The CNL: A gateway to better care?

The clinical nurse leader, a master's-educated nurse generalist, may hold promise for advancing evidence-based patient care.

By Linda Rusch, RN, APN, CNAA, MS, and Susan Bakewell-Sachs, RN, APN, PhD

The American Association of Colleges of Nursing (AACN) leads the development of the clinical nurse leader (CNL) role to address fragmentation, safety, and quality concerns identified by several national reports on healthcare and healthcare professions from the Institute of Medicine, The Joint Commission (formerly JCAHO), the American Hospital Association, and the Robert Wood Johnson Foundation. But what, exactly, does the CNL do? He or she is a clinician, a registered nurse with a master's degree, who's educated to assume accountability for patient/client outcomes through the application of evidence-based, client-centered, and cost-effective care.

The CNL is prepared to practice across care settings and with various client populations within the context of...
Joining the CNL pilot was viewed as an opportunity to address the needs for building leadership, advancing evidence-based practice, strengthening a culture of safety, and providing unit-based master's-prepared nurses in support of staff nurses at the point of care. Specific aspects of the proposed CNL role considered valuable for Hunterdon Medical Center (HMC) included enhancing communication and advocacy across the continuum of care, and the potential to strengthen interdisciplinary care delivery. Nationally, root cause analyses have identified communication issues as responsible for 66% of sentinel events. 

The basic unit structure at HMC includes nurse director, staff nurses, patient care assistants, and unit secretaries. Other roles that support patient care include case managers who are nurses, medical hospitalists, and transport and admission teams. In preparation for the implementation of the CNL role into a healthcare system, the national task force strongly recommended that systems issues be identified and addressed.

Redesigning care delivery based on a comprehensive assessment of care issues and inclusive of the CNL role maximizes overall success. Transforming Care at the Bedside (TCAB) is a national program supported by the Robert Wood Johnson Foundation. The program is aimed at evaluating and changing systems to allow nurses to spend more time in direct patient care and less time gathering back minutes to the nurse to facilitate spending more time with patients. This intentional process is also preparing the environment for implementation of the CNL role when the first cohort of students graduates in August.

In terms of complexity science and complex adaptive systems, the various departments are linked attributes within the system of HMC, and the employed process is using the richness of the diverse attributes within the organization to enhance the potential for systems adaptation of all involved in healthcare delivery. It was initially decided to focus the CNL pilot at Hunterdon on the three med/surg units. Three CNL students, one from each unit, were chosen by the nurse directors and CNO. Chosen nursing staff members were med/surg RNs already demonstrating leadership ability and willing to take on the new role.

To optimize the chance for success of a new initiative, information diffusion and stakeholder buy-in were essential. Stakeholder groups were identified by the overall partnership so that communication plans could be developed at each of the practice partner organizations. At HMC, the CNO, dean, and graduate division chair from The College of New Jersey first introduced the National Clinical Nurse Leader Pilot Program to nursing leadership. Joint representation of medical center and nursing education leadership demonstrated the partnership model of the pilot program and facilitated discussion regarding education and practice during the expected pilot. Nurse case managers were identified as a key stakeholder group in the introduction of the CNL at the medical center because of their role on the units. The case managers were also invited to the forum so that they could hear about the CNL role, ask questions, engage in dialogue with nursing leadership, and see how the CNL could interface with and augment their role. Following nursing leadership, presentations were made to the board of trustees, medical executive committee, and leadership forums. The medical staff leadership voiced the most optimism and enthusiasm regarding this new role.

Student support was another key area of focus seen as essential for success of the pilot, with additional emphasis at HMC on financial and emotional support. Tuition and academic costs, time off for classes, and flexibility in work schedules were specifically considered. In conjunction with human resources, arrangements were made to pay students' tuition and book costs upfront each semester instead of reimbursing them at the end of the semester. A commitment was also made to have health benefits remain the same despite changing work hours during the year since most of the CNL students dropped their working hours from 80 per pay period to 72 to manage their school requirements more effectively. Nurse directors were supportive of implementing the role and were supported by the CNO to work closely with the students to address scheduling needs and flexibility. Student support was part of the foundation laid to optimize student success in their course of study.

