



CNL Summit 2010

ABSTRACT PRESENTATIONS

January 22, 2010

CNL Summit

January 22, 2010

Town and Country Resort and Convention Center

Abstract Presentation Schedule

Friday, January 22, 2010

ROYAL PALMS 1

3:00 p.m.

The Clinical Nurse Leader Approaching Illness Prevention by Reaching into the Community

Nina Swan, MSN, RN, CNL

Maine Medical Center

Portland, ME

Email: swann@mmc.org

3:30 p.m.

CNL: Role in Acute Psychiatric Transformation to Recovery Focus

Pamela Bassett, MSN, BA, RN

Department of Veteran Affairs, VISN 23 CIH

Des Moines, IA

Email: Pamela.bassett@va.gov

4:00 p.m.

Incorporation of the Clinical Nurse Leader in Public Health Practice

Sallie Shipman, MSN, RN, CNL

Alabama Department of Public Health

Tuscaloosa, AL

Email: sallie.shipman@adph.state.al.edu

ROYAL PALMS 2

3:00 p.m.

The Role of the Clinical Nurse Leader in the Identification and Root Cause Analysis of Medication Errors: Multiple Methods, Similar Goals

Linda M. Tenofsky, PhD, ANP-BC; Sally Damata, RN, BS; Cindy Gardner, RN, BS-BC

Mary Hourihan, RN, BS, CGRN; Deb Toffee, RN, BS

Curry College, Division of Nursing

Milton, MA

Email: ltenofsk@curry.edu

3:30 p.m.

How Do My Genes Look? CNL Students Practice Patient-Centered Genetics Care

P. Bicknell, Ed. D. MSN, RN, ACNS-BC, CNL; C. Bradley, RN; A. Gresko, RN;

A. MacLennan, RN; M. Rafferty, RN; K. Welsh, RN

LaSalle University, School of Nursing and Health Sciences

Philadelphia, PA

Email: bicknell@lasalle.edu

4:00 p.m.

Initiation of Remote Telemetry Cardiac Monitoring on a Medical-Surgical Unit

Susan Ottenfeld, MSN, CNL

Jesse Brown VA Medical Center

Chicago, IL

Email: susan.ottenfeld@va.gov

ROYAL PALMS 3

3:00 p.m.

Making the Case for Evaluation of CNL Practice

Patricia Bicknell, Ed. D. MSN, RN, ACNS-BC, CNL

La Salle University, School of Nursing and Health Sciences

Philadelphia, PA

Email: bicknell@lasalle.edu

3:30 p.m.

Quantifiable Outcomes of the CNL

Barbara Bonnah, MSN, RN, CNL; Michelle Sheets, MSN, RN, CNL; Jennifer Kareivis, MSN, RN, CNL; Pamela Abraham, MSN, RN, CNL; Judd Strauss, MSN, RN, CNL; Marianne Sweeney, MSN, RN, CNL Student

Hunterdon Medical Center

Flemington, NJ

Email: bonnah.barbara@hunterdonhealthcare.org

4:00 p.m.

Microsystem Outcomes of a Dedicated Education Unit for CNLS

V. F. Engle, PhD, RN, FAAN; S. Webb, DNSc, RN; M. Gill, MSN, RN; L. McKeon, PhD, RN

University of Tennessee Health Science Center, College of Nursing

Memphis, TN

Email: vengle@uthsc.edu, vengle@utmem.edu

ROYAL PALMS 4

3:00 p.m.

Being There

Debbie Newman, MSN, RN, CNL

Central Texas Veterans Healthcare System

Temple, TX

Email: Debbie.Newman@va.gov

3:30 p.m.

Innovative Solutions to Assist Patients with Success Outside of the Hospital

Suzanne VanBoening, MS, RN, CNL

Mary Lanning Memorial Hospital

Hastings, NE

Email: svanboening@mlmh.org

4:00 p.m

No session scheduled

ROYAL PALMS 5

3:00 p.m.

Collaborating Wwith an External Partner to Launch an Online CNL MSN Program

Evelyn J. Norton. MS, RN, CNL, NEA-BC; Eshanthika Wijesinha, BA

Saint Xavier University and Deltak edu, Inc.

Chicago, IL

Email: norton@sxu.edu

3:30 p.m.

