Clinical Nurse Leader
EVOLUTION OF A REVOLUTION

The CNL Vision

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The membership of the American Association of Colleges of Nursing, in partnership with its practice partners, has initiated a national effort to create a new nursing role that is more responsive to the realities of a complex, technologically advanced, ever-changing healthcare system. This new role is the clinical nurse leader. Nurses in this new role will be prepared at the master's level and will act as lateral integrators of care, patient advocates over the many components of the continuum, as well as information manager to the multiple disciplines involved in care. Practice and education partners are working together to define the curriculum for this role and create a new care delivery model needed to maximize the skills of the clinical nurse leader and the other team members to achieve better patient outcomes. In this article, the department editor and her associates focus on the current state of healthcare, resulting educational requirements to meet the dynamic changes occurring, the curriculum for the clinical nurse leader, and how the clinical nurse leader will function in the practice setting.

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Worker shortages, financial crisis, rising healthcare costs, and alarming medical errors are abundant in the literature.[1-3] Healthcare expenditures are 15.5% of the US gross domestic product.[4(p4)] Although confronted with problems that plague the US healthcare system, no substantive change has addressed the crisis.[5-7] We continue to address the symptoms.

A plethora of safety initiatives have been initiated.[2,5,8] Joint Commission on Accreditation of Healthcare Organization's (JCAHOs) accreditation process outlines the requirement of safety initiatives and the hundred thousand lives campaign gives us a strategy to rescue patients faster with the use of rapid response teams.[8] Additionally, public reporting of outcomes has raised the visibility of healthcare with hope that consumers will drive healthcare change. The approaches show evidence of positive response in each area addressed,[1] but have we addressed the root cause of the malfunctioning healthcare system? If we understand and appreciate the complexity of the healthcare system, what is required to address that complexity?

Up to recently, we have viewed care delivery in separate, distinct parts and tried to solve issues with more specialized knowledge, discipline-specific approaches and, for the most part, narrowly defined process improvements. To address issues, we have used linear approaches or problem-specific thinking. In some cases, solving one problem created another. For example, cutting a hospital length of stay into 6 separate levels of care delivery that includes preadmission, OR, PACU, ICU, intermediate care, and finally, the surgical unit has maximized the financial efficiency of care hours per patient day. Work done on preadmission is provided in a low-cost outpatient setting. Care in the hospital is broken up in units of acuity level and the patient moves through each level of care

according to changing acuity needs. Although these changes seem to address the financial efficiency of matching expertise with patient need, they also contributed to our problems.

Communication Problems

A critical communication problem has emerged due to the increase in multiple patient hand offs coupled with gaps in communication and ever-increasing fragmented care. For example, the need to develop medication reconciliation programs is now required to compensate for the multiple prescribers of medications in each setting. An alarming outcome of this approach is that care givers now have little opportunity to get to know the patient. Relationship-based care, a cornerstone of nursing, is suffering and our ability to assess the patient from baseline and pick up on subtle changes is jeopardized. As Einstein said, "We cannot solve our problems with the same level of thinking we used when we created them." Fragmented, discipline-specific changes and symptom management have not been the answer.

Nelson et al[9(p489)] suggest a reason for the continuing dilemma in fixing the healthcare system. They say that past strategies have focused on the contributions of "clinicians, consumers, purchasers, managed contributors, care organizations, reimbursement, and policy makers in isolation using a fragmented approach."

Clinical Microsystems

In actuality, the *building blocks* in healthcare organizations, the clinical microsystems or the functional frontline units that provide *most of the healthcare to most people* need to be understood, and emphasis on changing these units may be the approach to influencing the restructuring of healthcare delivery. Such an emphasis may provide a multidisciplinary, patient-centered approach to *seamless, timely, efficient, and reliable healthcare*. A focus on changing the multiple microsystems will ultimately and positively affect the functioning of the macrosystem.[9-12] To change the functioning of the microsystem requires focusing on linkages between the disciplines, the patient, the processes of care, recurring patterns in care delivery, cultural and environmental influences, communication, and outcomes performance for the patient.[9]

Some healthcare leaders suggest that a large part of the answer to changing healthcare via the microsystems involves creating a highly educated work force.[9,11] The complexity of healthcare, coupled with ongoing advances in technology, treatments, interventions, and pharmaceuticals, needs to be matched with individuals educated at higher and more advanced levels. A number of nursing's clinical colleagues, such as those in pharmacy, social work, and physical therapy, are required to have advanced education to promote knowledge and performance in their discipline.

A New Role

New competencies, requiring a new and broadened knowledge base, are required if nurses are to be key players at the microsystem level. Our answer lies in the vision of the master's prepared clinical nurse leader (CNL) who will provide care in the new Partnership Care Delivery Model. The CNL, understanding and interacting with the whole continuum and in partnership with all the disciplines, will be in a much better position to manage a patient's care throughout the episode of care at the microsystem level.

