

## The Clinical Nurse Leader (CNL)<sup>®</sup>: Point-of-Care Safety Clinician

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### Abstract

The vision for the Clinical Nurse Leader CNL<sup>®</sup> role began in 2003-2004 in response to the Institute of Medicine's quality and safety reports. The CNL was envisioned as a nurse who would provide direct clinical leadership at the point of care, working to insure that care delivery is safe, evidence-based, and targeted towards optimal quality outcomes for the cohort of clients served by the CNL. In this article the authors describe the background and intent of the CNL role and explain how the CNL is prepared to facilitate a culture of safety and to enhance safety of the care provided for a group of patients. They illustrate how the CNL enhances safety across diverse settings and conclude by noting the power that CNLs have for building continuing coalitions of safety. The value of the CNL as a front-line care leader for building and sustaining safer and higher quality care delivery environments for the future is highlighted.

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Contemporary healthcare delivery systems entered the new millennium fraught with challenges to the provision of safe environments for those entrusted to their care (IOM, 1999; IOM, 2001; IOM, 2003). Over the last two decades, healthcare's quality-safety-performance-improvement infrastructure has burgeoned, but providing quality and safe care for patients and families remains challenging. Quality and safety-improvement activities no longer occur at the place where care is actually delivered. Often the offices and desks of quality and safety-improvement staff are located in back hallways, administrative areas, or even in separate buildings (Porter-O'Grady, Clark, & Wiggins, 2010). This results in a disconnect between care providers and the valuable safety and quality data that can be used to guide efforts and achieve sustainable results.

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The CNL is a clinician who brings the locus of control for safe and quality care from the administrative areas straight to the unit's providers who deliver the services.

The role of the Clinical Nurse Leader (CNL)<sup>®</sup> restores this vital connection. The CNL is a clinician who brings the locus of control for safe and quality care from the administrative areas straight to the unit's providers who deliver the services. "The CNL answers the call to rise above the staccato pace of fragmented and complex healthcare delivery and lead others to ensure that patient care is safe and effective" (Porter-O'Grady, Clark, & Wiggins, 2010, p. 40) In this article we describe the background and intent of the CNL role and explain how the CNL works both to facilitate a culture of safety and to enhance safety of the care for a group of patients. We show how the CNL enhances safety across diverse settings and conclude by noting the power that CNLs have for building continuing coalitions of safety. The value of the CNL as a front-line care leader for building and sustaining safer and higher quality care delivery environments for the future is highlighted.

The vision for the Clinical Nurse Leader role began in 2003-2004 in response to the quality and safety reports of the Institute of Medicine. Academic and clinical practice nurse leaders, including college deans and chief nurse executives, partnered closely to envision the first new professional nursing role in almost 40 years ([American Association of Colleges of Nursing \[AACN\], 2007](#)). As a nurse with both advanced, master's level preparation and specialized, health system clinical leadership competencies, the CNL is prepared for direct clinical leadership at the point of care (microsystem) to insure that care delivery is safe, evidence-based, and targeted towards optimal quality outcomes for the cohort of clients served by the CNL. The clinical microsystem is defined as the complex and dynamic point at which the healthcare delivery system interfaces with the patient, family, or population receiving care ([Mohr & Batalden, 2002](#)). Use of AACN's description of the fundamental aspects of the CNL role, as summarized in [Table 1](#), enables one to see that the CNL is a front-line care provider as well as a coordinator and leader for the healthcare team. Within the nursing paradigm, the CNL applies the nursing process at the point of care through the strategic assessment, diagnosis, intervention, and evaluation of the unit as a whole to guide efforts for systematic, quality, and safety improvements.

With specific regard to a culture of safety, a critical component of the CNL role centers on improving effective interdisciplinary communication and coordination at the point of care. One of the biggest challenges in our complex, healthcare settings is that of effective and timely communication among multiple healthcare providers, including physicians, nurses, therapists, and consultants. Without this communication care can become fragmented for the patient and family, increasing their risk of harm. An important part of the CNL role is to fill this gap by insuring that patient and family needs are not only assessed, but also consistently communicated with all members of the healthcare team so that care can be more effectively coordinated. This communication and coordination is also vitally important as patients move from setting to another within the system because gaps in care are prone to occur during these moves. This coordination of care between settings, often referred to as 'lateral integration,' enables the CNL to serve not only as the patient advocate/care navigator, but more importantly, as the stop-gap professional to reduce fragmentation in care that may lead to lapses in the safety of the care provided. As care-delivery-systems experts, CNLs help patients and families navigate the complex healthcare system; they advocate for both patients and families, as well healthcare providers, working within the system. The CNL is accountable for improving care delivery within the current healthcare delivery settings. More importantly, the core focus for CNL practice centers on maximizing safe, quality, evidence-based care within the complex systems that exist today.