Top Ten Reasons to Take Your CNL Program Online

Ola Fox, DNS, GNP, BC, CNL

Spring Hill College

Mobile, AL

Email: ofox@shc.edu

4:00 p.m.

Incorporating the Microsystem Assessment into a Model C CNL Program

Angela Jukkala, PhD, RN; Sylvia Britt, DSN, RN; Margaret Armstrong, ME, RN, CNL student;

Rachel Duncan, BS, RN, CNL student; Velinda Block, MSN, RN

University of Alabama at Birmingham

Birmingham, AL

Email: jukkala@uab.edu

ROYAL PALMS 6

3:00 p.m.

Using a Team Approach and Innovative Methods to Develop a New CNL Program Wiwth Multiple Partners

Cynthia R. King, PhD, NP, MSN, RN, CNL, FAAN

Queens University at Charlotte

Charlotte, NC

Email: kingc@queens.edu

3:30 p.m.

Selected CNL Student Immersion Projects

Joan M. Pryor McCann, PhD, RN, CNS, CNL
Otterbein College
Westerville, OH
Email: JPryor-McCann@otterbein.edu

4:00 p.m.

CNLs Perceptions About the Role and Implications for Sustainability

Linda Weaver Moore, PhD, RN, CNS, CNL and Cathy Leahy, MSN, MEd, RN, CNL
Xavier University, School of Nursing
Cincinnati, OH
Email: moore@xavier.edu

PACIFIC SALON 4

3:00 p.m.

A Case Study/Discussion Methodology Orientation Program Successfully Launches New Nurses Into Professional Practice

Donna S. Covin, MSN, RN, CNL and Kathleen H. Seneca, MSN, RN, CNL
University Medical Center at Princeton
Princeton, NJ
Email: dcovin@princetonhcs.org

3:30 p.m.

Outcomes Focused Residency Experience: A Case Study

Cindy Costanzo PhD, RN, CNL
Creighton University
Omaha, NE
Email: cindycostanzo@creighton.edu

4:00 p.m.

Clinical Nurse Leader Traineeship Successes and Lessons Learned

Marjory D. Williams, PhD, RN; Karen Spada, MSN, MPH, MHA, FNP; Linda Wolf, RN, MSN, OCN, CMPE
Central Texas Veterans Health Care System
Temple, TX
Email: marjory.williams@va.gov

PACIFIC SALON 5

3:00 p.m.

The Clinical Nurse Leader as Preceptor: Academic-Clinical-Community Partnerships in Sustaining Quality Immersion Experiences

Henrietta Brown, DNP, RN; Pam Neely, MSN, RN, CNL; Jennifer White, MSN, RN, CNL;
Linda Roussel, DSN, RN, CNL; Catherine Dearman, Ph.D, RN
University of South Alabama College of Nursing
Mobile, AL
Email: hbrown@usouthal.edu

3:30 p.m.

Transformational Leadership at the Microsystem Level

David R. Hughes MSN, RN, CNL
Central Texas Veterans Health Care System
Temple, TX
Email: david.hughes1@va.gov

4:00 p.m.

Creating the CNL Preceptor Role

Mary Catherine Rawls, RN-BC, MS, ONC & Denise A. Foster, CNL, MS, RN
Dartmouth Hitchcock Medical Center
Lebanon, NH
Email: Mary.Catherine.Rawls@Hitchcock.org

PACIFIC SALON 6

3:00 p.m.

Interventions for the Prevention of Central Venous Catheter Infections in a Surgical Intensive Care Unit

Melinda Davis, RN, MSN, CCRN, CNL
Veterans Affairs Tennessee Valley Healthcare System
Nashville, TN
Email: Melinda.davis@va.gov

3:30 p.m.

A CNL Designed Tool to Help Reduce the Duration of Indwelling Urinary Catheterization

Denise A. Foster, CNL, MS, RN & Mary Catherine Rawls, RN-BC, MS, ONC
Dartmouth Hitchcock Medical Center
Lebanon, NH
Email: Denise.A.Foster@Hitchcock.org

4:00 p.m.

Positive Outcomes Since Implementing the CNL Role at Thornton IMU

Miriam Bender MSN, CNL; Leslie Bartlett BSN; Jody Polyniak BSN; Kathy Ryan BSN
University of California San Diego Medical Center
La Jolla, CA
Email: mbender@ucsd.edu

PACIFIC SALON 7

3:00 p.m.

