Implementing the Clinical Nurse Leader Role: A Care Model Centered on Innovation, Efficiency, and Excellence

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Nurses must become full partners with other healthcare disciplines to become involved and take responsibility for identifying system problems. Nurses devise and implement improvement plans, track improvements over time, and make necessary adjustments as leaders who implement change and help improve the healthcare system.

We are facing the dilemma of fragmented healthcare that can only be improved through “new innovative care delivery models... that address patient needs and wants, span sites of care, result in more efficient use of resources, and demonstrate measurable improvement in patient satisfaction and quality outcomes over time.”

With the implementation of the clinical nurse leader (CNL) role, the innovation unit as developed at Rush Oak Park Hospital (ROPH) addresses current healthcare system concerns, such as the creation of more effective interdisciplinary care, point-of-care coordination, and the implementation of evidence-based practice findings.

ROPH in Oak Park, Illinois, is a 176-bed, not-for-profit, general medical and surgical community hospital that is a clinical partner of Rush University Medical Center in Chicago. The initial innovation unit was implemented on ROHP’s 24-bed telemetry unit in September 2012. The general population is a diverse, mainly elderly population with patient conditions including congestive heart failure, chronic renal failure, complications of diabetes, sepsis, and pneumonia.

The CNL role has been defined as a nurse who is a confident clinician, a leader within a microsystem, and a quality manager. The CNL seeks evidence-based practices and has the ability to analyze system outcomes. Research shows that the use of the CNL as a clinical decision-maker and active member of the interdisciplinary team helps to drive the design and direction of cost-effective, evidence-based care within a microsystem. The CNL role is being explored...
today by many practice institutions and employers. O’Grady and VanGraafeiland demonstrated that various uses of the CNL role since its development have helped to reduce the fragmented care in many institutions today. The reduction in fragmentation seen in ROPH since the implementation of the CNL role has led to improvements in care coordination, quality outcomes, patient satisfaction, and interdisciplinary relationships. The role of CNL is unique as compared with that of the registered nurse (RN) in that CNLs have the knowledge of a bedside nurse combined with the leadership skills to focus on patient- and family-centered care.

BACKGROUND
The innovation unit was developed with the ROPH vision and mission in mind to promote patient- and family-focused health, support, and education throughout a patient’s lifespan. The Rush Oak Park nursing care delivery model is a team-based, primary care nursing model for providing humanistic and focused patient-centered care based on Jean Watson’s Theory on Human Caring. The intended mission of the innovation unit is to develop processes for improving efficiency through the introduction of the CNL role. Processes for improvement were coordinated with all members of the interdisciplinary team utilizing the latest evidence-based practices. These processes promote the enhancement of patient safety, quality care, and patient and team satisfaction.

After designating certified CNLs from within the hospital to lead the innovation unit, hospital outcomes were reviewed. Information analyzed before setting goals included patient and RN satisfaction scores, nurse-sensitive indicators, and the latest evidence-based information. The innovation unit goals were to increase collaboration and satisfaction among members of the interdisciplinary team, enhance patient education, decrease average length of stay (ALOS), decrease patient 30-day readmission rates, decrease patient 30-day readmission rates, decrease patient 30-day readmission rates, decrease patient 30-day readmission rates, decrease patient 30-day readmission rates, and successfully implement the CNL role. With these goals in mind, specific interventions were created for the implementation of the innovation unit. The interventions chosen were daily, CNL-led interdisciplinary rounds, a unit status board, teach-back for heart failure patients, and post-discharge follow-up phone calls.

INTERVENTIONS
The admission process initiates the introduction of the CNL to patients and their families to help facilitate the patient’s progress through the healthcare environment. The CNL is a critical member of the interdisciplinary team who helps guide patients through today’s complex healthcare system and acts as a resource for solving complex nursing-related problems. As new admissions occur, the CNL makes contact with the patient and family to explain his or her role. Contact information is supplied to patients through business cards and a pamphlet (Figure 1). The CNLs monitor and help facilitate all patients’ progress toward discharge while they are on the unit.

Figure 1. CNL Patient Pamphlet

INTRODUCING YOUR
Clinical Nurse Leader (CNL)

YOUR CNL WILL:
Translate evidence-based practices into action, ensuring that your bedside nurses can offer you the latest advances.
Coordinate with your physicians, pharmacists and social workers, acting as a liaison between you and your other health care providers.
Facilitate your progress through the health care environment.
Assure congruence and continuity with the nursing plan of care, the medical plan of care, and your needs and wishes.
Design and evaluate your care by coordinating, delegating, and supervising the care provided by the health care system.
Keep your processes moving along.
Provide you with individualized patient education.

