

Commentary

Clinical Nurse Leaders: New Roles, New Responsibilities, New Preparation

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It is evident that leadership in nursing . . . is of supreme importance at this time. Nursing has faced many critical situations in its long history, but probably none more critical than the situation it is now in, and none in which the possibilities, both of serious loss and substantial advance, are greater. What the outcome will be depends in large measure on the kind of leadership the nursing profession can give in planning for the future and in solving stubborn and perplexing problems . . . if past experience is any criterion, little constructive action will be taken without intelligent and courageous leadership.

I.M. Stewart, *The Education of Nurses* (1953)

Although Isabel Stewart's words were penned more than 50 years ago, the critical situation remains unresolved. The outcomes that were recommended remain unattained. The call for intelligent and courageous leadership remains, at least in part, unfulfilled. In the half-century since Stewart's proclamation, the profession has experienced great change, most of which, however, has not been strategically planned but has evolved in response to rapid discoveries related to infection control, medications, technology, and care-delivery systems.

Based on long-standing desires and the essential need for creative leadership to guide the profession away from continuous cyclical crises, the American Association of Colleges of Nursing (AACN) charged the Task Force on Education and Regulation II with the preparation of a white paper. The outcome of this white paper was to predict roles that would be assumed by nurse leaders in the future and to outline how the academy could best prepare nurses to meet these role-related challenges. Following the developmental draft and response by an interdisciplinary reaction panel, a document was issued for member comment in May 2003. Although the document has not been finalized, it can be found in its entirety on the AACN website www.aacn.nche.edu.

The AACN white paper is more than 25 pages. This article summarizes the contents of the paper, without inter-

pretation, into three major sections: The Role of the Clinical Nurse Leader, Preparation for the CNL Role, and Education and Core Competencies of the CNL. The last section includes some implications for a CNL in pediatrics.

Implementation

Although the concept of a clinical nurse leader seems to be gaining acceptance, exactly how these individuals will be educated is under study. Currently there are several pilot projects under way across the United States. These projects have taken three basic forms. Content related to the development of a clinical nurse leader has been (a) integrated throughout a baccalaureate nursing curriculum; (b) placed into an additional internship occurring either as fifth year of academic preparation, first year of employment, or a combination of the two; or (c) placed in graduate programs of study. The most intensively studied approach seems to be the internship or academic/clinical partnership model. Results of the pilot projects are not yet available.

The Role of the Clinical Nurse Leader

The clinical nurse leader (CNL) is a leader in the healthcare delivery system across all settings in which care is delivered, not just acute care. The implementation of the CNL role, however, will vary across settings. **The CNL role is not one of administration or management.** The CNL assumes accountability for client care outcomes through the assimilation and application of research-based information to design, implement, and evaluate client plans of care. **The CNL is a provider and a manager of care at the point of care to individuals and cohorts.** The CNL designs, implements, and evaluates client care **by coordinating, delegating, and supervising** the care provided by the healthcare team, including licensed nurses, technicians, and other health professionals (AACN, p. 5) [**bold added for author's emphasis**].

At first reading, one might interpret the role of the CNL to be similar to that formerly ascribed to a clinical nurse specialist (CNS): clinical expert, educator, consultant,

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administrator, researcher. On further investigation, however, that impression is altered. AACN describes the CNL as a leader in the healthcare delivery system, not just within the acute care setting but in all settings in which health care is delivered. In several of the suggested models, BSN graduates (not the master's-prepared CNS) will enter the work world prepared with a specific knowledge base to allow them to begin assuming some leadership skills. They will be prepared in eight broad areas: clinician, outcomes manager, client advocate, educator, information manager, systems analyst/risk anticipator, team manager, and member of a profession (AACN, p. 12). The white paper describes aspects of the CNL role to include:

- Leadership in the care of the sick in and across all environments (e.g., plan client contacts with the healthcare system; have knowledge and authority to delegate tasks/supervise/evaluate other healthcare personnel)
- Design and provision of health-promotion and risk-reduction services for diverse populations
- Provision of evidence-based practice
- Population-based health care to individuals, clinical populations, and communities
- Clinical decision making
- Design and implementation of plans of care
- Risk anticipation (e.g., assess risk when new technology, equipment, treatment, medications, therapies introduced to care plan)
- Participation in identification and collection of care outcomes
- Accountability for evaluation and collection of care outcomes
- Mass customization (e.g., profiles patterns of need and tailors interventions using evidence-based approach)
- Client and community advocacy
- Education and information management
- Delegation and oversight of care delivery and outcomes
- Team management and collaboration with other health professional team members
- Development and leveraging of human, environmental, and material resources

- Management and use of client-care and information technology

Ten Assumptions for Preparation

There are 10 assumptions on which the development of this CNL role is predicated. During role actualization, the CNL will assume accountability for client care outcomes through the assimilation of research-based information; will design, implement, and evaluate plans of care; and will coordinate, delegate, and supervise the care provided by the care team. It is assumed that during the educational process, faculty members will role model the processes of advocacy and communications for students to learn and replicate. Faculty also will assure students the opportunity to interact with physicians, other nurses, pharmacists, and other health team members in the realm of health decision making. Each of these assumptions is discussed in detail within the white paper and is summarized below.

