

Developing the Clinical Nurse LeaderSM Role in the Twelve Bed Hospital[©] Model: An Education/Service Partnership

Rose Sherman, EdD, RN, CNAA, BC, CNL-BC,
Joan Shinkus Clark, RN, MSN, CNAA, BC,
and Janet Maloney, RNC, MHM/HM, ACN

The need for strong academic and service partnerships to bridge what the Joint Commission described as a “continental divide” between nursing education and practice has been a frequent recommendation in the literature.¹⁻³ In the past, nursing education curriculums have been developed and revised with little input from nursing experts in the practice setting. Competing priorities in the practice and educational environments often create challenges to forging partnership relationships. Yet the rapidly changing worlds of both health care delivery and nursing education present unique opportunities to dissolve some of the traditional barriers and develop strong cooperative relations. The development of the Clinical Nurse LeaderSM (CNL[®]) role is an example of an initiative with the potential to serve as a best practice model in nursing education and service partnerships.

The implementation of the clinical nurse leader project under the direction of the American Association of Colleges of Nursing (AACN) marked the first time in 35 years that nursing has introduced a new role to the profession.⁴ Remarkable progress has been made since the initial national partnership meeting in 2004. More than 190 health care agencies and 90 universities are involved in partnerships. The introduction of the CNL role has not been without controversy. Critics from both academic and practice settings have questioned the need and wisdom of introducing a new role to the



profession at this time and whether it duplicates other roles such as the clinical nurse specialist.^{5,6}

In this article, we provide an overview of the CNL project. We examine why one practice partner with a well-developed nursing role similar to the CNL role in an innovative model of patient care delivery, the Twelve Bed Hospital[®] model, chose to become involved in the project. We also discuss how the model is providing guidance for other partners as a best practice for nursing care delivery redesign to incorporate the CNL role.

THE CLINICAL NURSE LEADER PROJECT

Discussions leading to the development of the CNL role began in 2000 with an AACN board discussion about the future of the profession and declining nursing program enrollments.⁷ Over the next 4 years, two task forces appointed by AACN comprised of education and service partners met to discuss the need for new educational models and a new nursing role. In March 2004, a request for proposals to participate in the CNL pilot project was sent to AACN member universities and colleges.⁸ A unique feature of the project was an AACN requirement that universities and colleges that wanted to offer the CNL curriculum had to engage a service partner in the project that was committed to redesigning nursing care delivery to incorporate the new CNL role.

Like many colleges of nursing who received the request for proposals from AACN, the faculty of the Christine E. Lynn College of Nursing at Florida Atlantic University were intrigued with the CNL role but recognized a need to assess community nursing leadership interest in the project. There was an immediate positive response from many senior nursing leaders. The CNL role, as described in the white paper, addressed challenges being experienced in the local practice environment. These included the nursing shortage, fragmentation of care, a lack of nursing leadership at the point of care, inadequate coaching of novice nurses, impending reimbursement for performance and a need to redesign care delivery to become more team focused. A partnership was formed that included Boca Raton Community Hospital, Martin Memorial Health System, St Lucie Medical Center, the Palm Beach County School Nurse Program, and Children's Medical Services. Partnership meetings were held to discuss curriculum development and nursing care delivery redesign.

The partners agreed that this was a unique opportunity that they wanted to offer to their best and brightest experienced bedside nurses. The curriculum was built using the framework developed by AACN.⁹ The partnership goals in curriculum design were to meet the educational needs of students while recognizing the needs of service partners to improve patient outcomes, retain nursing staff, and enhance clinical leadership at the point of care.

BAPTIST HOSPITAL JOINS THE PARTNERSHIP

It has been noted that the strongest collaborative partnerships create synergy by focusing on mutual interests and building on the strengths of each partner.¹⁰ When Joan Clark, then vice president and chief nursing officer (CNO) of Baptist Hospital in Miami, indicated an interest in joining the partnership, it was seen as a unique opportunity by the partners to help with the challenges of CNL role implementation. Baptist had received national recognition for their innovative Twelve Bed Hospital[®] Model. The patient care facilitator (PCF) role in the model very closely aligned to the skills and competencies in the CNL role. The ability to capitalize on the extensive experience of one partner in redesigning care delivery provided a unique opportunity for the partnership both on a local and national level.

