Clinical Nurse Leader: Emerging Role to Optimize Unit Level Performance

MAJ Scott Phillips, AN, USA
MAJ Pauline A. Swiger, AN, USA
MAJ Robert Flores, AN, USA
Paula Clutter, PhD, RN, CNL
Carol Reineck, PhD, RN

Patient care delivery in complex healthcare delivery systems calls for emerging professional roles to navigate the labyrinth of quality and safety imperatives. The Clinical Nurse Leader® (CNL®) is one such emerging nursing role. This important role was developed by The American Association of the Colleges of Nursing (AACN) in collaboration with key nursing education leaders and stakeholders.[1] This article describes the CNL role as a means for achieving US Army Medical Department strategic outcomes, distinguish the CNL role from the Clinical Nurse Specialist role, give a case example, and recommend considerations for implementation in the US Army Medical Department. While others[2] have studied this new role in civilian settings, the unique contribution of this article is its application to the US Army setting.

DEFINING THE CLINICAL NURSE LEADER

The CNL is a registered nurse with a master's degree from a CNL education program who serves as an advanced generalist clinician. The CNL provides oversight of care coordination and integration of care for a defined group of patients at the microsystem (unit) level. The CNL is in a pivotal leadership role to incorporate evidence-based practice, quality improvement, and patient safety initiatives to ensure the Institute of Medicine's[3] (IOM) quality aims are met. The IOM's 6 aims for improvement are focused on healthcare being (1) safe, (2) timely, (3) effective, (4) efficient, (5) equitable, and (6) patient-centered.

The AACN[1(p10)] lists the following fundamental aspects of the CNL role:

- Leadership in the care of patients in and across all environments.
- Design and provision of health promotion and risk reduction services for diverse populations.
- Provision of evidence-based practice.
- Population-appropriate health care to individuals, clinical groups/units, and communities.
- Clinical decision-making.
- Design and implementation of plans of care.
- Risk anticipation.
- Participation in identification and collection of care outcomes.
- Accountability for evaluation and improvement of point-of-care outcomes.
- Mass customization of care.
- 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.
- Lateral integration of care for a specified group of patients.

THE CNL ROLE IN RELATION TO OTHER NURSING ROLES IN THE CLINICAL MICROSYSTEM

The CNL is not an administrative or management role. The CNL partners with the administrative and management staff and is a vital member of the interprofessional healthcare team. The AACN highlights the similarities, differences, and shared characteristics of the CNL and nurse manager roles.[4] In collaboration, the CNL and the nurse manager focus on improving the quality of care delivered in the healthcare system. The CNL and Clinical Nurse Specialist (CNS) roles are also complementary and collaborative. The AACN published a working statement[5] comparing the CNL and CNS roles, highlighting the similarities, differences, and complementary characteristics. Table 1 summarizes these similarities and differences in terms of education, certification title, clinical practice area, and value.

Regardless of specialty and focus, the CNS incorporates both the microsystems and the macrosystem into the care of the patient, staff and organization as described in the AACN[6] synergy model spheres. This model includes

these interrelated systems: the client/patient, the personnel/staff, and the organization/system. The spheres are incorporated into each of the 5 main roles of the CNS: clinical expert, consultant, educator, researcher, and clinical leader. Whether the CNS functions as a licensed independent provider or blends into the team, he or she uses the focus, specialty, and spheres to provide holistic care to the end user, our patients. By way of contrast, the CNL is an advanced generalist in nursing who is prepared to be a direct care provider accountable for the care outcomes of a clinical population or a specified group of patients/clients in a healthcare system. The CNL provides for lateral integration at the point of care (bedside) that promotes quality care outcomes. The CNL master's level curriculum is offered in response to the profound changes in the increasingly complex healthcare system mandating change to improve quality of care while reducing costs, improving access, eliminating disparities, and promoting safe practice. The CNL oversees the care coordination of a distinct group of patients and actively provides direct care in complex situations. As an advanced generalist, the CNL incorporates evidence-based practice, patient safety, and quality improvement to optimize healthcare outcomes. The CNL provides leadership to assure safe, timely, efficient, effective, and equitable patient-centered care.

