INTRODUCED IN 2004, the clinical nurse leader (CNL) is the first new nursing role in more than 30 years (American Association of Colleges of Nursing [AACN], 2007). The goal of the CNL role is to return expert clinicians to the point of care to strengthen the nursing professions’ contributions to improve the quality, safety, and outcomes of health care in the United States. The hallmark of CNL practice is the management of client-centered care and clinical excellence at the point of care (AACN, 2007; Hix, McKeon & Walters, 2009; Ott et al., 2009; Reid & Dennison, 2012).

Unlike other master’s-prepared roles in nursing, the CNL is an advanced generalist with unit-level responsibility. Because of their generalist orientation, the scope of CNL practice complements that of the frontline nurse manager, on the one hand, and the nurse practitioner and clinical nurse specialist, on the other (AACN, 2007). Graduate education for the CNL role extends the direct care skills acquired at the baccalaureate level to build competence in the area of policy and organizations, outcomes management, nursing leadership, and care
management (AACN, 2007). CNLs are educated to assume responsibility for interdisciplinary care coordination; managing clinical outcomes, with a particular focus on promoting health and preventing disease in populations; and implementing clinical quality improvement and risk management programs within the context of a clinical unit.

To promote the diffusion of the CNL role in both academic and practice settings, the AACN specified the development of CNL program curricula; clinical and didactic experiences required for certification as a CNL; and academic–service partnerships to serve as a mechanism for each partner to initiate the CNL role, with the goal of hiring CNL program graduates into formal CNL positions at the partner organization (Stanley, Hoiting, Burton, Harris & Norman, 2007). The White Paper on the Education and Role of the Clinical Nurse Leader (2007) outlined these requirements, which are also described elsewhere (Bartels & Bednash, 2005; Drenkard, 2004; Poulin-Tabor et al., 2008; Stanley, Hoiting, Burton, Harris & Norman, 2007; Tornabeni & Miller, 2008).

Although clinical practicum experiences are a common feature of nursing education programs, the role transition experience for individuals pursuing the CNL role differ in important ways from experiences provided in other graduate programs in nursing. Ideally, CNL education and transition to practice occur within the context of an academic–service partnership (AACN, 2007). The academic–service partnership model serves to promote CNL role implementation by aligning academic and organizational goals; each partner is committed to educating and employing nurses to lead and manage clinical improvement initiatives. CNL students complete between 400 and 500 clinical contact hours during the program, 300 to 400 of which are structured as an immersion experience in the CNL role with a dedicated preceptor and a faculty partner over a 10- to 15-week period (AACN, 2007). During the immersion experience, students have the option to select a new clinical practice area for the practicum experience as a means to promote transitions into a new practice area after graduation (Bombard et al., 2012).

Prior studies examining the transition experiences of nurses pioneering the CNL role provide important information regarding organizational factors that promote or hinder the adoption of the CNL role in clinical settings (Bombard et al., 2012; Moore & Leahy, 2012; Sherman, 2010; Stanton, Lammon & Williams, 2011). Two recent qualitative studies suggest that the CNL role is implemented differently across organizations and practice areas (Sherman, 2010; Stanton et al., 2011).

The purpose of this study is to develop understanding of factors that account for variation in individuals' self-efficacy in the CNL role. This study contributes to CNL implementation efforts by developing understanding of personal and contextual factors that explain variation in individuals' levels of self-confidence with performing the key functions of the CNL role. Understanding differences in CNLs' levels of self-confidence with the core competencies of the role will provide important information to develop targeted career transition interventions to gain the full benefit of CNL practice.

Role Transitions of CNLs

CNL practice, by definition, requires individuals to make career transitions that require adjustment to new professional work roles and responsibilities. Doing so also entails individual adjustment. Prior research suggests that experienced nurses moving into advanced practice roles experience difficulty during role transition because they are expected to function at a higher, more independent, practice level than previously demonstrated in traditional staff nurse roles (Jones, 2005; Sherman, 2010). More generally, an individual's ability to build a successful career is based on her or his ability to transition to increasingly complex work roles (Ashforth & Saks, 1995; Nicholson, 1984).