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The Clinical Nurse Leader roles and essential competencies are described in the AACN's White Paper on the Clinical Nurse Leader ([2007](#)), and a summary is provided in [Table 2](#). This White Paper on the CNL, a working document initiated in 2003 and drafted in its final form in 2007, details the background, significance, and essential actions needed both to prepare a nurse as a CNL and to practice the CNL role in clinical environments. The CNL both addresses gaps in today's healthcare delivery systems and works in tandem with other already well-established roles. Of particular note are the overlapping role functions among CNLs and Clinical Nurse Specialists (CNSs). Early concerns expressed by the National Association of Clinical Nurse Specialists (NACNS) ([NACNS, 2004](#) and [2005](#)) prompted an important national debate and led to greater clarity regarding CNL and CNS role delineation ([Spross et al., 2004](#)). Careful examination of the role competencies revealed significant overlapping competencies while simultaneously identifying three major CNL-CNS differences, as described in [Table 3](#). These two roles are now seen to be highly complementary. For example, a pulmonary CNS accountable for organizational-level outcomes for patients with COPD works closely with unit-based CNLs. In this relationship, the CNLs in the various units, for example, general medical units, emergency departments, and critical care areas, support the CNS's efforts by championing population-specific needs and evidence-based practices identified by the CNS.

Since the original CNL white paper was published in 2003, the clinical nurse leader initiative has experienced rapid and exponential growth. At present, eighty-eight schools of nursing engage in active partnership with practice organizations to educate clinical nurse leaders. By 2009 2,465 students were enrolled in CNL programs across the nation, and 654 graduates had entered practice ([Blakewell-Sachs & Stanley, 2011](#)).

Existing Master of Science (MSN) degree programs prepare CNLs as advanced generalist through a variety of

educational pathways. These pathways include entry for Registered Nurses who possess a baccalaureate degree in nursing (BSN to MSN programs), an associate degree to MSN pathway, and a master's entry for second degree/second career non-nurses who wish to enter nursing at an advanced level. Examples of Master's-entry programs include those offered at the University of Virginia, the University of Maryland, and the University of California-Los Angeles. Graduates of the master's-entry programs enter the workforce as novice nurses, as do all new graduates. After completing a nine-to-twelve-month transition-to-professional-practice period, they move into unit-based clinical leadership roles based on the needs of the unit and organization.

As complex, adaptive, healthcare systems evolve over time, healthcare professionals adapt their role functions in an effort to meet the ever-changing and complex needs of patients, families, and systems. While these adaptations provide short-term solutions to evolving challenges, they do not generally address long-range plans for system-wide transformation and improvement. This is not the case with the CNL role. Visionary creators of the CNL role designed a more durable and lasting solution that enables examination and redesign of care delivery at the point of care. It is important to recognize that CNLs do not solve quality-safety problems in isolation, but do so rather through effective teamwork, communication, team coordination, and direct clinical leadership. As a member of the complex, adaptive healthcare system, the CNL can fulfill a key role in helping to solve contemporary healthcare safety problems. The next section explains the preparation of the Clinical Nurse Leader in relationship to promoting a culture of safety.