Synergy of the Clinical Nurse Leader and Patient Care Facilitator Role

The origins of the PCF role were somewhat different from that of the CNL. On an ad hoc basis, staff nurses at Baptist Hospital described the need for a new nursing role that would provide continuity for patients and staff at the point of care. When encouraged to develop a job description, the concept of a PCF emerged. The primary concern of the staff nurses involved was that the nurse be an expert in care and that the role remained clinical with no management responsibilities. Unlike the CNL discussions, baccalaureate preparation was placed as an entry-level requirement for the position to encourage frontline staff interest.

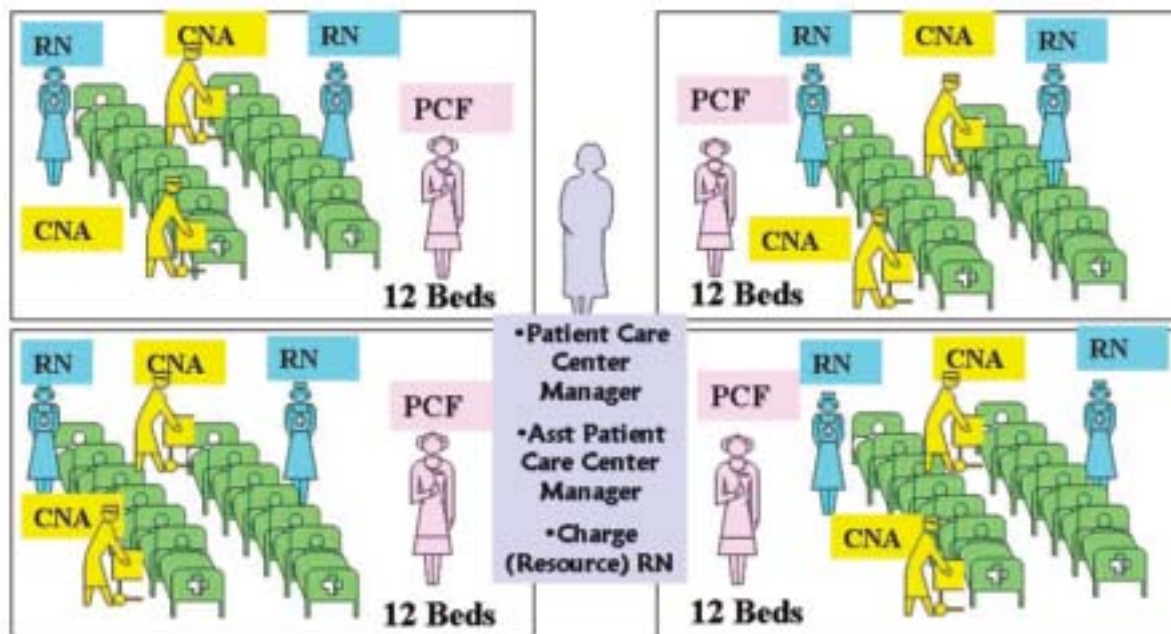
As the role development continued, a BSN was specifically required to ensure appropriate skills and competencies. As master's-prepared staff nurses expressed interest in the PCF role, an advanced PCF description was developed to further utilize advanced practice skills and competencies of the CNS as well as the advanced registered nurse practitioner. With the emergence of the CNL curriculum, a number of incumbent PCFs at Baptist Hospital expressed an interest in learning more about advancement through CNL preparation at the master's level.

Opportunity to Provide a Best Practice for Care Redesign

Between 2000 and 2004, the fully developed Twelve Bed Hospital[®] Model revolving around the PCF role had evolved at Baptist Hospital.¹¹ Hospitals in many of the CNL partnerships were looking for innovative models of nursing care delivery to redesign their own systems to incorporate the CNL role. Since most of the redesign of the care delivery model had already transpired at Baptist, it was felt that others might benefit from innovations and learned experiences as the model was implemented hospital-wide.

When the opportunity to partner with Florida Atlantic University occurred in summer of 2005, 11 individuals in

Figure 1. Twelve Bed Hospital[®] 48 Bed Unit



PCF roles at Baptist Hospital decided to enter the inaugural program. The partnership proved to be beneficial for the overall synergy in the classroom. PCFs speak from an experiential point of view to frame class discussions and at the same time benefit from a curriculum specifically designed to enhance competencies needed for the role.