Work role transitions entail two interdependent adjustment processes: personal development and role development. Personal development includes cognitive and psychological changes in knowledge, skills, confidence, and work identity, and motivation for feedback to improve work performance and prior professional socialization experiences. In contrast, role development is reflected in the design of the job within a specific organizational context. Managers are typically responsible for attending to the required changes in organizational systems, structures, reporting relationships, politics, culture, and resources needed to promote the adoption of a new work role (Edwards, 2008; Nicholson, 1984). In sum, the extent to which an individual is able to successfully transition to a new work role is predicated on personal characteristics that make her or him well suited for the job, on the one hand, and changes in organizational context and job design to promote person–job fit, on the other (Ashforth & Saks, 1995; Edwards, 2008; Stephens, 1994).

Self-confidence is an important factor associated with successful role transitions. Self-confidence is an attitude that enables individuals to have positive, yet realistic, views of themselves and their situations. Self-confident people trust their own abilities, have a general sense of control in their lives, and believe that, within reason, they will be able to do what they wish, plan, and expect (Stakjovic & Luthans, 1998). Prior research establishes that self-confidence is an important factor associated with a number of important work outcomes including successful career transitions, job satisfaction, job performance, and voluntary turnover (Stakjovic & Luthans, 1998; Judge, Erez & Bon, 1998).

Variations in nurses' self-confidence associated with transitioning into the CNL role is likely to be influenced by a number of personal and contextual factors. First, because nursing is a contextually situated practice, prior exposure to a particular clinical problem or practice situation builds competence and confidence in the ability to respond appropriately to similar situations (Benner, 2009; Tanner, 2006). Recent analyses of the content of registered nurses' (RNs') daily work suggest
that nurses do not have the time for care planning and coordination activities (Chow, 2008; Lucero, Lake & Aiken, 2009), lack skills either to assess the quality of care or integrate evidence into clinical decision making (Kovner, Brewer, Yingrengreung & Fairchild, 2010), or work in organizations that have been slow to adopt quality and process improvement techniques into daily routines (Watcher, 2010). Thus, although many CNLs are experienced staff nurses, their exposure to, and confidence with, the core activities of the CNL role may be limited. Similarly, experience in the CNL role is likely to affect nurses’ self-confidence in their abilities to perform the role competencies.

Second, educational preparation may affect nurses’ self-confidence with performing the core functions of the CNL role. CNL program curricula conform to the Institute of Medicine’s recommendations to promote clinicians’ effectiveness in complex organizational settings (Committee on the Quality of Health Care in America, 2001). There are currently five educational entry points for CNL practice. These include a traditional master’s program for individuals with a bachelor’s degree in nursing, including a small subset of programs offering master’s credits for a post-bachelor of science in nursing residency program; a direct master’s entry option for individuals with a bachelor’s degree in another field; RN-master of science in nursing (MSN) program designed for individuals with associate degrees in nursing; and a post-master’s certificate option for individuals with master’s preparation in another area of study.

Currently, more than 50% of CNLs are graduates of the direct master’s entry programs, or Model C programs (AACN 2012a, 2012b). Research on direct master’s entry programs suggests that nonnurse college graduates successfully develop into advance practice registered nurses (APRNs) and certified nurse midwives (CNMs; Pellico, Terrill, White & Rico, 2012). As noted previously, the care planning, outcomes management, and process improvement skills associated with CNL practice may represent new practice competencies for most CNL program graduates. Therefore, graduates from the Model C direct-graduate entry programs are likely to be as confident in their abilities to carry out the core functions of the CNL role as nurses prepared for the CNL role designed for individuals with a prior nursing education.

Third, organizational context may shape individuals’ perceptions of their ability to perform the CNL role competencies. According to the AACN, more than 200 health care organizations in the United States have partnered with schools of nursing to adopt the CNL role (AACN, 2012a, 2012b). The CNL role has been implemented in a variety of settings, including for-profit and not-for-profit hospitals, and most notably, Veteran’s Health Administration health system (Ott et al., 2009; VA Strategic Plan, 2009).