RUSH
OAK PARK HOSPITAL

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Interdisciplinary Rounds
The interdisciplinary rounds intervention is a collaborative, interdisciplinary, team-based patient rounding process. Rounds are completed at the patient’s bedside and used to share information and discuss the plan of care with input encouraged from the patient or family. Patients help identify their preferences related to their goals, care needs, discharge planning, and any transition barriers. The CNL leads interdisciplinary rounds for all admitted patients on a daily basis (Monday through Friday) and is responsible for reviewing the patient plan of care established by the team through any previous interdisciplinary rounds meetings. The CNL documents the outcome of rounds using the interdisciplinary rounds note (Figure 2). If the newly admitted patient has a diagnosis of heart failure, the CNL also completes the heart failure assessment note to document whether heart failure core measures have been met.
A CNL-developed tool called the Heart Failure Journey (Figure 4) is placed in the patient’s room as a visual reminder for all nurses caring for the patient to ensure that all heart failure core measures are met before discharge. Journey “reminder” signs were also developed for stroke, surgical care improvement process, acute myocardial infarction, venous thromboembolism, and falls.

During rounds, the RN is responsible for updating the team about the patient’s diagnosis, morning assessment, and progress; reviews with the team the patient's plan of care for the day; and updates the patient’s information board in their room. The pharmacist reviews scheduled medications (indications and side effects) with the patient during rounds and the case manager reviews discharge plans and any potential discharge barriers. The CNL is responsible for facilitating the resolution of any issues discovered in rounds regarding the patient’s plan of care and then obtains an estimated discharge date.

UNIT STATUS BOARD

During the unit’s change of shift, the charge RN uses the unit status board (Figure 5) to facilitate a brief discussion regarding patient code status, behavioral or safety risks, procedures, falls, and other indicators being followed. RNs and patient care technicians (PCTs) use the board to give others on the unit a subjective look at any status changes in their workload throughout their shift. With the use of a colored magnet system (red = “I’m swamped,” yellow = “I’m almost there, just give me another hour,” and green = “I’m good”), the RN or PCT may update the unit status board with any changes. The charge RN or unit clerk is responsible for frequently updating the unit status board with the number of anticipated discharges, admissions, transfers, and any changes in patient information. The charge RN is also responsible for coordinating the breaks and buddies (ie, the RNs and PCTs who cover for each other when off the unit) for the shift along with their estimated break times. The unit status board provides staff with a global picture of what is occurring on the unit. The unit status board, when updated at the beginning of each shift, is a shared process and visual indicator for managing breaks, staff workloads, patient flow, and patient status.

HEART FAILURE TEACH-BACK

At the time of admission, the CNL will have identified patients who have been admitted with a diagnosis of heart failure. The CNL educates those patients about the heart failure teach-back intervention and reviews information contained in patient education folders developed specifically for heart failure patients.

During focused heart failure education, the patient may be asked questions to ensure the teaching has been understood. The CNL asks the patient 4 specific heart failure teach-back questions daily to reinforce learning and assess patient understanding of what has been taught regarding heart failure. In teach-back, patients are asked to teach
back the information that has been taught to them, in their
own words, in response to the questions asked. This allows
the person teaching to understand whether the patient has
comprehended the information and also gives the teacher
insight into whether there is a need for the use of additional
teaching methods to help aid in comprehension. Heart
failure teach-back is a process designed to focus on
improving patient care and safety by increasing communi-
cation. This process allows for assessment of the patients’
understanding of information provided by using specific
disease-related questions.\textsuperscript{11} The CNL rein-
forces heart failure education at admission, at discharge,
and again during a post-discharge follow-up telephone call
using the heart failure teach-back process. The CNL docu-
ments the ability of the patient to answer teach-back ques-
tions through the completion of the heart failure teach-
back note (\textit{Figure 6}).

**TRANSITIONS ADVOCATE**

As a patient advocate, the CNL helps patients make a
smooth transition from hospital to home. In addition, the
CNL keeps the patient processes moving along post-dis-
charge. The CNL role allows better facilitation of progress
through the continuum of care with the coordination of
key activities.\textsuperscript{12} The CNL acts as a partner with the
patient’s attending physician to determine the necessity of
follow-up appointments and then schedules a follow-up
appointment with the patient’s primary care physician or

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**Table 3. Heart Failure Assessment Note (CNLHFASSESS)**

<table>
<thead>
<tr>
<th>Heart Failure Assessment Note (CNLHFASSESS)</th>
<th>Comments:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient specific discharge instructions for diet and activity ordered?</td>
<td></td>
</tr>
<tr>
<td>LVS function assessment completed?</td>
<td></td>
</tr>
<tr>
<td>If LVS function assessment is not required, has the reason been documented?</td>
<td></td>
</tr>
<tr>
<td>For patients with LVEF &lt; 40%, ACE-Inhibitor/ARB prescribed at discharge?</td>
<td></td>
</tr>
<tr>
<td>If ACE/ARB is not prescribed on discharge, is contraindication documented?</td>
<td></td>
</tr>
</tbody>
</table>

