The Role of the Clinical Nurse Leader: A Review of the Literature

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Abstract

The Clinical Nurse Leader role was created by the American Association of Colleges of Nursing (AACN) in 2003 in order to help improve health care quality. Masters-prepared nurses were trained in communication skills, advocacy, lateral integration and advanced clinical expertise in anticipation of employment at the microsystem level. The vision was that CNLs could advance nursing practice based on outcomes, encourage the use of evidence-based practice and improve patient health experiences. This review of the literature will explore themes within current research about the Clinical Nurse Leader, discuss current controversies this new role, and identify research gaps.
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The American health care system has undergone significant changes in recent years, as efforts to address complex health challenges meet with out-of-control spending (Gawande, 2009). As policy analysts, government and organizations struggle to reform our health care system on a national level, health care professionals must grapple with the day-to-day question of how to provide care within an imperfect system. The Clinical Nurse Leader (CNL) is the nursing community’s answer. The CNL role emerged in response to a growing conviction that directly linking nursing education with practice improves patient care (Tornabeni & Miller, 2008). The American Association of Colleges of Nursing (AACN) and other stakeholders believed that endowing bedside nurses with a graduate-level education in enhanced communication, advocacy, lateral integration and clinical expertise could make a difference to health care microsystems (AACN, 2007). The vision was that CNLs could advance nursing care based on outcomes, encourage the use of evidence-based practice, and most importantly, improve the experiences of individual patients and families (AACN). This review of the literature will explore themes within current research about the Clinical Nurse Leader, as well as discuss current controversies about this new role. Gaps in the literature will also be identified in order to explore possibilities for future research. As the role develops in the coming years and additional Clinical Nurse Leaders are certified and begin their practice, the potential for both creative role application and further research is significant and thought-provoking.

The CNL Role: Background, Support and Early Outcomes

Background: CNL History and Vision

The CNL role emerged in response to a growing realization that a fragmented health care system was contributing to significant adverse events and mistakes that often led to patient
injuries and deaths (AACN, 2007; Institute of Medicine [IOM], 2000; Tornabeni & Miller, 2008). Recognizing the central role that nurses played in improving health care, the AACN convened the Task Force on Education and Regulation for Professional Nursing Practice (TFER) in 1999, in order to begin a dialogue about educating and preparing nurses for the new challenges that faced the profession in the 21st century (Stanley, 2010). The conversation continued in 2002, when the AACN formed TFER II based on the first task force’s recommendations and began exploring the specific nursing competencies necessary to improve health care outcomes (Stanley). The notion of the Clinical Nurse Leader surfaced from the work of TFER II, and the role was further conceptualized in the 2003 Working Paper on the Role of the Clinical Nurse Leader (Stanley; Tornabeni & Miller). Following the publication of this white paper, the AACN formed an Implementation Task Force (ITF) in 2003, representing multiple stakeholders from both nursing education and practice to begin developing and implementing the CNL role (Stanley). A key component of the implementation process from the beginning was a strong education-practice partnership, in order to build a foundation of support in both academic and practice-based institutions (AACN; Rusch & Bakewell-Sachs, 2007; Stanley; Tornabeni & Miller).

The CNL vision was conceptualized by the AACN task forces, described in the 2003 Working Paper, and further refined in the 2007 White Paper on the Education and Role of the Clinical Nurse Leader (AACN). Conversations by task force participants led to the conclusion that the CNL must be prepared at the graduate level to obtain the multidisciplinary skills and clinical experience necessary to practice (Stanley, 2010; Tornabeni & Miller, 2008). The CNL would be considered a “generalist” because he/she could practice across a variety of clinical settings (AACN; Tornabeni & Miller). The CNL would also be expected to operate within the
microsystem, defined as “the smallest functional unit on the frontline of healthcare delivery systems” (Thomas, 2010, p. 120). By working as part of the direct care team, CNLs could affect health outcomes on the front lines and collaborate with other health care disciplines to ensure smoother coordination of care (AACN; Stanley; Thomas).