### **Clinical Nurse Leader Preparation in Relationship to a Culture of Safety**

A major component of the CNL role centers on fostering and sustaining a culture of safety for the patients and families entrusted into their care. Review of current evidence shows seven important subcultures within a culture of safety. These subcultures are leadership, teamwork, evidence-based care, communication, learning, justice, and patient-centeredness ([Sammer, Lykens, Singh, Mains, & Lackan, 2010](#)). The concepts underlying safety subcultures are infused throughout the CNL role competencies as highlighted in [Table 2](#). CNLs receive advanced education about risk anticipation and risk reduction. Clinical practice centers on monitoring and managing information related to risk, safety, and quality. CNLs are also prepared to address change by the use of failure modes analysis techniques (anticipating potential negative effects of change prior to instituting change), as well as to conduct root cause analyses for care delivery near misses and errors. As technology increases, teamwork and interdisciplinary collaboration grow more essential to safe care delivery. The CNL preparation includes a specific focus on communication skills targeted towards the teamwork, lateral integration of care, and conflict management needed to advocate for patient-centered, evidence-based care.

CNLs are analogous to point-of-care 'systems engineers' as they to continually assess and reassess vitality of each system's functioning at the point of care. Within the nursing paradigm, the CNL's 'patient' becomes the point of care. In short, the clinical nurse leader applies the nursing process to the point of care through the use of systematic, microsystem assessment techniques. For example, just as a nurse routinely assesses and prioritizes interventions based on patient findings, such as changes in vital signs, the CNL routinely monitors and intervenes based on the unit's 'vital signs,' or information about the unit's aggregate safety and quality functioning. The Clinical Nurse Leader serves as the advocate for the point-of-care providers, and has been called both the 'safety nurse' and the 'nurses' nurse' for the frontline staff delivering the care ([Rusch & Bakewell-Sachs, 2007](#)). Through advocacy at this level, the CNL fosters a just environment and enhances a culture of safety.

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### **Improving Safety through Clinical Nurse Leader Role Implementation**

The American Organization of Nurse Executives (AONE) has noted that the CNL role is aligned with the AONE's Guiding Principles for the Nurse of the Future. As a knowledge worker, the CNL brings evidence-based practice to the bedside and applies a "more robust knowledge of quality, safety, and statistical processes" ([Haase-Herrick & Herrin, 2007](#), p.60) at the point of care. The CNL monitors and manages patient outcomes and advances progress towards goals related to safety and quality. Implementation of the CNL role reflects a systems-level intervention and involves strategic care delivery redesign. The Joint Commission has identified the presence of a CNL in the acute care environment as an important contribution towards helping to solve healthcare's safety problems ([Joint Commission, 2008](#), p. 30). CNL role implementation now occurs in several major healthcare systems across the nation. The Department of Veteran's Affairs aspires to implement CNL roles in all of its facilities by 2016.

The following discussion describes specific examples of clinical leadership activities and strategies; it highlights

ways in which CNLs can intervene at a unit level to improve safety. Quality and safety improvements attributed, at least in part, to the efforts of CNLs and to the efforts of CNL student initiatives are offered.

### **CNL Initiatives**

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One of the early examples of the CNLs ability to provide strong evidence supporting point-of-care clinical leadership was the 12-bed hospital project at Baptist Hospital in Miami, Florida. Implementation of the CNL role, along with a work redesign, showed improved patient throughput, consistent scores in the top ten percent on Centers for Medicare and Medicaid Services (CMS) core measures, and high patient satisfaction ([Sherman, Clark, & Maloney, 2008](#)). The '12-bed hospital' model of care delivery, including the Clinical Nurse Leader, has been recognized by the Robert Wood Johnson Foundation as one of the most innovative and promising new care delivery models ([Kimball, Joynt, Cherner, & O'Neil, 2007](#)). Leaders at St. Joseph Medical Center in Bloomington, IL applied these concepts and implemented the CNL role in 2005. One-year findings attributed to the point-of-care leadership role included 67% reduction in the fall with injury rate and a sustained pressure ulcer prevalence rate of zero for the entirety of the year. Additional, one-year findings included increase in patient satisfaction and a decrease in staff turnover.

Another example of CNL role implementation in an acute care setting comes from a hospital in northeastern Florida. This hospital showed significant results in a 6-month pilot study. Improvements in nurse satisfaction and retention, patient satisfaction, and physician satisfaction were noted. Length of stay was reduced by 9%; and diminished use of temporary staffing contributed to cost savings. Most importantly, the presence of the point-of-care clinical leader led to a 38% reduction in restraint use, fewer falls, and a significantly reduced incidence of failure to rescue ([Smith, Manfredi, Hagos, Drummond-Huth, & Moore, 2006](#)).

