Commentary

Pioneering a new role: the beginning, current practice and future of the Clinical Nurse Leader

Introduction

In this article, seven Clinical Nurse Leaders (CNLs) describe the development of their role from its genesis to operationalization. They share their perspectives and experiences as the first group of nurses within their organization to assume this new nursing role. This cohort had an average of 17 years nursing experience, had been baccalaureate prepared, and came from various specialties within Maine Medical Center.
CNL History

Nursing has existed for hundreds of years in many different cultures. The term ‘nurse’ was made particularly popular thanks to Florence Nightingale in the mid-1800s. She strived to care for patients’ basic life needs while the physician cared for the disease. She set a shining example for nurses everywhere of commitment to patient care and compassion for each individual patient. She also made contributions in the compilation, analysis and presentation of statistics on medical care. She helped create what would become one of the most prevalent and well-respected professions. In fact, registered nurses constitute the largest single health care profession in the United States today.

However, the health care system has become complex and mired in the science and technology of medicine. Health insurance companies have increased restrictions in order to cut costs, which limits patients’ access to adequate health care. Patients move quickly through the system as if on a production line with a variety of disciplines providing fragmented care.

The complexity of today’s health care system has contributed to a growing dissatisfaction among nurses, who have begun to leave the profession. Much like these nurses, we had become interested in pursuing other career pathways. We were all in search of a change; either by refocusing our specialty or leaving the profession altogether. Many of us felt that nursing had become too task oriented and disjointed. We felt as if too little time was spent with the patient and we were frustrated and unable to develop therapeutic relationships and truly meet patients’ needs.

In 1999, leadership from the nursing profession and academia convened to find a potential solution to keep experienced nurses at the bedside. The Chief Nursing Officer (CNO)/Vice President of Nursing (VPN) at Maine Medical Center was a member of the task force that developed the new role of the clinical nurse leader. In introducing the role to us, she conducted a series of sessions to educate all nurses about the fragmentation of health care and the consequential problems. In these sessions, the nursing officer cited the AACN’s White Paper to emphasize the belief that the nursing profession needs to drive change.

Maine Medical Center formed a partnership with the University of Southern Maine (USM) and together these two institutions created the framework of our clinical nurse leader programme. The CNL programme offered us an opportunity to develop professionally while remaining engaged with patients at the bedside. The relationships we build with the patient and family allow us to be the one constant throughout the patient’s hospital course. As CNLs, we pave the way for continuity of care, and promote patient advocacy and educational management across the health care continuum.

CNL education

The practice and academic partners of AACN who had come together to create the new role of the clinical nurse leader had decided that the CNL should have a formal master’s degree programme of education. The CNL is a master’s prepared advanced generalist nurse. This differs from, but compliments, the role of the clinical nurse specialist (CNS), who is a master’s prepared advanced practice nurse with a specialty focus (AACN, 2004, 2007a). Maine Medical Center and University of Southern Maine (USM) designed this programme with the intent to graduate the first cohort of CNL students within 15 months so they could start practising in the role as soon as possible. A number of nurses applied and seven of us were selected from different areas of practice.

The core of the curriculum was nursing theories, complexity science theory, critical thinking, evidence-based practice, patient outcomes and advanced physical sciences. In preparation for the new role, our curriculum also incorporated classes on horizontal leadership, communication, health care systems and organization, and health care policy.

During the first semester, we had no patient care assignments, which allowed us the opportunity to break from the microsystem view of our nursing units and appreciate the complexities of the health care system as a whole. Our education at the graduate level truly gave us a global perspective and changed markedly the way in which we viewed our patients.

When we returned to our areas of clinical expertise, we did so as clinical nurse leader students. We were able to assume the responsibilities of the role even while still in school. Nurses and other health care professionals began to recognize us as CNLs and to utilize our new and developing expertise.

Immersion

The goal of the immersion experience was to facilitate full implementation of the role. Because we were all considered expert nurses, had already shown leadership abilities, and were returning to our respective units, we were able to direct some elements of the immersion. We felt that obtaining the bigger picture of the institution would be crucial to our success. Our approach was later called the ‘View from 40 000 feet’.

Our clinical time consisted of 1000 hours, which was considerably more than required by AACN (AACN, 2007b). We began the 40 000 foot view of the hospital during the summer of 2006 after one full-time semester of course work. We met weekly or bi-weekly with our CNO/VPN, nursing directors and nursing managers. They helped us to gain visibility in the organization and facilitated meetings with key leaders and interdisciplinary team members (see Table 1).

As we continued to meet with our colleagues during the autumn semester of 2006, we were able to introduce ourselves throughout the hospital and quickly disseminate information about our new role. Classes continued along with work on individual Capstone projects. This is a requirement of the programme that is a research-based or outcomes-based project that exemplifies the CNL role. All Capstone projects were approved by the hospital and university institutional review boards (IRB).

