Hospital Use of a Modified Clinical Nurse Leader

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Hospitals face many challenges to care delivery, including the problem of retaining seasoned, experienced nurses at the clinical bedside. The nursing profession has always encouraged the educational development of members. As nurses gained graduate education, however, their opportunities to use their knowledge at the bedside became limited. Nursing educators offered the master's-prepared role of the clinical nurse specialist (CNS) to fill this void. This specialist role focuses on a specific patient population while dividing CNS time into five general areas—clinical practice, teaching, research, consulting, and management.

The Institute of Medicine (IOM) (2003) noted, "All health professionals should be educated to deliver patient-centered care as members of an interdisciplinary team, emphasizing evidence-based practice, quality improvement approaches, and informatics." In 1999, nurse educators were faced with the fifth consecutive year of declining enrollments in baccalaureate nursing programs (American Association of Colleges of Nursing [AACN], 2003). The AACN Board of Directors faced three issues: failure to differentiate practice of RNs with different educational preparation, numerous reports showing that care provided to the patient lacked high quality, and finally, the increased knowledge base for nurses because of the complexity of the current health care system.

To meet these challenges, AACN developed a new graduate role in the clinical nurse leader (CNL), a generalist educational tract. The clinical nurse leader role provides a way to retain the master's-level nurse at the clinical bedside. This role, while similar to the CNS, eliminates the management component and further differed by being a generalist role, providing care coordination of a distinct group of patients. The emphasis was on active provision of direct patient care in the clinical environment using evidence-based practice to ensure that patients benefit from the latest innovations in care delivery. The CNL "evaluates patient outcomes, assesses cohort risk, continued on page 12
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and has the decision-making authority to change care plans when necessary" (AACN, 2003).

The Modified CNL Role
Flagler Hospital implemented and piloted a modified version of the clinical nurse leader role in May 2004. At that time, AACN had not finalized the current education and role functions, nor had it unequivocally established the CNL curriculum. The modified CNL role was incorporated into the staffing of a 43-bed cardiopulmonary unit. Prior to the implementation of the modified CNL role, this unit experienced some major issues with retention, quality of care, nurse/patient/physician satisfaction, and increased length of stay.

Three master's-prepared nurses were chosen to develop and implement the pilot and fill the CNL roles. Each was diversified in experience and education; one had a background in clinical procedure and education, one in business and finance, and one in administration. Benchmarking data were collected in the following areas: nurse satisfaction using the Conditions of Work Effectiveness Questionnaire II (CWEQ-II) adapted by Laschinger and Wong in 1999 (based on the Organizational Management Theory of Rosabeth Moss Kanter), patient/physician satisfaction using an industry provider, patient/physician surveys, length of stay, fall rates, restraint usage, contract labor use, and cost per patient day.

The model encouraged patient care diversity with a team-centered, self-governing approach focusing on shared values and employee development. Use of this care model gave the researchers the responsibility of negotiating and improving processes within the context of the patient care environment. From the start of the pilot, hospital leaders found that even a modified clinical nurse leader model helped patient care avoid segmentation and disassociation. The role identified breakdowns in the system to allow for analysis and resolution.

The model provided integrated care delivery by developing and bridging gaps between departments, thus eliminating stagnation that impedes the care process. This role provided a positive synergistic relation between members of the health care team. Hospital leaders deduced that the following topics have been greatly impacted by the modified CNL model: shared governance/empowerment, improved patient outcomes, increased nurse/patient/physician satisfaction, and improved cost effectiveness.

CNL Role in Shared Governance/Empowerment
"For two decades, the literature has promoted the notion that shared governance/shared leadership creates a more satisfying work environment" (Nevidjon & Erickson, 2001). Clifford (1988) notes that "time has shown that nurses will no longer accept the mere performance of tasks as their practice goal outcomes. Nor will they remain in systems that promote fragmented, uncoordinated care leading to dissatisfaction for everyone - the patient, nurse, and hospital." Furthermore, AACN (2003) states, "Health literacy is the foundation of independence, health promotion, and disease prevention, all of which are hallmarks of excellence in nursing practice."

