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Leading Transformation Implementing the Clinical Nurse Leader Role

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It has become a national priority to have an effective care delivery system for the 21st century. Improving the quality of care and ensuring that the care delivered in a patient-centered framework are goals for many organizations. Nursing practice will be at the core of these changes, working at the point of service as well as at the organizational level. In response to the need for nursing to realign our practices in accordance with the new healthcare mandate, the American Association of Colleges of Nursing has developed the clinical nurse leader (CNL) role.[1] The CNL is a master's-prepared RN educated to enhance the efficiency of care delivery and facilitate the coordination of care at the bedside through effective collaboration with all healthcare providers. Clinical nurse leader competencies align with key messages highlighted in the Institute of Medicine's 2010 report on The Future of Nursing, [2] including the need for a highly educated nursing workforce practicing at their full scope, and for RNs to become full partners with physicians and other health professionals in redesigning healthcare. The CNL role has been demonstrated to improve patient outcomes, [3] but it has not been widely adopted throughout the country. This article describes how a progressive care unit (PCU) redesigned its care delivery system to implement the CNL role, using Kotter's[4] Eight Change Phases model as a guide.

Steps in the Process

Establishing a Sense of Urgency

The PCU is a high-acuity unit in a metropolitan 119-bed medical teaching hospital. This fast-paced organization had not adopted significant redesign to meet the needs of the increasingly complex patient population. Busy healthcare providers did not have time for formal collaboration concerning a patient's plan of care. There was no individual accountable for coordination of care across disciplines, as defined in the CNL role. A creative approach was needed to reduce the often fragmented care without increasing the budget. The PCU was located in California, and the state-mandated nursing ratios taxed limited organizational resources. Another barrier to CNL role implementation in the region was the lack of academic practice partnerships to enhance training of CNL candidates. Many healthcare leaders in the area were unaware of the role and the possible outcomes. Potential CNL candidates were working as charge RNs, resource RNs, managers, and other leadership roles, but none were practicing as CNLs.

Forming a Coalition

One certified CNL, working as a staff RN on a unit within a healthcare facility, approached the manager about the CNL role and the possibility of a trial. The manager, enthusiastic about the possibilities, brought in key unit charge RNs to begin a collaborative discussion about what a CNL role would look like and how it could be implemented without an increase in staff full-time equivalents (FTEs). The CNL had the passion and motivation to advocate for the role, the manager had the vision for change and authority to modify care delivery on the unit, and the key charge RNs had the influence and respect of the staff RNs to support for the role if adopted. This small but strategic guiding coalition worked together to create a job description that contained CNL workflow duties and competencies and determined initial outcome measures based on organizational priorities to increase patient satisfaction and RN satisfaction with clinical support and education.

Creating a Vision

The coalition developed a strategy for pilot of the CNL role (known as p-CNL). The p-CNL nurses would coordinate patient care, intervene when needed, and serve as a resource for staff and physicians regarding evidence-based practices and organizational policies and standards. The coalition would meet weekly to review outcomes and refine the role based on successes/failures. The 26-bed unit required 2 p-CNLs, each accountable for 13 patients. The manager reallocated an unfilled assistant manager position and daytime resource-RN FTE to the p-CNL project. The p-CNLs would remain "staff RNs" in terms of job description and salary during the pilot, with the understanding that, if successful, the role would be petitioned for a clinical nurse IV job classification, and CNL certification would be mandatory. The immediate benefits to the incumbents were a regular 40-hour week instead of shift work. Job qualifications included 2-year direct unit experience to ensure familiarity with the patient population; CNL certification was preferred, but because of the limited pool of CNL candidates for the pilot, a BSN degree would be acceptable with a verbal understanding that pursuit of CNL certification and an advanced degree would be required; documented evidence of nursing expertise and leadership abilities; and a commitment to the role and vision.

Communicating the Vision

The manager announced the pilot and the opening for p-CNL roles at unit staff meetings and through e-mail. The coalition CNL team was charged with communicating the p-CNL job description and vision to staff through one-on-one discussion. This was considered the best way to answer questions and encourage feedback/suggestions about the role's daily workflow in an open manner. Charge RNs on the coalition team communicated the vision for the role and addressed staff concerns during shift interchanges. A number of potential candidates expressed interest in the role and were interviewed by coalition charge RNs. The p-CNLs were chosen (including the coalition CNL) based on their expertise and collaborative and leadership qualifications.