Table 1. Clinical nurse leader and clinical nurse specialist compared by education, practice, and value.

	Clinical Nurse Leader	Clinical Nurse Specialist
Master's Prepared	Yes	Yes
Advanced Practice Registered Nurse	No	Yes
Advanced Generalist Clinician	Yes	No
Vital member of the interprofessional healthcare team	Yes	Yes

Both roles require master's preparation and each role has a clear domain of influence and skills. The CNL and CNS roles are distinct in their respective preparation and collaborate in the mission to benefit the patient, staff, and system. In Thompson and Lulham's article,[7] these 2 master's degree-prepared roles have both demonstrated clear benefits. For example, the CNLs and CNSs who serve a cardiac population of patients within a university healthcare system together, have developed a collaborative relationship that benefits both staff and patients. Both worked together to differentiate role expectations, functions, and outcomes. In making patient care decisions, there are role similarities and overlaps, such as working with the multidisciplinary team, using advanced nursing skills for patient assessment, performing complex problem analysis, and supporting bedside staff. Despite these similarities, there are differences that reinforce the need for separate roles. The CNL manages a distinct population group through day-by-day management of clinical issues and decisions. The focus is on evaluating and supporting evidence-based decisions to ensure best possible outcomes. By contrast, the CNS aims to help staff deal with disease processes and treatments from a broader perspective, focusing on a group such as patients with cardiac diagnoses and solving problems at the macrosystem level. The CNLs directly assist staff to implement evidence-based or patient care changes with each individual patient at the microsystem level. The CNS may coordinate hospital-wide orientation programs and provide formal staff education, such as teaching new employees in the skills laboratories. The CNL assists with staff development and education but deals mainly with individual staff members at the bedside. According to Thompson and Lulham,[7] they collaborate to build staff nurses' skills and abilities, especially with regard to critical thinking and fostering patient education.

PROGRAM OF STUDY

The CNS program of study focuses on one of several specialties: (1) medical-surgical, (2) critical care, (3) geriatric, (4) pediatric, (5) mental health, (6) oncology, or (7) community health nursing. Within these populations, the CNS may also focus on patients with a particular diagnosis or condition such as heart failure, wounds, or pain.

The CNL major at the School of Nursing, University of Texas Health Science Center at San Antonio was initiated during the fall of 2010. The CNL curriculum was developed using the CNL Essential Curriculum Elements[4] as a guide and is congruent with the AACN's Essentials of Masters Education.[8] The CNL major consists of 40 semester credit hours and 495 clinical practicum hours. Table 2 presents course names, numbers, respective semester credit hours, and clinical hours. During the last semester, and at the conclusion of the CNL capstone clinical experience, the student is eligible for the AACN Commission on Nurse Certification CNL credentialing examination to obtain national CNL certification.

APPLICATION OF THE CNL ROLE IN THE US ARMY

The Clinical Nurse Leader (CNL) is key to meeting both the Army Medical Department (AMEDD) macrosystem objectives and the Army Medical Command's (MEDCOM) strategic objectives. The MEDCOM created a balanced scorecard (BSC) to align all Army medical organizations toward "achieving its overarching strategic objectives."[9] The BSC builds on the AMEDD's mission (why we exist), vision (where we want to be), and strategic themes ("pillars of excellence").[10(p7)] In 2009, the MEDCOM Chief of Strategic Planning noted that:

Table 2. Clinical nurse leader curriculum (required courses), School of Nursing, University of Texas Health Science Center, San Antonio.

