

# The Case for Clinical Nurse Leaders: *Guiding Nursing Practice into the 21st Century*

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**T**wenty-first century realities affecting health-care are dramatically and radically changing the landscape for nursing practice.<sup>1</sup> Much of the intensive and comprehensive professional and role development for the entire field of nursing grew out of the focused action of nursing leaders during the 20th century. These efforts directed to the development and

maturation of the profession occurred in an industrial-era context, reflecting many of the values, constructs, and work processes of the age. Even the conceptual and contextual framework that guided the development of nursing thought, principles, and practices was grounded in the Newtonian processes that were the earmarks of the industrial age.<sup>2</sup>

Also, since the nursing profession was moving through the early stages of formalization, much of the characteristics of employee work group structures, practices, and behaviors drove the development and activities of nursing practice. Since nursing development and growth paralleled the expansion of hospital-based healthcare in the United States, and nursing education was grounded in these institutions, much of the characteristics of medical dominance, tight hierarchical control, gender and role subordination, and work process functionalism informed and framed the development of the profession. Although there were strong efforts to counter these forces through expansion of practice roles and the movement of nursing education out of hospitals and into the academic setting, the preponderance of nurses practiced in overwhelming numbers within the hospital industry. This reality has created both challenges and opportunities for the development of the profession.<sup>3</sup>

As medical care and clinical services have become more complex, narrowly defined, and increasingly technologically based, the requisites for specialization, depth of knowledge, and advancing clinical competence have created both the requisite for highly skilled practice and increasing dependence on the centrality of the nurse's role in correlating, integrating, and facilitating the continuum of care. Dramatically accompanying these transitional circumstances has been the radical transformation of all clinical services through the development and application of digitalization, ushering in a new age for human experience. Since the introduction of the silicon chip, the fast movement of the social, business, service, and technological infrastructure has radically altered every level of human existence. The resulting social, technological, and economic reconfiguration of global realities has altered much of the human experience forever. In addition, the new understanding of the action of quantum mechanics, complexity, and network theories has changed the very foundations of human organization and action.<sup>4</sup>

As we move further into the 21st century, the intersection and relatedness of technology and human action have created new foundations for that action and the intercourse necessary to sustain it.<sup>5</sup> Traditional, industrial-age focus on reductionism, vertical design, functionalism, process-driven methodologies, and unilateral provider-based decisions and actions are no longer relevant foundations for practice. The challenge for nursing is translational. The full 20th century was built on a reductionistic, process-driven infrastructure. It has been so inculcated in the dynamics of the nursing profession and the action of its members that, in today's world, they have become an impediment to adaptation and the establishment of new practices. Now it is necessary in the digital age to move nursing practice from process to synthesis, from enumerating function to delineating value, from focus on the action of work to the product of that work, from the emphasis on effort to the determination of value.

Nurses' traditional approach to valuing their work is now only partially meaningful. In this age of evidence, critical thinking and effort must more clearly reflect the interface between effort and outcome within the contex-

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tual framework of obtaining real and sustainable value—in short, making a difference in the life and health circumstances of those whom nurses serve. Obtaining value is now the outflow of the convergence of principle, evidence, and effort. Practice relevance now must more clearly reflect a stronger connection between resource application (money, material, work) and what is obtained from their use. Increasingly, nurses, as with all disciplines, will need to substantiate effectiveness, impact (making a difference), adaptation, and sustainability. For the nurse, this means radically altering focus and effort, and recognizing a new set of realities in highly technologically defined and complex adaptive health systems.<sup>6</sup>

Nursing now moves from unilateral purveyor of particular and specific nursing-designed principles, applications, and practices. Nurses now must more strongly partner and intersect with other disciplines to create an integrated complex of actions and responses, mutually derived and clearly articulated, with a level of well-defined shared accountability that represents the individual's role expectations in what is essentially a collective accountability. The collateral action of the shared partnership in care delivery is now the foundation of evidentiary practice rather than the traditional nonaligned, unilateral, siloed, practice frames of the past. True evidence-based practice represents the confluence of contributions that every discipline has made to value-based outcomes. Evidence of value is embedded in this convergence of effort.<sup>7</sup> The nurse, at the center of this community of practice, maintains the primary responsibility for linking, networking, intersecting, and integrating this collective clinical effort.