**CNL Role Functions**

The envisioned responsibilities of the CNL reflect the leadership and clinical expertise that can be contributed to the multidisciplinary health care team and implemented across a variety of clinical settings (AACN, 2007; Stanley, 2010). The CNL is expected to be a team manager, acting as a leader within the team to identify patient-centered interventions, and delegating responsibility for implementation of these outcomes (AACN; Begun, Tornabeni, & White, 2006; Spitzer, 2010). This requires coordinating patient care and integrating and planning treatment plans from multiple disciplines (AACN; Brown, 2008; Stanley et al., 2008). Managing care requires that a CNL be a skilled clinician, recognizing the relationships between interventions and health outcomes, and facilitating the use of evidence-based practice among the disciplines (AACN). Planning interventions also necessitates that the CNL manages outcomes, utilizing and synthesizing data from within the microsystem to evaluate the effectiveness of interventions for both individuals and populations (AACN).

The CNL serves as an educator by providing direct patient education when appropriate, as well as facilitating learning opportunities by making sure that staff nurses have access to evidence-based teaching materials (AACN, 2007). Members of the multidisciplinary team can also benefit from the CNL’s educational expertise through education modules and in-services (AACN). The CNL must also be an advocate for patients by communicating with care providers, ensuring that quality care is provided by detecting potential gaps in care plans, and identifying
issues of access and equity for both individual patients and patient populations (AACN; Brown, 2008; Carol, 2009). The CNL advocates for the nursing profession by improving communication patterns among the system’s health care providers (AACN), as well as by serving as a trustworthy member of the direct care team is not considered part of of “management” (Sherman, Edwards, Giovengo, & Hilton, 2009). As an advocate, the CNL is also serving the broader role function as a member of a profession. By pursuing opportunities for self-improvement and learning, as well as seeking chances to develop new knowledge and skills, the CNL is contributing to the advance of the nursing profession (AACN).

Leadership skills should also include an ability to understand the system in which one works, which is conceptualized within the systems analyst/risk anticipator role function. By analyzing the microsystem as a whole about quality improvement plans, sentinel events, and outcome data, as well as reviewing individual patient care plans for safety risks, the CNL can contribute to improving trends within the system and increasing safety for individual patients (AACN, 2007). The CNL should also possess a strong understanding of information management in order to harness technology for data analysis, trend review, and financially justifying the need for improvement projects (as well as the need for an established CNL position) (AACN; Harris & Ott, 2008).

The roles and responsibilities of the CNL are not foreign concepts in health care. Stanley (2010) pointed out that the CNL skill set had already been identified as a need in many health systems without the CNL label. Some facilities had already hired personnel in roles similar to that of a CNL, but training was done on-the-job rather than through a graduate-level education (Drenkard, 2004; Gabuat, Hilton, Kinnaird, & Sherman, 2008; Nelson, 2005; Stanley). Because training varied from facility to facility and no standardized competencies or role definitions
existed, however, it was difficult to assess the efficacy of these nursing roles or account for their impact on health care outcomes (Stanley). The individual roles played by the CNL have also been identified as valuable. For example, the importance of coordinating care has been recognized as critical to improving health care quality and has been implemented through positions such as care managers and care coordinators (Drenkard). Lateral integration among multiple disciplines has been identified as a critical component of quality health care (Spitzer, 2010). CNL supporters advocate that integrating these role functions into a bedside nursing position will have positive implications for patient care outcomes (AACN, 2007).

Support for the CNL Role

Practice-based support for the CNL role has been especially strong among nurse administrators, who recognize the potential value that CNLs could bring to their organizations. The American Organization of Nurse Executives (AONE) has discussed how the CNL can improve nursing practice (Haase-Herrick & Herrin, 2007), with many nurse executives considering how CNLs can contribute to tracking and improving performance on core measures and quality indicators, which makes the role financially rewarding to administrators (Sherman, 2008). Decisions to hire CNLs are also based on contributions they can make to improving patient safety, reorganizing care delivery models, mentoring other staff (particularly novice nurses), and improving physician-nurse relationships (Gabuat et al., 2008; Sherman).

The support of these executives was critical to the successful implementation of the CNL role in a health care facility because it was important to communicate that nursing leadership valued this new role (Drenkard & Cohen, 2004; Gabuat et al., 2008; Poulin-Tabor et al., 2008; Rusch & Bakewell-Sachs, 2007; Sherman). Executive support was also critical because of the importance of practice-partnerships between health care facilities and academic institutions.
Without the support of nurse executives, these practice partnerships were less likely to happen (Drenkard & Cohen).

