Factors Influencing Organizational Participation in the Clinical Nurse Leader℠ Project

EXECUTIVE SUMMARY

- When the American Association of Colleges of Nursing introduced the Clinical Nurse Leader℠ (CNL) pilot project in 2004, it was the first time in more than 40 years that an attempt was made to introduce a new role to the profession.
- This new role was designed to address many challenges related to patient care in the current health care delivery system including a need for more effective clinical problem solving, better coordination at the point of care, stronger interdisciplinary relationships, and more rapid implementation of evidenced-based practice findings at the patient-provider interface.
- Critics from both academic and practice settings have questioned the need and wisdom of introducing a new role to the profession at this time.

The factors that led some nursing leaders in early stages of this project to be proactive and involve their organizations as early adopters of the CNL role were examined in this study.

- Five major factors were identified from the research to form a framework designed to explain organizational participation: organizational needs, a desire to improve patient care, an opportunity to redesign care delivery, the promotion of the professional development of nursing staff, and the potential to enhance physician-nurse relationships.
- The ability of academic and service partners to forge the types of relationships and promote best practices as is occurring in the CNL project may be a critical success factor in confronting the current and impending nursing shortage.

The introduction of the CNL role has not been without controversy. Critics from both academic and practice settings have questioned the need and wisdom of introducing a new role to the profession at this time (Erickson & Ditomassi, 2005). Members of the National Association of Clinical
Nurse Specialists (2005) expressed concern about role duplication and overlap between the CNL and clinical nurse specialists roles. In an era where the need for evidence-based practice is being emphasized, the lack of evidence to support the need for this initiative has been noted (Hayne & Polifroni, 2005; National League for Nursing, 2005). Despite skepticism within the profession, many nursing leaders have stepped forward and involved their organizations in the CNL project. Chief nursing officer (CNO) support is a critical success factor to leading innovative change in their organizations (Morjikian, Kimball & Joynt, 2007). The purpose of this article is to present the findings of a qualitative research study conducted during 2005-2006. The investigator explored the driving factors that influenced the decisions of CNOs to promote the involvement of their organizations in the CNL project.

**Literature Review**

From an historic perspective, discussions about the need for the CNL role began in 2002 when AACN convened stakeholders to discuss what changes were needed in nursing education to prepare nurses with the competencies which they need to work in the current and future health care system (AACN, 2005b). Participating nursing leaders were urged to think completely out of the box and take a close look at the issues and challenges of today’s health care delivery system. There was consensus that it might be time to consider a new role for nursing and that preparation should be at the graduate level. In introducing the need for the CNL role, the AACN (2004a) highlighted the challenges occurring in practice environments expressed by nursing leaders. These included the nursing shortage, growing fragmentation of patient care, lack of nursing leadership at the point of care, inadequate coaching of novice nurses, impending reimbursement for performance, and a need to redesign care delivery to become more team focused.

In March 2004, a request for proposals to participate in the CNL pilot project was sent to AACN member universities and colleges (AACN, 2004b). A unique feature of the project was an AACN requirement that universities and colleges that wanted to offer the CNL curriculum had to engage a service partner in the project that was committed to redesigning their professional practice model to incorporate the new CNL role. Using curriculum guidelines provided by AACN, the partnerships worked collaboratively to plan the CNL programs. The CNL graduate curriculum is designed to expand on the skills and competencies of baccalaureate graduates. Upon graduation, the CNL is expected to serve as a lateral integrator of care for patients at the micro-system or clinical unit level (Tornabeni, Stanhope, & Wiggins, 2006).

The project has now evolved to include partnerships in the four geographic regions in the United States (Stanhope & Turner, 2006). The first CNL students have graduated, taken their certification exam, and are now in practice. An evaluation framework has been developed for the project using a balanced scorecard approach (AACN, 2006). Early evaluation outcomes from clinical partner sites appear very promising (Harris, Tornabeni, & Walters, 2006; Hartranft, Garcia, & Adams, 2007; Smith & Dabbs, 2007; Smith, Manfredi, Hagos, Drummond-Huth, & Moore, 2006). Interest in the CNL role is building nationwide as nurse leaders face a health care environment where reimbursement is shifting to focus on patient outcomes, many of which are nursing sensitive. The factors that led some nursing leaders in early stages of this project to be proactive and involve their organizations as early adopters of the CNL role were examined in this study.