Empowering Others to Act

Coalition meetings with the p-CNLs were set up to finalize the CNL workflow, decide on a work schedule, and set up weekly meetings to review progress, discuss successes and failures, and provide support during the initial stages of implementation. The manager

communicated the p-CNL start date through staff meetings and e-mail. The p-CNLs administered an in-house survey to gauge staff satisfaction with current unit workflow and encourage feedback about RN-CNL collaboration. The results of the survey were posted on the unit's nursing board, along with the comments, and the p-CNL daily workflow was revised based on survey results and feedback.

Creating Short-term Wins

The implementation date arrived, and the p-CNLs began their work. The p-CNLs initiated RN rounds to discuss daily patient care goals and promote teamwork to facilitate accomplishment of the goals. Initially, staff members voiced skepticism about possible intrusiveness of the teamwork approach. This slowly faded with the realization that the new model resulted in more efficient and better patient care. Ancillary staff (physical therapy, occupational therapy, nutrition, infection control, wound ostomy, etc.) were actively included in daily p-CNL rounds. These disciplines were happy to collaborate and contributed a wealth of information that the p-CNLs utilized for care planning and education. Physicians were initially uncomfortable with p-CNL presence (and facilitation of the patient's RN attendance) at daily rounds. They soon realized the p-CNLS were knowledgeable about the patients, were committed to patient centered care, and could highlight and prioritize unmet care needs, thus increasing efficiency. The physicians eventually recognized the benefits of the support and follow through and actively pursued input from the p-CNL staff regarding patient care, even outside rounding times. The patients were enthusiastic about the role. They enjoyed having a daily, familiar presence helping to organize their care team to consider their overall plan of care. Press Ganey scores measuring nurse-sensitive indicators demonstrated immediate, significant, and sustained increases throughout the 1-year pilot.

Reviewing Outcomes

Four months into the pilot, physician rounding was solidified, and p-CNL collaboration occurred with the entire healthcare team throughout the day. Staff RNs were surveyed about satisfaction with the role, and the majority agreed that there was more support for patient care and care planning than before. Results of outcomes were posted and discussed at staff meetings. New and float RNs were immediately enthusiastic about the role. The coalition readdressed p-CNL role outcome measures and added others, such as accountability for improving peer feedback through bedside reporting, which is an institutional review board-approved study currently under way. The coalition facilitated the formation of a unit shared-governance council, where p-CNL role outcomes and projects are reported monthly. The p-CNL nurses collaborated with the Transforming Care at the Bedside representative to facilitate a Foley-prevalence study as a new initiative supporting quality. New collaborations with staff RNs on unit projects assisted in creating a shared commitment to improving unit quality outcomes.

Institutionalizing the New Model

The improved patient and staff satisfaction outcomes supported the success of the CNL role pilot. Presentations to executive leadership about the p-CNL role implementation and accomplishments at the 6-month and 1-year mark received positive reviews. Nursing leadership recognized the pilot provided supporting evidence for the organizations'

application for Magnet® designation, as the role embodies the 5 ANCC Magnet Recognition Program® model components: transformational leadership; structural empowerment; exemplary professional practice; new knowledge, innovation, and improvements; and empirical outcomes. The unit manager formalized the CNL role by developing and receiving organizational approval for the CNL job classification. The unit currently employs 2 CNLs: 1 certified and a former p-CNL also currently pursuing certification. Other managers have expressed interest in the role, and efforts are currently under way to gauge resource availability to implement the CNL role organization-wide. The pilot has been presented at national and local conferences increasing awareness of the role to healthcare organizations regionally and across the country. Next steps include initiation of a dialogue with regional nursing universities about partnerships to train and place CNLs across the organization. It is important to continue to develop and monitor additional outcome data to further support the CNL role. During this pilot, the CNL role improved patient outcomes by creating a collaborative culture at the bedside with efficient use of resources. The role also supported career advancement opportunities for nursing staff who want to develop their bedside careers.

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