Differences in organizational ownership, mission, and strategy, including the maturity of quality improvement programs (Watcher, 2010) and nursing practice models are likely to shape the environment for CNL practice that, in turn, will influence nurses’ perceptions of their ability to perform the core functions of the CNL role. Thus, CNLs’ perceptions of their confidence with carrying out the role competencies are likely to vary by organizational context.

Finally, geographic location may also influence nurses’ perceptions of their confidence with carrying out the CNL role functions. CNLs from regions with a larger concentration of CNL programs and organization that have adopted the role are likely to be more confident in their abilities to function in the CNL role because there is a community of practice for learning and consultation.

**Design and Methods**

I gathered cross-sectional survey data from a national sample of RNs who passed the national CNL certification examination administered by the Commission for Nurse Certification (CNC), an autonomous arm of the AACN.

**Sample**

The population \( N = 1,378 \) of RNs certified as CNLs in March of 2011 received an invitation to participate in the study sent to the e-mail address listed in the CNC database. The invitation included a link to the Clinical Nurse Leader Self-Efficacy Scale (CNLSES) survey that was created and managed using the Qualtrics survey software (Qualtrics.com). The CNLSES survey was open from March to September 2011. Eligible participants received three e-mailed reminders sent at 6-week intervals until the survey site was closed. The study was reviewed and approved by the Institutional Review Board at New York University.

**Instruments and Variables**

Respondents’ perceptions of their confidence in performing practice competencies associated with the CNL role were measured with the CNLSES (Gilmartin & Nokes, in press). The CNLSES is a 35-item state-specific self-efficacy scale that assesses nurses’ perceptions of their ability to function effectively as a CNL. The CNLSES items are presented in Table 1. Based on Bandura’s (2006) well-established survey assessment of self-efficacy, the CNLSES assesses individuals’ confidence in performing 35 CNL role competencies using a 5-point Likert scale (1 = not at all confident through 5 = extremely confident). Respondents rated their self-confidence in performing each of the 35 role activities on the day that they completed the CNLSES survey. Because the survey was sent to all certified CNLs, respondents serving as program faculty were asked to rate their self-confidence in teaching each of the 35 CNL practice competencies.

The CNLSES reflects the AACN’s prescribed CNL practice competencies in the domains of (a) nursing leadership: to actively manage care coordination activities; (b) clinical outcomes management: to promote evidence-based practice and data-based clinical decision making; and (c) care environment management: to promote clinical quality and safety (AACN, 2007). The
Table 1. The Clinical Nurse Leader Self-Efficacy Scale

Index 1 “population-based care” (α = .93)
1. Acquire information about the population through information systems
2. Seek knowledge about specific populations from the research literature
3. Identify population-level health problems
4. Use information systems to track population-level health problems
5. Resolve population-level health problems
6. Translate clinical research to improve practice routines
7. Review unit performance to project risks to client safety
8. Review unit performance to project risks to quality of care
9. Incorporate evidence-based practice changes into clinical information technology systems

Index 2 “care planning” (α = .93)
1. Assume accountability for the welfare of client populations served on your unit
2. Identify client population risk based on a comprehensive assessment
3. Collaborate with cohorts of clients to design a total plan of care
4. Collaborate with clients in gaining their endorsement for the total plan of care
5. Consult appropriately with other health professionals to design a total plan of care for your clients
6. Advocate effectively on behalf of the client with the intervention team

Index 3 “unit-based strategic leadership” (α = .89)
1. Represent your unit on organizational committees
2. Know the organization’s mission
3. Apply the organization’s strategic plan to guide practice on your unit
4. Practice in accordance with the values of the organization

Index 4 “managing financial resources” (α = .92)
1. Identify waste on your unit
2. Identify opportunities for cost savings on your unit
3. Use technology to reduce costs
4. Identify opportunities for revenue enhancement to benefit clients
5. Create proposals to modify your unit using alternative business models
6. Create proposals to modify unit incorporating return of investment (ROI) analyses

Index 5 “team management” (α = .83)
1. Meet regularly with intervention team
2. Evaluate the intervention team’s performance with achieving patient care outcome goals

Index 6 “continuing education” (α = .91)
1. Assure the continuing education of the team members
2. Educate your unit’s staff on innovative practices

Index 7 “mobilizing others” (α = .86)
1. Appropriately deploy human resources to improve outcomes
2. Mobilize managers to deploy resources
3. Mobilize informal leaders to deploy resources

Index 8 “professional leader” (α = NA)
1. Act as leader in relevant professional organizations

Index 9 “mentor” (α = .98)
1. Mentor other CNLs
2. Act as a preceptor for other CNLs

* Items in this factor failed to reach the .600 threshold for item loading. These items should be subjected to further testing.