**Study Design**

A grounded theory methodologic approach as described by Strauss and Corbin (1998) was used to explore why CNOs involved their organizations in the Clinical Nurse Leader project. Semi-structured face-to-face interviews using eight open-ended questions (see Table 1) were conducted by the investigator. The interviews were transcribed and evaluated. The themes and concepts that emerged from the data were coded into categories that

### Table 1. Interview Questions

- What led to your decision to promote the involvement of your organization in the CNL project?
- What outcomes do you hope to see from the project?
- What are the risks of involvement for your organization?
- How has your staff responded to the decision to participate?
- What is your vision for redesigning care in your organization to incorporate this new role?
- How might this role move nursing forward professionally?
- What do you anticipate the benefits will be for patients?
- How have your co-leaders outside of nursing responded to the involvement of your organization in the project?

**NOTE:** Additional questions were asked to clarify emerging themes in the data.
formed an explanatory framework for organizational involvement (see Figure 1). Institutional review board approval was obtained from Florida Atlantic University.

**Sample**

Twenty-five chief nursing officers from health care agencies in the State of Florida participating in the clinical nurse leader project were invited by letter in 2005 to participate in the research study. Data saturation was reached when a convenience sample of ten of the original 25 CNOs contacted were interviewed. Demographic information on the study participants is presented in Table 2. Of the sample interviewed, 100% were women with an average age of 52.8 years. The CNOs interviewed were experienced leaders with a range of 16 to 36 years in leadership positions and a mean of 9.7 years in their current CNO position. Nine of the ten CNOs worked in acute care facilities. Three of the participating CNOs were leaders in organizations that achieved Magnet® recognition and six were in organizations on the Magnet journey. Study participants were all master’s-prepared either in nursing or a related field.

**Data Collection and Analysis**

Interviews with the CNOs were conducted by the investigator onsite at their facilities either in their office or a conference room. One hour was scheduled for each interview. Participants were eager to share their thoughts about why they were participating in the CNL project. The interviews were taped and transcribed. MAXQDA was used for qualitative software support in managing the interview data. The investigator began with the list of questions from the interview guide (see Table 1) and did an open reading of text, writing memos, and tagging segments. This allowed for an inventory of what was in the data to identify other emerging issues prior to coding the data. The data were then

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**Figure 1. Major Categories of Factors Affecting the Decision of Chief Nursing Officers to Involve Their Organizations in the CNL Project**

**Table 2. CNO Demographics (N=10)**

<table>
<thead>
<tr>
<th>Age (Average)</th>
<th>52.8 Years (Range 48-61)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gender</td>
<td>100% Female</td>
</tr>
<tr>
<td>Years of Nursing Experience (Mean)</td>
<td>32.1 Years (Range 24-39)</td>
</tr>
<tr>
<td>Years in Nursing Leadership (Mean)</td>
<td>23 Years (Range 16-36)</td>
</tr>
<tr>
<td>Years in Current CNO Position (Mean)</td>
<td>9.7 Years (Range 2-26)</td>
</tr>
<tr>
<td>Highest Level of Education</td>
<td>2 - BSN/MBA</td>
</tr>
<tr>
<td></td>
<td>1 - BSN/MHA</td>
</tr>
<tr>
<td></td>
<td>1 - MSN/MBA</td>
</tr>
<tr>
<td></td>
<td>6 - MSN</td>
</tr>
<tr>
<td>Type of Health Care Agency</td>
<td>1 - Health Care District/School Nurse Program</td>
</tr>
<tr>
<td></td>
<td>2 - For-Profit Community Hospital</td>
</tr>
<tr>
<td></td>
<td>7 - Not-for-Profit Community Hospitals</td>
</tr>
<tr>
<td>Magnet Recognition</td>
<td>3 - Currently Accredited</td>
</tr>
<tr>
<td></td>
<td>6 - On Magnet Journey</td>
</tr>
<tr>
<td></td>
<td>1 - Not Applicable</td>
</tr>
<tr>
<td>Number of RN FTE in Agency</td>
<td>2 - 1,000 to 2,000 RN FTE</td>
</tr>
<tr>
<td></td>
<td>3 - 500 to 999 RN FTE</td>
</tr>
<tr>
<td></td>
<td>5 - Less than 500 RN FTE</td>
</tr>
</tbody>
</table>
Factors Influencing Organizational Participation in the Clinical Nurse Leader™ Project

Study Findings

Five major factors were identified from the research to form a framework designed to explain organizational participation (see Figure 1): organizational needs, a desire to improve patient care, an opportunity to redesign care delivery, the promotion of the professional development of nursing staff, and the potential to enhance physician-nurse relationships.

