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NACNS Update on the Clinical Nurse Leader (CNL)
September 2005

In May of 2003, the American Association of Colleges of Nursing (AACN) released a Working Paper on the proposed new role of the Clinical Nurse Leader (CNL). At that time, the role was described at the baccalaureate level of nursing education. The document outlined a series of competencies that mirrored and overlapped the competencies articulated in the National Association of Clinical Nurse Specialists (NACNS) *Statement on Clinical Nurse Specialist Practice and Education* (1998; 2004). NACNS responded with a Position Paper on the CNL (March 2004) that clearly outlined our concerns with the overlap.

More than a year after our concerns were initially stated, the CNL demonstration project is well underway with an increasing number of education/service partnerships engaged in a pilot initiative. Of major concern is the fact that since the initial NACNS position paper of March 2004, the educational level of the CNL has been increased to a master's level preparation creating even further overlap with the competencies of the CNS. This new, in some cases, entry level nurse is proposed to target current and future leadership needs in all levels and types of health care settings, to implement outcomes-based practice and quality improvement strategies, and to create/manage microsystems of care (AACN, 2004).

NACNS recognizes that the AACN is proposing this role in response to the perceived quality gaps in the current health care system as articulated by the Institute of Medicine (2001). The chasm between current patient safety and quality patient care outcomes and the health care needed in the future is also of primary concern to our members. Our members, however, continue to have many questions related to the implementation and further development of the CNL and we offer the following observations as points of intelligent dissonance to frame the continued dialogue regarding the role and its evaluation.

1. **Challenge in evaluation of CNL outcomes given implementation diversity.** The role is already being implemented in various facilities, regardless of additional educational preparation of those who are being called CNLs by their institutions. As a result, the AACN Evaluation Task Force for the CNL has numerous challenges ahead given the diversity of CNL curricula, varying entry levels of CNL students, and reported implementation variance, including institutional reassignment of Clinical Nurse Specialists (CNSs) and Nurse Practitioners (NPs) to CNL positions. It is unclear how this pilot program will be able to clearly define outcomes than can be solely attributed to the implementation of the new role, particularly with institutional reassignments.

2. **Overlap between CNS and CNL competencies.** Although the AACN continues to state that there are significant differences between the CNL and CNS, there are few differences that are clearly articulated by those who are being educated as CNLs, those who say they are practicing as CNLs, or as described in recent documents created by AACN. Our continued analysis of documents includes recent publications by AACN, such as the *Example of a CNL Job Description for an Acute Care* setting (AACN, 2005) and *Working Statement Comparing Clinical Nurse Leader and Clinical Nurse Specialists Roles: Similarities, Differences and Complementaries* (Stanley, Spross, Hamric, Hall, Minarik, and Sparacino, 2004). We remain concerned about several areas in particular that are 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, 1998; 2004). We continue to seek clarification about how the CNL role and competencies will be differentiated from the CNS role. The American Nurses Association has raised some of these same issues in a list of *Questions/Concerns to be Addressed Regarding the Clinical Nurse Leader* (ANA, 2005).

3. **Scarce resources.** In a time of a major nursing shortage and limited fiscal and human resources, creating a new role that is duplicative of many current roles, such as CNSs, Case Managers, and Nurse Managers, is worrisome. Concerns continue to be voiced from practicing CNSs and CNS educators about the similarity in the described roles, the resulting role confusion, and issues regarding a clear use of educational and institutional resources for duplicative efforts at a time when resources are scarce. CNSs are recognized clinical leaders and experts at managing clinical outcomes (ANA, 2004). Hospitals are seeking CNSs to help with improving the work environment and nursing practice quality as a route to obtaining highly desired Magnet status. The nursing profession needs to promote cost containment, prevent unnecessary duplication of services and ensure that high quality services are provided to best serve the public need. Focusing on creating a new professional role that will supposedly "attract quality men and women into nursing" (AACN, 2003) rather than addressing work environment issues that contribute to why talented qualified applicants choose other careers warrants thoughtful consideration and discussion.

4. **Support for the baccalaureate degree as entry into professional practice**. NACNS, like many other national organizations, remains committed to advancing baccalaureate education as the entry into professional nursing practice (American Organization of Nurse Executives, 2005; National League for Nursing, 2005; Sigma Theta Tau, 2005). Nurse executives (Erickson & Dittomasi, 2005) have argued that the CNL will add further role confusion about nurses for the public. They articulately provide support for CNS practice by saying: “What is it about this role (CNL) that will catapult the nursing profession to a new level that could not occur by advancing the professional development of clinical nurses, reinstituting the CNS role throughout the United States, showcasing and adopting best practices in care delivery and role implementation, and most strategically, coming to consensus about entry into professional nursing practice at the baccalaureate level?” (p. 100).

