Clinical Nurse Leader Certification Review
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Clinical Nurse Leader
Certification Review

Second Edition

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Sally O’Toole Gerard, DNP, RN, CDE, CNL

Editors
To all the clinical nurse leaders and clinical nurse leader students who are working hard to make all aspects of our health care system a model that will exceed expectations of quality and safety for all Americans. We gratefully recognize the dedication of faculty and health care organizations who are working collaboratively to support these master's-prepared nurses to lead change in this important era of health care.
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Foreword

I am pleased to provide a foreword for the second edition of the Clinical Nurse Leader Certification Review by Cynthia R. King and Sally O’Toole Gerard. Drs. King and Gerard continue to provide an excellent review, reinforcing major skills and responsibilities of this advanced nursing practice role. This book will be most useful for students as they prepare for certification. The new revision provides an in-depth review, illustrated by examples on content that underpin the clinical nurse leader role. Competencies and curricular expectations for clinical nurse leader education and practice are integrated in the presentation of key areas of focus, including risk mitigation, lateral integration, interprofessional skills, care coordination, and evidence-based practice. I know that students and faculty will appreciate the authors’ attention to detail as they continue to reach for this text as a resource for successful certification preparation.

Linda Roussel, PhD, RN, NEA-BC, CNL
Co-Author, Initiating and Sustaining the Clinical Nurse Leader Role: A Practical Guide
Preface

Clinical Nurse Leader Certification Review is written by experts on the new clinical nurse leader (CNL) role. The book is written for nurses who have completed a qualified CNL program and are ready to take the certification exam, as a guide for faculty on how to design a review course, and as a resource for use during the CNL program. Because of the changes and additions to the “new” topics in the certification exam, this book may be especially helpful for faculty preparing the CNL curriculum and CNL review courses. This second edition has been enhanced to serve as a quality resource for all of these purposes, with new chapters, a glossary, and new multiple-choice questions and case studies.

Chapter 1 describes the history and journey of developing the CNL role. Chapter 2 helps individuals and groups make the best use of this book, while Chapters 3 and 4 provide information on the actual certification exam and how to prepare for it. The remaining chapters cover the key topics outlined in the new Examination Outline (Appendix A). Chapters 5 through 9 are grouped in the content outline under Nursing Leadership. Chapters 10 through 14 are grouped under Clinical Outcomes Management. The last chapters, 15 through 21, fall under Care Environment Management.

Of those chapters more specifically related to nursing leadership, Chapter 5 focuses on topics related to horizontal leadership, while Chapter 6 describes interdisciplinary collaboration and communication skills. Chapter 7 identifies key concepts related to health care advocacy and how CNLs serve as advocates. Chapter 8 outlines the specifics of how CNLs must integrate their new role into their health care setting. Chapter 9 is the last chapter related to nursing leadership in this section and describes the CNL’s role in lateral integration of care services.

In the section devoted to clinical outcomes management, Chapter 10 discusses management of illnesses and diseases, while Chapter 11 focuses on knowledge management as a role for CNLs. Other areas of importance for CNLs are health promotion and disease prevention, which are outlined in Chapter 12. Chapter 13 describes the importance of using the latest evidence in practice by learning about and implementing evidence-based practice (EBP) in any of the key roles in which CNLs might be serving. The key components of advanced clinical assessment that CNLs need to be able to implement in practice are included in Chapter 14.
Care environment management is the last major section of the exam outline for CNLs. This section opens with Chapter 15, which focuses on team coordination. CNLs have a key role as members of a variety of interdisciplinary teams, influencing outcomes and managing costs. Chapter 16 describes health finance and economics, while Chapter 17 identifies health systems versus the specific microsystems in which CNLs work. In addition to being involved in outcomes, it is expected that CNLs be involved in health care policy (Chapter 18). The CNL role was developed specifically to help with quality and safety issues related to patient care. Chapter 19 focuses on quality management, which is equal in importance to health care informatics, the topic of Chapter 20. Finally, Chapter 21 discusses ethics and ethical principles.

