Clinical Nurse Leader
EVOLUTION OF A REVOLUTION

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The Evolution of a Revolution in Nursing

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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 (CNL). 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 managers 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 CNL and other team members to achieve better patient outcomes. In this department, the author outlines the history of this endeavor, the progress of the work to date to make this role a reality, and sets the stage for future articles that will provide actual case studies of pilots and early outcomes experienced around the country.

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Decades of failing to come to consensus about entry into practice has stalled needed improvements in both professional nursing practice and patient care. The need to move away from defining what makes a nurse to what nursing must do to propel itself into a leadership role in redefining the healthcare delivery system has begun to unfold. Over 5 years, a steady evolution using a very different approach to defining the future of nursing and ultimately improving patient care has emerged.

Healthcare leaders speak eloquently of a broken system of healthcare. Studies indicate that medical errors made in organizations have little to do with the quality of staff but rather cumbersome and complex delivery systems.[1-3] Our healthcare workers function in fragmented, complex, specialized, and siloed healthcare systems with gaps in communication, numerous handoffs, and discipline-centered versus patient-centered care.

In 2005, Leape and Berwick wrote, "Although a substantial minority among both clinical and the lay public continue to doubt that injury and mortality rates are as high as the IOM claimed, subsequent data from various sources suggest that the IOM may have substantially underestimated the magnitude of the problem."[4(p2385)] This is a wake-up call to healthcare leaders. If unnecessary deaths are to be reduced, nurses must lead the effort. However, nurses risk losing their ability to lead the change by their resistance to changing themselves and the profession. We continue to debate role clarity and licensure issues; we address nurse shortages and high turnover with the same old solutions of sign-on bonuses, 12-hour shifts, salary adjustments, and other short-term fixes. This perpetuates our treating the symptoms rather than addressing the root cause of the real issues of nursing.

The work force is not the problem, but rather it is the work itself. The profession of nursing must be redesigned, changing the context of how nurses practice and aligning it with an entirely different healthcare system than what existed 50 years ago. As Formella and Rovin wrote, "Unless we ask the hard questions and mobilize our creative resources now, the very essence of what each of us believes to

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be the nursing profession is at risk of becoming extinct."[5(p264)] Porter O'Grady adds, "The times indicate that our experience is not much different today from the time at the end of the 18th century when the trade guilds of Europe were becoming extinct…Holding on to old notions and practices that no longer characterize the demands of the time will do nothing but exacerbate the conditions which facilitate the demise of nurses and nursing work."[6(p184)]

As the healthcare needs of the patients we serve have dramatically changed, we have systematically and consistently given away much of our former work to other disciplines. As other disciplines, such as respiratory care, pharmacy, and social work, evolved, they assumed much of the care nursing once provided. Nurses tended to distance themselves from the work of these individuals and have not generally provided facilitation, coordination, and oversight of the care these disciplines provide. One could contend that this distancing and lack of involvement by nursing has contributed significantly to the fragmentation and gaps in communication between care givers, rifts that exist between disciplines, diminishment of nursing's identity, and increased complexity of care. This, in turn, has adversely affected patient care. Finally, we have many healthcare workers, unhappy and disillusioned in their roles, leaving the profession with insufficient numbers of people entering the healthcare profession.

Nursing, as the most trusted profession, is in a central and unique position to redesign the complex and fragmented patient care delivery system that currently exists. The new role being designed in nursing, the Clinical Nurse Leader (CNL), is poised to take a pivotal position in accomplishing the goal.

Evolution of the CNL Role

Designed to address the longstanding and unaddressed issues with both nursing and patient care, a quiet but steady revolution has evolved over the last 5 years that led to the creation of the CNL role. In 2000, the American Association of Colleges of Nursing (AACN) board of directors engaged in extensive deliberations about the future of the nursing profession related to declining school of nursing enrollments. The AACN board members agreed that major and fundamental changes had to be made in education, practice, licensure, and credentialing if nursing was to be a career choice for potential nursing applicants.[7] The AACN board created 2 task forces: Task Force on Education and Regulation for Professional Nursing Practice (TFER1) and Task Force on the Hallmarks of Professional Practice Environments. The latter task force was charged with making recommendations regarding practice environments that supported professional nursing practice.

TFER1 was charged with examining issues and trends for new education and licensure models; developing models effectively linking education, practice, and licensure; identifying barriers that would inhibit implementation of new models; suggesting the strategies to address these barriers; and providing recommendations for action.[7]

Throughout TFER1's work, consultation from practice and regulatory constituencies occurred. It quickly became clear that the challenges nursing and the delivery system faced could not be addressed in the same ways attempted in the past. More highly educated nurses with new skills and competencies were needed at the point patients receive care. The TFER1 concluded that there needed to be nurses educated at the master's level to lead and guide practice at the point of care. Simultaneously, it was determined that the patient care delivery system needed to be redesigned to assure the new skills and competencies were fully maximized.

In 2002, TFER1's final report was released recommending that new educational models were needed to be developed as well as a new role for nursing with new competencies.[7] The issues and challenges needed to be addressed at both the education level and at the patient care delivery site require new relationships and partnerships to take place between practice and education. TFER2 was then created with members from both education and practice and charged to conceptualize the new role and competencies needed for high-quality patient care to meet the needs of society now and in the future.[8]

In 2003, TFER2 held an external stakeholder panel that confirmed the new role and competencies needed for this new role. In May 2003, TFER2, The Working Paper on the Role of the Clinical Nurse Leader, was written.[9] The new role of the CNL will be the first role to be added to the nursing profession in

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over 35 years. In October 2003, a CNL preconference was held in conjunction with the AACN semiannual meeting. Nurses in both education and practice, interested in exploring this new role, were invited. Several nurses from healthcare organizations that had piloted a similar role presented at the CNL preconference.