At this time, we also identified the meetings and rounds we needed to attend regularly within our microsystems and which patients and patient populations we would follow. Full immersion occurred in the spring semester of 2007. By then, we were at the hospital 5 days a week with 2 hours a week in class discussions with our clinical advisor. During this time on our units, we began to have an impact on patient outcomes. Even as students, we had success stories with individual patients, patient populations or systems and were acting as CNLs in every sense of the role.

### Examples of the CNL role in the clinical settings

The following examples are given by Sonja Orff from the Special Care Unit, Rebecca Quirk from the Paediatrics Unit, Paulette Gallant from the Cardiothoracic Surgical Unit and Nina Swan from the Medical Cardiology Unit. Though the examples are specific to the units in which each CNL works, the functions and implementation of the role are similar for all of the CNLs.

#### Coordinating multidisciplinary long-term ventilation rounds

Mechanically ventilated patients are generally the sickest, most complex patients in the hospital, utilizing the majority of resources (Davidson et al. 2007). They encounter multiple health care givers, often working independently without the time to coordinate efforts or resources. As a result of fragmented care, patient’s length-of stay (LOS) can increase and this can create a financial impact on a hospital.

In response to this, two of us assembled a multidisciplinary team and coordinated rounds on patients who required mechanical ventilation for greater than 5 days. The team integrates early detection and early intervention with the plan of discharge, starting on admission. The objectives of the team are to decrease LOS, facilitate flow among and between departments, improve quality outcomes, and decrease costs to the patient and facility. As advocates for this patient population, the Long Term Ventilation Team has included patients and families in rounds when appropriate. This has proven successful and has given patients and families an avenue for expressing their preferences and remaining the focus of our care. Communication and collaboration are crucial because we know and share the patient’s story.

The Long Term Multidisciplinary Team has been in operation now for 14 months. The team has made rounds on more than 500 patients, with an average of 11–12 patients a week. The results are positive and sustaining. As of 2007, there has been a decrease in time from intensive care unit (ICU) admission to admission to the assisted ventilator unit (AVU), which is a step-down/weaning unit, by 18.2%. This is equivalent to 6 days in the ICU per person. These 6 days can be projected to a cost savings of $800 000 in 14 months. By saving these patients 6 days in the ICU, it opens up ICU beds for other critically ill patients coming into the unit. What’s more,
the team has decreased the return rate, or bounce back rate, from the AVU to the ICU by 6.6%. Saving patients’ time in the ICU and improving outcomes is attributed to our diligence in educating caregivers regarding criteria for admission, developing a partnership between the ICU and the AVU, and opening lines of communication.

Paediatrics

As the CNL on the Paediatrics Unit, I follow and manage the care of the most complex paediatric patients. Often, I collaborate with the CNL who works in the Paediatric Intensive Care Unit (PICU), helping to transition the patient and family from the ICU environment to the inpatient unit. One of the more challenging populations is that of the paediatric tracheostomy patient. In working with these patients and their families, I identified opportunities to improve teaching and better engage patients and families for whom English was not their primary language. I created educational materials and used an interactive teaching method to help parents transition their children back to the home environment. The original focus broadened and I eventually addressed systems deficits and nursing documentation tools. Furthermore, I integrated the interests and needs of the paediatric patients into the hospital’s existing adult tracheostomy policy. Outcomes related to my work in paediatrics have included increased patient and family satisfaction, decreased hospital stay and increased patient safety. In one particular case, a complex patient was discharged 1 month earlier than expected due to my continuity in teaching.

Early intervention and collaboration

The patients that I follow often have complicated surgical wounds, pressure ulcers, newly diagnosed diabetes and multiple co-morbidities. This population of patients and their families are very vulnerable and are overwhelmed by both the illness and the health care system. As the patient’s CNL, I can ensure adequate communication of vital information to the patient and family and across the breadth of health care providers.

Often, I can discover issues that might otherwise never be addressed. As a result, there are earlier interventions, consultations and follow-up, and less time duplicating efforts. Examples are presented in Table 2.

Follow-up phone calls

Follow-up phone calls ensure that patients of all areas understand how to manage their health and are completing instructions given during discharge from health care settings (O’Connor et al. 2003). It is important to have a working knowledge of the patient and any potential problems that could develop from their previous admission. The impact that a follow-up phone call can make not only benefits the individual but also the health care institution. Examples are presented in Table 3.

The future of the CNL role

As we move into our futures as clinical nurse leaders, we remain grounded with the original concept of the role. This means that we will continue our professional development engaged as: clinician, outcomes manager, client advocate, educator, information manager, systems analyst/risk anticipator, team manager, member of a profession and life learner.