Clinical Nurse Leader Certification Review also includes four appendices. Appendix A contains the overall exam content, while Appendix B contains reflection questions to help nurses prepare for this exam. Appendix C includes multiple-choice questions and unfolding case studies, while Appendix D contains the correct answers for these questions and the rationale for the correct answers. In this new edition, a glossary of key terms has been added.

Cynthia R. King
Sally O’Toole Gerard
Acknowledgments

Cyndy King would like to thank her parents, Martha R. King and the late Dr. John A. King, for encouraging a career in nursing and for their love and support. She would also like to thank all her mentors, colleagues, students, and the patients and their families, who have added to her love of nursing and lifelong learning. Cyndy also thanks her late husband, Michael A. Knaus, who believed in this book and who always provided love and support. Lastly, special thanks to Dr. Carla Gene Rapp, who worked collaboratively with the editors to oversee the multiple-choice questions and case studies in this second edition.

Sally O’Toole Gerard would like to acknowledge the generosity of her colleagues who have mentored her in the wonderful journey of interprofessional improvement work. She would especially like to thank her CNL graduates, who are wonderful ambassadors of what this education was envisioned to create: creative, intelligent, collaborative leaders. In addition, she acknowledges that the support of her husband, Bill, and her children, Jack, Christian, and Holly, is the key to all good things.

Cynthia R. King
Sally O’Toole Gerard
I

Becoming Familiar With the CNL Role and Certification Exam
The Clinical Nurse Leader Journey for Clinicians and Academics  

*Teri Moser Woo*

The clinical nurse leader (CNL) role evolved out of a partnership between nursing education and practice leaders to address the need for master’s-educated nurses in a complex, changing health care delivery environment. This was developed in the early 2000s and was the first new nursing role in 35 years.

### Background

In order to understand the need for a new nursing role, it is critical to understand the health care environment and where the profession of nursing was in the late 1990s and early 2000s. This section will describe the health care background and the need for the CNL role.

### The Health Care Environment

*To Err Is Human*, a landmark report published in 1999 by the Institute of Medicine (IOM) proposed that the health care system was not as safe as it should and could be (Table 1.1). The IOM report suggested that between 44,000 and 98,000 people died in hospitals annually due to medical errors (1999). Faulty systems, processes, and conditions that lead to errors were identified as the cause of most errors and the IOM called for a nationwide focus on leadership, research, tools, and protocols to improve patient safety.

In 2001, the IOM published a second report focusing on quality titled *Crossing the Quality Chasm: A New Health System for the 21st Century*, which proposed the U.S. health care system was too focused on acute and episodic care, when the aging population required care for complex chronic conditions. The 2001 IOM report noted the health care system...
was too complex and uncoordinated, leading to a waste of resources, poor quality, and safety issues (Table 1.1). The Quality Chasm report identified six aims to improve health care quality, stating that care should be: (a) safe, (b) effective, (c) patient-centered, (d) timely, (e) efficient, and (f) equitable. Ten rules or principles were proposed in the Quality Chasm report to guide health care redesign:

1. Care is based on continuous healing relationships.
2. Care is customized according to patient needs and values.
3. The patient is the course of control.
4. Knowledge is shared and information flows freely.
5. Decision making is evidence based.
6. Safety is a system property.
7. Transparency is necessary.
8. Needs are anticipated.
9. Waste is continuously decreased.
10. Cooperation among clinicians is a priority.

These new expectations for health care to improve patient safety, quality, and satisfaction provided the backdrop for the development of a new nursing role with the skills to meet the challenge of health care in the 21st century.

*Nursing at the Turn of the 21st Century*

The nursing profession was experiencing its own pressures at the turn of the century. Buerhaus, Staiger, and Auerbach (2000) published a report predicting another 20% decrease of RNs by 2020. The average age of RNs in 2000 was 44, and the number of students enrolled in baccalaureate programs was not enough to replace the aging RN workforce (American Association of Colleges of Nursing, 2007; U.S. Department of Health and Human Services, 2010). The Joint Commission weighed in on the looming nursing shortage, stating “the impending crisis in nurse staffing has the potential to impact the very health and security of our society” (p. 5). The Joint Commission recommended that the workplace be transformed, that nursing education and clinical experience align, and health care organizations invest in high-quality nursing care (2002).