Organizational needs. The current and future needs of their organizations played a prominent role in the decision-making process for CNOs as they considered involvement in the CNL project. The CNOs interviewed identified an organizational need to do a better job of complying with ever-increasing regulatory requirements. The CNL role was viewed as having the potential at the point of care to help with JCAHO regulatory issues, monitoring of core measures, and assessment of performance on nursing-sensitive indicators. CNOs predicted that with the movement toward pay for performance in acute care settings for both core measures and nursing-sensitive indicators, they could easily demonstrate the financial value of the CNL role.

Most indicated that they would work hard to make the position budget neutral and saw few risks to their organizations. Their longevity in their organizations and the support of their executive colleagues were seen as factors contributing to their willingness to become involved in innovative projects. One CNO reflected the thoughts of others when she observed, “I guess I don’t see a lot of risks for involvement. If something does not work – you can always stop it but you have to move forward.”

Desire to improve patient care. Improving patient outcomes in systems that are already overburdened is not an easy task. As one CNO commented, “At the end of the day, my biggest motivation for getting involved in the CNL project is that I want to make a difference in our patient’s lives and I see this role doing this.” CNOs identified the CNL as the point person at the unit level who could fix systems problems, improve lateral team communication, keep the patient better informed, introduce new evidence-based nursing interventions, and ensure continuity of care. The analogy of the “air traffic controller for clinical care” was used by several CNOs to describe how they envisioned the role.

Specific patient outcomes desired that were identified included a decrease in length of stay and re-admission rates for chronic illness, a decrease in infections, increased patient satisfaction, and a decrease in patient falls. CNOs hoped the CNL role would make the acute care environment safer for patients by reducing the probability of medical errors and improving discharge planning efforts. Medical-surgical and telemetry units were special areas of concern for CNOs, and the environments where they hoped to initially pilot the new role. One CNO shared the observation that, “I think we are flying by the seat of our pants in nursing today. It is a survival skill to get from day to day particularly on our medical-surgical units. I think this will help. It will reduce the chaos and hopefully the environment will be calmer.” Another commented, “Acute care, especially med-surg, is an area where we need to make radical changes. It is hard to keep staff and to coordinate care.”

Opportunity to redesign care delivery. The opportunity to redesign care delivery was a key factor in the decision-making process to participate in the project for several of the CNOs. One CNO reflected thoughts echoed by others: “Regardless of what other nursing leaders may think, in the future – I don’t think we will have enough RNs to deliver care the way we do today. I think we need to grow our RNs through education so they can oversee the care of groups of patients with caregivers other than RNs. The CNL role fits this need.”

At the time of the interviews, many of the CNOs were unsure about how they would redesign care to most effectively use the CNL role but felt the CNL students should be included in the process. They expressed a desire to fix some of the problems with continuity that they observed with most current nursing staff working 12-hour tours. Two CNOs redesigned their models of care delivery prior to the CNL project and had roles similar to the CNL which they felt were working well. Key points raised included a need to make care delivery more seamless, move from a task-oriented approach to care, and improve communication. Several CNOs indicated that their organizations had recently moved back to a team nursing approach to care delivery and found their professional nurses struggling with supervision and delegation issues. They saw a need for strong professional nursing leadership at the point of care.

Patient needs were a major concern of CNOs in looking at innovative delivery models that promoted relationship-based care. This concern was reflected in the comments of one CNO: “I want patients to feel confidence in their care delivery and hope. Again and again I am told, I was not informed about what was going on with me or people were not responsive to my needs. To me, it all comes down to relationships and I hope the CNL can promote those relationships.”
Promotion of professional development. The professional disengagement of nursing staff was a theme throughout the interviews. CNOs hoped that the CNL role will professionally improve the image of nursing in acute care settings by acting as a role model, mentor, and coach to staff. They had special concern about a need to improve transition for novice nurses. One CNO observed, “I think the CNL role may stop some of the victim mentality that we see in nursing today and enhance professionalism. We need to enhance the level of critical thinking and look at the big picture and not just a task.” The CNO vision expressed was that the CNLs will work to motivate and challenge staff to use a evidenced-based approach to practice and encourage professionalism. Many indicated that they wanted to reverse a trend that they see in clinical practice where as one CNO reflected, “The majority of staff nurses are just trying to make it through the day...I don’t think they are asking themselves about what impact they can have on the patient for the next 12 hours.” They acknowledged the difficulty of changing practice at the point of care and hoped the CNL could help their organizations achieve more consistency at the point of care when new policies or procedures were implemented.

