The Current Evidence Base for the Clinical Nurse Leader: A Narrative Review of the Literature

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The clinical nurse leader (CNL) is a relatively new nursing role, introduced in 2003 through the American Association of Colleges of Nursing (AACN). A narrative review of the extant CNL literature was conducted with the aim of comprehensively summarizing the broad and methodologically diverse CNL evidence base. The review included 25 implementation reports, 1 CNL job analysis, 7 qualitative and/or survey studies, and 3 quantitative studies. All CNL implementation reports and studies described improved care quality outcomes after introduction of the role into a care delivery microsystem. Despite preliminary evidence supporting the CNL as an innovative new nursing role capable of consistently improving care quality wherever it is implemented, CNLs are still struggling to define the role to themselves and to the health care spectrum at large. Although the AACN CNL White Paper provides a concise model for CNL educational curriculum and end competencies, there is a compelling need for further research to substantively delineate the CNL role in practice, define care delivery structures and processes that influence CNL integration, and develop indicators capable of capturing CNL-specific contributions to improved care quality. (Index words: Clinical nurse leader; CNL; Review) J Prof Nurs 30:110–123, 2014. © *2014 Elsevier Inc. All rights reserved.*

THE CLINICAL NURSE leader (CNL) is a relatively new nursing role, developed to enhance the efficiency with which care is delivered and to coordinate and laterally integrate care through collaboration at the microsystem with the entire health care team (American Association of Colleges of Nursing [AACN], 2007). Since its introduction in 2003, more than 200 reports have been published describing CNL theory, conceptual framework, education, and implementation. The role has been implemented in many health care organizations, with numerous reports of enhanced collaborative practice and improved patient outcomes. This article presents a comprehensive narrative review of reports describing CNL implementations and research on the role found in the literature to date, as well as suggestions for future study.

Methodology

A narrative approach was used to summarize the current evidence regarding the CNL. Narrative review is considered a valid strategy for organizing a comprehensive knowledge base that is broad and methodologically diverse (Collins & Fauser, 2005), such as the current CNL evidence base. A search of CINAHL, PsychINFO, Pubmed, and Dissertations & Theses was undertaken using the phrase *clinical nurse leader*, from January 1995 to November 2011, with a repeat search in June 2012 to capture any newly released publications. The grey literature was also searched, including Google, Google Scholar, AACN Web site, AHRQ Innovations Exchange Web site, and a review of all references listed in extracted publications. The search returned 204 unique records. All implementation and research reports on the CNL were included in the narrative review. No reports were excluded on the basis of poor methodology, in the

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interest of comprehensiveness. Explanatory, theoretical, or historical articles on the CNL; abstracts; journalism; brief editorials; and articles addressing the CNL tangentially were excluded from the review. The final sample included 25 implementation reports, 1 CNL job analysis, 7 qualitative or survey studies, and 3 quantitative studies (see Figure 1).

Results

CNL Pilot Implementations

After the initial CNL White Paper was published in 2003, The AACN established a CNL Implementation Task Force (ITF) in 2004, charged with developing the curriculum and end-of-program competencies for CNL education, as well as a standardized evaluation framework for CNL pilot implementations (Bartels & Bednash, 2005; Harris, Tornabeni, & Walters, 2006). Seventy-nine schools of nursing and 143 practice sites were involved in the first phase of the pilot CNL education and practice implementations (Tornabeni, 2006). The ITF developed numerous education/practice partnerships across the country to educate and train the first CNLs who pioneered the role in their respective practice settings. The results of many of these pilot implementations, as well as independent CNL intervention trials, have been described in the literature. These reports describe the work completed through partnership between academia and practice settings to operationalize the education and clinical training of the first CNLs, and describe how organizations operationalized the role within their practice settings (for details please, see Table 1). The articles report a host of quality improvements demonstrated after CNL integration into various care delivery systems. These include the following: increased nursing time spent with the patient; improved staff, physician, and patient satisfaction; efficiencies in patient care processes and lengths of stay; improved nursing quality indicators such as falls, discharge teaching, sitter hours, and hospital acquired pressure ulcers; increased staff registered nurse (RN) certification rates; improved home health referral rates; decreased staff turnover; improved patient outcomes targeting infection rates, ventilator-associated pneumonia, transfusion rates, and restorative dining; and improved interdisciplinary communication and collaboration (see Table 1).

CNL Job Analysis

The Commission on Nursing Certification (CNC) authorized a job analysis in 2011 to establish the link between CNL certification examination test scores and the competencies being tested (CNC, 2011). Job descriptions, journal articles, reference books, Web sites, and other relevant search materials were reviewed to create a draft list of essential CNL skills and activities. An expert panel then worked to clarify performance activities, knowledge skills, and abilities required of a competent certified CNL. The results formed the basis of a survey instrument sent (via e-mail) to 1,560 certified CNLs across the country to validate skills and activities. The adjusted response rate was 16.7%. The survey content was determined to be adequate: 98% respondents indicated that the survey either adequately or completely covered the important tasks performed by a competent CNL. Reliability was calculated as Cronbach's alpha .99 for importance ratings. Although all respondents were certified CNLs, only 26% were currently working in a formally titled CNL role. Other job titles included nurse educator (16%), staff RN (10%), and manager/director (13%). The rest were spread across a wide swath of job titles. Fifty-nine percent worked in the acute care setting, 14% worked in schools of nursing,

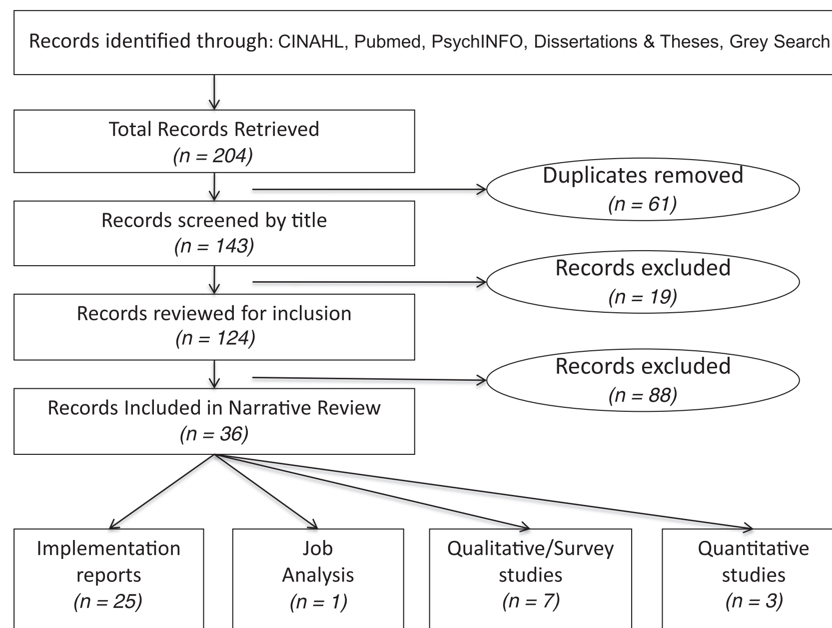

Figure 1. Literature search flow diagram.

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