	5	<input type="checkbox"/>
Caring Practice						N/A
<input type="checkbox"/> Administer Sedation –Procedures	1	2	3	4	5	<input type="checkbox"/>
<input type="checkbox"/> Administer Local Anesthesia	1	2	3	4	5	<input type="checkbox"/>
<input type="checkbox"/> Other_____	1	2	3	4	5	<input type="checkbox"/>
Respond to Diversity						
<input type="checkbox"/> Facilitate Team Meetings	1	2	3	4	5	<input type="checkbox"/>
<input type="checkbox"/> Other_____	1	2	3	4	5	<input type="checkbox"/>
Collaboration						
<input type="checkbox"/> Participate in Medical Rounds	1	2	3	4	5	<input type="checkbox"/>
<input type="checkbox"/> Participate in Nursing Rounds	1	2	3	4	5	<input type="checkbox"/>
<input type="checkbox"/> Contribute Nursing Staff Evaluations	1	2	3	4	5	<input type="checkbox"/>
<input type="checkbox"/> Contribute Medical Staff Evaluations.	1	2	3	4	5	<input type="checkbox"/>
<input type="checkbox"/> Other_____	1	2	3	4	5	<input type="checkbox"/>
Systems Thinking						
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<input type="checkbox"/> Coordinate Patient Care/Services	1	2	3	4	5	<input type="checkbox"/>
<input type="checkbox"/> Other_____	1	2	3	4	5	<input type="checkbox"/>
Advocacy/Moral Agency						
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<input type="checkbox"/> Other_____	1	2	3	4	5	<input type="checkbox"/>
Clinical Inquiry						
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<input type="checkbox"/> Disseminate Research	1	2	3	4	5	<input type="checkbox"/>
<input type="checkbox"/> Participate in Research	1	2	3	4	5	<input type="checkbox"/>
<input type="checkbox"/> Initiate Research	1	2	3	4	5	<input type="checkbox"/>
<input type="checkbox"/> Other_____	1	2	3	4	5	<input type="checkbox"/>
Facilitator of Learning						
<input type="checkbox"/> Patient/Family Education	1	2	3	4	5	<input type="checkbox"/>
<input type="checkbox"/> Nursing Education (formal/informal)	1	2	3	4	5	<input type="checkbox"/>
<input type="checkbox"/> Physician Education (formal/informal)	1	2	3	4	5	<input type="checkbox"/>
<input type="checkbox"/> Precept Students	1	2	3	4	5	<input type="checkbox"/>

57. **I'm interested in taking a Certification Exam for Pediatric Acute Care Nurse Practitioners.**

- a. Yes b. No

58. **I'm interested in taking a Certification Exam for Pediatric Clinical Nurse Specialists.**

- a. Yes b. No

59. **What Benefits could you achieve through a National Certification Exam?**

60. **How much would you be willing to pay for a certification exam? \$_____**

61. **I'm interested in having my name and contact information in a Directory for APNs pediatric critical care.**

- a. Yes b. No

Thank you for your willingness to complete this survey.

We will be forwarding a copy of the results to you.

Your participation is greatly appreciated!