Because of the significant demands of these emerging foundations for practice, nurses must work with system leadership and others to end the barriers and workarounds. Furthermore, the organization's dependence on nurses compensating for poor structure, bad fixes, and hierarchical and organizational barriers needs to end, replaced by a clearer understanding and application of the principles of complex adaptive systems and the role they play in sustaining the dynamics of change and adaptation. In the

delivery of healthcare services, structural and process impediments to good flow, synthesis, hand-offs, and communication are the significant foundation of error, lack of safety, and reduced perceptions of patient care quality.<sup>8</sup>

Evidence of the current challenge to the nurse role is apparent at almost every level of healthcare service delivery. Although the nursing shortage operates as one of the driving forces affecting nursing priorities and workload concerns, it is not the only one. Traditional organizational boundaries in design, distribution, and disposition also create “noise” in the clinical system. Moving accountability away from the point of service into huge offices of clinical support has shifted the locus of control and reduced the possibility of obtaining or improving clinical outcomes. The development of huge support initiatives and offices for quality, safety, measurement, and data management has shifted control for quality practices and safety out of practitioners’ hands. This loss has resulted in practitioners working to the measures, data, and forms, diminishing connectedness to the patient experience.

Instead of correcting quality and safety issues in a sustainable way, by virtue of the intensity of the relationship between patient and provider, these overwhelming measurement methods have created a disconnect, impeding the possibility of sustainable, safe, and high-quality care. Instead, the effort becomes data driven, measurement based, and score related. In this scenario, nurses are forced to practice to the score and, only by reflection, actually relate with any degree of intensity to the unique characteristics and needs of individual patients. Yet, in the digitally based, value-driven era, the need for specificity, individuality, and meeting the unique and particular needs of patients accelerates as their demand for this level of care grows.

Within the context of this new scenario, a critical need for a new kind of practitioner emerges. Nursing practice is clearly in need of significant change. However, huge historical precedent must be overcome and confronted directly, challenged in ways that call historical practices into question and seek new solutions. Both transformational and translational work is required to make this necessary shift to a new age of practice. This agent of change must have an appreciation for the cultural and historic conditions and circumstances out of which the nursing profession has matured and the healthcare system has transitioned. This change agent must understand the application of leadership skills and have a significant personal capacity to adapt and adjust to the growing demand for new, value-based clinical practices.

Furthermore, this individual must be clinically based, with a broad understanding of the principles of clinical practice and the ability to adapt and adjust these practices across a wide cross-section of practices and practitioners. This leader must exemplify, in her or his own clinical practice, the ability to shift, adjust, adapt, and build in the overarching influences of evidence as a fluid part of practice competence. In addition, this practice leader must be talented in relationship-building, both within the discipline and among others. This role calls for a higher level of translational skills, allowing this agent of leadership and change to both hold and facilitate conversations across disciplines and services, all directed to

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building strong communities of practice, stimulating interdisciplinary relationships, role modeling practice partnerships, and advancing collective, evidence-based, effective patient care. In short, these role expectations serve to define the demand for, content, and expectations of the emerging role of clinical nurse leader (CNL).<sup>9,10</sup>

#### **A NEW AND EMERGENT ROLE FOR NURSING**

The CNL is the first new role in nursing since the nurse practitioner was introduced over 35 years ago. The CNL evolved after the American Association of Colleges of Nursing (AACN) convened a task force to identify ways to improve quality of patient care and determine how to prepare nurses with the skills and competencies needed to thrive in the current and future healthcare system. The original task force on education (TFER 1) developed models for nursing education and regulation. A second task force (TFER 2) was established, and from that work, a new role emerged—the CNL.<sup>11</sup>

The role, outlined in a white paper (available at <http://www.aacn.nche.edu/Publications/WhitePapers/ClinicalNurseLeader.htm>), is prepared in a new master of nursing curriculum that educates nurses to understand how to provide care and improve quality in today’s complex healthcare system. The coursework provides theoretical and clinical experiences that result in competencies that prepare the CNL to be a strong leader and clinician in today’s healthcare setting. Skills and competencies include system thinking, risk analysis, techniques in quality improvement at the micro- and mesosystem level, use of evidence-based practices, and the ability to laterally integrate care over the healthcare continuum for vulnerable and complex patients. In essence, the CNL is capable of managing complex systems of care<sup>12</sup> while raising the quality of outcomes by making improvements at the point of care, returning the locus of control for quality to its rightful place.

Early outcomes of more than 600 certified CNLs across the country demonstrate that the role is accomplishing what the architects envisioned for nursing practice in the 21st century. Multiple examples<sup>13-15</sup> of high-quality patient outcomes and quality improvements are being directly related to the new role. Core measures established by the Centers for Medicare & Medicaid Services (CMS) and national patient safety goals put forth by the Joint Commission are being addressed by the CNLs. The CNLs working in partnership with clinical nurses, physicians, other allied health professionals, and the patients and families are strengthening patient-centered care through a team approach. Leading processes of care, the CNLs are able to synthesize best practices from all disciplines and reach improved outcomes on patients' behalf while breaking down discipline-centric silos.