Emotional Comfort: Patient Healing is Both Physical and Emotional

Judith Ann Tinelli, BSN, RN, ONC
University of Pittsburgh School of Nursing
Pittsburgh, PA
Email: jtinelli@comcast.net

3:30 p.m.

The CNL Role Impacting the Geriatric Evaluation and Management Clinic

Kim Hall, RN, MSN, CNL and Mary Mather, RN, MSN, CNL

South Texas Veterans Health Care System

San Antonio, TX

Email: Kim.Hall@med.va.gov

4:00 p.m.

Improving Patient Satisfaction Indicators: Pain

Margaret Hiler, MSN, RN, CNL

Maine Medical Center

Portland, ME

Email: hilerm@mmc.org

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Royal Palms 1

The Clinical Nurse Leader Approaching Illness Prevention by Reaching into the Community

Nina Swan, MSN, RN, CNL

Maine Medical Center

Portland, ME

Email: swann@mmc.org

Royal Palms 2

The Role of the Clinical Nurse Leader in the Identification and Root Cause Analysis of Medication Errors: Multiple Methods, Similar Goals

Linda M. Tenofsky, PhD, ANP-BC; Sally Damata, RN, BS; Cindy Gardner, RN, BS-BC

Mary Hourihan, RN, BS, CGRN; Deb Toffee, RN, BS

Curry College, Division of Nursing

Milton, MA

Email: ltenofsk@curry.edu

Royal Palms 3

Making the Case for Evaluation of CNL Practice

Patricia Bicknell, Ed. D. MSN, RN, ACNS-BC, CNL

La Salle University, School of Nursing and Health Sciences

Philadelphia, PA

Email: bicknell@lasalle.edu

Royal Palms 4

Being There

Debbie Newman, MSN, RN, CNL

Central Texas Veterans Healthcare System

Temple, TX

Email: Debbie.Newman@va.gov

Royal Palms 5

Collaborating Wwith an External Partner to Launch an Online CNL MSN Program

Evelyn J. Norton. MS, RN, CNL, NEA-BC; Eshanthika Wijesinha, BA

Saint Xavier University and Deltak edu, Inc.

Chicago, IL

Email: norton@sxu.edu

Royal Palms 6***Using a Team Approach and Innovative Methods to Develop a New CNL Program With Multiple Partners***

Cynthia R. King, PhD, NP, MSN, RN, CNL, FAAN
Queens University at Charlotte
Charlotte, NC
Email: kingc@queens.edu

Pacific Salon 4***A Case Study/Discussion Methodology Orientation Program Successfully Launches New Nurses Into Professional Practice***

Donna S. Covin, MSN, RN, CNL and Kathleen H. Seneca, MSN, RN, CNL
University Medical Center at Princeton
Princeton, NJ
Email: dcovin@princetonhcs.org

Pacific Salon 5***The Clinical Nurse Leader as Preceptor: Academic-Clinical-Community Partnerships in Sustaining Quality Immersion Experiences***

Henrietta Brown, DNP, RN; Pam Neely, MSN, RN, CNL; Jennifer White, MSN, RN, CNL;
Linda Roussel, DSN, RN, CNL; Catherine Dearman, Ph.D, RN
University of South Alabama College of Nursing
Mobile, AL
Email: hbrown@usouthal.edu

Pacific Salon 6***Interventions for the Prevention of Central Venous Catheter Infections in a Surgical Intensive Care Unit***

Melinda Davis, RN, MSN, CCRN, CNL
Veterans Affairs Tennessee Valley Healthcare System
Nashville, TN
Email: Melinda.davis@va.gov

Pacific Salon 7***Emotional Comfort: Patient Healing is Both Physical and Emotional***

Judith Ann Tinelli, BSN, RN, ONC
University of Pittsburgh School of Nursing
Pittsburgh, PA
Email: jtinelli@comcast.net

THE CLINICAL NURSE LEADER APPROACHING ILLNESS PREVENTION BY
REACHING INTO THE COMMUNITY

Nina Swan, MSN, RN, CNL
Maine Medical Center
Portland, Maine

Background: Due to today's current work force and 12 hours shifts for Registered Nurses, the Clinical Nurse Leader (CNL) role has become the continuity for the patient and family during the hospital stay. The "patient's story" that the CNL holds from the patient's admission to their discharge, not only makes the hospital stay easier, but helps to make the transition to home more safe. Expectations of the role are stated in the white paper from the American Association of Colleges of Nursing and it is clear, even in the early stages of the Clinical Nurse Leader (CNL) role, that it can be integrated into all healthcare settings and produce essential differences in clinical outcomes. In an era of healthcare reform, the CNL should clearly be reaching into the community for illness prevention.