- *Assumption 1: Practice is at the systems levels.* The CNL will be accountable for the care and outcomes of clinical populations (e.g., persons with diabetes, school-aged children).
- *Assumption 2: Population-level care outcomes are the measure of quality practice.* The success of the CLN will be measured by the extent of improvement in clinical and cost outcomes of individuals or groups.
- *Assumption 3: Practice guidelines are based on evidence.* The CLN will demonstrate nursing practice based on research and evidence-based outcomes, not ritualistic and process-based thinking.
- *Assumption 4: Client-centered practice is intra- and interdisciplinary.* As the member of the healthcare team who has the most comprehensive knowledge of the patient, the CNL will coordinate a variety of health team members who participate in the planning of patient care. The CNL will communicate with other nurses and colleagues caring for the patient to ensure coordinated, continuous and safe care.
- *Assumption 5: Information will maximize self-care and client decision making.* In this arena, health literacy is

the key. Clients require in-depth, up-to-date knowledge about themselves, their specific health problems, and their treatment options. The CNL will teach colleagues, clients, families, and communities to be independent managers of their own care. Literacy assessment is integrated into each nursing assessment.

- *Assumption 6: Nursing assessment is the basis for theory and knowledge development.* With the explosion of knowledge, healthcare professionals cannot know everything that is required for safe, high-quality care, but the CNL will be able to use technology for decision support and communication of research/evidenced-based data.
- *Assumption 7: Good fiscal stewardship is a condition of quality care.* The CNL will be accountable for cost-effective and efficient use of human, environmental, and material resources.
- *Assumption 8: Social justice is an essential nursing value.* The profession of nursing is based on altruism, accountability, human dignity, integrity, and social justice. Many nursing curricula, however, tend to gloss over the concepts of cultural competence and health disparities that lie at the heart of social justice. The CNL will strive to eliminate disparities in the availability and distribution of health care.
- *Assumption 9: Communication technology will facilitate the continuity and comprehensiveness of care.* The CNL will leave his/her preparation with the ability to diagnose, educate, treat, and evaluate care of clients using varied and distant technologies. Communication skills must include abilities of face-to-face as well as electronic interactions with individuals and groups.
- *Assumption 10: The CNL must assume guardianship for the nursing profession.* With additional education, the CNL will be expected to assume positions of leadership in clinical agencies, education, policy development, regulatory bodies, and professional organizations.

Preparation for the CNL Role

Throughout the AACN white paper, it is clear that the faculty in basic nursing education (BSN) programs must

assume responsibility for the preparation of the beginning clinical nurse leader. This responsibility will be actualized through didactic and clinical experiences that may look quite different from those enacted today. The new CNL graduate proposed in this educational model may still be prepared in the same 4-year period; in order to include all the newly expected competencies, something will have to change. It is also clear that attitude and expectations of those employing these new graduates will have to change. In the view of this author, major conceptual alterations will focus on

- Strengthened academic-clinical partnerships
- A required "extended" clinical experience prior to graduation, which is mentored by an "experienced" CNL
- Emphasis on the new graduates' abilities to delegate, supervise, and evaluate . . . not necessarily deliver client care.
- An early educational focus on the larger picture of national and international healthcare delivery and disparity, rather than on individual nursing skills.

Education and Core Competencies of the CNL

Liberal arts foundation. To produce the proposed clinical nurse leader, the White Paper Task Force supports the continuation of liberal education as a foundation for expanded nursing knowledge. It acknowledges the need for broad-based learning activities that include students from other disciplines; recommends emphasis in biological, physical, and social sciences; economics; epidemiology; genetics; informatics, etc.; suggests the importance of nurses being able to communicate in English and other common languages; and establishes the expectation that the following competencies will be gained from the liberal arts foundation/core: (a) develop and use higher-order problem solving and critical thinking; (b) integrate concepts from all sciences in order to understand self and others; (c) interpret and use quantitative data; (d) use scientific process and data for developing, implementing, and evaluating nursing interventions; (e)

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synthesize information and knowledge; (f) communicate effectively in a variety of written and spoken formats; (g) engage in effective working relationships; (h) appreciate cultural differences and bridge cultural and linguistic barriers; (i) understand the nature of human values; (j) develop and articulate personal standards against which to measure new ideas and experiences.

Core knowledge. As is true in most current curricular models, the proposed nursing curricula for the basic education of CNLs would be established on the liberal arts foundation and would include core knowledge and clinical experiences related to nine major content areas:

- Health promotion, risk reduction, and disease prevention
- Illness and disease management
- Information and healthcare technologies
- Ethics
- Human diversity
- Global health care
- Healthcare systems and policy
- Provider/designer/manager/coordinator of care
- Member of a profession

Please refer to the original document (AACN, pp. 18–25) for specific outcome behaviors that have been identified for each of these knowledge components.