Dependent Variables

CNL Role Competencies

The nine role competencies associated with CNL practice is the dependent variable.

Predictor Variables

1. **Experience as a CNL.** Measured as the time employed as a CNL in years and months.
2. **Graduate program model.** There are five types of master’s degree programs preparing CNLs recognized by the AACN. These include the following: Program Model A designed for graduates holding a bachelor’s degree in nursing (BS); Program Model B designed for BS graduates that includes a post-BS residency that awards master’s credit; Program Model C designed for individuals with a bachelor’s degree in another discipline (i.e., direct master’s entry program); Program Model D designed for associate degree graduates (RN-MSN program); Program Model E awarding a post-master’s certificate for individuals with a master’s degree in nursing in another area of study. These data were collapsed into the following categories: Model A, which included responses from those attending both Model A and B programs; Model C programs; and Model D, E, and N/A categories, which were used as the referent group in the regression models.

3. **Year graduated from CNL program.** Measured as the year graduated from a CNL program.

4. **Years of experience in nursing.** Measured as the calendar year graduated from a basic nursing education program to become a RN.

5. **Organizational ownership.** Organizational ownership was measured in one of four categories: for-profit, not-for-profit, public, and Veteran’s Administration. The VA was used as the referent group in the regression models because it is an early adopter of the CNL role. The not-for-profit and public ownership categories were merged into one category for regression analysis.
6. Employed in a position with a CNL title. Measured as a binary yes/no categorical variable. CNL job title = 1; no or not applicable = 0. Respondents working as CNL program faculty were included in the no or not applicable category.

7. Geographic region. Measured as a categorical variable using the United States Census regions. Collapsed into four regions: Midwest, Northeast, South, and West. The Western region was used as the referent group in the regression model.

Data Analysis

Data were analyzed using a general linear regression model (GLM) to account for the use of a dependent variable measured on an ordinal scale with predictor variables measured on categorical, interval, and ordinal scales. I checked for potential multicollinearity among the predictor variables and found none. Analyses were conducted using Statistical Analysis Software version 9.1.

Results

One hundred ninety seven surveys were returned. Of the returned surveys, 50 had missing data for all the items, suggesting that respondents activated the survey link and decided not to complete the survey after it was launched. These 50 cases with missing data for all questions were deleted from the data set, leaving a final sample of 147 cases and a response rate of 9.4% (147 respondents/1,378 eligible participants). This response rate compares reasonably well with the rate obtained for the CNC's 2011 job analysis survey (258 respondents/1,560 eligible participants). This response rate compares reasonably well with the rate obtained for the CNC's 2011 job analysis survey (258 respondents/1,560 eligible participants; 16.7% response rate; Tan, 2011). So as to maintain statistical power, the 22 respondents serving as CNL program faculty were retained in the analytic sample. I conducted analyses comparing the characteristics of respondents to the population of CNLs; results from these analyses (reported below) indicate that the sample largely represents the CNL population.

Sample

The respondents are predominately female (93% of respondents), hold a BS degree as their first degree in nursing (69% of respondents), and have an average of 19.9 years ($SD = 12.24$ years) of experience in nursing. Fifty-five percent of the respondents attended a Model A CNL program, a master's degree program designed for graduates with a bachelor's degree in nursing, with nearly 50% of the respondents graduating from a CNL program in 2009 or 2010. Twenty-one percent of the respondents were included in the no or not applicable category.

