The clinical nurse leader: a catalyst for improving quality and patient safety

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Aim The clinical nurse leader (CNL®) is a new nursing role introduced by the American Association of Colleges of Nursing (AACN). This paper describes its potential impact in practice.

Background Significant pressures are being placed on health care delivery systems to improve patient care outcomes and lower costs in an environment of diminishing resources.

Method A naturalistic approach is used to evaluate the impact the CNL has had on outcomes of care. Case studies describe the CNL implementation experiences at three different practice settings within the same geographic region.

Results Cost savings, including improvement on Centers for Medicare and Medicaid Services (CMS) core measures, are realized quickly in settings where the CNL role has been integrated into the care delivery model.

Conclusions With the growing calls for improved outcomes and more cost-effective care, the CNL role provides an opportunity for nursing to lead innovation by maximizing health care quality while minimizing costs.

Implications for nursing management Nursing is in a unique position to address problems that plague the nation’s health system. The CNL represents an exciting and promising opportunity for nursing to take a leadership role, in collaboration with multiple practice partners, and implement quality improvement and patient safety initiatives across all health care settings.

Keywords: clinical nurse leader, microsystems of care, patient safety, pay-for-performance, quality improvement

Accepted for publication: 25 March 2008
Introduction

In 2004, 78 schools of nursing with multiple and diverse practice partners responded to an invitation sent by the American Association of Colleges of Nursing (AACN) to join a national initiative to develop a master’s curriculum to prepare graduates with the set of competencies, skills and knowledge delineated in the AACN white paper titled The Education and Role of the Clinical Nurse Leader (2007). These education-practice partnerships were also challenged to transform one or more units within the health care setting to integrate the CNL role into the care delivery model. Since that time, the number of partnerships engaged in the initiative has grown to include 92 schools with 192 health care institutions. The practice sites are primarily acute care facilities but also include school health departments, visiting nurses associations, public health agencies, and long-term care and rehabilitation facilities.

In autumn 2006, the first CNLs graduated from 12 master’s nursing programmes. These graduates represented both post-baccalaureate nursing master’s programmes and second degree or generic master’s degree programmes1. The CNL® Certification examination, developed by AACN and first administered in autumn 2006, created a unique credential for graduates of the CNL programmes. The CNL® credential, a registered trademark, indicates the individual has met a national standard of requisite knowledge and experiences, including graduation from a master’s programme that prepares him/her with the CNL competencies, has had specific required clinical experiences, and has practised in the CNL role in a formal clinical immersion experience (AACN 2007). As of February 2008, 329 individuals have successfully achieved the CNL credential and over 1250 students were enrolled in CNL programmes across the country (AACN 2008).

From the beginning, evaluation has been an important component of the CNL initiative. The CNL Implementation Task Force, the first task force charged in 2004 with overseeing the CNL initiative, worked with education and practice representatives to develop an evaluation plan. At the centre of this plan was the CNL Evaluation Scorecard, patterned after the Kaplan and Norton (1992) Balanced Scorecard. The CNL Evaluation Scorecard includes four domains: quality internal processes, satisfaction, financial outcomes, and innovation. Within each domain, a set of possible metrics are identified, which could be measured by data already being collected by most health care settings. In 2006, the CNL Scorecard was piloted at TennValley Inc. over a 3-month period on several units where a CNL had practised for at least 6 months. The purpose of the pilot was to test the definitions, data collection processes and analyses. In this brief 3-month period, positive patient care outcomes were observed, including a decrease in readmission rates and decreased length of stay for heart failure patients, decreased patient falls, and decreased post-surgical infection rates (Harris et al. 2006). Following the pilot, education-practice partners were asked to replicate the evaluation in health care settings where CNL graduates and students were beginning to practise. The goal of these evaluation efforts was to expand data collection and comparison of findings to additional and diverse sites and over extended periods of time. This paper describes some evaluation efforts to date in three different practice sites.