Hunterdon Medical Center partnered with the College of New Jersey to create a nursing education program to prepare clinical nurse leaders while also implementing the CNL role in the practice environments ([Rusch & Bakewell-Sachs, 2007](#)). At Hunterdon, CNLs began practice by conducting safety assessments and serving as 'documentation police.' Over time, however, the role evolved so that the CNL began serving as a point-of-care teacher and mentor who both stimulated stronger clinical reasoning skills among the staff and engaged everyone in the culture of safety. At Hunterdon, CNL role performance evaluation focuses on key quality indicators, including National Database of Nursing Quality Indicators<sup>®</sup> (NDNQI) and Press Ganey measures of patient satisfaction ([Rusch & Bakewell-Sachs, 2007](#)). The NDNQI includes quality indicators that are highly sensitive to nursing care delivery, such as pressure ulcer prevalence, fall, and infection rates. Press Ganey indicators of patient satisfaction include items measuring patient and family perceptions of care, such as timely response to needs, discharge education, and effective pain management.

University Hospital in Augusta, GA, piloted a CNL role in an acute care environment and documented significantly improved, patient-centered care through CNL assessment and advocacy ([Bowcutt, Wall, & Goolsby, 2006](#)). These CNLs communicated carefully with patients to determine their needs other than those specific to the current medical diagnosis. In each case the CNL's ability to assess the patient's unique needs and advocate with the healthcare team led to significant realignment of the treatment plan with the patient's needs and preferences.

### **CNL Student Initiatives**

Although the broad goal related to a culture of safety is the ability to demonstrate sustained improvements over time based on fundamental and enduring practice changes, short-term gains demonstrated by CNL students in an academic program can also be significant. Two of these initiatives will be discussed in detail below. [Table 4](#) notes other safety improvements achieved by students in the University of Virginia's CNL track in the MSN program.

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In one example, "Bundling Up Clostridium Difficile (C.Diff) Infection Control and Prevention in the Surgical, Trauma, Burn ICU," the student championed efforts that led to the C. Diff rate plummeting from an average of 10 cases per month to zero cases for a three-month period. During the final CNL role-immersion practicum, this

student not only assessed hand washing and care patterns in the unit, but more importantly, assessed communication patterns among staff related to hand washing. The student noted that nurses, who are the primary patient advocates, were hesitant to point out lapses in hand-washing compliance to other providers. More importantly, the student discovered that even when lapses were pointed out to a colleague (i.e. the nurse 'spoke up' on behalf of the patient), the colleague did not respond by completing the appropriate hand hygiene. After presenting these observations and related audit findings to the interdisciplinary staff on the unit, the providers not only became more aware of their hand-washing behavior, but also changed their behavioral response when a hand-hygiene lapse was pointed out. Across the country, infection control departments continuously struggle to improve hand-hygiene compliance rates. This project illustrates how restoring the locus of control for safe and quality care to the point of care and to the providers who deliver these services is most readily achieved through direct bedside clinical leadership vis-a-vis a CNL as a point-of-care champion for safety improvement.

In a student leadership effort that focused on infection control in an acute care general medicine area, a team of students used an appreciative-based approach. An appreciative-based approach focuses on things that are working well and builds on existing strengths in a system, rather than focusing on the things that are broken or functioning poorly in the system ([Cooperidder & Whitney, 2005](#)). Through a systematic assessment of the unit, students discovered a deficit in core knowledge about hand-hygiene importance among support staff, especially nutrition and housekeeping services personnel. The students provided basic hygiene and health promotion information to employees in these departments. One nutrition services employee remarked, "I know we are supposed to wash our hands, but I never understood why. Now I am teaching my kids at home about the importance of washing your hands."

Another appreciative-based and engaging feature of this project involved staff getting 'ticketed' or 'caught' washing their hands. Staff entered their tickets into a weekly raffle for a small prize. Additionally fun pictures of individuals being 'caught' were posted in the staff break room. The specific interventions applied to this unit were directly based on the students' assessment and understanding of the unique features and needs of these environments. Interventions, such as improved placement of hand sanitizers and improved signage about hand hygiene, increased the hand-hygiene compliance rate from 30% to over 70%. This provides yet another specific example of how point-of-care clinical leadership can contribute to the building of safety cultures and safe care environments.