Experience in the CNL Role

Experience in the CNL role was a significant predictor for two of the nine role competencies. Respondents with longer experience as a CNL were more confident in performing the role functions associated with the CNL role competencies. Respondents were most confident in their abilities to function as a unit-based strategic leader ($M = 3.55, SD = 0.508$) and most confident in their abilities to function as a unit-based strategic leader ($M = 3.55, SD = 0.508$) and most confident in their abilities to develop and implement a total plan of care for individual clients ($M = 4.20, SD = 0.703$).

Educational Preparation

Graduates from the Model A and B CNL master's programs designed for individuals with a bachelor's degree in nursing were less confident in performing the role functions associated with unit-based strategic leadership and assuring the continuing education of unit staff than other respondents.
in performing seven of the nine role competencies associated with the CNL role. Compared to others, the Model C program graduates were less confident in performing activities associated with population-based care, care planning, unit-based strategic leadership, team management, continuing education, mobilizing others, and serving as a mentor to other CNLs.

Organizational Type

CNLs working in for-profit organizations were less confident in their team management abilities than the respondents working in the VA organizations. In comparison, CNLs working in not-for-profit or public hospitals were more confident in their abilities related to ensuring the continuing education of the nursing staff and serving as a mentor to other CNLs than respondents employed in other organizations.

Position Using the Skills of a CNL

Respondents who did not hold a formal job title of CNL, but used the knowledge and skills associated with CNL practice, were more confident in their abilities to effectively manage the care team than respondents employed in a formal CNL position.

Geographic Region

Respondents reported differences in their confidence to carry out the CNL role competencies that varied by geographic region. Respondents employed in the Midwestern region of the United States were more confident in performing the care planning activities and ensuring the continuing education of unit staff than other respondents/respondents from the Western region (referent group). At the same time, respondents from the Midwestern region were less confident in their abilities to function effectively as a unit-based strategic leader than other respondents. Respondents from the Northeastern region of the United States were more confident in their abilities to perform effectively in the population-based care, continuing education, mobilizing others, and mentoring role competencies than other respondents. Finally, respondents living in the Southern region of the United States were less confident in their unit-based strategic leadership abilities on the one hand, and more confident in their abilities to ensure the continuing education of unit staff than other respondents, on the other.

Discussion

The findings from this study have implications for research, education, and practice to inform strategies that promote effective role transitions to gain the full benefit of CNL practice. Using self-report data from a national sample of nurses certified as CNLS, this study adds to the literature on the implementation of the CNL role by empirically identifying personal and contextual factors that explain variation in individuals' levels of self-confidence in performing the key functions of the CNL role. The results of this study point to a number of new avenues for research on CNL role implementation.

Psychological Factors

The findings from this study extend prior work on the role that psychological factors play in the day-to-day work performance of nurses pursuing careers as CNLS (Dzurec et al., 2006). In particular, self-confidence is an important psychological factor associated with successful
careers (Stakovic & Luthans, 1998; Stephens, 1994), and my results show how self-confidence varies among CNLs. There has been only one other prior study of the role of psychological factors associated with CNL performance: Dzurec et al. examined data from a sample of direct master's entry CNL students and found that, in comparison to traditional undergraduate nursing students, the CNL students were less depressed, less fatigued, and more pessimistic in their outlook.

Future studies should extend the work above by including key measures of individual characteristics such as the Big 5 Personality traits (i.e., extraversion, agreeableness, conscientiousness, emotional stability, and openness; McCrae & Costa, 1987), core self-evaluation traits (i.e., self-esteem, generalized self-efficacy, locus of control, and emotional stability; Judge & Bono, 2001), or openness to change (Oreg, 2003).

### Educational Preparation to Become a CNL

Contrary to expectations, respondents who graduated from direct-graduate entry Model C programs had low levels of confidence in performing seven of the nine competencies associated with the CNL role as compared to graduates of other program models. According to data from the Commission for Nursing Certification, there are currently 913 graduates from Model C programs, comprising approximately 56% of the CNL population (AACN, 2012b). This result suggests the need for a focused intervention and career transition strategy to bolster self-confidence in this group of CNLs.

