

Clinical Nurse Leader: A Role for the 21st Century

A clinical nurse leader (CNL) is an advanced generalist prepared at the master's degree level to oversee the lateral integration of care for a specific group of patients (American Association of Colleges of Nursing [AACN], 2013). According to Reid and Dennison (2011), the intended purpose of the CNL was to provide clinical leadership directly at the point of care to ensure safe, evidence-based, high-quality care delivery that produces optimal patient outcomes. The AACN's *White Paper on the Education and Role of the Clinical Nurse Leader* (2007) explained the CNL role encompassed such roles as clinician, outcomes manager, client advocate, educator, information manager, systems analyst, risk anticipator, team manager, member of a profession, and lifelong learner. The CNL role is unique to the nursing profession because, similar to an attending physician with resident physicians, it returns graduate-prepared clinicians to the bedside to coach and mentor nursing staff to provide patient-centered care that will improve patient results. As identified by Nelson, Batalden, Godfrey, and Lazar (2011), the immediate need of health care should be to focus attention prophylactically on frontline processes, where direct patient care is accomplished, and provide a concentrated opportunity for making pinpoint corrections that could avoid fatal medical errors.

Because the CNL is a registered nurse, the provision of direct patient care, assistance during rapid response situations or resuscitation, and clinical assistance during the clinical nurse's shift are just a few of the benefits for any unit with an assigned CNL. The CNL is considered the protector of nursing care because he or she provides leadership while combining evidence-based research, hands-on instruction, and clinical assistance at the bedside (AACN, 2007). Harris, Roussel, and Thomas (2014) noted the CNL was created to be an expert clinician equipped with graduate-level competencies in illness and disease management, to think critically as well as interpret and analyze clinical interventions. An experienced nurse with this knowledge set is bound to be a vital resource for the entire health care team in the care of medically unstable patients.

The CNL is not intended to accept a patient assignment similar to a clinical nurse. The CNL is not an admission discharge nurse or extra nurse in staffing. Additionally, the CNL should not perform routinely the duties associated with the clinical nurse's role, such as

administering daily medications, performing dressing changes, or completing routine patient care tasks. The CNL's purpose is to assess psychosocial issues, provide service recovery, anticipate risks related to patient outcomes, and identify commonly missed patient signs known to increase the hospital length of stay, jeopardize healing, foster readmissions, and increase health care costs. According to Stachowiak and Bugel (2013), the CNL has the ability to use "advanced clinical assessment to evaluate each patient within the cohort, while evaluating quality of care and patient safety metrics for the entire cohort and comparing current care practices to the best evidence available" (p. 59). Because the CNL possesses this knowledge of the microsystem, he or she easily serves as a reinforcement for the nursing team, available for patient-related questions and concerns nurses may hesitate to ask other health care team members.

Microsystem Assessments

A review of relevant terms is needed to understand the basic constructs in which a CNL operates. A *clinical microsystem* is a "small group of people who work together on a regular basis to provide care to discrete subpopulations of patients...It evolves over time and is often embedded in larger organizations" (The Dartmouth Institute, 2014, para. 5-6). Through direct assessment of the microsystem, the CNL is able to identify strengths, weaknesses, opportunities, and threats to high-quality care and improved outcomes. A *risk analysis* is a vital component of the CNL role that requires the ability to anticipate potential errors or breakdowns in processes before they occur or are repeated. CNLs rely on tools, such as failure mode analysis, root cause analysis, and quality improvement procedures, to identify and prevent risks to high-quality patient care (Harris et al., 2014). The *5 P assessment* is an in-depth systematic approach to a thorough microsystem assessment. The 5 Ps include the purpose, patients, professionals, processes, and patterns of a microsystem (Harris et al., 2014). The purpose of a microsystem must be agreed upon by all members within the microsystem to ensure cohesive efforts toward a common goal. "CNLs can align quality improvement efforts in the microsystem to strategic initiatives and organizational goals while simultaneously focusing attention on the front lines to impact change" (Harris et al., 2014, p. 226). The CNL must be able to distinguish the patients and professionals of the microsystem to assess trends in disease processes, infections, and medical errors. CNLs then can use this information to direct improvement activities for understanding disease processes, manage

staff education with the assistance of the unit educator, and facilitate resource identification and care coordination. The CNL also can use knowledge of professionals within the microsystem to influence clinical and academic advancement, leadership promotion, and staff development efforts. Lastly, an assessment of the processes and patterns that routinely occur within the microsystem provides a clear view of potential weaknesses and defects of care delivery. This assessment requires asking the uncomfortable “why” questions of patterns and processes that could have been created decades prior to the assessment so attention can be focused on searching the literature for evidence-based options.

Through this precise management of the microsystem, the CNL thus can augment roles of the hospital administrator, nurse manager, clinical nurse, physician, and clinical case manager to mend fragmented care. Baernholdt and Cottingham (2010) noted employing nurses who operate at a systems level while employing clinical leadership at the patient's bedside are beneficial and innovative strategies that hold promise for global health care advancement. Metrics, such as nursing turnover rates, hospital-acquired conditions, patient satisfaction scores, length of stay, readmission rates, and physician satisfaction scores, are many of the focal points the CNL tracks to cause positive change within the microsystem. With this thorough knowledge of the microsystem, the CNL is positioned to monitor interventions as a team leader, foster effective communication, coach and mentor at the point of care, and coordinate and manage care through lateral integration and linking of all members of the health care team (Harris et al., 2014).