The introduction of the CNL role provides an opportunity to keep the best and brightest nurses at the bedside particularly in medical-surgical settings by offering career advancement for nurses who complete graduate programs. Most CNOs expressed concern about the growing numbers of associate degree-prepared nurses in their settings and hoped that the CNL could be a strong influence in the decision to return for a BSN. Long-term acceptance of the role by staff nurses was seen as key to the success of the project.

Potential to enhance physician-nurse relationships. The improvement of collegial relations with physicians is an outcome that CNLs interviewed hoped to see with the introduction of the CNL role. They predicted that the ongoing presence (5 days a week) of a clinical leader on the unit should significantly improve communication with physicians. It would also reduce the current frustration that many physicians have about no one in nursing knowing the patient’s story. CNLs noted that the practice of nurses rounding with physicians has been lost in many nursing environments today and hoped that the CNL would role model this for the nursing staff. One CNO described her desire that, “Patients will get care earlier, have better discharge planning, and more family involvement. I believe their physicians will also know more about what goes on with the patient during the 23 hours and 55 minutes that they are not here.”

CNOs reported that physician colleagues generally embraced the pilot project when it was presented to them. One CNO shared her vision: “I am looking for a nurse who will step up to the plate and be accountable for clinical nursing care on a collegial level with a physician which I don’t believe we have today.” The CNL was also seen as an organizational bridge at the point of care for projects that involve physicians like SBAR (situation-background-assessment-recommendation) focused reports or CPOE (computerized physician order entry).

Other key findings. Many of the CNOs interviewed described themselves as innovators but were realistic about the implications that redesigning nursing practice to incorporate this role would have for their environment. AACN recommended to partners that they review the work done by Kotter (1996) on leading change in organizations. CNOs reported that they had already begun the process of establishing a sense of urgency for change within their environments. Without exception, they wanted to offer this opportunity to their “best and brightest nurses” and work with their academic partners to design flexible curriculums to allow this to occur. One CNO noted, “the CNLs will have to be clinically strong or they won’t have leadership credibility. We have looked for candidates who have this credibility and the ability to think on a systems level.”

The selection of the initial pilot units and support of the nurse managers on those units were felt to be key success variables by the CNOs interviewed. One CNO acknowledged that, “It was hard to find floors who wanted to pilot this; we ended up with units that are having problems and looking for new answers, a new way to do things.” Most of the CNOs built strong supportive coalitions within their organizations to help move the project forward. They also worked hard to establish a business case for the position and identified specific outcome measures that they hoped to see (see Table 3). As one CNO noted about her organization, “We are becoming very outcomes focused and this role prepares nurses to be able to focus on outcomes.”

The CNOs recognized the importance of their ongoing involvement in the project. They saw themselves as playing a key role in communication efforts to staff about the project. One CNO shared her observation that “I think there will be a tipping point for this project. The good outcomes will become so obvious that it will become the way we do things, but for that to happen I will need to move this vision forward in our organization.” The credibility of their academic partners and past experiences with innovative partnerships was mentioned by CNOs as playing a role in their decision to move forward with the CNL project.

Limitations and Discussion

The sample size of CNOs interviewed for this study was small and limited to one geographic area. Perceptions about the CNL role
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Table 3.
CNL Role Outcome Measures

- Improved performance on CMS core measures
- Improved performance on NDNQI measures
- Reduction in length of stay
- Reduction in hospital-acquired pressure ulcers
- Reduction in patient falls
- Improvement in patient throughput
- Reduction in ventilator-associated pneumonia
- Reduction in nosocomial infection
- Staff retention
- Improved patient and family satisfaction
- Fewer medical errors
- Reduced re-admissions
- More effective new graduate transition
- Fewer near misses
- Improved physician satisfaction
- Use of evidenced-based practice at point of care
- Improvement in end-of-life decision making

nursing staff. As the CNL pilot project journey continues, the ultimate success of the CNL role will depend on what value this new role adds to patient care and to the organizations who implement it.

Implications for Nursing Leaders
Chief nursing officer support for the CNL project has been critical to securing organizational participation. The successful implementation of a new role in nursing is not without challenges. CNOs have entered the CNL project with great enthusiasm but also have specific outcome goals that they hope to see as a result of their organization’s participation in the project. Some of the identified outcomes mentioned in this study were identified in the AACN CNL Evaluation Framework (2006) and are being studied as part of the pilot project evaluation of indicators. Early outcomes data from partners involved in the project are very encouraging. There is a need for additional outcomes research at the health care agency or academic partnership level to assess the impact of the role on patient care, the organization, and nursing staff.

REFERENCES
continued on page 249