Master's entry programs in nursing, usually completed in 3 years of study, are designed for individuals with a degree in another field who are entering nursing as a career change. First developed in the 1960s (Pellico et al., 2012), these programs seek to reduce the time it takes to produce new nurses with the goal of meeting the national demand for advanced practice nurses. Pellico et al.'s recent integrated review of graduate entry programs in nursing suggests that nonnurse college graduates successfully develop into APRNs and CNMs. This evidence bodes well for graduates of the Model C CNL programs. Although the literature suggests that individuals do successfully transition into new nursing roles, understanding of the career transition process for direct master’s entry graduates is limited.

It is important to note that the current research on the transitions of nonnurse master's entry to practice graduates focuses on the well-established advanced

### Table 3. Respondents’ Confidence in Performing the CNL Role Competencies

<table>
<thead>
<tr>
<th>Variables</th>
<th>Pop</th>
<th>Care</th>
<th>Care plan</th>
<th>Strat lead</th>
<th>Finan resou</th>
<th>Team mgmt</th>
<th>CE</th>
<th>Mobiliz others</th>
<th>Prof lead</th>
<th>Mentor</th>
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</thead>
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<td>SD</td>
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<td>0.508</td>
<td>0.902</td>
<td>0.796</td>
<td>0.838</td>
<td>0.864</td>
<td>0.919</td>
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<th>C model</th>
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<td>Program type</td>
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<tr>
<td>C model</td>
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</tr>
<tr>
<td>Year complete CNL</td>
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</tr>
<tr>
<td>Year complete basic RN</td>
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<tr>
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</tr>
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<tr>
<td>Pr &gt; F</td>
<td>&lt;.001</td>
<td>&lt;.0001</td>
</tr>
</tbody>
</table>
practice RN and CNM nursing roles. Respondents' relative low levels of self-confidence may be related to the development of the CNL role, rather than the personal adjustment component associated with career transitions. That is, given the newness of the CNL role and the lack of knowledge on the part of other nurses, health professionals, and managers regarding the scope of practice and potential benefits to patients and the organization (Moore & Leahy, 2012; Sherman, 2010), CNLs may be placed in a situation of justifying the CNL role and their credentials to function in the role, a situation that is likely to diminish self-confidence. More research focused on the direct-graduate entry to practice group of CNLs is warranted to understand the relationship of personal adjustment and role development on the career transitions of nonnurses into a high-profile clinical leadership position.

Organizational Context

Results from this study suggest that organizational ownership is associated with CNLs' confidence in performing difference aspects of the role. Ownership is a variable that researchers commonly use as a proxy for an organization's mission, values, and strategy (Reuf & Scott, 1998). Differences in organizational ownership may be related to variation in the goals of CNL practice, which, in turn, may affect CNLs' confidence in their ability to achieve these goals. For example, the chief nurse officer that adopts the CNL role to improve performance as important contextual factors that may account for variations in the design of the CNL role, and by extension, a determinant of an individual's confidence in performing the core role functions (Nicholson, 1984; Stephens, 1994).

Another aspect of the organizational context that merits further study is the content and structure of CNL academic–service partnerships used to formalize and institutionalize the CNL role (De Geest et al., in press). According to the AACN (2007), the purpose of academic–service partnerships is to promote the rapid diffusion and adoption of the CNL role into practice settings. In the ideal model, the academic partner is responsible for ensuring that graduates possess the knowledge, skills, and abilities to effectively lead care coordination, quality improvement, and clinical outcome management activities. In turn, the service partner is responsible for creating a receptive environment for CNL practice by attending to changes in organizational systems and structures, including role descriptions, reporting relationships, staff education, and performance expectations (AACN CNL Tool Kit, no date; Smith & Dabbs, 2007).

More than 50% of the respondents participating in this study do not hold a job title of CNL, suggesting that they are employed in organizations that have not formally adopted the CNL role. More work to understand the nature of the academic–service partnership that are both committed to the CNL initiative and aligned to educate and employ nurses as CNLs will be important to understand the adoption and diffusion of the CNL role over time and across organizations.