Theoretical Core Courses for all Graduate Students:	
NURS 5339 Leadership for Quality, Safety, and Health Policy	3 semester credits
NURS 5306 Advanced Theory for the Practice of Nursing	3 semester credits
NURS 5307 Using Research for the Practice of Nursing	3 semester credits
NURS 5356 Financial and Economic Evidence in Healthcare	3 semester credits
Clinical Nurse Leader Major Courses	
NURS 6317 Healthcare Information Systems and Patient Care Technology	3 semester credits
NURS 6380 Foundations of Epidemiology	3 semester credits
NURS 5338 Advanced Pathophysiology	3 semester credits
NURS 6210 Advanced Health Assessment and Clinical Reasoning	2 semester credits
NURS 6110 Advanced Health Assessment and Clinical Reasoning: Clinical Application	1 semester credit 45 clinical hours
NURS 6302 Advanced Pharmacotherapeutics	3 semester credits
NURS 6230 Clinical Nurse Leader (CNL) I: Role of the Advanced Generalist in Healthcare Microsystems	2 semester credits
NURS 6233 Clinical Nurse Leader (CNL) I: Role of the Advanced Generalist in Healthcare Microsystems: Clinical Application	2 semester credits 90 clinical hours
NURS 6120 Clinical Nurse Leader Role II: Seminar	1 semester credit
NURS 6822 Clinical Nurse Leader Role (CNL) II:Clinical Application for the Advanced Nursing Generalist	8 semester credits 360 clinical hours
Total Semester Credit Hours: 40 **Total Clinical Hours: 495**	

> The Surgeon General likes to use the muddy stream analogy: sometimes our organization can appear mired and moving in multiple, random directions. The balanced scorecard is our way of getting everyone moving in the same direction; gathering momentum as we go.[9]

The skills of a CNL can clear that "muddy water" at the individual hospital unit level while keeping the AMEDD's BSC in the forefront. The CNL can help focus the staff while implementing strategic objectives.

The AMEDD Balanced Scorecard was last updated in March of 2011 and states the AMEDD's vision is to "bring value and inspire trust."[10] Two strategic themes and desired results are particularly well-suited to the skills of the CNL: (1) maximize value in health services, and (2) balance innovation with standardization. The first, maximize value, seeks a result of "effectively and efficiently provide(ing) the right care at the right time"[10] which is a primary goal of the CNL. Units within the Department of Veterans Affairs that employ the use of a CNL reported that "integration of the CNL role in all areas of practice in every care setting has the promise of streamlining coordination of care"[11(p382)] which would lead to improved efficiency. The CNL can aid in the second strategic theme, balancing "innovation with standardization,"[11(p382)] by maximizing the use of best practices resulting in optimal patient outcomes, also in accordance with the MEDCOM BSC. The CNL is best positioned to implement evidence-based practices on the unit because "as a master's prepared nurse generalist, the CNL is prepared to deliver and direct evidence-based practice, evaluate patient outcomes, and assess risk, while improving the overall coordination and delivery of care for an individual/ group of patients at the microsystem level."[1] Upon review of the BSC, depicted in the Figure, the authors noted, by outlining in red, the ends, ways, and means of positive effect by CNLs.