Core competencies. Based on the liberal arts foundation, core nursing knowledge, and the professional values (altruism, accountability, human dignity, integrity, social justice; see Assumption 8 above), the following have been identified as the core competencies for the new Clinical Nurse Leader (AACN, 2003, pp. 15–18):

- **Critical thinking** underlies independent and interdependent decision making; includes questioning, analysis, synthesis, interpretation, inference, inductive and deductive reasoning, intuition, application, and creativity; includes the ability to use evidence gathered through personal experience and through the research of others in evaluating and designing models and plans of care.
- **Communication** is a complex, ongoing, interactive process and forms the basis for building interpersonal

relationships; includes critical listening, critical reading, and quantitative literacy, as well as oral, nonverbal, and written communication skills; requires effective use of a wide range of media, including not only face-to-face interactions, but also rapidly evolving technological modalities.

- **Assessment** forms the foundation of evidence-based practice; includes gathering information about the health status of the client, analyzing and synthesizing those data, making judgments about nursing interventions based on the findings, evaluating and managing individual care outcomes; includes understanding the family, community, or population, and using data from organizations and systems in planning and delivering care.
- **Nursing technology and resource management** acquisition and use of client care technology and nursing procedures are required for the delivery of nursing care. While the CNL must understand the principles related to and be adept at performing skills, major roles will include teaching, delegating, and supervising the performance of skilled tasks by others.

Please refer to the original document for specific outcome behaviors that have been identified for each of these competencies.

Summary and Implications for Clinical Nurse Leaders in Pediatrics

In reviewing the AACN document, this author was impressed with the very thorough analysis and critique that has been done by our educational and nursing service colleagues. The concepts suggested are futuristic, but not unattainable; attaining them, however, will require a great deal of negotiation and attitude readjustment. Since the demise of diploma education, clinical agencies have expressed frustration because new nurse graduates have been ill prepared to assume realistic patient care assignments within acute care settings (adult and/or pediatric), unable to assume charge and leadership roles on units for at least 1 year

and woefully lacking in the ability to delegate responsibilities to others. The dawn of the most recent staff nursing shortage has only intensified these beliefs.

Baccalaureate degree programs in nursing have been placing some emphasis on leadership and management theory for decades, and although the new grad is never totally prepared to step out of school and into the "charge" role on a unit, they are arguably more ready to do so than many of their predecessors. Although many will readily embrace this newly proposed concept of the Clinical Nurse Leader, it will take a readjustment of expectations from both educators and employers.

Educators must become ready and willing to turn over clinical teaching/learning to experienced CNLs as reality-based mentors. Management theory, as currently taught, will have to take on a much more pragmatic focus. The faculty role will become more involved with teaching and evaluating the mentor (and their ability to teach, evaluate, and provide constructive mentorship) than the traditional teacher/student interaction. Experienced nurse leaders are going to have to find room in their already overcrowded schedule to work directly with undergraduate nursing students, while at the same time trying to develop a cadre of CNLs on their own units to take over additional teaching/mentoring responsibilities. A collaborative partnership between existing CNLs and nursing faculty will be an imperative if this new concept is to work—and any change in that direction certainly is not all bad. We may find that genuine caring and support can/does exist between nursing service and nursing education.

For those involved in nursing care of children, there are several very positive factors that have not yet been mentioned. First, this task force continually calls for both liberal arts and nursing courses that include content "across the life span"; this means that pediatric and family-related issues should not be omitted in upcoming curricular revisions for the new CNL. Second, the identification of health literacy as a foundational assumption also speaks to needs we, in pediatrics, have identified as critical to our teaching mission. And last, the entire concept of mentoring our young has been in place in most

pediatric facilities for a number of years—this we do pretty well. Granted, most pediatric nurses are used to mentoring new graduate orientees so the focus may be slightly different, but the skills needed to be successful in the role are really the same.

Working in concert with nursing faculty to sharpen clinical teaching, mentoring, and evaluation skills will benefit clinicians in many arenas. Clinicians, take up the challenge. Take hold of a positive attitude. Invest yourself in the development of the next generation of clinical nurse leaders in this newer, more formal approach. Be prepared for novice nurses to need more time to learn the skills and tricks of the trade. Acknowledge that not everything can be taught in a 4-year curriculum, and that in the long run it will benefit the patient, the organization, and the profession if our new graduates are more proficient at communication, critical thinking, delegation, etc., and are given the time to learn population-specific skills and techniques on the job. You, and the profession, will undoubtedly gain from this broad-minded approach. Then, perhaps in 2053, no one who is reviewing this document, is shaking her head and saying: "Isn't it a shame, they couldn't learn from their previous nursing leader that 'the outcome depends in large measure on the kind of leadership the nursing profession can give in planning for the future'" (Stewart, 1953, p. 3)?

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Note: The White Paper is a "document in process." New additions/corrections may be placed on the Web site at any time; therefore, please review the full text of the White Paper on the AACN Website: www.nche.edu.

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