In addition to executive support, the literature demonstrates the importance of a positive relationship between the CNL and the unit manager, especially as managers’ administrative responsibilities intensify (“Clinical nurse leader,” 2010; Gibson, 2005). Supportive nurse managers were important to demonstrating positive regard for the CNL role to other nursing staff (Sherman, 2008). A trusting and collegial relationship also meant that the manager could delegate management of clinical outcomes to the CNL (Carol, 2009; Gibson; Newkirk, 2005).

Clinical outcomes are beginning to show promising results in settings where CNLs are being implemented. Although the role is still in its infancy, early results demonstrate that the skills and abilities that CNLs can offer are making a difference.

Initial Outcomes

Our knowledge of the CNL’s impact on health care outcomes is thus far limited to individual health systems (Bowcutt & Goolsby, 2006; “Clinical nurse leader,” 2010; Gabuat et al., 2008; Hix, McKeon, & Walters, 2009; Ott et al., 2009; Stanley et al., 2008; Tachibana & Nelson-Peterson, 2007). The role is so new that longitudinal data and meta-analysis are not yet possible. Early results are promising, however. CNL presence on units is correlated with increased patient and physician satisfaction (Gabuat et al.; Stanley et al.; Tachibana & Nelson-Peterson) and individual, patient-specific positive outcomes (Bowcutt & Goolsby; Stanley et al.). Health care systems that have implemented CNLs are demonstrating improved quality outcomes, such as decreased rates of appointment cancellations (Hix et al.; Ott et al.), increased implementation of prophylactic interventions (Hix et al.), and decreased length of stay (Tachibana & Nelson-Peterson). CNLs have contributed to improved core measures related to
specific diagnostic groups such as congestive heart failure and myocardial infarction (“Clinical nurse leader”; Gabuat et al.). Studies are also showing improved work environments and greater nurse satisfaction, especially among novice nurses (Gabuat et al.; Sherman et al., 2009; Stanley et al.). Despite these promising results, however, unanswered questions and controversies remain about the appropriateness of the CNL role.

### Current Controversies

Questions regarding the CNL have emerged in the literature, centering on three themes: role confusion, the appropriateness of implementing a new role in nursing, and controversies regarding overlap with the Clinical Nurse Specialist role. An ongoing challenge facing CNLs is role definition (Harris, Tornabeni, & Walters, 2006). The introduction of the CNL means the addition of a new role to the nursing profession, and many health care providers are unfamiliar with the CNL’s capabilities (Drenkard & Cohen, 2004; Harris & Ott, 2008; Newkirk, 2005). CNLs possess a diverse skill set that makes them valuable, and they must have a clear understanding of where their responsibilities lie so that they do not become pulled in too many directions (Brown, 2008). The difficulty of being unknown entities in health care, where many colleagues and patients may not understand what they can contribute, may also result in role conflict with other professionals, such as patient care coordinators (Gabuat et al., 2008; Ott et al., 2009).

At the heart of the CNL debate lies the question of whether creating a new role truly addresses the challenges facing today’s nurses. Because role clarification has been a challenge for CNLs, one of the concerns voiced about the CNL addresses the speed and process with which the role was implemented (Grindel, 2005; McCabe, 2006; Newkirk, 2005). The time period from AACN’s initial task force in 1999 to the development of a CNL certification and examination in
2007 spanned less than a decade (Stanley, 2010), and some nursing leaders are advising caution about whether the rapid addition of a new role will truly address the challenges of 21st century nursing (McCabe). Is nursing “creating a jack of all trades and master of none” (McCabe, p. 254) or does the profession need this new role swiftly to respond to a health care crisis? Will the creation of a new leadership role in nursing lead to the neglect of other nurses in the development of their leadership skills (Grindel)? Will focusing on the CNL as the answer to contemporary health care challenges result in a failure to reform the rest of nursing education (McCabe)? Nursing leaders concerned about the speed of the CNL role development warn that hastily adding “new initials” to the profession may not be the answer that nursing is seeking (McCabe, p. 252).