### **Point-of-Care Clinical Leadership Across Diverse Settings**

The Clinical Nurse Leader vision emerged out of concerns related to inpatient care. Hence current nursing and healthcare literature most often describes the CNL role in tertiary care environments. Additionally, tertiary care hospitals include systems in which the quality of nursing care is most directly guided by nurse-sensitive-indicator measurements, trending, and improvement efforts.; However, CNLs are also prepared to provide and coordinate care for individuals, families, groups, and communities in varied settings ([AACN, 2007](#)). In the coming years, as the number of CNL graduates increases and this new role continues to mature, CNLs will bring their unique educational preparation and skills to increasingly diverse settings, including home health, rehabilitation, long term, community, and ambulatory care. In addition, increasing emphasis on globalization and global healthcare will provide another important opportunity to apply the unique skill sets of the Clinical Nurse Leader.

Barnett, Stanton, and Blakney ([2010](#)) have identified the CNL role components that are of particular interest to diverse healthcare professionals, such as clinical leaders, care coordinators within and across healthcare settings, outcomes managers, staff education, and mentors. Our partner agencies have identified the CNL educational focus on human diversity and cultural competence as a major support to the development of evidence-based healthcare practices and protocols in diverse settings. Hix, McKeon, and Walters ([2009](#)) reported a direct correlation between CNL interventions and improved microsystem outcomes in diverse settings, including ambulatory, diagnostic, and long-term-care areas. These findings support the CNL role as a force in sustaining desired performance in settings other than acute and intensive care settings.

Leadership within a global healthcare context is a core competency of CNL practice ([AACN White Paper, 2007](#)). CNLs learn about the global environment in which healthcare is provided and are prepared to adapt care in response to global environmental factors. To meet the global health knowledge and competencies delineated in the vision of the CNL role ([AACN, 2007](#)), graduate students at the University of Virginia have engaged in interdisciplinary clinical and leadership experiences in many settings around the world, including Denmark, South Africa, Guatemala, the Bahamas, and India. The number and breadth of these experiences varies based on student interest and experience. However, students generally focus on community health needs related to health promotion, nutrition, sanitation, and hygiene.

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justice, and patient-centeredness are infused within the experiences. An interdisciplinary water improvement project in a community in rural South Africa illustrates these skills on the part of a CNL student. While engineering students and other professionals were repeatedly challenged to help a community sustain a clean water delivery system, it was the CNL student's assessment of a gap in the community understanding of relationships between water and health that enabled this project to finally succeed (Cunningham, Botchwey, Dillingham, & Netshandama, 2009). The student conducted a qualitative study of the community's understanding of water and health by giving community members cameras to take pictures of water and tell stories about the pictures. The student discovered through

these pictures and stories that the community equated clean water with affluence, but did not equate clean water with health. Based on this, the student led an educational intervention to provide basic health and sanitation information to the community to help sustain the clean water supply efforts. This project illustrates the important role of the Clinical Nurse Leader in global environments.

## Conclusion

In the advent of the new millennium and amid the many challenges facing contemporary healthcare delivery systems, we bear witness to the conception, development, and application of the first new role in nursing in over forty years, that of the Clinical Nurse Leader. As an advanced, master's-level-prepared nurse, having specialized health system clinical leadership competencies, the CNL provides direct clinical leadership at the point of care to advance care delivery that is safe, evidence-based, and targeted towards optimal quality outcomes for those served. The power of the CNL as a front-line care leader will be an invaluable asset for building and sustaining safer and higher quality care delivery systems in the years ahead.

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## References

- American Association of Colleges of Nursing (AACN). (2007). *White paper on the education and role of the clinical nurse leader*, 23. Available: [www.aacn.nche.edu](http://www.aacn.nche.edu).
- Barnett, C. A., Stanton, M.P., & Blakney, J. L. (2010). Innovative partnerships: The clinical nurse leader role in diverse clinical settings. *Journal of Professional Nursing*, 26(5), 258-263.
- Bowcutt, M., Wall, J., & Goolsby, M.J. (2006). The clinical nurse leader: promoting patient-centered outcomes. *Nursing Administration Quarterly*, 30(2), 156-161.
- Cooperidder, D., & Whitney, D. (2005). *Appreciative inquiry: A positive revolution in change*. San Francisco, CA: Berrett-Koehler Publishing, Inc.
- Cunningham, T., Botchwey, N., Dillingham, R., & Netshandanama, V. (2009). *Understanding water perceptions in Limpopo Province: A photovoice community assessment*. International Conference on Bioinformatics and Biomedical Engineering: Environmental Pollution and Public Health Conference, Beijing, China (June 14-16).