Background of the need for a new health care professional

Over the past decade, reports from the Institute of Medicine (2000), the Joint Commission on Accreditation of Healthcare Organizations. (2002) and the American Hospital Association Commission on Workforce for Hospitals and Health Systems (2002) have described the US’s health care system as broken and in serious need of repair. Other reports (Institute of Medicine 2001, 2004) have stressed that the health care system does not make the best use of its resources, and others (Kimball & O’Neill 2002, Institute of Medicine 2003) have urged the health professions to educate future practitioners differently. With a heightened awareness of the need to enhance health care quality and patient safety, national nurse sensitive indicators have been identified that are being used to determine the quality of care being provided. These include the 2008 National Patient Safety Goals (NPSG) established by the Joint Commission (2008a,b) and the 15 National Voluntary Consensus Standards for Nursing Sensitive Care developed by the National Quality Forum. The Centers for Medicare and Medicaid Services (CMS) have implemented pay-for-performance on core measures, which encourages improved quality of care in all health care settings. CMS is collecting data on 34 quality measures related to five clinical conditions, and hospital-specific data are being publicly reported on the CMS web site. Hospitals scoring in the top 10% for a
A nurse with 5 years experience was encouraged by the Director of Women’s and Children Services to apply to the CNL programme, and was subsequently admitted. The student was employed on a maternal-child and understandings (Wolf & Tymiz 1977). The case study is the most appropriate form for reporting the results of a naturalistic, summative evaluation such as this (Guba & Lincoln 1981).

To highlight the early impact the CNL is having on the health care system, three different partnerships or health care agencies were asked to describe the implementation of the CNL within that setting, changes that have occurred, and the impact on patient care. These three settings, selected from one geographic region, represent different agencies and patient populations, and are at very different stages of the implementation continuum. Implementation of the CNL within health care settings varies depending upon the institution, type of setting, and patient population. Each site has experienced unique outcomes and challenges, which are highlighted here in three separate case studies.

Findings
Case study 1
In 2004, the University of Florida (UF) College of Nursing, along with its clinical partner Shands Jacksonville, committed itself to implementing the CNL education-practice model. The education model implemented was a post-baccalaureate master’s degree programme. This model was selected to expedite graduation of the first cohort of CNLs, which in turn would facilitate role implementation and evaluation. Shands Jacksonville, a 733-bed not-for-profit academic health centre located in northeast Florida, was equally committed to seeing the role implemented and evaluated on an acute care unit within its health care system.

A new patient-centred care delivery model described by AACN, guided the collaborative efforts of UF and Shands to design, execute and evaluate the CNL role implementation. Ongoing education-practice liaison meetings included the CNL Track Coordinator at UF and Shand’s Director of Education and Practice Councils, along with the identified unit’s nurse manager, a nurse educator, and a master’s-prepared preceptor. Data base managers and quality improvement personnel were consulted in the design of the evaluation plan. The results of these meetings included a CNL job description, curriculum and preparation of the selected ‘model’ unit for a full-time 480-hour CNL clinical immersion experience or residency.

Methodological approach
Responsive evaluation examines behavioural phenomena using a naturalistic approach. The evaluation of an entity, such as the implementation of the CNL within the health care system, is organized around concerns and issues of the various stakeholder audiences (e.g. patient satisfaction, nurse retention, patient falls, readmission rates, patient education). Using this approach, the CNL’s impact on outcomes is compared with an external set of requirements or with what is considered desirable by the identified stakeholders or in this case, the national patient safety goals (Guba & Lincoln 1981). The outcome of the naturalistic approach is a description of what exists, how people feel, perceptions,
unit, but for the immersion experience, was placed on the model unit for the 12-week residency. This student’s immersion experience served as the activity around which the role was evaluated. The programme assessment was framed by AACN’s CNL Evaluation Scorecard.

Shands Jacksonville hosts over 30,000 admissions per year and has over 4000 employees, 700 of which are nurses. The model unit for the residency was a 17-bed oncology unit, with 12 RNs, one LPN, and five patient care assistants (PCAs). The unit also accommodated some medical-surgical overflow patients when needed.

The CNL student’s 3-month residency occurred in summer 2007. A non-experimental evaluation design was used to track outcome indicators on the model unit. The evaluated data consisted of monthly data from a patient satisfaction survey, length of stay data extracted from a monthly report provided to the nurse manager, and fall data manually extracted from incident reports and the patient safety and quality department. Retrospective data, prior to the student’s practice on the unit, from as far back as a year, also were evaluated. Impact was measured as follows.