THE TWELVE BED HOSPITAL[®] MODEL

The care delivery model practiced at Baptist Hospital has been evolving as a hybrid of many of the popular models of delivery, taking some of the best elements of each of the traditional models and combining them in a model that helps the hospital address some of the most perplexing issues faced in the current environment. The role of the PCF was originally described by nurses in direct care positions, as an approach to assuring that nurses on the unit have the leadership needed to deal with all of the complexity that characterizes the hospital environment today.

The initial request for the PCF role emerged on a busy cardiovascular unit when staff were asked to provide input on the ideal staffing pattern for the unit, as well as to make recommendations on whether some of the support functions (housekeeping, dietary, phlebotomy, etc), decentralized during the re-engineering efforts in the 1990s, should be recentralized, allowing nursing staff to concentrate on patient care duties. What surfaced in the discussion was the need for a consistent figure to act as a point person for staff, physicians, patients, and families. It was preferred that this individual be an expert nurse, and that the patient caseload be kept to around 12 (no more than 16) patients. The nursing director for the car-

diovascular unit encouraged the staff to write a job description that described this role, some of the experts complied, and the nursing director received the CNO's approval to pilot the first PCF on a 12-bed section of the unit in late 2000.

Results of the pilot were so encouraging in the initial phases that discussions immediately began around extending the number of PCFs to cover other beds on the unit. In the meantime, the medical-surgical nursing director submitted a proposal to the CNO to further the pilot to two additional 48-bed medical-surgical units, requesting that all four PCFs begin simultaneously on each unit. The CNO received the chief executive officer's (CEO) approval to move forward with the revised pilot, and the CNO appointed a project manager from among the staff nurses who authored the original job description to ensure continuity with the original concept.

Development of the Model

As the PCF role was piloted on these units, the total concept as a *model* came together. In the Twelve Bed Hospital,[®] the nursing unit is broken down into small manageable segments led by a PCF. This allowed a large urban hospital to *act small*, a concept passionately promoted by the CEO as a vision for staff at Baptist Hospital. Within the Twelve Bed Hospital,[®] care delivery revolves around the patient, providing an expert nurse as that single, identifiable professional that a patient can name as *my nurse* during hospitalization (Figure 1). Because the model keeps the caseload at about 12 to 16 patients, the PCF is able to follow every patient and act as an advocate, liaison, and support to the patient and family.

In the hospital setting today, medical care via hospitalists or a variety of specialists can lead to fragmented communication and understanding of the patient's wishes. Clinical staff work flexible shifts, and many times patients do not see the same caregivers from shift to shift. In addition, inpatient acuity is increasing and lengths of stay are declining, which has challenged nursing to look for ways to provide the same level of education and preparation for patients in less time than in the past. The PCF is responsible for knowing all the patients in the Twelve Bed Hospital,[®] acting as *traffic control* for all parties involved in care. The PCF

coordinates the patient needs related to a safe and effective plan for discharge and works with case managers to ensure that arrangements are made to enhance continuity in the posthospital setting.

Staff assigned to work with a PCF within a consistent geographic area of the patient care center are scheduled consistently within each Twelve Bed Hospital.[®] The PCF positions are an addition to the staffing pattern for the individual patient care centers and, although they do not factor into the direct care component relative to staffing, they provide care as needed, especially during emergencies or to assist novice staff.

The Twelve Bed Hospital[®] Model is in many ways the best aspect of a number of traditional delivery models. It is *primary nursing* because one nurse (PCF) oversees the care when the patient is admitted to that 12-bed area. It is *team nursing* because the same staff works together consistently and the PCF acts a team leader, assisting the team to adjust flexibly to the demands of each particular Twelve Bed Hospital.[®] The model is also *modular*, in that it is confined to specific geographic regions of a patient care center. The PCF also acts as the primary *nurse case manager*, facilitating the discharge plan for the interdisciplinary team.

The presence of a PCF, an expert nurse who maintains a continuous oversight of patient issues, as well as the needs of the entire team, promotes unified and expedient care, allowing the hospital to *act small*. The PCF is held accountable day and night. PCFs carry beepers, allowing staff, patients, and families constant accessibility.