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Figure 3. Heart Failure Assessment Note

Figure 4. Heart Failure Journey

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[Image]
physician’s office if necessary. The CNL is responsible for contacting all heart failure patients post-discharge to assess patient satisfaction and understanding of their diagnosis, education, and self-care. With the use of an outpatient electronic medical record charting system made available to the CNL, telephone follow-up phone calls are completed and documented through the CNL discharge phone call note (Figure 7). Calls are made weekly until 30 days post-discharge. Furthermore, the CNL has the ability to follow up with the attending physician through e-mail to communicate any questions or concerns that the patient may have post-discharge.
To determine the success of the innovation unit, specific measures were defined to determine whether the interventions have led to positive outcomes. Project-wide measures include determining whether there is an increase in collaboration and satisfaction among all members of the multidisciplinary team. Collaboration and satisfaction was measured with the use of the Healthcare Team Vitality Instrument tool, which was administered before the implementation of the innovation unit and 1 year post-implementation. Other project-wide measures to be used in determining positive outcomes that indicate successful implementation of the CNL role were measures such as HCAHPS scores, core measures, ALOS, and 30-day heart failure readmission rates provided by the Rush Oak Park Quality department. Measures are used to determine whether the innovation unit helped to enhance patient education, decrease the ALOS, improve specific quality indicators, and improve overall satisfaction.

**OUTCOMES**

The care model change was implemented October 1, 2012, on our telemetry unit. Through the implementation of the CNL role, data collected have shown improvements in all outcomes: decreased ALOS and improved CMS core measures, reduced quality indicators (falls, pressure ulcers, central line infections, and urinary tract infections), and increased HCAHPS scores (Figure 8). Subjective data have shown an increase in overall staff satisfaction and an increase in the knowledge base of staff. On the initial unit (telemetry), the readmission rate for heart failure patients (Figure 9) dropped from 23.5% (October 2012) to 7.1% (February 2014). On our medical-surgical unit, where the

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**Discharge Phone Call Note (CNLDCCALL)**

<table>
<thead>
<tr>
<th>Comments:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Have you experienced any new symptoms or have previous symptoms worsened?</td>
</tr>
<tr>
<td>Did you receive a discharge summary and have you reviewed it?</td>
</tr>
<tr>
<td>Do you have an appointment with your primary care physician for follow-up? Have you had your follow-up appointments?</td>
</tr>
<tr>
<td>Are you waiting for any follow-up tests?</td>
</tr>
<tr>
<td>Are you receiving any type of home care?</td>
</tr>
<tr>
<td>Has your home health provider contacted or visited you yet?</td>
</tr>
<tr>
<td>Has your transition back to home been difficult?</td>
</tr>
<tr>
<td>Do you have questions about your medications?</td>
</tr>
<tr>
<td>Were you able to fill all of your prescriptions?</td>
</tr>
<tr>
<td>Are you having any problems with your medications (headaches, dizziness, nausea)?</td>
</tr>
<tr>
<td>Are you weighing yourself daily?</td>
</tr>
<tr>
<td>What is the name of your water pill?</td>
</tr>
<tr>
<td>How much weight gain would you want to report to your healthcare provider?</td>
</tr>
<tr>
<td>What high-salt foods do you need to avoid/be aware of?</td>
</tr>
<tr>
<td>Can you name 3 to 4 symptoms in the yellow zone (warning signs when you want to call your healthcare provider)?</td>
</tr>
<tr>
<td>Is the patient advised to call PCP or specialist physician?</td>
</tr>
<tr>
<td>Is the patient advised to go to the ED?</td>
</tr>
<tr>
<td>Need to call MD and call patient back?</td>
</tr>
<tr>
<td>Need to call outpatient pharmacy and call patient back?</td>
</tr>
</tbody>
</table>

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*Figure 7. Transitions Advocate Discharge Phone Call Note*
CNL role was initiated in October 2013, data have shown a decrease in ALOS (Figure 10) from 5.73 days (October 2013) to 4.85 days (May 2014). Data collection has been ongoing for both the telemetry and medical-surgical units with consistent improvements on both units being realized. This was a cost-effective strategy because the care model was designed without adding any additional full-time equivalent personnel.

**DISCUSSION**

With the implementation of the CNL role, the innovation unit developed at ROPH helps to address current healthcare system
Throughout the implementation process, a learning process has occurred and challenges have been encountered and addressed. Overall, the implementation of the CNL role has led to improved outcomes. Precise data collection and review continue to help in understanding how to further develop and fully integrate the CNL role hospital-wide so that nursing can continue to use the latest evidence-based care while coordinating with all members of the interdisciplinary team, promoting the enhancement of safety and quality patient care, and improving patient and team satisfaction. Using the CNL role to meet today’s healthcare challenges should be synonymous with becoming a pivotal leader in change in an ever-changing, complex healthcare system.

References


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