CNLs are putting a new face on nursing as a true partner in care with colleagues across the healthcare system by acting as an integrator of the threads of care provided by many to weave a new fabric of comprehensive, coordinated care. Nurses have always been patient advocates and did what needed to be done for patients, no matter what the circumstances or environment in which they practiced. Today, nursing is called upon to rise above the staccato pace of fragmented and complex healthcare delivery and lead, as well as partner with, others to ensure that patient care is safe and effective. The CNL is a fresh new role that is helping to answer this call and holds great promise for the future in a time when it is desperately needed.

### STAKEHOLDER ENGAGEMENT

A major challenge in the evolution of the CNL role has been making the transition from singular roles within settings with large coverage areas or populations to the integration of the CNL into an organization's model of practice. This scenario has often arisen because of the challenges of sufficient numbers of CNLs, in addition to tight staffing budgets that prevent justification for large scale implementation. Attempting to adequately justify the addition of these practitioners, many nurse executives have had difficulty articulating, in consistent terms, the CNL's contribution to patient care and improved outcomes. Often perceived as "another layer" by peers, many nurse executives are unable to make an effective case for the return on investment in terms of quality, cost, and other organizational outcomes. Clearly, it is time to identify a relevant vocabulary that will facilitate the industry's understanding of this role and its relationship with 21st century nursing.

A critical step in the development of a shared language when describing the CNL is identifying the various stakeholders and the relevant messages that will promote understanding of the role in the context of individualized viewpoints. From the perspective of CNOs, academia, and nursing at large, the language used to describe this role should include the broader focus of the microsystem and the essential nature of the CNL in advancing evidence-based quality and patient safety foci at the point of care and in manageable segments. In this dialogue, it is important to include the context of the CNL as working with the broader interdisciplinary team to synergize optimal outcomes and modi-

fy practice based on identification of aggregate patterns within the context of the microsystem.<sup>16</sup>

At another level of dialogue are other stakeholders who are important to understanding the role's purpose and contribution. At the center of the focus are the patient, family, and significant others, and moving outward are physician team members and administration, specifically those invested in understanding the return on investment in this role. A much less difficult discourse occurs with the patient and loved ones because they generally welcome and expect a consistent figure who helps to translate the experience in a patient-centric context. In the case of physicians, CNLs are generally welcomed once they understand and experience the specific nature of their focus in the context of their patients.

A more difficult conversation takes place within the administrative areas when characterizing the necessity for this additional caregiver in the context of the nursing model. How language is used in illustrating the needs within the current environment and casting a vision for driving expertise back to the bedside is critical to garnering support in an increasingly constrained hospital operational environment.

The discussion of the CNL also occurs within an even broader context when considering the payer environment and the various environments in the community. It is critical how the role is introduced and how consistently the narrative ties back to the a clear, crisp, and shared language aimed at the right audience at the right time.

### MESSAGING

In the context of the realities of today's healthcare environment and couched in terms, stories, and language that are appropriate to the audience, the CNL role should be described around a framework that consistently includes the *realities* that have led to the emergence of this role. In addition, the narrative should include an expression of the CNL *role* and the type of person who is ideally recruited. How the CNL *contributes* to improvements within his or her environments is a critical factor that may need varied descriptors, depending on the stakeholder involved. Although varied by audience, it is essential that the contribution be framed in terms of appropriate *content* areas around improvements in quality, safety, satisfaction, expertise, cost avoidance, risk avoidance, improved nurse retention and mentorship, and the like.

Also, the *utility* of the CNL's contributions in measurable terms and results is essential to the dialogue, whether the audience is a family member or the chief of finance. In that way, an *expectation* is created that helps build a case for what the stakeholder can anticipate in terms of deliverables.

### CNO ROLE

As an agent of change, the CNL role provides promise for modeling leadership and expertise at the direct patient care level of the organization. Although results of initial pilots and some hospital-based models have demonstrated the potential of this role to lead more broad-based improvements in nursing practice and patient outcomes, clearly an opportunity exists for the CNO to examine how the CNL role fits into



the context of the practice model, as well as how patient care is delivered. It is in the context of hospital-wide models that new paradigms or nursing practice will emerge.

The nurse executive needs to partner with the CNL to develop a shared language around this role and involve their nurses in providing input into how the model should change around this clinical leader.<sup>12</sup> Moving away from the industrial thinking that has shaped nursing models in years past, CNOs must understand that new ways of practice are essential to creating and sustaining excellence in the work environment and patient care. The CNL role is that agent of change. It is up to the CNO to serve as the leader in crafting the landscape and translating it to other stakeholders, creating an environment that allows the CNL to lead in that change and advance the nursing role for 21st century practice. **NL**

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