CNL Role Compared to Advanced Practice Nurses

The CNL is the first master's-prepared role added to the nursing profession in more than 35 years, created to augment other clinically based, master's-prepared nursing roles. The clinical nurse specialist (CNS) operates at a macrosystem level which can include many smaller microsystems that are managed by CNLs. The CNS addresses a larger, more comprehensive group that includes many microsystems, such as a specific disease type (e.g., end-stage renal disease) within a patient population, nursing staff within a specific division (e.g., surgical division, cardiac division), and/or the entire health care system (Stuesse, 2014). The CNS is an advanced practice registered nurse who is educated to diagnose and treat a macrosystem, a larger population than that which the CNL was designed to cover. He or she often provides teaching to patients, families, and nursing staff at the unit and system levels whereas CNLs tailor care and interventions to specific patient-centered needs within their microsystem (unit level). Essentially, a CNS's focus spans and impacts nursing care on a broader level than the CNL, who focuses on care at the bedside within a microsystem.

The nurse practitioner (NP) also is an advanced practice clinician prepared with specialist education at the

master's or doctoral level in a defined area of practice (AACN, 2012). The NP diagnoses and treats a population of patients. Although studies reveal NPs interact with nurses almost as much as physicians (Kilpatrick, 2012), the interaction often consists of disseminating orders, dictating directions, and/or providing brief real-time teaching for an immediate patient care concern. Coaching, mentoring with bedside hands-on instruction, reiteration, and follow up are provided in more depth by the CNL.

The CNL depends on these advanced practice clinicians to coordinate and execute the plan of care to improve patient outcomes. The CNL must collaborate with the CNS and NP to draw upon their specialized education and skill sets to enhance care delivery (Stuesse, 2014). Each role must be clarified and understood by all members of the interdisciplinary team.

CNL Role at Carolinas Medical Center

At Carolinas Medical Center (CMC, Charlotte, NC), Chief Nurse Executive Grace Sotomayor began intense research of the CNL role in 2007. She created a collaborative with local university faculty who were interested in developing a CNL degree program. Sotomayor obtained grant funding to provide financial assistance to nurses interested in completing education for this new role, and approached the president of the hospital to gain support. She determined CNLs could not be included in nurse staffing ratios but instead would fill a distinct role similar to CNSs or NPs. She then began recruiting nurses interested in a new master's-prepared role. The grant provided funding to initiate the CNL program on medical-surgical units within the hospital.

Sotomayor required the model for the CNL role to follow a 12-bed microsystem (one CNL to a 12-bed assignment). She also structured the CNL schedule to manage care for the same 12 beds on the medical-surgical unit 5 days a week to restore continuity of care. The CNL keeps the same room assignment every workday to serve as a constant resource at the bedside so changes in patient health status may be identified earlier.

A CNL job description was developed from the AACN (2007) White Paper to avoid confusion with other roles. A chain of command was developed that required the CNL to report to the unit's nurse manager for unit-related issues. This chain also allowed the CNL to report role-related issues directly to the CNL coordinator. If escalated assistance from administration was warranted, the CNL coordinator then reported the issue to the assistant vice president (AVP) in charge of the CNLs. All issues, both resolved and unresolved, are reported to the chief nurse executive by the AVP, but her assistance with the resolution would be requested only if needed.

Program Evaluation

To evaluate progress with the role and allow for collaboration and planning time, the CNLs assemble monthly into a workgroup meeting. Guest speakers are

invited for continued learning opportunities, evidence-based research and capstone projects are presented, unit reports are conducted, CNL progress is evaluated, and plans are developed for future program growth. This meeting allows CNLs to identify common opportunities and issues throughout practice. An annual retreat also is held to allow CNLs to reconnect to the role's purpose, review the vision, and plan for the future.

The CNL role is active on 10 units within CMC with more than 30 CNLs and CNL students. The collaboration with Queens University has allowed faculty to match CNL students in the Charlotte area with CNL preceptors for clinical hours. Students from as far as Dubai have benefitted from the precepting experiences at CMC. Administrators also allow nurses interested in the CNL role to shadow a CNL. Numerous CNLs throughout the nation have shadowed the CNLs at CMC and asked them to speak at conferences to discuss their impact on patient outcomes. Some CNLs now are taking the role beyond medical-surgical units to other areas, including high-risk obstetrics transitions in care, the surgical trauma intensive care unit, and the bone marrow transplant unit. Many more innovations are expected as the number of CNLs at CMC continues to grow.

