Clinical Nurse Leader Integration Into Practice: Developing Theory To Guide Best Practice☆

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Numerous policy bodies have identified the clinical nurse leader (CNL) as an innovative new role for meeting higher health care quality standards. Although there is growing evidence of improved care environment and patient safety and quality outcomes after redesigning care delivery microsystems to integrate CNL practice, significant variation in CNL implementation has been noted across reports, making it difficult to causally link CNL practice to reported outcomes. This variability reflects the overall absence in the literature of a well-defined CNL theoretical framework to help guide standardized application in practice. To address this knowledge gap, an interpretive synthesis with a grounded theory analysis of CNL narratives was conducted to develop a theoretical model for CNL practice. The model clarifies CNL practice domains and proposes mechanisms by which CNL-integrated care delivery microsystems improve health care quality. The model highlights the need for a systematic approach to CNL implementation including a well-thought out strategy for care delivery redesign; a consistent, competency-based CNL workflow; and sustained macro-to-micro system leadership support. CNL practice can be considered an effective approach to organizing nursing care that maximizes the scope of nursing to influence the ways care is delivered by all professions within a clinical microsystem. (Index words: Clinical nurse leader; Theory; Practice model; Interpretive synthesis; Care quality; Nursing care delivery) J Prof Nurs 32:32–40, 2016.

Background

THINKING ABOUT HEALTH care has shifted over the last two decades, moving away from a concept of health care as medical interventions to treat disease and toward an understanding that health care is a complex process of delivering care (including medical interventions) involving multiple disciplines and interrelated activities. This attention to health care processes was prioritized after *To Err is Human* (Institute of Medicine, 2000) made clear that medical error was occurring at an alarming rate, but had less to do with clinical "ineptitude" than with dysfunctional health care design and delivery. Health care delivery redesign is now considered essential for improving structures and processes that influence care quality and safety.

The nursing profession has been challenged to address this demand for quality health care and identify care models that can consistently improve patient outcomes (Institute of Medicine [IOM], 2011). One promising model incorporates a new role, the clinical nurse leader (CNL). Policy, executive nurse, and education leaders worked together to develop the curriculum framework and end-of-program competencies for CNL education (Bartels, 2005; Harris et al., 2006), including clinical leadership, care environment management, and clinical outcomes management (American Association of Colleges of Nursing [AACN], 2007). End competencies were developed with an understanding of microsystem dynamics in mind, such as the need for clinical leadership, interdisciplinary collaboration, teamwork, and process improvement (Nelson et al., 2008). An

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implementation task force, funded in part by the Agency for Healthcare Quality and Research (AHRQ), was subsequently established in 2004 to oversee the evaluation of the first CNL education-to-practice partnerships (Stanley et al., 2007; Tornabeni & Miller, 2008).

The results of these pilot projects and from many other health systems that have subsequently implemented CNL practice are reported in the literature and describe CNL implementation and outcomes. There is growing body of evidence showing improved care environment and patient safety and quality outcomes after redesigning care delivery microsystems to integrate CNL practice. This includes 15 case reports describing the development and implementation of CNL practice in federal, community nonprofit, and for-profit settings with subsequent improvements in staff, physician, and patient satisfaction with care practices, interdisciplinary communication and collaboration, patient care processes, lengths of stay, and nursing-sensitive quality indicators such as falls and staff registered nurse (RN) certification rates (for an in depth examination of these reports, see Bender, 2014). The evidence also includes two correlation studies associating CNL practice with improved nurse satisfaction, turnover, and leadership practices (Guillory, 2012; Kohler, 2010) and two short interrupted time series studies quantifying a moderate-to-strong correlation between CNL implementation and improved care environment and quality outcomes (Bender, Connelly, Glaser, & Brown, 2012; Bender, Murphy, Thomas, Kaminski, & Smith, 2015).

Study Problem and Objective

However, variation in CNL implementation, practice, and outcomes has been found across reports, making it difficult to causally link CNL practice to the reported outcomes (Bender, 2014). This ambiguity reflects the overall absence in the literature of a well-defined CNL theoretical framework that describes the "what" and "how" of CNL practice and explains the connection between CNL practice and quality outcomes. Without a clear understanding of CNL practice, implementation will continue to vary across organizations with the consequence of varied and potentially unpromising outcomes. To address this important gap in knowledge, the purpose of this study was to develop a theoretical understanding of CNL practice that describes fundamental structures, practices, and expected outcomes.

Methods

Interpretive synthesis design was used to develop a theory of CNL practice, which involves reinterpretation and reanalysis of text-based forms of evidence (Pope, Mays, & Popay, 2007). The texts were identified via purposeful sampling of the literature using CINAHL, PsycINFO, Pubmed, and Dissertations & Theses, from 2000 to 2012, using the term *clinical nurse leader*. A grey search was performed in Google and identified the Virginia Henderson International Nursing Library, AHRQ Innovations Exchange, and AACN Web sites as additional sources of CNL texts. Texts were analyzed using Strauss and Corbin's grounded theory methods (Strauss & Corbin, 2007). This qualitative, comparative approach is well suited to reinterpretation and reanalysis of text-based forms of evidence (Pope et al., 2007). Data handling and analysis were conducted in Dedoose, a Web-based qualitative and mixed methods analytical application package (dedoose.com). Institutional review board approval was obtained to conduct the study.

Results

The sampling strategy, quality appraisal, and details of included report have been described elsewhere (Bender, 2015). Briefly, the search returned 473 unique documents, of which 295 were included in the synthesis (see Figure 1). The synthesis identified four fundamental domains of CNL practice: (a) preparing for CNL practice, (b) structuring the CNL workflow, (c) CNL practice activities, and (d) CNL outcomes (see Table 1 for details). The following sections describe these domains more extensively.

Preparing for CNL Practice

Systematic preparation for CNL implementation shows organizational commitment to CNL practice success and includes acknowledgment of care delivery deficits, system-wide leadership support, and an effective change management strategy. These components are described in more detail in the following sections.

Acknowledgement of Care Delivery Deficits. Knowledge of care delivery deficits and an understanding of how they affect care across the health care spectrum is the most important first step for successful CNL implementation. Organizations with successful CNL practice articulated a clear understanding of their care delivery deficits, which were described as the basis for their decision to redesign care delivery to include the CNL. As one executive leader described it, "The floors are so busy that it is sink or swim basically. Our ratios are good, but our patients are really sick. New staff get overwhelmed easily and feel very lost in the system" (Sherman, 2010). Another wrote: "Among the priorities identified was selecting and implementing a care model that acknowledges the changing climate within health care and addresses the future needs for care delivery in the hospitals" (Harris & Roussel, 2010).

In organizations where CNL practice was less successful, there was resistance to the idea that there were deficits in care delivery. A common belief in organizations that did not emphasize the gaps in care delivery was that problems could be solved by "more of the same," such as more staffing, but without changing the *ways* staff were caring for their patients: "there was skepticism… regarding how it would be helpful to have a nurse overseeing a group of patients. Why not decrease the number we have and give her some patients of her own" (Hartranft, Garcia, & Adams, 2007). Overall, organizations that fully acknowledged their care delivery