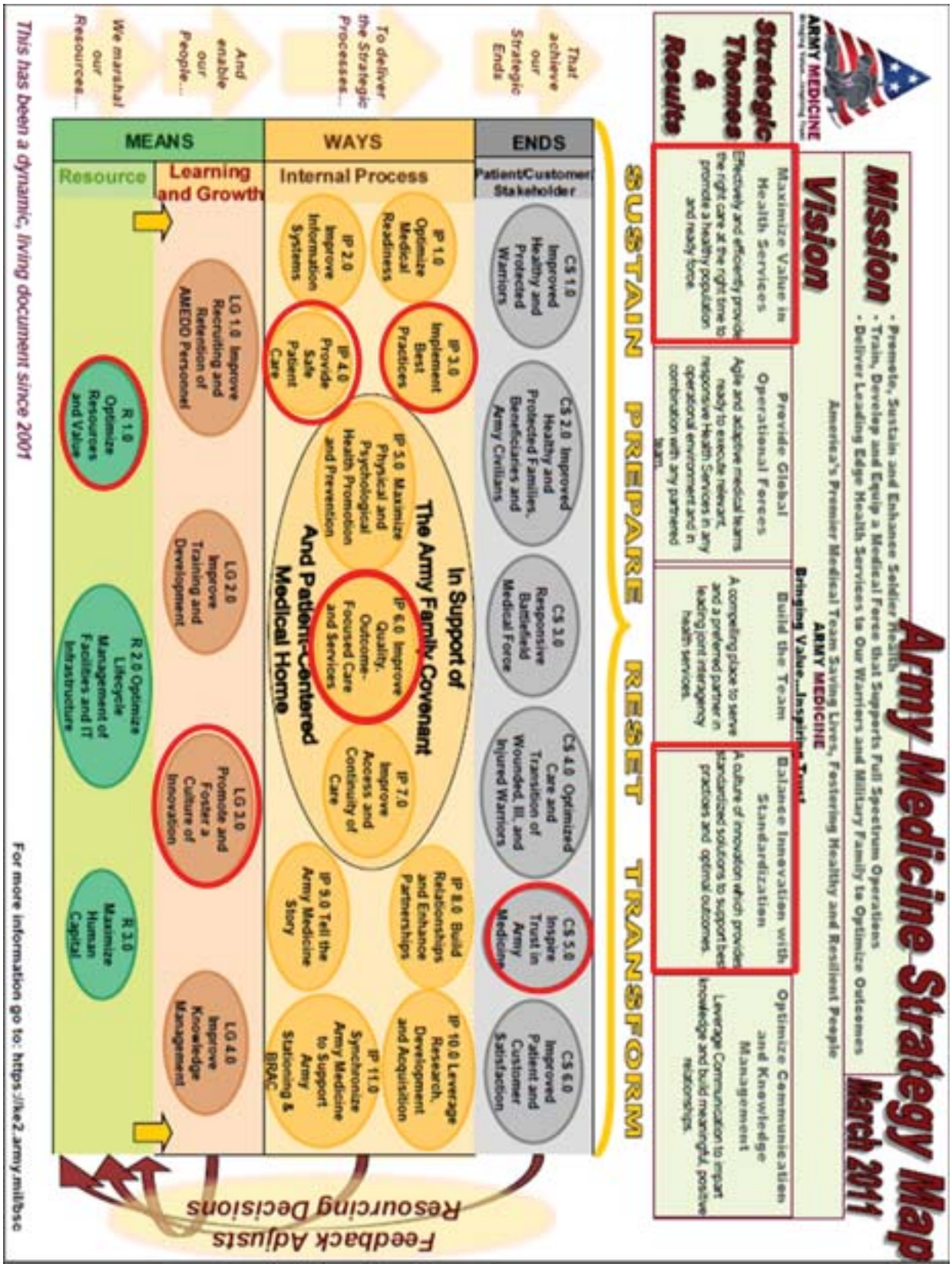
The military healthcare workforce faces a unique situation of scheduled transition into and out of its facilities. This creates challenges with continuity around which a CNL can navigate using evidence-based practice with care coordination improving overall patient satisfaction. The following case example illustrates pilot implementation of the CNL role by an Army Nurse Corps officer prior to formal graduate education. The example points out the importance of graduate education and appropriate structural decisions pertaining to the role.

CASE EXAMPLE: IMPLEMENTING THE CNL ROLE

The Clinical Nurse Leader role was piloted on one nursing unit at William Beaumont Army Medical Center (WBAMC), Fort Bliss, Texas. The WBAMC is a Phase II site for the BG (R) Anna Mae Hays Clinical Nurse Transition Program (CNTP), which is designed to ensure the readiness of the Army's new registered nurses (RNs). From this program, the new RNs are assigned to Army military treatment facilities or medical centers.

The CNTP requires one year, combining didactic and clinical orientation for the novice RN. The program affords each new RN similar experiences and exposure to large numbers of diagnoses and patient volume. By planned preparation of the RN prior to moving to a potentially smaller duty station or a deployed setting, the training opportunities actually benefit the overall military healthcare system.