- The Innovation domain was measured through content analysis of the student’s journals using QSR’s XSight qualitative data management tool (Pugh Computers Ltd 2006). Journal entries were broken into individual scenarios and examined for common themes.
- Quality was measured by rates of falls, falls with injury, and the percentage of patients reporting ‘excellent’ in response to a pain management item in a patient survey. Fall rate metrics matched those of the AACN evaluation pilot.
- Satisfaction was measured by the percentage of patients reporting ‘excellent’ in response to an item asking about the nurse’s response to calls, as well as an item on overall nursing care. These and the pain management satisfaction data were compiled by an outside agency, which sampled 5–6% of the unit patients at the end of each month via a phone survey.
- Length-of-stay data were abstracted to measure the financial domain on the evaluation scorecard. Unit data from summer 2006, the same time period as the student’s immersion, were provided for comparison purposes.

### Innovation

Analysis of the student journal showed that she had focused on refining and improving already existing initiatives on the unit, including an hourly rounding initiative. She also streamlined patient access to certified chemotherapy nurses and created a protocol and patient education materials for oral mucositis. Falls were targeted through an initiative that included counselling patients to ask for assistance, placing fall precaution signs within patient view, and guiding staff to proactively offer assistance for toileting activities and ambulation.

Journal analysis showed that a majority of the student’s time was spent addressing needs of individual patients (75%), followed by nurses (9%), with the remainder (the unit, family, physicians, patient aggregates, and other personnel or departments) 4% or less. The most common role functions performed were those of communication, especially in the advocate role (29%), followed by risk assessment (15%), care coordination (14%), outcome management (12%) and patient education (9%). All CNL role competencies, as described by AACN (2007), were achieved by the student during the immersion experience.

### Quality, financial and satisfaction domains

Table 1 describes outcomes from the quality, financial and satisfaction domains. The 3-month post-CNL residency values measure the time period that the CNL student was on the unit for the clinical immersion experience. Data points continued to be provided through the last quarter of 2007 and through January
2008, which was after the CNL student had left the unit and returned to her unit of employment.

Data in all three domains revealed changes during the residency. In addition, after leaving the unit, many of these changes reverted to the values seen prior to the CNL’s immersion experience on the unit. Some of the changes (e.g. pain management satisfaction, nurses response to calls, and overall nursing care satisfaction) were favourable, while others, specifically the fall rate, were not. Also, the financial domain metric, length of stay, was difficult to measure and interpret due to the short time period and variability of types of patients prior to and during the student’s immersion experience on the unit.

Fall and fall with injury rates increased rather than decreased during the student’s CNL residency experience. One reason, supported by the student’s journal entries, is that in the process of frequent rounding, patients were found to have fallen. Reported fall rates decreased after the CNL student left the unit at the completion of the immersion experience.

Case study 2

In 2004, Morton Plant Mease, a four-hospital 1200-bed not-for-profit health system located in Clearwater, FL, agreed to partner with the University of South Florida College of Nursing in implementing the CNL role. Morton Plant Mease’s nursing leaders chose to become involved in this initiative with the goal that the CNL would:

- improve the quality of patient care through emphasis on implementing evidence-based practice, specifically CMS core measures;
- improve communication among the team caring for the patient;
- provide guidance for less experienced nurses; and
- assure the patient a smooth flow through the health system.

The goal was also that these outcomes would be accomplished as a budget-neutral project. Since employing the first two CNLs in May 2006, these goals have been met and exceeded.

Two units were initially chosen as pilot units: a 45-bed oncology unit and a 43-bed medical-surgical unit with 15 telemetry beds remotely monitoring patients. The CNL was responsible for 14 patients on the oncology unit, with a majority of these patients being immuno-compromised. The CNL on the medical-surgical unit was responsible for providing oversight for the care of the patients in the 15 telemetry beds. Following the CNL’s employment, one of the earliest impacts seen was an immediate improvement in communication on the remote telemetry unit. The CNL quickly discovered that there was little communication between the remote telemetry unit and the units where the telemetry was being monitored. She ordered signs with the monitoring technician’s phone number to be posted in each remote telemetry room so the nurses could contact the technician immediately if there were questions regarding the patient’s rhythm. She also made sure the monitor technician had the contact numbers for the nurses on the remote unit so he/she could contact the nurse directly if there was a change in the patient’s cardiac rhythm.