Nurses require the freedom to teach the complex care needed by patients and their families. Patients need to be informed and active participants in their own care. This requires in-depth, up-to-date knowledge about their specific health problems and treatment options. Even a modified CNL role allows master's-prepared nurses the opportunity to provide comprehensive, evidence-based, patient-centered professional care. This is a basic underlying principle of primary nursing and the time necessary to develop and free primary nurses for more teaching roles with their patients.

The CNL is able to discuss the patient's problems and agree with the team on a common course of action. This comprehensive knowledge enables the coordination of care among team members participating in the plan of care, which results in the quicker resolution of issues or problems. Therefore, CNLs are in a unique position to develop a direct and constant care relationship with the nursing team, patients, and families while enhancing open communication. The leadership component allows for continuity of patient care as well as the opportunity to maximize and develop individual and team nursing knowledge and skills.

As leaders and role models, modified CNLs at Flagler Hospital were able to perform as coaches or personal trainers by encouraging the nursing staff to self reflect, learn, and practice critical thinking, as well as find enthusiasm and energy to complete tasks. Hospital leaders believed that the CNLs challenged and energized the nursing staff to not only enjoy reaching beyond ordinary thinking but also to create
positive, empowering, and visionary ideals. This role drove and motivated team members toward personal and professional service excellence.

The Unit Nurse Perspective

The unit nurse perspective has been critical to evaluating the effectiveness of this program to date. Unit nurses were originally asked to participate in the unit for the introduction of the CNL role. CNLs were instructed to guide staff nurses; their expertise resulted in the unit becoming more productive and informed, and generated a notable cost saving. This freed staff nurses to have more time to spend with patients.

At first, the unit encountered shock waves as nurses transferred to other units and/or facilities. Hiring and training both new and seasoned nurses became a priority, and hospital leaders had to become more united with them in the changing of roles. After the dust settled, those who remained were from a variety of backgrounds united by one common goal: making the modified CNL role work. The nursing staff at Flagler Hospital dedicated themselves to making this change a positive experience.

Prior to CNLs arriving on the unit, patient care was fragmented. The holes in scheduling and staffing were filled by agency nurses, both RNs and LPNs, with minimal orientation to the facility. This made continuity of care nearly nonexistent, driving costs up. Nursing vacancies, length of stay, and recidivism on this unit were high. There was decreased patient, nurse, and physician satisfaction. Nurses not only had little time to teach their patients, they did not have time to attend in-services to keep themselves informed of changes within the medical arena.

The modified CNL role kept seasoned nurses at the bedside, which is extremely important to quality care. It was believed that the CNLs provided an invaluable service to novice nurses because they assisted with decision making and prioritization. They also identified problems, after which, they implemented corrective actions with all departments affected within the hospital.

The increase in communication with physicians and interdepartmental staff on the unit was a huge relief to the nursing staff. A “domino effect” followed; agency nurses were eliminated, and use of restraints and fall rates were reduced. Immediately, the nurse-to-patient ratio dropped, allowing more time to teach and spend time with patients. Patients’ perceptions of increased time surmounted to better care, and they become increasingly more satisfied with their care.

The CNLs encouraged and empowered nurses to decide which elements would allow them to attain the highest pay scale on the clinical ladder. They helped the unit retain its experienced nurses and provided the ultimate educational atmosphere for training new nurses. All of these things increased nursing satisfaction.

Patient Outcomes

Errors and variability can undermine the delivery of safe and effective patient care. In the past, hospitals have attempted to drive costs down by withholding and rationing services. Delegation of patient care tasks were often misguided, and patient outcomes were adversely affected when activities were assigned to nursing personnel less prepared.