Erickson and Ditomassi[13(p100)] suggest that "*systems thinking* is the art of seeing the world in terms of wholes and the practice of focusing on the relationships among the parts of a system." Enter the CNL and the partnership between practice and education to refocus the healthcare delivery system and the educational process for the development of a nurse whose sole purpose is to revitalize patient centered care. The restructuring of the whole so a relationship will exist between the parts (of education and practice) is to accomplish the mission of improving patient care outcomes. The Partnership Care Delivery Model is the first such partnership initiative since the 1970s when the quintessential partnership between education and practice to educate nurses in diploma programs began to unravel.

The Master's Prepared Nurse

From the 1950s through the 1970s, nurses could be educated at the master's level for new roles, such as nurse administrator/manager, case manager, clinical nurse specialist, and nurse practitioners, including nurse midwives and nurse anesthetists. These educational roles emerged and were elevated to master's level education, however, with little to no input from those in

nursing practice. As a result, these well-educated nurses have not been consistently used in practice as the educators envisioned. In some instances, they have not found their place in healthcare delivery because administrators, other healthcare providers, and policymakers do not understand the contributions they can make to quality patient outcomes. Likewise, they have not been able to consistently demonstrate their own value or contributions.[12]

The development of the CNL gives education the opportunity to provide a well-educated nurse whose contributions are understood by the practice arena because the design of the role has involved the system of nursing as a whole. CNL stakeholder meetings held in May and March 2003, the partnership conference in June 2004, 5 regional meetings in 2005, and other forms of communication with the nursing community have been used to solicit input into the development of the role.[14]

Management versus Leadership

Although there is often confusion about the distinction between management and leadership, the literature is clear that these roles are distinct and may or may not be practiced in tandem. Many good managers may also be good leaders. However, the work of management is designed to produce predictability, stability, and order so organizational goals can be achieved efficiently.[15,16] The work of a good leader, on the other hand, focuses on influencing relationships between the leader and the follower, in this instance, for the purpose of

accomplishing change in nursing care delivery to improve patient care and health outcomes.[17] Leaders bring a different set of values to meeting the goal of improved patient care and outcomes, including those of adaptability, innovation, and flexibility.[17] Sullivan[18] says that *influence is more important than authority*, although we know that authority relationships must exist if organizational goals are to be met.

Curriculum

The CNL education and practice role is designed to extend and expand on the role of the baccalaureate graduate (RN) and to make changes in healthcare through influence. The curriculum for the education of the CNL suggests that this nurse will be educated to establish relationships internal to nursing and external to the many disciplines and others who contribute on a daily basis in hospitals, agencies, and communities for the purpose of influencing the outcomes of patient care delivery.

One of the major foci of the curriculum is the education of nurses to use their talents effectively in working with others to improve the quality of patient care, to enhance the efficiency with which care is delivered, to anticipate and thwart risks to patient safety, to maximize the abilities of the nurse providing direct patient care and the multidisciplinary team in their efforts to improve each patient's quality of care, quality of the healthcare experience, and to improve their health status.[19] The curriculum also emphasizes and extends the

clinical knowledge of the nurse learned in the baccalaureate educational process, emphasizing the importance of participation in illness/disease management using knowledge from the biological sciences; knowledge management by understanding of cause and effect relationships in illness prevention, and health promotion; the appropriate utilization of data to establish trends in defined quality indicators so plans can be made for improving care delivery; how to reduce patients personal risk for illness, sequel, and complications; and the use of evidence-based practice interventions to provide care that is effective, safe, and of high quality.[19]

In addition, the curriculum emphasizes the development of a nurse who is able to engage in the coordination of the healthcare team, especially the nursing staff. The CNL is involved in the delivery of patient care, with an understanding of the cost of care to the patient, strategies for making change in the microsystem, and policies that affect patient care. The CNL engages in these activities to provide a positive environment for quality patient care and for the staff who do the work.[14]

Role Functions and Competencies

The role, functions, expectations, and competencies for the CNL nurse can be found in Table 1. The role functions are related to the curriculum elements that can be found in the educational programs. Will this nurse engage in nursing administration/management? No! Is this nurse a specialist? No! Is this nurse a case

manager? No! This nurse is a leader of other staff, working in tandem with nursing staff and the multidisciplinary team for the purpose of delivering effective and efficient quality care and to improve patient health status. The CNL will report to the nurse manager and collaborate with nurse specialists to improve the quality of patient care. The CNL will serve as the integrator of care for patients in a microsystem (or clinical unit) (Table 1).[19]

Nurse administrators, nurse managers, case managers, and nurse specialists are all essential members of the nursing care team to support improvements in direct patient care. However, because of increasing responsibilities, complexity of healthcare operations, and demands placed on these members of the team, they are often removed from the direct care arena. As a result, there has been no one to provide

Table 1. *Role Functions, Expectations, and Competencies for the Clinical Nurse Leader*