On the oncology unit the impact was the guidance provided by the CNL to the less experienced nurses on the unit. Three nurses who had voiced their intention to leave the unit decided to stay. These three nurses described the CNL role implementation and the support they received as making them feel safer in performing their jobs and therefore willing to stay. Conservative estimates for the cost of replacing a nurse is $50,000; therefore, retaining these three nurses resulted in an immediate $150,000 saving for the hospital.

Unfortunately, the way data on nosocomial pressure ulcer rates, falls with injury, and core measure compliance were collected prior to the CNL’s being assigned to these units makes it impossible to compare similar outcome data for the beds she was responsible for. However, since the implementation of the CNL role on these two units nearly 2 years ago, the unit reports no nosocomial pressure ulcer development, 100% compliance with pneumonia and flu vaccine administration, and the implementation of heart failure patient education and smoking cessation counselling. The site also reports that there has been one fall with injury (not serious) on the oncology unit and none on the remote telemetry unit.

An unexpected outcome noted on the oncology unit was the decrease in the average length of stay (LOS) on the unit. In 2006 the average LOS was 6.58 days; in 2007 the average LOS was 5.71; a decrease of 0.87 days. Because the remote telemetry unit was a newly opened unit when the CNL began, it is not possible to see if there was a similar decrease in the average LOS on that unit as well.

In January 2007, a second CNL was added to the oncology unit. Although she did not graduate from the CNL education programme until the end of 2007, the unit benefited from her implementation of the role even as a student. To illustrate the value of the CNL role to improving patient care, each of the CNLs on the oncology unit provided a brief narrative of their role.
Continuity, lateral integration of care and developing a therapeutic relationship

Developing a patient/nurse relationship happens over time. Trust and understanding occurs between both, allowing for difficult decisions to be examined and the best course of action to be selected. M. Godfrey, a CNL working on an adult oncology floor, said in a personal statement in Tucson, AZ in January 2008:

‘As a CNL I have been fortunate in being able to develop such relationships and assist my patients to make choices that will affect their lives. I bring a different perspective to the patient care setting. I am able to step back from the day-to-day tasks and activities that need to be done and look at the patient’s entire treatment plan, needs, risks, expectations and how these intertwine. Because I am there five days a week and work with the patients not just during the current admission but frequently over time, I am able to understand the patient’s needs and choices. I also am able to get to know and work with the family and other caregivers. I do a great deal of patient and family education regarding the diagnosis, treatment plan, expected side effects, and potential complications. Because of the long-standing relationship with many of the most complex patients, I also am more readily able to identify when changes occur in the patient’s physical or psychological status. The long term relationship also allows for a sense of trust to develop between the CNL and the patient.

Another important aspect of my role is working with the physicians and other health professionals caring for the patient. Because of my relationship with the patient and family, I frequently accompany the physician when discussing the treatment plan and expected outcomes. Having heard the information provided to the patient, I am able to more appropriately address concerns, reactions, and questions. Lateral integration of care across settings is another key component of my role. I frequently become involved in the timely and smooth transition from one setting to another which significantly impacts the patient’s satisfaction and quality of care.

Although I am a direct care giver, I do not have responsibility for implementing daily care to a group of patients; I oversee the care. This allows me to spend more time with patients when needed, get to know them and their needs, integrate their care, communicate with all involved in the care, and provide continuity to the care received.’

Impacting care coordination, patient satisfaction

The second CNL assigned to the oncology unit, while still a CNL student, described some of the ways her role had impacted patient care. The two areas she highlighted were care coordination and improved patient satisfaction. As a CNL student:

‘I have been able to work with other disciplines to more effectively transition patients from one healthcare setting to another. For example, working with the county health department, I coordinated a hearing from a patient’s hospital room that included physicians, attorneys, and health department representatives to have the patient declared a ward of the state so he could be admitted to the state tuberculosis hospital for treatment. As a result of my intervention as a CNL, the patient received appropriate care and was discharged safely without putting others at risk.