After the first semester of course work, the students were granted 1 day per week in their work schedules to "play in the role." So as not to overly prescribe the role at the outset, students were encouraged to focus on three areas: newly admitted patients, safety, and issues that they observed might need problem solving involving systems changes. In addition, the students were asked to keep journals of their experiences to aid in reflection as they transitioned into the role and to chronicle their story in this pioneering effort. Concurrently, the CNO began meeting with all of the CNL students and their nurse direc-
nursing and 190 healthcare institutions comprised the participating education-practice partnerships, with over 325 full-time and 150 part-time students enrolled in CNL programs.\textsuperscript{9} A pilot certification examination was ready in December 2006, and the first regular administration of the exam is expected by spring 2007.

**Curriculum**

Four curriculum options for the pilot are: a traditional postbaccalaureate master’s program; master’s program with a postbaccalaureate residency; master’s program designed for post-high school entry, including a pre-nursing baccalaureate degree and a master’s degree in nursing or a master’s degree program for individuals with a nonnursing bachelor’s degree; and a master’s degree designed for associate degree registered nurses.\textsuperscript{10} The CNL curriculum framework specifically emphasizes nursing leadership, clinical outcomes management, and care environment management.\textsuperscript{11} Students are expected to meet competencies in each of the areas while completing 400 to 500 hours of clinical work, including an immersion practical experience the last semester of the program.

Healthcare systems and organizations is an area of focus in the curriculum under care environment management that includes emphasis on unit-level healthcare delivery and micro-systems of care, complexity theory, and managing change theories. Complexity theory hasn’t previously been a national recommendation for a nursing curriculum, and the inclusion in the CNL framework ignited a great deal of interest.

The CNL students, in their emerging role, didn’t have direct patient care responsibilities during their 1 day per week to “play in the role” but saw themselves as the “safety nurse.” The safety nurse at HMC must be mindful of all potential handoffs between caregivers and how the CNL could support the fabric of greater safety. In terms of safety, the CNL students have focused primarily on preventing falls, decreasing pressure ulcers, and monitoring infection control practices to reduce multiple resistant organisms. The areas chosen were supported by the literature and emphasize how nursing care and surveillance affect these three areas. Falls with injury and nosocomial pressure ulcers are reportable to the State Department of Health. HMC also participates in the National Database of Nursing Quality Indicators (NDNQI) and continually measures these indicators, which will be utilized in evaluating the impact of the CNL role at HMC. The CNL also facilitated meetings between the CNL students and key department directors in the organization that could support their role as safety nurse. The students met with risk management, data analysis, infection control, pharmacy, and the wound care specialist. The students were also empowered to augment the list by meeting with relevant department directors such as hospice or cardiopulmonary rehabilitation, depending upon the specific unit on which they worked.

Meeting monthly has been beneficial for the CNL students, directors, and the CNO. The discussions have helped to clarify the emerging role and allowed for support and problem solving during early role transition and acceptance. Each student is rising to leadership among peers on units where he or she has worked for varying lengths of time. The CNO and nurse directors can lend support for project ideas and assist with any barriers that may arise. For the CNO, it’s gratifying to see staff nurses becoming leaders and to strategically focus on facilitating the role for the future. The CNO’s direct involvement with the students has also allowed her to best represent practice elements with her academic partner at monthly meetings with all of the partners.

At HMC, the CNL evaluation includes benchmarking on all of the key quality indicators using NDNQI. Press Ganey is used to monitor patient satisfaction. Root cause analyses are tracked and appropriate care measures followed closely. The baseline for these indicators was established prior to the students beginning their weekly practice. Once the CNL students are in their role full time and graduate to the official role of CNL, all of the above indicators will be monitored to determine the effects the CNLs have on the overall quality and safety of patient care programs.

HMC is embracing all of the competencies set forth by the AACN for the CNL role while emphasizing specific priority competencies for the emerging role at HMC of systems analyst/risk anticipator, outcomes manager, and information manager. These areas represent the major areas of new learning in the program for the experienced nurses from HMC—synthesizing and utilizing data to achieve optimal client and care environment outcomes. These areas also have great potential for demonstrating the cost/benefit of fully implementing the role.