CNL Job Title

Interestingly, holding a formal job title of CNL was not a significant predictor of respondent's confidence with performing core competencies associated with the CNL role. This finding provides some evidence supporting a shift away from conceptualizing the CNL as a formal unit-based role with responsibilities for microsystem functioning to conceptualizing the core knowledge associated with CNL practice as a skill set with applications to a range of existing positions with responsibility for clinical quality, safety, and performance improvement. More research is needed to understand differences in the practice patterns and the associated self-confidence with the role competencies of nurses employed in formal CNL positions with those who bring new knowledge of leadership, outcomes management, and performance improvement gained through graduate education as a CNL to other clinical or management positions.

Regional Differences

The results suggest that CNL's confidence with performing the key competencies associated with the role vary by geographic region. For example, respondents working in the Northeastern region of the United States were more confident in their abilities to perform population-based care, continuing education for unit staff, mobilizing others, and the mentoring functions associated with the CNL role than others. In comparison, respondents from the Midwest region of the United States were more confident in their abilities for care planning and ensuring continuing education for staff, but were less confident in their abilities to function as a unit-level strategic leader than other respondents. These findings point to local variations within communities of practice that warrant further study.

Faculty Self-Confidence

More research is needed on CNL program faculty members' confidence with teaching the core role competencies. To date, no studies have examined faculty
members' mastery of the key knowledge and skills associated with CNL practice. Quality improvement, patient safety, and organizational performance are relatively new content in the educational curricula of the health professions (Cronenwett et al., 2007; Institute of Medicine, 2001, Institute of Medicine, 2003). Because CNL program faculty are on the forefront of educating a new generation nurses as point-of-care quality and safety clinicians (Reid & Dennison, 2012), there are likely to be variations in faculty confidence with teaching the prescribed curriculum outlined in the Clinical Nurse Leader White Paper (2007). For example, nurse faculty may be very confident with teaching advanced care planning and risk reduction strategies because the nursing process is an important foundation for professional practice and a core element of undergraduate and graduate curricula. In comparison, nurse faculty may have less exposure and familiarity with teaching CNLs how to assess unit (microsystem) performance and to develop a successful change management plan focused on improving a particular practice problem (McKeon et al., 2009). More research focusing on CNL faculty would be useful to understand the contributions of faculty expertise to the personal development aspect of the work role transitions of their students.

Person by Environment Interaction Effects

Finally, my results point to a number of new avenues for research examining interactions among both personal characteristics and the organizational environment that may affect nurses' transitions into the high-profile CNL role. For instance, consider the relationships among personality, work experience, and organizational support for the CNL role. It may be that an expert staff nurse with a strong belief in his or her ability to control his or her future (i.e., high internal locus of control) working in a hospital with a formal CNL academic–service partnership may be more confident in his or her abilities to function in the CNL role than a less experienced nurse, who believes that his or her career is in the hands of others (i.e., high external locus of control), despite working in a hospital with a formal CNL partnership. New studies with larger sample sizes should focus on understanding how personal and organization characteristics interact to promote or hinder nurses’ transitions into the CNL role.

Limitations

Of the population of certified CNLs, the final sample of respondents is relatively small. Despite this limitation, the sample reflects the demographic characteristics of the population of nurses credentialed as CNLs. Further, the response rate is acceptable for a nonsolicited on-line survey (Cook, Heath, & Thompson, 2000) and is similar to the response rate for the recent CNL job analysis survey conducted by the Commission on Nurse Certification during approximately the same period that this survey was in the field (Tan, 2011).

Conclusions

This study contributes to the literature on the implementation of the CNL role by identifying key variables associated with the personal adjustment and role development involved in successful career transitions to the CNL role. Respondents' confidence in their ability to carry out the core functions associated with the CNL role varied across practice competency, geographic region, and organizational type and by the type of graduate program model attended to become a CNL. This evidence can be used by nurse managers and program faculty to develop targeted interventions to bolster CNL's self-confidence in performing the core competencies associated with their role. Because self-confidence is an important predictor of successful career transitions, it is important to understand variations in CNLs' confidence in their ability to function in the role to promote the overall performance, job satisfaction, and retention of the nurses pioneering this innovative clinical leadership role.

References


