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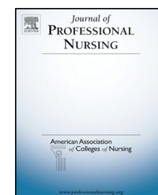

Roles enacted by Clinical Nurse Leaders across the healthcare spectrum: A systematic literature review☆

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ABSTRACT

The Clinical Nurse Leader (CNL) is a master's prepared nurse envisioned to provide clinical leadership at the microsystem level to ensure safe, high quality patient-centered care. The American Association of Colleges of Nurses defined ten 'fundamental aspects' of CNL practice, but as the certified CNL population grows, data suggest they are filling a variety of positions besides formally designated CNL roles. This article reports the results of a systematic review of CNL literature to better understand what roles and activities certified CNLs are enacting when not hired into formally designated CNL roles. Sixty-nine articles met inclusion criteria. Roles identified include: faculty, 62%; clinical management/executive, 12%; specialty clinician, 11%; and staff nurse, 9%. In these roles, certified CNLs are reviewing literature, conducting research, and/or writing commentaries on CNL education and practice and other health foci such as alarm fatigue, insulin practices, and physical exercise for cancer-related fatigue. Results indicate that despite a lack of formal tracking of certified CNLs over time, the available information identifies a variety of roles and job titles used by this group of professional nurses. The study findings add to the body of knowledge informing overall understanding of the CNL initiative.

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Introduction

The Clinical Nurse Leader (CNL) is the first new nursing role to be introduced in the U.S. in over thirty-five years (AACN, 2004; Gabuat, Hilton, Kinnard, & Sherman, 2008; Harris, Roussel, & Thomas, 2018; Jeffers & Astroth, 2013). The American Association of Colleges of Nursing (AACN) introduced the role in 2007, in its *White Paper On The Education And Role Of The Clinical Nurse Leader:*

> The CNL is a leader in the healthcare delivery system across all settings in which healthcare is delivered… The CNL functions within a microsystem and assumes accountability for healthcare outcomes for a specific group of clients within a unit or setting through the assimilation and application of research-based information to design, implement, and evaluate client plans of care. The CNL is trained to identify the clinical and cost outcomes that will improve safety, timeliness, effectiveness, efficiency, quality and patient-centeredness.
> [(AACN, 2007, pp. 6–7)]

Since the fall of 2007, the Commission on Nursing Certification (CNC) has offered a national CNL certification examination for qualified graduates of CNL education programs (AACN, 2015). The CNC received National Commission for Certifying Agencies accreditation for the CNL certification examination in 2014. The education and certification was developed with a specific formal CNL practice in mind, functioning at the microsystem level and focused on the 10 "fundamental aspects" of practice: (1) clinical leadership for patient-care practices and delivery; (2) participation in identification and collection of care outcomes; (3) accountability for evaluation and improvement of point-of-care outcomes; (4) risk anticipation and mitigation; (5) lateral integration of care; (6) evidence-based practice; (7) team leadership, management and collaboration; (8) information management; (9) resource stewardship; and (10) advocacy for patients, communities, and the health professional team (AACN, 2013).

Data suggest that many certified CNLs are not practicing in formally titled or designated CNL roles (Ailey, Lamb, Friese, & Christopher, 2015; Moore & Spence Cagle, 2012; Beauvais & Frost, 2014b, 2014a; Karas-Irwin & Hoffmann, 2014; O'Grady & VanGraafeiland, 2012). This fact leads to questions about what other roles and/or job titles certified CNLs are enacting, and how these roles are aligned with and/or advancing the overall CNL initiative. To answer these questions, we conducted a systematic review of the literature focused on the certified Clinical Nurse Leader (CNL) who is not hired into a formal CNL role.

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Methods

Literature search

A comprehensive and systematic review was conducted using the guidelines set forth in the Preferred Reporting Items for Systematic Reviews and Meta-Analyses (PRISMA) statement (Moher, Liberati, Tetzlaff, & Altman, 2009). The data sources included PubMed and the Cumulative Index to Nursing and Allied Health Literature (CINAHL). The key words included "Clinical Nurse Leader" and "CNL". The Boolean operator OR was used to maximize the penetration of terms searched (e.g., 'Clinical Nurse Leader OR CNL'; 'All fields'). We used the "Customize range" feature to set a time parameter of 2006 through 2016 because the CNL certification exam was first administered in 2006.