Budgeting for the CNL positions is a significant consideration of this project. In the first year at HMC, the CNL position will be part of the overall budget for full-time equivalents and hours per patient day, with a goal of budget neutrality. If the CNL role can be shown to be effective in reducing falls, pressure ulcers, and nosocomial infections, as well as other quality outcome measures, it won’t be difficult to make a case for the position to be added to the existing staff because the cost benefit would be evident.
In complexity theory or science, healthcare organizations are viewed as complex adaptive systems, moving away from the mechanistic view of organizations where the focus is on specifying and controlling parts of the system to effect predictable outcomes. Viewing organizations through the lens of complexity encourages leaders to be adaptable and flexible, think and plan strategically but follow simple rules, recognize the effects of individual agents and the relationships among them, appreciate the potentially large effects of small changes, and be reflective. As a thread in the CNL curriculum, complexity science was expected to help students in learning about leadership and leading change.

One partnership
The College of New Jersey (TCNJ) School of Nursing joined the national CNL pilot in 2004 with three practice partners, one of which was Hunterdon Medical Center (HMC). A post-baccalaureate master’s degree curriculum was chosen because TCNJ already had a master’s degree program with several options. HMC and its chief nurse officer (CNO) were already using complexity science principles to guide leadership throughout the organization.

The first cohort of TCNJ CNL students matriculated in fall of 2005. All enrolled part-time, taking two courses per semester to maintain the cohort in order for students to build relationships during their course of study and lay a foundation for a collegial network after graduating. Currently, students are in the next-to-last semester of course work. They’ll begin their final practicum in May and graduate in August 2007. (See “Hunterdon case study.”)

Discussion
Several considerations are relevant for CNOs when deciding whether or not to embrace the CNL role in their organization. Obviously bringing new knowledge and competencies to the point of care has the potential to contribute significantly to a healthcare delivery system. Establishing a new role or position within an organization, however, is a major undertaking even when the expected outcomes are considered essential.

Potential benefits of the CNL can be gleaned from the available documents at the CNL section of the AACN website at http://www.aacn.nche.edu. The white paper, a comparison of CNL and CNS, curriculum framework, competencies, and job description, can help you begin to consider the potential benefits in your organization. The practice-education partnership is paramount to the success of introducing a new curriculum and implementing the role. Although this was required for participation in the national pilot, these partners highly recommend frequent open dialogue, openness to learning from each other, and close collaboration for all aspects of the education and implementation process. Monthly or other regularly scheduled meetings should include the CNO, faculty leaders, and academic administrators. Periodically, students, involved faculty members, and other practice administrators should also participate in meetings to provide feedback with regard to education and implementation issues.

Investment in the change process is a major consideration. It’s essential that the CNO be directly involved throughout the program. The CNO must think about commitment and investment in establishing vision; obtaining buy-in; educating key stakeholder groups; selecting the first students; assessing, developing, and precepting the first students; preparing the environment; and shaping and supporting the emerging role. The HMC partnership involved monthly meetings with the academic partner and two meetings per month inside the organization.

Every partnership will experience different challenges. Several observed...
Preparing the unit environment is critical and challenging. Nursing should lead the assessment process, involving the many departments that affect care delivery, then redesign the care delivery model with the CNL role in mind. Experienced senior nurses who return to school to become a CNL may not initially appreciate the rigors of graduate study and the impact on one’s life. Selection in collaboration with the academic partner can help in advising potential students.

The CNL offers staff nurses across the care spectrum the opportunity to advance clinically and remain involved in direct nursing care without moving to the different advanced practice paradigm. HMC has found this pioneering effort exciting and the education-practice partnership model valuable.

REFERENCES

ABOUT THE AUTHORS
Linda Rusch is chief nurse officer at the Hunterdon Medical Center, Flemington N.J. Susan Bakewell-Sachs is Carol Kuser Loser dean and professor of nursing at The College of New Jersey, Ewing, N.J.