Once the 12-month program is complete, the nurse officer is eligible for a permanent change of station reassignment. This is a core difference in current Army Nurse



The Army Medicine Strategy Map. Source: US Army Medical Department, http://www.armymedicine.army.mil/news/scope/Summer_2011_Scope.pdf

Corps utilization policy compared with that prior to the CNTP. Historically, the RN may have been assigned for 1½ to 2½ years on a medical-surgical nursing unit. This allowed more time to fully progress from novice to (at least) advanced beginner. The secondary organizational benefit was additional time for staff to progress through more of Benner's novice to expert stages[12] while having access to staff at higher stages as mentors. While the Army provides no definite time line for progression through Benner's novice to expert stages, Kaminski reported that it takes approximately 5 years to move through the 5 stages, but also noted that not all novices become experts.[13]

The WBAMC medical surgical section is small in comparison to other major medical centers. The CNTP posed a challenge to the section because the program's new RNs arrive and depart in groups. On average, the program's RNs are at WBAMC for 15 months, since most leave 3 months after completing CNTP. Their presence results in less experienced RNs making up a larger percentage of the overall staff. Further, the staged rotation means that nurses who become the most knowledgeable leave and few remain to precept. These 2 circumstances decreased the effectiveness of the CNTP at WBAMC because there was less knowledge being passed to incoming nurses during preceptorship, and less expertise to access when clinical questions arose. WBAMC chose to fill this knowledge gap with the CNL.

For the CNL on the surgical nursing unit at WBAMC, the first task was role creation. The nurse researcher and section chief assisted with literature research, job description creation, and rating scheme development. At that time, there was not a long-term health education training opportunity to be a CNL, nor was the CNL incumbent master's prepared. Leaders selected the CNL based on clinical expertise and leadership ability. The CNL had 10 years RN experience within the medical, surgical, critical care, and teaching environments combined, and had just returned from a deployment to Operation Iraqi Freedom.

OUTCOMES MEASUREMENT

The metrics for effectiveness will always be established by the facility. Some of these metrics are highlighted in this article. The metrics employed could be influenced by increasing communication and attention to the nursing process. The effective evaluation and implementation of the nursing process is essential to success as a CNL. The nursing process is the foundation for effective nursing care, and, by extension, improves the measurable metrics. For example, a thorough pain assessment with proper planning, implementation, and reassessment may decrease falls and length of stay while increasing patient satisfaction. The CNL provides expertise in each step of the process for the staff RNs.

To this end, the first performance improvement (PI) project at WBAMC assessed communication handoff and determined that reports were incomplete during the morning report and pertinent information was not being relayed. It also became clear that absence of communication was a measure of decreased understanding of the nursing process. The PI project used observational and descriptive cross-sectional analysis of communication data. Point measures were the communication of code status, assessment findings, vital signs, laboratory values, intravenous access points, and the plan of care. Data were collected one month before education and 3½ months after education. Increases in percentage points are shown in Table 3. Dramatic improvements were noted in all aspects of communication during patient care transitions. Those improvements were directly associated with CNL role implementation.

These improvements were a measurable function of the CNL working within the clinical microsystems, rounding on and interacting with patients, inquiring about the plan of care with the RN, and functioning as a clinical resource. The CNL is a generalist, but, at the same time, an expert—the "go to" person at the point of care when knowledge gaps are present. They bring the expert assessment to the bedside, help the staff create a plan, foster communication from that plan to the physician staff, and work to implement and reevaluate the patient care. Through these capabilities and actions, the CNL benefits the staff and the organization. They are the constant resource and an integral team member. The CNL role became a recognized success at WBAMC when the staff began to regularly ask for input and help. The phrases (from the staff) "can you explain this?" and "can you help me with…?" and "can you take a look at this patient with me?" became success measures.

Table 3. Improvements in communication during patient care transitions and handoffs associated with CNL role implementation at one military medical center.