*Nursing Responds With a New Role*

In a response to the IOM report and in recognition of declining enrollments in baccalaureate nursing programs, the leadership of the American Association of Colleges of Nursing (AACN) formed the Task Force on Education and Regulation for Professional Nursing Practice #1 (TFER #1) to explore new educational models and nursing roles (Long, 2003) (Table 1.1). The TEFR #1 committee recommended a new nursing role with a different scope of practice and license from the RN. The recommendations of TEFR #1, including creating a new license, were not accepted by the National Council of State Boards of Nursing (NCSBN), and the AACN convened the Task Force on Education and Regulation for Professional
Nursing Practice #2 (TEFR #2) in 2002 to continue the work of TEFR #1 (Long, 2003; Table 1.1). TEFR #2 outlined the competencies of the “New Nurse” which led to the development of the draft white paper The Role of the Clinical Nurse Leader in May 2003.

**Practice/Education Partnership in Developing the CNL Role**

From the beginning, the CNL role has evolved out of a strong partnership between nursing education and practice. In October 2003, the AACN convened a meeting of education and practice partners to further define and refine the role of the CNL (Table 1.1). The only requirement to attend the meeting was that each educational program was required to bring a practice partner to the meeting and over 100 potential education/practice partnerships attended (Stanley, 2014). The Clinical Nurse Leader Implementation Task Force formed in January 2004 was tasked with the development of the skills and competencies of the CNL role and comprised of members from both education and practice, including the American Organization of Nurse Executives and the Veterans Health Administration (Tornabeni & Miller, 2008). In 2004, the AACN sent a request for proposal (RFP) to all member schools, inviting them to submit a proposal to develop a CNL master’s curriculum and were required to include a plan by their practice partner to implement the CNL role on at least one unit in the practice setting (Stanley, 2014). The requirement for every CNL program to have a committed practice partner continues into the present (AACN, n.d.).

The strong alliance between practice and education has been crucial to the success of implementing the CNL role. The academic partner solicits and incorporates input from the practice partner when developing the curriculum to educate CNL students. Likewise, the practice partner utilizes input from their academic partner to redesign care and implement the CNL role (Harris, Stanley, & Rosseter, 2011). Sherman (2008) interviewed chief nursing officers (CNOs) to identify the five factors that influence the CNO decision to involve their organization in the CNL project. The five factors are: (a) organizational needs, (b) desire to improve patient care, (c) opportunity to redesign care delivery, (d) promote professional development of RN staff, and (e) enhance physician–nurse relationships. One major nationwide practice partner has been the Veterans Health Administration (VHA), who was an early adopter of the CNL role with 50 Veterans Affairs Medical Centers (VAMC) sites participating in the initial pilot projects in 2004 (Ott et al., 2009). Based on the positive practice outcomes, the VHA developed a plan to implement the CNL role in all VAMCs by 2016 (Ott et al., 2009).
CNL Education

The first pilot CNL master’s degree programs began in the 2005–2006 academic year, with rapid growth to 70 programs in the 2006–2007 academic year enrolling 1,270 students (Fang, Htut, & Bednash, 2008). The number of CNL degree programs has grown steadily from the first pilot programs to 130 programs and 190 practice settings in 2015 (Commission on Nurse Certification [CNC], 2015a). There are programs in all regions of the United States and online programs available for students who are place bound.

CNL Education Models

CNL education is at the graduate level in master’s or post-master’s programs. There are five curricular models for educating the CNL:

1. Model A for BSN graduates.
2. Model B for BSN graduates with a post-BSN residency that awards master’s credit toward the CNL degree.
3. Model C for students with a degree in another discipline. These are also known as second-degree or entry-level programs.
4. Model D for ADN graduates. These are also known as RN to MSN (master of science in nursing) programs.
5. Model E are post-master’s certificate programs.