One of the most significant controversies since the introduction of the CNL role has been protest over its apparent resemblance to the Clinical Nurse Specialist (CNS) (Goudreau, 2008; Grindel, 2005; Nelson, 2010). The National Association of Clinical Nurse Specialists (NACNS) released a position paper (2004) in direct response to AACN’s unveiling of the CNL. The position paper is still available on the NACNS website but has not been updated since 2005. The confusion centers on overlaps between role competencies, some of which NACNS specifically lists as “hallmarks of CNS practice, including integrating evidence-based practice into health care, designing and developing innovative nursing interventions and programs of care, and providing leadership and education to nurses and nursing practice” (NACNS 2005). The concern among clinical nurse specialists is that parallels in these fundamental role functions will lead to role confusion, and many have questioned the necessity of a new role that may not be differentiated from the CNS in the actual practice environment (Goudreau, 2008). Thompson & Lulham (2007) acknowledge that similarities do exist in that both CNLs and CNS’ provide
leadership and education to improve health care outcomes. They argue, however, that these roles complement rather than compete with one another. The specialty training focus of CNS’ allows them to provide expertise throughout the macrosystem, while CNLs provide support to both staff nurses and patients on a microsystem level (Brown, 2008). This seems to be reflected in practice as well; despite published concerns about role confusion, CNLs and CNS’ do appear to be working together effectively on a local level (Nelson, 2010).

**Gaps In the Literature**

Literature about the CNL role has concentrated almost exclusively on the acute care setting. Although the CNL’s potential impact among other populations has been identified, research has yet to be conducted on these areas. Community health is an especially ripe area for CNL participation (Edouard-Trevathan, 2010; Poulin-Tabor et al., 2008). Not only can CNLs act as a “bridge” to the community, ensuring continuity of care as patients leave the acute care setting (Poulin-Tabor et al., p. 626), but CNLs have the opportunity to plan interventions that promote healthy living in the community (Edouard-Trevathan). CNLs can also work in the community to address health disparities and social justice issues (AACN, 2007; Carol, 2009; Keiswetter & Brotemarkle, 2010). The potential value of CNLs has also been identified in rural health, particularly because rural nurses provide care to patients with a variety of health needs. CNLs in these settings can support nurses to access education and maintain competencies in diverse areas of nursing (Courtney & Dorwart, 2010; Stanton, 2006). CNLs can also serve valuable coordination and lateral integration functions in psychiatric nursing, which has been identified as needing more effective continuity of care between settings (Karshmer, Seed, & Torkelson, 2009). CNLs’ abilities to provide leadership in a variety of health care venues make them valuable beyond the acute care setting.
There is also a lack of discussion about the individual role functions within the CNL’s scope of practice (AACN, 2007). With the exception of lateral integration (Begun, Tornabeni, & White, 2006; Spitzer, 2010), the literature offers few details about how the CNL can integrate these competencies into daily practice (Harris, Tornabeni, & Walters, 2006). “Day-in-the life” articles (Brown, 2008) are helpful glimpses of a CNL’s job functions, but more detailed explorations of CNL competencies and what they mean theoretically and practically would provide a stronger foundation for describing the CNL role in the literature. The potential role of the CNL in nurse retention, particularly in supporting new graduate nurses, should especially be explored (Begun, Tornabeni, & White, 2006; Sherman, 2008).

**Concluding Thoughts**

There are many unanswered questions about the Clinical Nurse Leader role, but data is beginning to demonstrate that CNLs do contribute to improved outcomes. Because of the role’s novelty, there is potential for creativity in the education and training of CNLs (Maag, Buccheri, Capella, & Jennings, 2006). CNLs can offer clinical and leadership skills across diverse settings in health care. By serving as the integrators and coordinators of care, CNLs are also advocating for the nursing profession as the heart of health care. As University of Washington Dean Maria Salmon (2010) wrote, “More than ever nurses are being looked to as an answer to the increasingly complex challenges of health care today. Nurses are at the crucial interface between the science, technology, financing, policy, service system, and the people whose lives and health are impacted by these” (para. 2). Implementing a new nursing role whose responsibilities are focused specifically on meeting these complex challenges will support nurses to answer this call.
References