Metric	One Month Before Education	3½ Months After Education	Increase in Percentage Points
Code status	63%	87%	+24
Assessment	79%	94%	+15
Vital signs	73%	82%	+9
Lab values	67%	73%	+6
Intravenous (IV) access and fluids	20%	95%	+75
Plan of care	60%	93%	+33

RECOMMENDATIONS

Due to the complex nature of changes within personnel proponency, planning for force structure integration of the CNL must begin immediately. The positions identified for the CNL should be filled with nurses who are master's prepared as CNLs, whether Department of the Army civilian or major or lieutenant colonel Army nurses.

For the CNL to be most effective within the individual units, we recommend that they work in partnership with, but are not rated by, the head nurse (HN). This arrangement could prevent "mission creep" in that the HN may want to assign workload to the CNL instead of working together toward a common goal while staying in their respective roles. The HN should be focused on future planning, organizational level goals, and employee ratings and awards. The CNL should focus on interdisciplinary collaboration, improvement science, and policy development. The delineation between the HN and the CNL will be of paramount importance, requiring education of the hospital staff on the appropriate role of the CNL. Without this, the CNL could be perceived as a "ghost" head nurse and spend his or her time attending inappropriate meetings in place of the HN. The section chief would be an appropriate choice as a rater given that some head nurses may be outranked by the CNL assigned to their unit. For a captain (promotable) or major, the senior rater must be at least a colonel. In most situations, the CNL should be rated by the section chief and senior rated by the assistant chief nurse, providing that person is a colonel. If the assistant chief nurse is not a colonel, then the chief nurse would be the appropriate senior rater.

To create the standardization that the BSC seeks, the AMEDD would have to adopt the goal of placing CNLs in at least the 5 major medical centers. If the positions are not delineated on the Table of Distribution and Allowances, they may be reabsorbed into the staff of a given unit. Annual meetings or conferences of all clinical nurse leaders assigned to medical centers, in person or via video teleconference, would decrease variability in role performance across the medical centers, and highlight any trends to misassign CNLs within the clinical environment.

The ratio of head nurses to CNLs in the medical center would be optimal at one to one. That is, a CNL on each nursing unit will be a force multiplier for every head nurse. The CNL would be an advocate and conduit for implementing best practices and evidence-based practice within the AMEDD facilities. To aid in this role, the CNL should have access to library databases such as EBSCO (EBSCO Information Services, Birmingham, Alabama). The introduction of any new role will have challenges. Decreasing confusion and role clarification must be priority one when implementing a CNL into the practice setting. The following are suggestions on initial implementation:

1. Clearly define the role and be completely comfortable articulating it. This communication is important up and down the chain of command. It is essential that senior leaders and RN staff know the CNL's role and goals.

2. Know everyone and become known in the clinical environment. As with any new job or facility, the incumbent in a new role must establish a baseline within the inner workings of the facility. Working with staff members as their mentor provides familiarity with all tasks, locations, code combinations, and processes within a unit or ward. Spending 2 day periods with several different members of the nursing staff, a combination of stronger and weaker nurses, is advisable. Thus, the CNL can begin to quietly evaluate the staff while showing an ability and willingness to "get my hands dirty" in the course of caring for patients. During CNL interactions with physicians, it is important to explain the CNL roles in care coordination, clinical improvement in care delivery, and enhanced communication between the physician and nursing staff.

3. The duty location of a CNL is in the nursing unit, at the bedside and overtly available to the staff. The CNL is their resource. The CNL's ability to act as such is diminished by absences from the care environment for meetings. While some may be necessary, most will not. Have the support of the senior leader to say no, and remain at the bedside.

In order for the CNL position to realize its potential as a valuable resource in the provision of healthcare within AMEDD, CNLs must be given the proper tools and responsibilities to demonstrate their value and effectiveness. Only then can they successfully educate the hospital staff, both leadership and those directly involved in patient care, about the important role of the CNL in their facility operations. With careful planning prior to implementation of the CNL positions, AMEDD will find that the CNL quickly becomes indispensable to meeting many of their strategic objectives.