Many positive, unsolicited comments have come from patients’ families and reflect the care coordination role of the CNL. In one instance, a patient’s daughter stated after his transfer to the oncology unit after a two-week hospitalization “this unit is a bright light in a bleak experience; someone has explained to me what is happening to my father.” Another patient commented “it is wonderful here; you have a central person who pulls it all together”.

In 2007 the hospital changed vendors for the physician satisfaction survey, which makes it impossible to compare before and after data related to the CNL’s residency. However, physicians have made unsolicited comments on the improved communication, better patient care and improved team work among the nurses on the unit. The physicians refer to the CNL as their ‘go to person’ on the unit. One CNL had a physician say, ‘If I knew you were still here this late, I would not have come in. I would have called you for an assessment first’. Another physician commented that the CNLs think critically and have good suggestions about the patient’s needs when they call.

The nurse manager on the oncology unit commented, ‘The unit runs so much smoother when the CNLs are there’. This is supported by similar comments made by
case-management personnel. The nurse manager further stated, ‘The CNLs are able to offer support to the less experienced nurses and the physicians talk to [the CNLs] first before seeing their patients. They know the patient’s story because they are here five days a week. I am so enthusiastic about this role’.

The hospital now has five CNLs on staff covering four different units. There are three additional CNLs on track to graduate in December 2008, with an additional two in December 2009. All will be placed on hospital units. The long-term goal is to have a minimum of one CNL on each unit. The administration is pleased with the outcomes produced through the CNL role implementation and finds it a cost-effective method to improve patient care.

Case study 3

St Lucie Medical Center (SLMC) is a 194-bed for-profit organization located in Port St Lucie, FL. In the summer of 2004, an opportunity arose to partner with Florida Atlantic University (FAU) in the clinical nurse leader project. The SLMC nursing leadership team viewed this initiative as an opportunity to further improve patient care and revise the current nursing care delivery model. Thus a decision was made to move forward with the partnership. After a comprehensive selection and interview process, four staff nurses were selected, and in the fall of 2005, began their education to obtain the CNL master’s degree.

Two pilot units were selected to participate in the CNL project: a 36-bed Progressive Care Department and a 45-bed General Medical/Surgical Department. These units were chosen because of a high number of new nursing graduates, inconsistent patient satisfaction scores, and a high percentage of patients requiring core measure monitoring. The CNL project was implemented in December 2006. Each CNL was assigned 18 to 23 patients and worked with three registered nurses (RN) and two patient care assistants (PCA). The responsibilities of the CNLs included: lateral integration of care, interdisciplinary care planning, physician liaison, resource management, system analysis, and promotion of evidence-based practice (see Figure 1). A sample of the activities engaged in by the CNLs is depicted in Figure 2.

The outcome measures for the CNL project are directly tied to SLMC’s vision of employee engagement, customer loyalty and quality care, cost effectively. The outcome measures described here are specific to a general medical/surgical department (see Table 2).

Employee engagement

The CNLs on the General Medical/Surgical Department have taken the responsibility of supporting a relatively novice nursing staff. SLMC has been fortunate to recruit new, graduate RNs from two local nursing schools. The CNLs focus on mentoring the novice nurse and building his/her skills in a manner that allows them to learn in both theory (knowledge) and practice. The learning occurs through various venues; some examples include review of procedures prior to performance, direct supervision of an unfamiliar nursing procedure, and one-on-one education. The CNLs are viewed as clinical experts that encourage learning by all staff nurses and emphasize the importance of evidence-based practice. In addition, the CNLs incorporate learning situations into everyday practice at the point of care and sponsor monthly clinical conferences that address nursing topics triggered by events on the unit. These efforts of the CNLs proved to be successful, as reflected

| Lateral integration of care: facilitate, coordinate, and oversee the care provided by the health care team. |
| Interdisciplinary care planning: communicate and collaborate with other members of the health care team. |
| Physician liaison: collaborate with physicians regarding the patient’s plan of care by taking an active role in patient rounds. |
| Resource person: educate staff through mentoring, coaching and clinical conferences. |
| System analyst: manage and coordinate care at the multidisciplinary level. |
| Evidence-based practice (EBP): raise questions to challenge existing practices in an effort to promote EBP. |

Figure 1

St Lucie Medical Center CNL job description.