Those who envisioned the role at AACN, Maine Medical Center and the University of Southern Maine anticipated outcomes from the introduction of our new role. However, as the role has evolved, we have catalyzed changes that have had many unanticipated positive outcomes. The vision is to hire more CNLs to provide two on every unit in the hospital. With this number, the true value of the role will become manifest.

Already, we have had a measurable impact on systems improvements at the micro and macro levels. By maintaining a balance among all resources (human, systems, equipment and supplies) we will continue to realize cost savings while increasing quality of care. This will support the expansion of the role into other venues by linking the role to the positive financial impact it has vs. its cost.

We will continue to identify processes that improve patient outcomes, nurse sensitive indicators and patient satisfaction. As lateral integrators of care, we are changing the focus from discipline-centred to patient-centred care. In the future, we will realize this change and build strong partnerships among the care providers that our patients see. Because we know the patients’ stories, we welcome them to become fully engaged and they, too, will eventually be true partners in their own health care.

The hope is that there will be CNLs in all health care settings. The patient’s story does not begin or end at the doors of the hospital or rehabilitation centre or even at home. The future for the CNL role will include a bridge to the community. Having connections with the home health nurses, primary care physicians, physician offices or clinics, insurance company liaisons, case managers, acute care, rehabilitation, long-term care, and hospice facilities, will benefit patient care and improve outcomes dramatically.
Table 2
Examples from cardiothoracic surgical patients

<table>
<thead>
<tr>
<th>Example</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Example 1</td>
<td>A 56-year-old patient did not have prescription coverage and had not taken his insulin prior to admission. I discovered this early in the patient’s hospitalization during a discussion with the patient about his uncontrolled diabetes. In addition, this patient also had a new diagnosis of heart failure requiring a regimen of multiple medications. I consulted the diabetic clinical nurse specialist as well as the heart failure CNS for the best approach for in-hospital and outpatient goals for this patient. As a result of working with the patient, physician assistants, doctors, social worker, dietician and clinical nurse specialists, we were able to send the patient home on medications he could afford at a discount store. We also facilitated application for prescription drug coverage through the state insurance. The patient was discharged safely home without readmission for recurrence of symptoms of heart failure or diabetic ketoacidosis. He called me after several weeks to say he was doing well.</td>
</tr>
<tr>
<td>Example 2</td>
<td>A 48-year-old patient who had heart surgery also had a glycosylated haemoglobin A1C of 13 (normal laboratory value of 5.7 or less). I saw him on post-operative day 2 to have a general discussion about his diabetes and his feelings about changing his medical regimen. He also voiced his concerns about his uncontrolled glucose levels. I sent a referral to the CNS for the appropriate approach to his diabetes. With the patient, we discussed a plan of education and follow-up after discharge. We were concerned that his glucose levels would drop after discharge so we placed a great deal of emphasis on hypoglycaemia and his ability to notify the right people. A week after discharge, he called me. I was able to call the surgeon because he had not yet seen the endocrinologist. He changed the insulin regimen and avoided hypoglycaemia.</td>
</tr>
</tbody>
</table>

Table 3
Examples from medical cardiac patients

<table>
<thead>
<tr>
<th>Example</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Example 1</td>
<td>A 37-year-old male was hospitalized with chest pain and found to have left lower lobe pneumonia. He was discharged after 7 days without outpatient nursing services. I made a follow-up phone call a week post-discharge to verify his health status. The patient was complaining of not having ‘enough energy yet to get back to his normal routine’ and considering a return to the emergency room though he had no other symptoms. After we discussed the impact of pneumonia and approximate time to recovery, the patient agreed to wait until the end of the week before re-entering the health care system. In a second follow-up phone call, I found the patient feeling better and appreciative to have avoided an unnecessary visit to the emergency department.</td>
</tr>
<tr>
<td>Example 2</td>
<td>A 74-year-old female was hospitalized with a post-surgical colectomy and intra-operative myocardial infarction. She was hospitalized for 2 weeks and discharged home with her 79-year-old husband to care for her with the help of outpatient nursing services. I made a follow-up phone call 4 days after discharge and found the patient barely able to speak on the phone. She stated that she was not eating or drinking and felt nauseated from intense pain. I spoke with her husband for verification and discovered that no outpatient appointments had been made. We discussed the proper use of her pain medication and formed a plan to comply with her discharge instructions. In a second follow-up phone call, I found the patient had taken her pain medication, began to eat and drink and felt well enough to make all outpatient appointments.</td>
</tr>
<tr>
<td>Example 3</td>
<td>A 47-year-old male was hospitalized with a large anterior myocardial infarction and new onset atrial fibrillation. I made a follow-up phone call and discovered that the patient was not taking his coumadin and had only received a 3-day supply from the pharmacy. I requested that the patient call his cardiologist for verification of necessity of the coumadin.</td>
</tr>
<tr>
<td>Example 4</td>
<td>A 67-year-old female was hospitalized with heart failure and discharged to a skilled nursing facility (SNF) for rehabilitation. I made a follow-up phone call to the patient and discovered that the patient was not on a 2 g sodium diet restriction or fluid restriction and was not being weighed daily. I then called the charge nurse of the unit at the SNF and discussed a plan for daily weights and a nutrition referral to avoid the possibility of re-entry into the acute health care system.</td>
</tr>
</tbody>
</table>

Conclusions

The utilization of CNLs in this practice setting has proven its value in a short period of time. We have been very successful in operationalizing the new role while working within the context of the most complex patient populations. This would not have been possible without the confluence of a number of factors.