ACKNOWLEDGEMENTS

The authors gratefully acknowledge Dr Mary "Kelly" Dunn for editorial review and Ms Cecelia Dornfield for clerical assistance.

REFERENCES

1. *White Paper on the Education and Role of the Clinical Nurse Leader*. Washington, DC: American Association of Colleges of Nursing; 2007. Available at: http://www.aacn.nche.edu/publications/whitepapers/ClinicalNurseLeader.pdf. Accessed June 21, 2012.
2. Moore L, Leahy C. Implementing the new clinical nurse leader role while gleaning insights from the past. *J Prof Nurs*. 2012;28(3):139-146.
3. Institute of Medicine. *Crossing the Quality Chasm: A New Health System for the 21st Century*. Washington, DC: The National Academies Press; 2001. Available at: http://www.nap.edu/books/0309072808/html/. Accessed June 21, 2012.
4. Ott KM, Haase-Herrick K. Working statement comparing the clinical nurse leader and nurse manager roles: similarities, differences and complementarities. [American Association of Colleges of Nursing website]. March 2006. Available at: http://apps.aacn.nche.edu/CNL/pdf/tk/roles3-06.pdf. Accessed June 21, 2012.
5. Spross JA, Hamric AB, Hall G, et al. Working statement comparing the clinical nurse leader and the clinical nurse specialist roles: similarities, differences and complementarities. [American Association of Colleges of Nursing website]. December 2004. Available at: http://apps.aacn.nche.edu/CNL/pdf/CNLCNSComparisonTable.pdf. Accessed June 21, 2012.
6. The AACN synergy model for patient care page. American Association of Critical-Care Nurses website. Available at: http://www.aacn.org/WD/Certifications/Content/synmodel.content?menu=Certification. Accessed June 23, 2012.
7. Thompson P, Lulham K. CNL and CNS role delineation in the acute care setting. *J Nurs Adm*. 2007;37(10):429-431.
8. *The Essentials of Master's Education in Nursing*. Washington, DC: American Association of Colleges of Nursing; 2011. Available at: http://www.aacn.nche.edu/education-resources/MastersEssentials11.pdf. Accessed June 21, 2012.
9. Aligned scorecards provide cohesive plan. *The Mercury*. March 2009. Available at: http://www.armymedicine.army.mil/news/mercury/09-03/BSC-cascade.cfm. Accessed November 10, 2011.
10. Pere S. Balanced scorecard, strategy focused. *The Army Medicine Scope*. Summer 2011:7. http://www.armymedicine.army.mil/news/scope/Summer_2011_Scope.pdf. Accessed November 10, 2011.
11. Ott KM, Walters SE, Haddock KS, et al. The clinical nurse leader: impact on practice outcomes in the Veteran's Health Administration. *Nur Econ*. 2009;27(6): 363-383.
12. Benner P, Tanner C, Chesla C. From beginner to expert: gaining a differentiated clinical world in critical care nursing. *ANS Adv Nurs Sci*. 1992;14(3):13-28.
13. Kaminski J. Theory applied to nursing informatics-novice to expert. *Can J Nurs Inform*. 2011;5(4):1-3. Available at: http://cjni.net/journal/?p=967. Accessed August 3, 2012.

AUTHORS

MAJ Phillips is Clinical Nurse Specialist and Education Officer, US Army Burn Center, US Army Institute of Surgical Research, Fort Sam Houston, Texas.

MAJ Swiger and MAJ Flores are master's degree students at the School of Nursing, University of Texas Health Science Center at San Antonio.

Dr Clutter is an Assistant Professor, Department of Health Restoration and Care Systems Management, School of Nursing, University of Texas Health Science Center at San Antonio. A Major in the USAFR Nurse Corps, Dr Clutter is Deputy Chief Nurse of the 433rd Medical Squadron, Lackland AFB, Texas.

Dr Reineck is Chair and Professor, Department of Health Restoration and Care Systems Management, School of Nursing, University of Texas Health Science Center at San Antonio. Dr Reineck is a retired Colonel, US Army Nurse Corps.