Figure 2

A day in the life of a CNL at St Lucie Medical Center.
in the low turnover and vacancy rates in the General Medical/Surgical Department (see Table 2).

Customer loyalty

- Patient satisfaction and patient-centered care are areas that the CNLs have identified as priorities on the General Medical/Surgical Department. The CNLs focus on improving patient and family awareness and involvement in the care planning process through continuous communication. The CNLs visit patients on a daily basis to review their care plans and diagnoses; patient/family involvement in developing the plan of care is encouraged (Figure 2). Some of the strategies implemented by the CNLs include intentional hourly rounding, a unit specific welcome letter for patients and families, bedside care boards, interdisciplinary rounds, and post-discharge follow-up phone calls. On the most recent patient survey results, the General Medical/Surgical Department showed an improvement on questions related to: (a) concern shown by staff, (b) family kept informed, (c) nurses providing explanation, (d) staff communication, and (e) patient treated as a person. SLMC believes that these improvements in patient satisfaction scores are direct results of the CNLs’ efforts in providing a patient and family-centred care approach.

- Physician collaboration is an important aspect of the CNL role. By taking an active role in physician rounding, the CNLs are able to develop strong partnerships, resulting in improved staff communication. Through this relationship, physicians are afforded a better insight into the role of the CNL. Most importantly, acting as a physician liaison, the CNLs have managed to bridge the gap and address the issue of care fragmentation by providing crucial information to all disciplines involved in caring for the patient. A recent physician satisfaction survey validates the effect of the CNLs in improving staff communication and the image of nursing (Table 2).

Quality care, cost effectively

Improvement on the core measure results for SLMC also can be attributed to the efforts made by the CNLs in staff education and physician collaboration. On the General Medical/Surgical Department, patients with pneumonia and congestive heart failure (CHF) and chronic complex patients are the primary focus of the CNLs. To ensure compliance with core measure indicators, strategies implemented by the CNLs include colour-coded chart labelling, core measure alert checklist, concurrent chart review, and continuous staff and physician education on core measure components.

Conclusion

While it is tempting to suggest a direct relationship between the implementation of the CNL role and changes in outcome measures, the primary value of examining early outcomes experienced by first adopters of the CNL role is to raise awareness of the potential for improved outcomes of care and cost savings. In addition, it stresses the need to compare findings of outcomes from multiple sites. The intent of the CNL Evaluation Plan is to learn more about what CNLs do and their impact on patient outcomes in diverse health care units and with different patient populations. Early evaluation efforts like these provide glimpses into the potential the CNL role holds for improving patient care outcomes. In addition, the experiences of these three settings demonstrate significant cost savings in very short periods of time. Similar outcomes are also being reported at other sites across the country.

Implications for nursing management

Numerous efforts in the US, including the work of the Institute for Health Initiatives (IHI) and the Robert Wood Johnson Foundation funded Quality and Safety Education for Nurses (http://www.qsen.org), have focused on quality improvement and patient safety and are achieving positive outcomes. The CNL is not an isolated answer. However, through formal, standardized education programmes, and nationally recognized role competencies and expectations, the CNL represents a promising opportunity for nursing to take a leadership role in implementing quality improvement and patient

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Table 2
Outcomes of the CNL Implementation at St Lucie Medical Center
Before and after CNL implementation outcomes on the General Medical/Surgical Department

<table>
<thead>
<tr>
<th>Indicators</th>
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<tr>
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<td>Vacancy rate</td>
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<tr>
<td>Customer loyalty</td>
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<td>Patient satisfaction</td>
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<td>3.13</td>
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<tr>
<td>Quality care cost effectively</td>
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</tr>
<tr>
<td>Core measure – AMI†</td>
<td>90%</td>
<td>97%</td>
</tr>
<tr>
<td>Core measure – CHF†</td>
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<td>96%</td>
</tr>
<tr>
<td>Core measure – Pneumonia†</td>
<td>80%</td>
<td>85%</td>
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*Annual survey.
†Overall hospital score.
safety initiatives across all health care settings. Cost savings are being realized very quickly in settings where the CNL role has been integrated into the care delivery model. With the growing calls for improved outcomes and more cost-effective care, the CNL role provides an opportunity for nursing to make a significant impact in these areas.

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