We came to the role as experienced clinicians who understood the daily tasks and were able to transcend them to focus on the patient as a whole. This gave us the confidence and critical thinking skills to immediately assume a leadership position.

Our educational programme was crafted and targeted to the needs of our institution and academia. The nature of the role requires that nurses be embedded in the culture of the organization and that the academic partner have the capacity to execute the curriculum in the context of its specific needs. Because of this partnership, the programme was rich and diverse and unlike any other standardized post-baccalaureate or master’s level nursing programme.

Our immersion was longer than many other CNL programmes and gave us a global perspective of our hospital. As students, we were able to begin building relationships with leaders and clinical experts. As we had worked with some of these health care professionals
as staff nurses and had developed trusting relationships, we were able to effectively build the new relationships. The nature of these relationships evolved into collaborative partnerships. We are recognized for our expertise and this has helped to improve communication and introduced a new resource within the hospital.

Because we are a team of seven CNLs, we have had good visibility within the organization. In and of itself, this is an important factor. However, it is equally important that we are a team of colleagues. We meet regularly to share best practices and work on common initiatives. We also collaborate on patient transfers, where we share the plan of care, treatment history and patient’s story. Furthermore, we support each other in a role that is unique in the practice setting and the synergy has helped us to define our functions and responsibilities and maintain the purity of the role.

We focus on patients as a whole rather than as a sum of their parts. As this has not been the traditional approach in medicine, it is a noticeable difference to the patients and families that we touch. We humanize and personalize the health care experience and in doing this, have rediscovered the art of nursing. We model a role to which the bedside nurses can aspire and raise their own professional standards. In addition, we foster an environment where creative insight, alternative possibilities and critical thinking occur.

As CNLs we balance the art and science of nursing, aligned with the vision of Florence Nightingale. We compile, analyse and report metrics and statistics in order to identify and act on opportunities to improve patient care and outcomes. We have been given the opportunity as nurses to redefine our profession in a health care system that is in crisis. We believe that the role of the CNL will be instrumental as a coordinator and change agent to meet not only the demands of today but to anticipate the demands of tomorrow.

**Implications for nursing management**

In an era of a worsening nursing shortage (Buerhaus et al. 2000) and an ageing population, it is imperative to keep highly educated and skilled nurses at the bedside. This allows for a balance between evidence-based practice and safe patient- and family-centred care. The flexibility and broad scope of this role allows for its use in any practice setting to realize gains in quality outcomes, cost savings, improved patient flow, increased safety, nurse satisfaction and increasing organizational capacity. To attain the full benefit from this new role, nursing management needs to fully commit to and support its development, implementation and sustainability.

**Author contributions**

Danielle Poulin-Tabor was responsible for the CNL History section. Rebecca Quirk was responsible for the CNL Education section. Lauri Wilson was responsible for the Immersion section. Sonja Orff, Rebecca Quirk, Paulette Gallant and Nina Swan were responsible for the Examples of the CNL Role in the Clinical Setting section. Nicole Manchester was responsible for The Future of the CNL Role section. The remaining sections were a collaboration among the authors.

**Acknowledgements**

We would like to thank Marjorie S. Wiggins, RN, MBA, CNAA, BC, Vice President of Nursing and Chief Nursing Officer at Maine Medical Center, for providing the vision for the CNL role, the opportunity to be the pilot cohort for the programme, the financial support and continuing encouragement. We would also like to thank Jane M. Kirschling, RN, DNS, Dean and Professor of the College of Nursing at the University of Kentucky, for her strong collaboration with Maine Medical Center in the development of the academic programme. We would further like to thank Phyllis F. Healey PhD, RN, CS-FNP, Associate Professor at USM, and Susan B. Sepples, PhD, CCRN, Director, School of Nursing and Associate Professor, for their continuous support, encouragement and mentoring during the programme. Finally, we would like to thank Kristiina Hyrka¨s, PhD, LicNSc, MNSc, RN, Director, and Denise Dende, BA, MFA of the Center for Nursing Research and Quality Outcomes at Maine Medical Center, for their time, effort and expertise.

**References**