Summary

We believe that the roles that can accomplish the bridging of the chasm already exist in the system. NACNS believes that it is imperative that the nursing profession provide support for CNS education and practice. CNSs have demonstrated the ability to close the quality chasm in the past when available in sufficient numbers. Further, in order to accurately assess the potential impact of this new CNL role it is imperative that nursing leaders, including CNSs in practice, CNS educators, and administrators who employ CNSs, **be vigilant to clearly distinguish between the two roles.** Any unique contributions of the CNL role to the nursing profession and to the safety of our patients must be demonstrated. AACN indicates that the CNL will be focused on microsystems such as groups of patients (AACN, 2005), they will work as “lateral integrators” (Tornabeni, 2005) and will not be in competition with CNSs in terms of practice scopes, or job opportunities. In a time of scarce nursing resources it is important that CNL curricula include content about all advanced practice nursing roles including CNSs so that future CNLs will understand the value and appropriate utilization and referrals for these resources.

In the event that the CNL pilot demonstrates through clear evidence that the CNL role improves patient care, the NACNS will welcome the additional support for its members. Until that time, we look forward to continuing the dialogue and clarifying the expectations from our members who remained concerned about the proposed CNL role.

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NACNS POSITION STATEMENT ON THE CLINICAL NURSE LEADER

March 14, 2004

Citing a need to focus education on preparation of nurses capable of addressing the health care dilemmas of the future, the American Association of Colleges of Nursing (AACN) proposes a new entry level master's prepared nurse. This new entry level nurse is proposed to target current and future leadership needs in all levels and types of health care settings and to implement outcomes-based practice, to improve quality, and to create/ manage systems of care. The new nurse role – labeled the Clinical Nurse Leader – is conceptualized based on 10 assumptions, 3 core competencies, 7 knowledge competencies and 3 role competencies. No data are offered to support this conceptualization.

The National Association of Clinical Nurse Specialists (NACNS) monitored the progress of this proposal since it came into the public domain May 2003. Recently AACN's Board of Directors approved master's preparation for the new nurse. The move to master's education heightened existing concerns by NACNS members and the clinical nurse specialist (CNS) community at large. In response, NACNS conducted a systematic analysis of the competencies of the new nurse. The analysis was based on a comparison of competencies described in the *Working Paper on the Role of the Clinical Nurse Leader* (AACN, 2003) with competencies described in NACNS's *Statement on Clinical Nurse Specialist Practice and Education* (NACNS, 2004). Rationale for this comparison is that the CNS is a recognized a clinical leader and expert at managing clinical outcomes (ANA, 2004). The knowledge and competencies described in the working paper were also compared with *The Essentials of Baccalaureate Education for Professional Nursing Practice* (AACN, 1998) because the proposed new role is an entry point into nursing practice.

The results of the comparison demonstrate that the proposed new nurse is an overlaying of the baccalaureate essentials on knowledge and competencies of the CNS. From this comparison, it is NACNS's opinion that **the proposed competencies of the new nurse duplicate the competencies of the CNS. Additionally, it is NACNS's position that a clinical leader with systems level responsibilities cannot be prepared at the baccalaureate level; to be a leader requires competencies in the direct patient care level at the baccalaureate level upon which the master's preparation builds to prepare a clinical leader.** CNS competencies build on baccalaureate competencies, therefore, the graduate degree awarded by programs preparing CNSs are focused entirely on advanced nursing practice. NACNS questions the ability of a master's program to include both the competencies needed for entry into practice and the competencies to practice in a leadership/advanced role as described in the working paper.

For AACN to propose this new nurse as either a replacement for or duplication of baccalaureate entry-level nurses who provide direct clinical care at a time of severe nurse shortage is a questionable use of scarce educational resources. The current number of CNSs is inadequate to provide the needed clinical leadership. **Continued efforts to implement this new nurse proposal will disenfranchise clinical nurse specialists**, a role that has been providing leadership to meet the needs of health care of the public for the past 50 years. This new nurse role should not progress to implementation. Rather than spending scarce financial and faculty resources on developing this new role when there is a national shortage of nurses, including CNSs, **the nursing profession would be better served to support baccalaureate nursing and CNS programs**. NACNS acknowledges that baccalaureate nurses are in need of clinical mentoring and practice support and believes that CNSs are prepared to provide that support. NACNS is eager to collaborate with baccalaureate programs/health care agencies to develop mechanisms to enhance the actualization of baccalaureate leadership competencies. In addition, NACNS is interested in discussing with AACN and other organizations opportunities for supporting and strengthening CNS programs.

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