Haase-Herrick, K. & Herrin, D. (2007). The American organization of nurse executives' guiding principles and American Association of Colleges of Nursing's clinical nurse leader. *Journal of Nursing Administration*, 37(2), 55-60.

Hix, C., McKeon, L., & Walters, S. (2009). Clinical Nurse Leader impact on clinical microsystems outcomes. *Journal of Nursing Administration (JONA)*, 39(2), 71-76.

Institute of Medicine. (2001). *Crossing the quality chasm: A new health system for the 21st century*. Washington, DC: The National Academies Press.

Institute of Medicine. (2003). *Health professions education: A bridge to quality*. Washington, DC: The National Academies Press.

Joint Commission White Paper on the Hospital of the Future. (2008). Chicago IL: The Joint Commission.

Kimball, B., Joynt, J., Cherner, D., & O'Neil, E. (2007). The quest for new innovative care delivery models. *Journal of Nursing Administration*, 37(9), 392-398.

Mohr J., & Batalden, P. (2002). Improving safety on the front lines: The role of clinical microsystems. *Quality & Safety in Health Care*, 11(1), 45-50.

National Association of Clinical Nurse Specialists. (2005). *National Association of Clinical Nurse Specialists update on the clinical nurse leader*. Retrieved September 2, 2011 from [www.nacns.org/docs/PositionOnCNL.pdf](http://www.nacns.org/docs/PositionOnCNL.pdf).

National Association of Clinical Nurse Specialists. (2004). *Statement on clinical nurse specialist practice and education*. Harrisburg, PA: National Association of Clinical Nurse Specialists.

Porter-O'Grady, T., Clark, J., & Wiggins, M. (2010). The case for clinical nurse leaders: Guiding nursing into the 21<sup>st</sup> century. *Nurse Leader*, 37-41. Retrieved August 28, 2011  
[www.tpogassociates.com/reference/The\\_Case\\_for\\_Clinical\\_Nurse\\_Leaders.pdf](http://www.tpogassociates.com/reference/The_Case_for_Clinical_Nurse_Leaders.pdf)

Rusch, L., & Bakewell-Sachs, S. (2007). The CNL: A gateway to better care? *Nursing Management*, 38(4), 32, 34, 36-37.

Sammer, C., Lykens, K., Singh, K., Mains, D., & Lackan, N. (2010). What is patient safety culture? A review of literature. *Journal of Nursing Scholarship*, 42(2), 156-165.

Sherman, R., Clark, J., & Maloney, J., (2008) Developing the clinical nurse leader in the twelve bed hospital project: An education/service partnership. *Nurse Leader*, 6(3), 54-58.

Smith, S., Manfredi, T., Hagos, O., Drummond-Huth, B., & Moore, P. (2006). Application of the clinical nurse leader role in an acute care delivery model. *Journal of Nursing Administration*, 36(1), 29-33.

Spross, J.A., Hamric, A.B., Hall, G., Minarik, P.A., Sparacino, P.S.A., & Stanley, J.A. (2004). *Working statement comparing the clinical nurse leader and clinical nurse specialist roles: Similarities, differences and complementarities*. Washington, DC: American Association of Colleges of Nursing. Retrived September 2, 2011 from [www.aacn.nche.edu/cnl/pdf/CNLCNSComparisonTable.pdf](http://www.aacn.nche.edu/cnl/pdf/CNLCNSComparisonTable.pdf).