During a nursing retreat in fall of 2002, the CNO presented a report to nurses in leadership positions and others, including the CEO, on the early results of the Twelve Bed Hospital[®] on the three nursing units. The idea of the model as a hospital-wide model emerged as the CNO presented, when spontaneous discussion from managers of the ED and critical care began, related to the model's applicability within their specialty. As a re-

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sult of this presentation, the CEO approached the CNO with excitement about moving the model quickly to other areas of the hospital. The CEO asked for an implementation plan and made an initial budget variance to accommodate an estimated 45 positions (less offsets) when fully implemented. The return on investment for the cost of the model was the ability to focus a group of 45 people on achieving key clinical organizational objectives.

MODEL OUTCOMES

The CNO and other nursing leaders developed a roll-out plan for the Twelve Bed Hospital,[®] which began in 2002 and was fully implemented by 2004. All nursing units have implemented the

model with the exception of inpatient rehabilitation, the interventional nursing areas, PACU/surgery, radiation oncology and diagnostic areas that employ nurses. The CEO's and CNO's vision aligns the PCF role with key organizational outcomes. These include improving patient throughput (11 AM discharge), achieving top 10% on the CMS core measures and maintaining patient satisfaction at or above the 90th percentile. There has been significant improvement in all of these areas following the full implementation of the Twelve Bed Hospital[®] and the focus of the PCFs placed at the *sharp end* of each process. As the model has evolved from a nursing to a hospital-wide care delivery process, the expected outcomes have moved from being specifically defined at a nursing and departmental level to measurement at the individual PCF level.

CNL ROLE DEVELOPMENT IN THE MODEL

Although the Twelve Bed Hospital[®] supports the advanced practice preparation of a CNS or ARNP in advanced PCF roles, the CNL curriculum provides specific education that prepares nurses at an advanced generalist level for clinical leadership. According to PCFs who have enrolled in the program, topics such as conflict management, delegation, and team building have proven very helpful in daily skills needed for direct clinical leadership. As the PCFs complete additional coursework within the curriculum and engage in dialogues with nurses from other sites within the partnership, the PCF role will continue to evolve.

With a shift to a predominantly master's-prepared PCF workforce, it is expected that these individuals will play key roles in ensuring quality and safety at the bedside, comfortably using evidence-based approaches to continuously improve patient care. The Baptist Model, which will ultimately include both advanced practice nurses and CNLs in PCF roles, will provide opportunities to evaluate the performance of nurses

with different educational skill sets in leadership roles at the point of care.

LESSONS LEARNED

The first CNL class from this partnership has completed the curriculum, achieved certification, and now practice as clinical nurse leaders. It has been a journey for the partnership. The involvement of Baptist Hospital as a practice partner in the CNL project has allowed other partners on both the local and national levels to benefit from lessons learned on the care delivery redesign that Baptist has pioneered. The Baptist Twelve Bed Hospital[®] model was presented on one of the AACN national clinical nurse leader teleconferences and in other conference forums.¹² It has also been recognized by the Robert Wood Johnson Foundation as one of the most innovative and promising new care delivery models.¹³ Several CNL partnership teams have made onsite visits to Baptist Hospital. The positive results that they have experienced on their outcomes such as more effective patient throughput, performance on core measures, and patient satisfaction are providing guidance to local and national partners on the potential for positive organizational outcomes with CNL role implementation.

The successful implementation of a new role in nursing is not without challenges. Both the academic and service partners involved in the pilot project have assumed risks with their involvement. Early evaluation reports from partners nationwide indicate that the CNL project has generated positive clinical outcomes and an ongoing level of education and practice partner interaction that is unprecedented in nursing.¹⁴⁻¹⁶ The development of the CNL in the innovative Twelve Bed Hospital[®] Model serves as one example of the pioneering efforts of academic and service partners to improve nursing care delivery. Ultimately, the propagation of these types of partnerships will serve as a critical success factor in confronting the current and impending nursing shortage.

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Rose Sherman, EdD, RN, CNAA, BC, CNL-BC, is the director of the Nursing Leadership Institute at Christine E. Lynn College of Nursing in Boca Raton, Florida. She can be reached at rsberman@fau.edu. Joan Shinkus Clark, RN, MSN, CNAA, BC, is the senior vice president and system chief nurse executive for Texas Health Resources in Dallas/Fort Worth, Texas. Janet Maloney, RNC, MHM/HM, ACN, is the Twelve Bed Hospital[®] Project Director at Baptist Hospital of Miami in Florida.

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