As of 2015, approximately half (49%) of CNLs were educated in Model C programs, followed by Model B graduates, who represent 35% of CNLs (CNC, 2015b).

CNL Curriculum

The AACN (2007) outlined CNL competencies and provided a curricular framework for schools to utilize when developing a program. The CNL curriculum builds on a liberal education as the basis for developing clinical judgment and professional values as the foundation for practice. The values deemed essential for the CNL include altruism, accountability, human dignity, integrity, and social justice. The 2007 white paper outlined the competencies for the CNL to include (AACN, 2007):

- Critical thinking
- Communication
- Assessment
- Nursing technology and resource management
- Health promotion
• Risk reduction
• Disease prevention
• Illness and disease management
• Information and health care technologies
• Ethics
• Human diversity
• Global health care
• Health care systems and policy
• Provider and manager of care
• Designer/manager/coordinator of care
• Member of a profession

To assist with the design and implementation of CNL curriculum, AACN provided a “CNL Toolkit” with resources for schools and their practice partners.

In 2013, an update of the CNL competencies and curricular expectations was published based on the 2011 *Essentials of Master’s Education in Nursing* and the changing health care environment, and replaced the original 2007 document (AACN, 2013). The competencies align with the *Master’s Essentials* and guide curriculum development and revision.

**CNL Certification**

After completion of formal CNL education, which includes 400 hours of clinical practicum including a 300-hour immersion experience, graduates are qualified to take the CNL Certification Exam. The exam is administered by the CNC, and the first exams were administered in 2007. In 2007, CNL became a registered trademark of the AACN to protect the title, with only those who pass the exam entitled to use the CNL title (CNC, 2014). The certification exam was updated in 2012 to reflect a job analysis study of the essential knowledge and skills required of the CNL. As of May 2015, there were 3,820 clinical nurse leaders reported by CNC (CNC, 2015b).

**CNL Association**

In 2008, a group of CNLs from Portland, Oregon, and Maine Medical Center joined forces to form the Clinical Nurse Leader Association (CNLA). Bylaws were written and approved, and the first board officers were elected from the original steering committee. According to its mission statement, “The mission of the Clinical Nurse Leader Association is to provide a forum for members in all practice settings to collaborate, collect data, publish results,
network, promote high standards of practice, maintain a professional presence and stay abreast of issues affecting their practice.” (CNLA, 2015). By 2011, CNLA had become a fully functioning association with 503(c)3 status, holding an annual conference and providing regional continuing education offerings. In 2015, there were 411 members of CNLA throughout the United States (B. R. Shirley, personal communication, July 15, 2015).

**Growth of the CNL Role**

The development and implementation of the CNL role involved a partnership between education and practice, providing a practice environment to operationalize the CNL role. The nation’s largest employer of nurses has made a commitment to implement the CNL role in all of the VAMCs nationwide by 2016 (CNC, 2015a; Ott et al., 2009). The majority of CNLs are employed in acute care settings, working to decrease readmissions, improve patient outcomes, and smooth care transitions across the continuum of care (Harris et al., 2011). CNL also practice in specialty areas such as pediatrics (O’Grady & VanGraafeiland, 2012), oncology (Murphy, 2014), in community or public health, and in long-term care (Harris et al., 2011). The broad skill set of the CNL is particularly valuable in the rural, critical-access setting where underserved and poor patients can challenge the health care system (Jukkala, Greenwood, Ladner, & Hopkins, 2010). As more outcomes data have been published, it is clear the implementation of the CNL role leads to improved patient outcomes.