In terms of impact to the patient, any defect in the delivery of quality health care can result in loss, which can be costly in terms of life, time, and money. While the term “quality” can take on many definitions based on various perspectives, most clinicians have come to embrace the definition offered by the IOM (1990), “Quality is the extent to which health services for individuals and populations increase the likelihood of desired health outcomes and are consistent with current professional knowledge.”

The modified CNL role enabled resources using synthesized data, information, and knowledge to evaluate and achieve optimal patient outcomes. The modified CNL was able to evaluate individual and group outcomes and safety issues, and modify intervention strategies and treatments as a means to improve the outcomes. The use of risk analysis tools and quality improvement methodologies at the primary level further allowed patient outcomes to be positively affected.

The modified CNLs had limited expertise in case management and utilization areas required in the AACN role. To optimize the limitation of knowledge in these areas, staff met daily with social services and utilization review to point out and expedite resolution of issues. These daily meetings evaluated all patients with length of stay greater than four days to facilitate care planning, goal setting, and discharge planning by solving problems or issues that could hold up discharge.

Nurse/Patient/Physician Satisfaction

Nursing staff were administered the CWEQ-II developed by Laschinger and Wong, and based on the Management Theory of Kanter, which measured six components of structural empowerment (opportunity, information, support, resources, formal power, and informal power). Nurses were surveyed before the implementation of the CNL program and again at six months, with significant improvement in all areas to rival, and in some instances, surpass, those of Magnet hospitals.

Patient satisfaction was measured using an industry standard reporting agency. Overall patient satisfaction has increased in every category that nursing directly impacts (such as nurses keeping patients informed, skill of the person starting the IV).

The CNL program did have a positive impact on nurse/physician collaboration. The nurse’s experienced improved relationships between themselves and physicians. Physician satisfaction with nursing care rose from 67.4% pre-CNL program to 95% currently.

Cost Effectiveness

Success in this area requires that the CNL understand how to identify waste and manage resources within the system. The CNL must also thoroughly understand the fiscal context in which he or she is practicing. CNLs at Flagler Hospital understood the costs associated with delivery of care, the ways to efficiently expedite diagnostic care, the results of ser-
vice excellence, and the cost that can be realized by reducing length of stay, improving patient outcomes, and practicing quality management.

Health care leaders at Flagler Hospital have found that outcomes is a defining instrument to quantify the CNL relationship and efficacy and is a crucial key to striking a balance between the goals of cost and quality in health care. Results to date reflect an increase in the case mix index from 1.32 to 1.39, which reflects a 5.3% increase in patient acuity. Length of stay was reduced from 4.46 days to 4.18 days for a cost savings of $412,150.00. Cost per patient per day showed only a $1.00 difference between the old model and the current model. This figure includes the three CNL salaries.

Positive unanticipated results included a 38% reduction in restraint usage, fall rate below the hospital average, no cardiopulmonary arrests since the first month of the new program, and complete elimination of contract labor use. Success in these areas was attributed to nurses having more time to spend with their patients and the timely intervention of the CNL in resolving problems before they impact discharge.

Conclusion

Flagler Hospital’s nursing care delivery model provides increased nursing professionalism, optimizes patient care through a team-centered, self-governing approach. This new care delivery model focuses on shared values and employee development. The model is based on the premise that outcomes of care are only as good as its weakest link. The care model that incorporates CNLs gives them the responsibility of negotiating and improving processes within the context of the environment and within the entire hospital organization, not just in their department or unit. The modified version of the CNL program at Flagler Hospital keeps patient care from becoming segmented and disassociated. Changes made have enhanced the professional image of the nurse and reinforced professional relationships with other health care team members. If the success of the modified role is an indication, the credentialed role can offer advanced practice nurses an opportunity to keep their talents at the clinical bedside. It is believed that the CNL role gives an organization the tools to help the nursing team be more productive and effective in meeting the objectives of the patient.

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