In January 2004, an implementation task force was appointed to identify education and practice partners who would work together to create the curriculum for this role and redesign practice sites in which this role would function. This task force, in keeping with the new approach to the change occurring, was made up of both practice and educational leaders and chaired by a person whose career had been in the practice arena. This ongoing partnership emphasizes that this effort represents not one change, but rather simultaneous changes of both education and redesign of patient care delivery. Practice and education must be intricately linked to assure that both are working in tandem to implement the needed changes. This is significant because, in the past, education and practice rarely collaborated for systemwide changes, often faulting each other's shortcomings in education or practice settings.

In March 2004, seeking education and practice partner/teams to pilot the CNL role and redesign the patient delivery models in which the CNL would function, the implementation task force sent out a request for proposals. There were 79 schools of nursing and 143 practice sites that responded. In June 2004, all partners were invited to attend a conference to begin the implementation process. This meeting was designed to set the parameters for the curriculum as well as set the stage for the revolutionary change that needed to occur at the patient care delivery site. The partners needed to understand that the CNL was not an add-on role to an already cumbersome and fragmented delivery model. From January 2005 to April 2005, the CNL implementation task force held a series of 5 regional meetings to prepare for the major change envisioned. An evaluation committee made up of practice, education, and research experts was appointed in March 2005 with the charge of identifying the outcomes expected from the CNL initiative. This committee is responsible for developing an evaluation tool for the partnerships around clinical outcomes expected, educational model used, and the success of the CNL immersion into practice.

The partnership continues to grow, with a total now of 88 schools of nursing and 183 practice sites. According to the American Nursing Credentialing Center, 87% of the current CNL practice sites either have Magnet status or are in the application process. Additionally, membership from the American Organization of Nurse Executives was added to the implementation task force and the evaluation committee. A series of conference calls were held with the American Nurses Association to create dialogue and understanding about the work underway. The revolution had started; it is a revolution that has the potential to radically and positively impact the quality and safety of patient care delivered in our healthcare organizations through thoughtful, planned change.

Why Is This Effort Different?

One may ask why the CNL role is needed and what makes it different from other nursing initiatives. Although the CNL is a provider for all settings in which nurses practice, it is important to first review the structure of our current patient care delivery unit where most of the studies of error, patient care quality, and nursing care delivery are done. A typical patient care unit is staffed with nurses and assistive personnel and managed by a director who has 24-hour accountability for the operations, financial performance, communication, hiring and firing, and evaluation of unit personnel. Over the years, the director's span of control and work load have grown significantly while at the same time organizations have downsized patient care support staff. The pressure to reduce costs often has resulted in elimination of unit-based educators, clinical nurse specialists, multiple layers of shift management, or other supportive staff. As financial pressures intensified, organizational leaders tended to cut resources in areas closest to the patient, yet most venerable to errors or patient safety concerns. These organizational staffing changes might contribute to the fact that although there is clear recognition, conversation, and focus on patient safety in healthcare organizations, there is little quantifiable evidence that quality improvement has occurred.[4] These organizational changes have also contributed to nursing dissatisfaction around work design, work

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force management, quality care, and staffing adequacy.[10]

A Joint Commission on the Accreditation of Healthcare Organizations 2002 report stated that nurse "staffing levels have been a factor in 24% of the 1609 sentinel events—unanticipated events that result in death, injury or permanent loss of function—that have been reported to the Joint Commission as of March 2002."[11(p6)]

As patient acuity has risen, so has the complexity of medical care and options available for treating patients. New technology, procedures, pharmaceuticals, and medical interventions have resulted in a plethora of new and specialized disciplines working in hospitals, such as cardiovascular technicians, clinical application specialist, peripheral vascular technicians, physician assistants, and subspecialties in respiratory care and pharmacy. These specialized providers, with narrowly focused roles, have not been matched with either a role or environment that recognizes the potential for errors caused by specialization and fragmentation. Each discipline sees its role and responsibilities related to patient care, but only one discipline, nursing, has responsibility for the total care of the patient. As more and more roles have emerged, the fragmentation, compartmentalization, hand-offs, and communication gaps have increased. The director who oversees the entire operations and business of a unit cannot realistic be expected to also competently oversee the clinical delivery of care.

The CNL role has been especially designed to view the patient as a whole, recognizing and correcting gaps in communication, facilitating effective handoffs, and creating systems that eliminate the fragmentation of care. The role becomes the lateral integrator for the patient care unit. Lateral integration is the integration of care provided by multiple, interdependent, and independent disciplines across a continuum of a patient admission or experience. There has been no one who manages patient care laterally and is able to intervene, facilitate, or coordinate care for the entire patient experience. Lateral integration of care is what is missing in our delivery system.

The CNL will serve as the patient advocate for a cohort of patients, manage the patient care outcomes required, coordinate and facilitate care with multiple disciplines. And, of significant importance, the CNL will have a dramatic effect on patient safety by reducing the number of errors and sentinel events, saving millions of dollars for organizations now attempting to determine why these events occur and how to prevent them in the future. This role in no way diminishes the role of the others, but rather will serve to enhance all disciplines by both understanding the contributions others can make in patient care and assuring the right disciplines are engaged when the patient or other care givers require their expertise.

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