Example of CNL Impact

A CNL spent 2 days arranging a new primary care physician follow up for a 77-year-old patient admitted to the CNL's microsystem. The CNL determined the reason for the patient's nonadherence to his medication regimen as noted in the medical record. Although the patient had informed everyone, including his attending physician, that he had finished his prescription a week earlier, the CNL questioned him further and learned he last took his blood pressure medicines over 1 month ago; his primary doctor of many years had dropped him as a patient after his last visit because the office no longer accepted his insurance. After many phone calls, the CNL found a primary care provider to accept the patient and ordered a new insurance card with his new physician's name on it. The patient was discharged the next day with the CNL's work telephone number as a reference. The CNL ensured the clinical case managers arranged home health for the patient and enrolled him in the pulmonary program for continued respiratory follow up. The patient called the CNL the day after his discharge. He reported the new doctor's office left a voice mail message indicating care could not be provided due to problems with his insurance. The error was not found until after office hours. The apologetic patient asked the CNL to help him and voiced concern he would not get his blood pressure medicines after he had promised to take better care of himself. After gaining clarity from the primary doctor's office, the CNL phoned his insurance carrier and arranged an appointment with a new primary doctor. The CNL called the patient to inform him of the plans. The patient was extremely grateful and said "never had a nurse

shown such care for him before." That CNL checked with the patient a week later to learn he kept his appointment, he was taking his medications as prescribed, and he liked his new doctor. Although the patient had been discharged and was no longer a patient of the hospital, the CNL saw the bigger picture of patient-centered care, the risk of poor health outcomes, and the potential for readmission.

CNL Impact Summary

Although it is virtually impossible to quantify the impact of a CNL on patient care, testimonials such as the previous example highlight the ultimate return on investment. Other indications of the benefit of this role include hospital-acquired condition metrics. Since the CNL role began at CMC in 2009, units with a CNL have experienced a 53% reduction in central line infections, a 59% reduction in deep vein thrombosis, a 47% reduction in catheter-associated urinary tract infections, a 63% decrease in falls, and greater than a 5% reduction in nursing turnover rates (Carolinas Healthcare System, 2014). These reductions equate to cost savings of more than \$3 million. In addition, the number of clinical and academic advancements on the CNL units has increased markedly since the initiation of the CNL role. Most CNL units have achieved and maintained Tier I status, which denotes top percentile staff satisfaction within the workplace. Additionally, more than half the CNL units have achieved marked improvements in physician satisfaction scores concerning nursing care. These data suggest the CNLs at CMC not only are improving patient outcomes but also are improving workplace satisfaction for other team members. Finally, one CNL unit received the prestigious Academy of Medical-Surgical Nurses PRISM Award in 2014.

Conclusion

Clinical nurse leaders are trained to look at the "big picture" of the patient's care. They ask questions that clinical nurses may be too busy to ask as they care for multiple patients. Use of the CNL role can have marked impact on current health care. In addition to financial benefit, this role helps the clinical nurse gain confidence, autonomy, and leadership skills to improve patient outcomes through coaching, mentoring, and role modeling at the bedside. **MSN**

REFERENCES

- American Association of Colleges of Nursing (AACN). (2007). *White paper on the education and role of the clinical nurse leader*. Retrieved from <http://www.aacn.nche.edu/aacn-publications/white-papers/cnl-white-paper>
- American Association of Colleges of Nursing (AACN). (2012). *Clinical nurse leader frequently asked questions*. Retrieved from <http://www.aacn.nche.edu/cnl/CNLFAQ.pdf>

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- American Association of Colleges of Nursing (AACN). (2013). *Competencies and curricular expectations for clinical nurse leaders education and practice*. Retrieved from <http://www.aacn.nche.edu/publications/white-papers/cnl>
- Baernholdt, M., & Cottingham, S. (2010). The clinical nurse leader – new nursing role with global implications. *International Nursing Review*, 58(1), 74-78.
- Carolinas HealthCare System. (2014). *Clinical nurse leader unit report*. Unpublished internal document.
- Dartmouth Institute, The. (2014). *About us: What is a microsystem?* Retrieved from <http://www.clinicalmicrosystem.org/about-us>
- Harris, J., Roussel, L., & Thomas, P. (2014). *Initiating and sustaining the clinical nurse leader role: A practical guide* (2nd ed.). Burlington, MA: Jones & Bartlett Learning.
- Kilpatrick, K. (2012). Understanding acute care nurse practitioner communication and decision-making in healthcare teams. *Journal of Clinical Nursing* 22, 168-179. doi:10.1111/j.1365-2702.2012.04119.x
- Nelson, E., Batalden, P., Godfrey, M., & Lazar, J. (Eds.). (2011). *Value by design: Developing clinical microsystems to achieve organizational excellence*. San Francisco, CA: Jossey-Bass.
- Reid, K., & Dennison, P. (2011). The clinical nurse leader: Point-of-care safety clinician. *The Online Journal of Issues in Nursing*, 16, 1-11.
- Stachowiak, M., & Bugel, M. (2013). The clinical nurse leader and the case manager: Are both roles needed? *American Journal of Nursing*, 113(1), 59-62.
- Stuesse, E. (2014). Clinical nurse leaders and clinical nurse specialists: Harmonious partners. *American Nurse Today*, 9(4). Retrieved from <http://www.americannursetoday.com/clinical-nurse-leaders-and-clinical-nurse-specialists-harmonious-partners/>

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