As the CNL role has matured, the AACN has provided support and structure to foster the role. The first national AACN–CNL Partnership Conference was in January 2008 in Tucson, Arizona, bringing education and practice partners together to share outcomes of the early pilot programs. This early meeting has evolved into an annual CNL Summit conference which provides a forum for individuals from academic and health care settings who are exploring or have fully implemented the CNL role. The CNL Summit provides a setting for health care partners to share CNL successes in quality and safety initiatives and for education to present innovations in CNL education. The CNL Summit is preceded by the CNL Research Symposium, a 1-day preconference workshop focused on the CNL’s role in data collection that provides a venue for reporting clinical outcomes.

**The CNL Role and Patient Care Outcomes**

The CNL role evolved out of a growing concern for patient safety and the need to improve the quality of care delivered. From the beginning, the importance of measuring the impact of the CNL role on patient care outcomes was stressed. This measurement of the role was not only to document
the improvement in care but also to demonstrate the cost effectiveness of adding a role devoted to improving quality and safety. Improved patient care outcomes have been disseminated at the CNL annual meetings (podium and poster presentations) and in publications. In a 5-year review of the impact of the CNL role in a tertiary care center in the Northeast, the CNL role demonstrated decreased: (a) readmission rates, (b) rapid response and code blue rates, (c) bloodstream infections, (d) length of stay, and (e) pressure ulcers (Wilson et al., 2013). The CNL role has also demonstrated improvement in fall rates, patient satisfaction, pain management, restraint use, and staff turnover (Bender, 2014). The Veterans Health Administration has tracked the impact of the CNL closely since its implementation and has reported improvement in pressure ulcer rates, ventilator-associated pneumonia, and the number of cancelled gastrointestinal procedures (Ott et al., 2009). Research is ongoing and there is an early body of evidence suggesting the CNL has met the goal of improving patient care quality, safety, and satisfaction.

**Resistance to the CNL Role**

Change as significant as introducing a new role into the health care team is bound to have some resistance. The clinical nurse specialist (CNS) role has some similarities with the CNL role and leaders in the CNS field have been vocal regarding the introduction of the CNL role (Goudreau, 2008). Goudreau proposes using educational resources to increase the number of CNSs rather than developing a new nursing role (2008).

Resistance to the CNL role may come at the administration or system level. In a qualitative analysis of 22 CNLs in practice, the CNO and/or middle nurse manager were identified as putting up roadblocks to the success of the CNL. Most frequently, they cited the cost of hiring CNLs rather than more bedside nurses as the reason for resistance (Moore & Leahy, 2012). Sherman (2008) identified resistance to the CNL role by unit managers was one barrier CNOs had to overcome to implement the initial CNL pilots. Organizations with less resistance to the CNL role are those with the following: (a) organizational needs, (b) desire to improve patient care, (c) opportunity to redesign care delivery, (d) desire to promote professional development of RN staff, and (e) methods to enhance physician–nurse relationships (Sherman, 2008).

**The Future of the CNL**

The CNL role is in its infancy, with the early programs less than 10 years old. The change the Affordable Care Act is demanding of the health care system calls for all health care team members to be focused on achieving
maximum outcomes for patients and families. The CNL competencies are well matched with the need for high-quality, cost-effective care across the care continuum (Jeffers & Astroth, 2013). The CNL is educated to work in a team to provide high-quality integrated care in an accountable-care environment. The patient-centered medical home team can benefit from a CNL working with the patient and family to address health issues surrounding chronic illness. The nurse shortage is looming and the need for nurses educated to improve quality and safety will grow as the shortage deepens.

The CNL role will likely spread globally as the need to improve quality and decrease cost is universal. Coordinating, managing, and evaluating care across the care continuum are nursing competencies that are needed worldwide (Baernholdt & Cottingham, 2011). The AACN and CNC are working with a group of faculty from Japan to develop a CNL education program at Tsukuba University (AACN, 2015).

Conclusion

In a short 15 years, the CNL role evolved out of an identified crisis in health care to an active part of the health care team. Integrating CNLs into health care settings has demonstrated improved patient care outcomes across the care continuum. The clinical nurse leader role is fulfilling the vision of becoming the “new nurse” of the 21st century.

Resources