**Table 1: Fundamental Aspects of the CNL Role (AACN, 2007)**

- Leadership in the care of the sick 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 healthcare 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

**Table 2. Clinical Nurse Leader Role Functions in Relation to a Culture of Safety**

<b>CNL Core Role</b>	<b>CNL Role Function</b>	<b>CNL Competencies</b>	<b>Contribution to the Safety Subculture</b>
<b>Leadership</b>	<b>Advocate</b>	<p>Effects change through advocacy for the profession, interdisciplinary healthcare team, and the client.</p> <p>Communicates effectively to achieve quality client outcomes and lateral integration of care for a cohort of clients.</p>	<p><i>Leadership</i> <i>Just</i></p> <p><i>Leadership</i> <i>Teamwork</i> <i>Communication</i> <i>Patient-centered</i></p>
	<b>Member of a Profession</b>	Actively pursues new knowledge and skills as the CNL role, needs of clients, and the healthcare system evolve.	<i>Leadership</i> <i>Learning</i>
<b>Clinical Care Environment Manager</b>	<b>Team Manager</b>	<p>Properly delegates and utilizes the nursing team resources (human and fiscal) and serves as a leader and partner in the interdisciplinary healthcare team.</p> <p>Identifies clinical and cost outcomes that improve safety, effectiveness, timeliness, efficiency, quality, and the degree to which they are client-centered.</p>	<p><i>Leadership</i> <i>Teamwork</i> <i>Communication</i></p> <p><i>Learning</i> <i>Patient-centered</i></p>
	<b>Information Manager</b>	Uses information systems and technology at the point of care to improve healthcare outcomes.	<i>Evidence-based</i> <i>Communication</i>
	<b>Systems Analyst/Risk Anticipator</b>	Participates in systems review to critically evaluate and anticipate risks to client safety to improve quality of client care delivery.	<i>Communication</i> <i>Learning</i>

<b>Clinical Outcomes Manager</b>	<b>Clinician</b>	Assumes accountability for healthcare outcomes for a specific group of clients within a unit or setting recognizing the influence of the meso- and macrosystems on the microsystem.  Assimilates and applies research-based information to design, implement, and evaluate client plans of care.	<i>Patient-centered</i>  <i>Evidence-based Learning</i>
	<b>Outcomes Manager</b>	Synthesizes data, information, and knowledge to evaluate and achieve optimal client and care environment outcomes.	<i>Evidence-based Learning</i> <i>Patient-centered</i>
	<b>Educator</b>	Uses appropriate teaching/learning principles and strategies as well as current information, materials and technologies to facilitate the learning of clients, groups, and other healthcare professionals.	<i>Leadership</i> <i>Teamwork</i> <i>Communication</i>

<b>Table 3. CNL – CNS Role Major Differences</b>	
Clinical Nurse Leader (CNL)	Clinical Nurse Specialist (CNS)
Advanced general clinical knowledge (advanced generalist nurse)	Advanced clinical specialty knowledge (advanced specialist nurse)
Not credentialed as an Advanced Practice Registered Nurse (APRN)	Credentialed as an APRN
Unit level (point of care, or microsystem) domain	Institutional (macrosystem) domain

<b>Table 4: Safety Culture Improvements Resulting from Student CNL Role-Immersion Practicum Experiences</b>
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Bundling Up Clostridium Difficile: **Infection Control and Prevention** in the Surgical, Trauma, Burn ICU: During this project, the C. Diff infection rate went from an average of 10 cases per month to zero for 3 months.

Interdisciplinary Infection Control in General Medicine: The **hand hygiene compliance** rate improved from 30% to over 70%.

Maximizing Bedside Use of Electronic Patient Information: This project improved the system for providers to **access and use electronic data** gathered preoperatively for use in the thoracic-cardiovascular ICU.

Increasing Interpreter Use for the Hospitalized **Limited English Proficiency Patient**: Multiple student projects have improved interpreter use, especially in the use of assistive technologies at the bedside.

Interdisciplinary Communication Surrounding Off-Service Patients in the Coronary Care Unit: This project exemplified **lateral integration of care** and communication systems improvement for the patient cohort.

Implementation of an **SBAR Communication** Tool in Digestive Health: EBP communication strategies were implemented in the acute care setting to improve how important information is passed to others.

Mucositis Management Project: Multiple student projects have focused on system-wide improvements of the **prevention, assessment, and management of oral mucositis** in hematology-oncology patients.

**Tuberculosis Screening in Long-term Care**: This student improved the system of care for tuberculosis screening and improved compliance to institutional benchmark levels.

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