Inclusion criteria

Inclusion criteria contained the following: the reports were written in English, and articulated roles certified CNLs are enacting outside of formally designated CNL roles. In this study, the CNL role is defined as one who functions within a formally designated job title as a master's prepared nurse with specific education based on the AACN Clinical Nurse Leader Competencies and Curricular Expectations (2013) and CNL certification through the Commission on Nurse Certification (AACN). We defined roles outside of this formal designation as "not hired as" (NHA) CNL. The exclusion criteria applied to reports that did not contain any information about NHA CNL roles. The process of exclusion included the researchers reading the title, abstracts, author affiliations, the text itself and the acknowledgements. An audit trail of this process was documented and maintained in a comprehensive Excel workbook.

Quality appraisal

The focus of the review was to identify NHA CNL roles, not synthesize research reports to obtain effect sizes, so appraisal was not focused on the quality of any article's methodology. Quality control measures were instituted by reviewing the documents for duplicates of direct object identifiers and multiple publications with slightly different titles. Additional quality control measures were taken when one author (JCH) assigned NHA CNL role classification and a second author (MB) independently assigned such classifications and the two sets of classifications were subsequently compared and agreement found.

Data extraction

After we created our inclusion list, we extracted data on: publication year, first author, title, story-summary, theme, NHA CNL role description, role type, broad role type, duplicate author, roles NHAs were filling, NHA CNL Summary, and CNL competencies. The reason we chose the headings of the year of publication, first author and title was to efficiently identify each of the included reports in this study. The story summary and theme headings provided a brief description of the content of the article and the perspective of the article as it related to the CNL role. The role types were extracted because it allowed the researchers to identify and categorize among the many NHA roles reported in the studies. The rationale for extracting data on the NHA CNL role description, role filled, and summary was to clarify what NHAs were doing and to remain focused on our research question that asked what roles NHA CNLs are enacting. The duplicate author criteria informed us of how often NHAs are involved in writing varied types of articles as single authors or co-authors.

Data analysis

For all data extracted, we conducted descriptive statistics to determine frequencies and/or rates of data categories, for example NHA CNL activities counts and percent of total. To derive the categories of NHA CNL roles, we used qualitative content analysis to identify and label NHA roles. Content analysis is a means to categorize data through close reading of text (Elo & Kyngas, 2008). It is an appropriate method to use for inquiry into informational content of relevant texts, such as the information provided about NHA CNL roles in the literature (Forman & Damschroder, 2008). For this review, once an article's title, abstract, main content, author's information, or acknowledgement section indicated that a certified CNL was involved, the entire article was read and all places where a CNL was involved were highlighted. The article was subsequently reviewed again to delineate the specific role and/or title of the highlighted CNL involvement. When CNL involvement was found to be outside of a formally designated role, i.e. an NHA CNL, that article was retained for inclusion in the final set of articles, and data was extracted. Both investigators iteratively developed categories of NHA roles based on close reading of the texts and cross comparison of NHA roles across all texts.

Results

Article selection and characteristics of included articles

Fig. 1 demonstrates that our initial search resulted in 519 reports. The reviewers read all titles and abstracts and removed 100 duplicate reports. The researchers then reviewed the full text of the remaining 419 documents and found that 350 did not contain any information about the NHA CNL role. This selection process yielded a final number of 69 reports that were included in this systematic review. Table 1 details included report characteristics. The types of articles included reports/research on some aspect of CNL education or practice (46%), articles describing the potential of CNLs in practice (20%), and non-CNL research reports (25%). The majority (77%) of reports were published in 2011 or later.

"Not Hired As" (NHA) CNL role types

Table 1 details role types by article. The role types described in the included reports spanned across clinical and non-clinical roles. Importantly, each individual article many times described more than one NHA CNL role, so the frequencies add up to more than 69 (the number of included articles). The most frequently reported role, *faculty*, refers to CNLs who are formally working as professors, assistant professors, lecturers, program directors, and adjunct instructors. There were 59 (62%) NHA CNLs identified practicing in a faculty role. The second most frequently identified role was the *clinical management* role (12%), such as chief nursing officer, clinical executive director, and unit manager. Then came *specialty clinical* roles (11%) that included advanced practice nurses, clinical administrators, clinical educators, clinical coordinators, and informatics specialists. The traditional *staff nurse* role was the next most frequently reported role (9%), followed by a variety of other roles ($N = 5$, 5%). There were 13 NHA CNLs that were represented in more than one article. The majority described the same NHA role across articles, but 15% ($N = 2$) reported different roles across articles over time.

NHA CNL role activities

Table 1 details role activities by article. In reviewing the included articles, the researchers found that NHAs are involved with a host of activities. The most frequent activity was expert commentary (33%) on topics such as: potential for CNL practice in new settings or with unique patient populations; pain management outcomes for total

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