Graduate Level Curriculum Elements	CNL Role Functions	CNL Role Expectations	End of Program Competencies
Nursing Leadership	Client Advocate	• Keeps clients well informed • Includes clients in care planning • Advocates for profession • Works with interdisciplinary team	Effects change through advocacy for the profession, interdisciplinary healthcare team, and the client
Nursing Leadership	Member of a Profession	• Effects change in healthcare practice • Effects change in health outcomes • Effects change in the profession	Actively pursues new knowledge and skills as the CNL role, needs of patients, and the healthcare system evolve.
Care Environment Management	Team Manager	• Properly delegates and manages • Uses team resources effectively • Serves as leader/partner on interdisciplinary team	Properly delegates and utilizes the nursing team resources (human and fiscal) and serves as a leader and partner in the interdisciplinary healthcare team. Identifies clinical and cost outcomes that improve safety, effectiveness, timeliness, efficiency, quality, and the degree to which they are client-centered.
Care Environment Management	Information Manager	• Uses information systems/technologies • Improves healthcare outcomes	Uses information systems and technology at the point of care to improve healthcare outcomes.
Care Environment Management	Systems Analyst/Risk Anticipator	• Participates in system reviews • Evaluates/anticipates client risks • Prevents medical error	Participates in systems review to critically evaluate and anticipate risks to client safety to improve quality of client care delivery.
Clinical Outcome Management	Clinician	• Designer/coordinator/evaluator • Competent care deliverer • Emphasizes health promotion • Risk reduction	Functions within a microsystem and assumes accountability for healthcare outcomes for a specific group of clients within a unit or setting. Assimilates and applies research-based information to design, implement and evaluate client plans of care.
Clinical Outcome Management	Outcomes Manager	• Uses data • Achieves optimal client outcomes	Synthesizes data, information, and knowledge to evaluate and achieve optimal client and care environment outcomes.
Clinical Outcome Management	Educator	• Uses teaching/learning principles/strategies • Uses current Information/materials/techniques • Patient educator • Staff educator	Uses appropriate teaching principles and strategies as well as current information, materials, and technologies to teach clients, groups, and other healthcare professionals.

oversight of direct patient care delivery and the multiple health-care providers now providing that care to patients. After 5 years of deliberation, review of evidence to support the care delivery system problems, and input from numerous sources, the CNL is the proposed answer to this problem.

CNL in Action

The CNL role focuses on understanding the interdependency of all disciplines providing care, and the need to tap into the expertise of the team, rather than individual providers. By doing this, the move from discipline-centered care to patient-centered care can occur. The simple fact of understanding the interdependencies between roles, the contribution each role can bring to enhancing patient care, and bringing these disciplines together will do much to elevate both the value and visibility of the different disciplines while at the same time impacting the care being delivered to patients. The independent and compartmentalized structure of our delivery system has minimized the appreciation of the contribution and value that each discipline brings to high-quality patient care. Likewise, because the value, knowledge, and expertise each discipline brings to patient care is not understood, there is no full utilization of the intellectual capital that exists within organizations. The CNL could be seen as the conductor of care much like the conductor of an orchestra. The ability to intervene, to know when disciplines are needed to respond to patient and family issues, the CNL, like the conductor, will bring in each of the players, to create a symphony of quality care.

The CNL, prepared as a highly educated generalist with competencies in evidence-based practice, relationships, communication, change management, and systems thinking, will work closely and effectively with staff to mentor, support, educate, and facilitate changes in patient care delivery. The CNL will be a well-educated resource for staff, skilled in facilitating change, reducing the number of interruptions in care nurses experience, and mentoring and supporting staff by intervening in patient care issues. This will enhance both the professional advancement of nurses as well as elevate the satisfaction of the staff nurse.

The CNL role will demonstrate the value of leading through influence via effective negotiation, ability to build and sustain strong relationships, facilitation, and communication skills. For example, if there was a rise in patient falls, the CNL would consult with the clinical nurse specialist to develop a fall protocol for the unit and work with the clinical nurse specialist to implement the protocol and to monitor results. The case manager might be called if lengths of stay were being effected by inability to admit patients to home health or long-term care on the weekends. The CNL would act as the facilitator in addressing these issues but not serve as the expert in solving the issue. Finally, the CNL would assess the results of the implementation of the fall protocol comparing trends before and after protocol implementation to determine the influence of the evidence-based protocol on practice in the unit, reporting these trends to the nurse manager.

Successfully Transitioning the CNL into Practice

Although there has been debate and deliberation about the direction of this role and questions about the ability of this graduate to lead others, there is a companion question. Has nursing education been able to prepare a new graduate from any program, graduate or undergraduate, as a polished product on the day of graduation? The answer, of course, is no. However, the CNL educational program includes 2 elements to attempt to develop the graduate for the role using a preceptor/mentoring process. First, the graduate will have completed an immersion experience under the direction of a faculty and clinical preceptor partner. Second, it is recommended that a clinical mentorship be provided by the employer and that a competency assessment be used in the employment setting to determine the new CNL readiness to enter the role (Table 1).[19]

Nine success characteristics for microsystems of care are provided from the research completed by Nelson et al.[9] They are leadership, culture of work, organizational support, patient focus, staff focus, healthcare team interdependence, information technology, processes improvement, and an emphasis on performance patterns. Say the authors, it takes leaders to transform the units of care, to maximize performance, to meet and exceed patient expectations,

and to perfect linkages of care to realize "seamless, patient-centered, high-quality, safe, and efficient healthcare delivery."[9(p491)] Enter the clinical nurse leader.

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