Description of Methods: A natural progression of empowerment has taken place with CNL's initially pioneering the role within a 606 tertiary care and teaching institution, to reaching out into the community for illness prevention. Illness prevention occurs with CNL's completing follow-up phone calls to patients and family members post discharge and visiting physician's offices to assist staff in a thorough post discharge wound assessment. Visits and follow-up phone calls are made to skilled nursing and rehabilitation facilities to check on a patient's status and to assist staff in looking globally at the needs of the patient and family. CNL's have also developed and organized interdisciplinary health fairs and offered a Passion for Life program within an independent living community.

Outcomes: Examples of reduced recidivism, medication errors caught post discharge, and changes to patient care plans for best outcomes while in skilled nursing or rehabilitation facilities will be provided. Results of community health fairs and a Passion for Life program hosted by a CNL will show improvements in safety, mobility, socialization, and nutrition.

THE ROLE OF THE CLINICAL NURSE LEADER IN THE IDENTIFICATION AND ROOT
CAUSE ANALYSIS OF MEDICATION ERRORS:

MULTIPLE METHODS, SIMILAR GOALS

Linda M. Tenofsky, PhD, ANP-BC

Sally Damata, RN, BS

Cindy Gardner, RN, BS-BC

Mary Hourihan, RN, BS, CGRN

Deb Toffee, RN, BS

Curry College Division of Nursing, MSN (CNL) Program

Milton, Massachusetts 02090

Since the publication of the Institute of Medicine's *To Err is Human* (1999), it is estimated that there have been over one million medication related deaths in the United States. There has been substantial press devoted to high publicity errors (Dennis Quaid's twins receiving overdoses of heparin, Betsy Lehman's chemotherapy overdose). The Clinical Nurse Leader fills an important role in the identification and reduction of medication errors. "Most errors are caused by faulty systems, processes, and conditions that lead people to make mistakes or fail to prevent them" (IOM, 1999). The Agency for Healthcare Research and Quality recommends that a root cause analysis for an untoward medication event incorporate institutional, management, environmental, team, staff, task and patient factors. The Institute for Safe Medication Practices identified three things that must be determined in the care environment in the identification of a medication error; what happened, why it happened, and what can be done to reduce the likelihood of a recurrence.

To accomplish this goal, CNL students applied multiple models in performing root cause analyses of medication errors and near misses. Each student applied a different model to their own clinical practice microsystem. Case study exemplars with outcome analyses and risk reduction strategies will include the following:

AC/DC-CHEST PAINS, FRIES & STEAK. This root cause analysis was performed using Bill Wilson's (2007) tool. The letters represent the terms Activity, Culture, Direction and Competence, each having a subset of terms. Medication error: route of administration.

THE THREE BUCKET PREDICTION APPROACH predicts errors using a three bucket approach: self bucket, context bucket, task bucket. Medication error: sound-alike drugs. FISHBONE ANALYSIS is a cause and effect format that "enables a team to focus on the content of the problem, not on the history of the problem or the differing personal interests of team members" (Picard, 2002). Medication error: drug overdose.

TREE STRUCTURED HIERARCHY identifies actions and conditions that occurred so that the consequences can be understood. Medication error: pediatric vs. adult dosage.

MAKING THE CASE FOR EVALUATION OF CNL PRACTICE

Patricia Bicknell, Ed. D. MSN, RN, ACNS-BC, CNL
La Salle University School of Nursing and Health Sciences
Philadelphia, PA

Background: Outcomes from CNL practice are virtually unexplored. Early efforts have been aimed at identifying clinical outcomes linked to quality indicators and data measurement. CNL students have logged hundreds of hours of practice that can provide important information about the role of the CNL in the clinical microsystem and their impact on quality and safety. Six graduating CNL student portfolios were investigated using case study methodology to determine what information could be added to the evolving body of current CNL practice outcomes.

Purpose: The purpose of this study was to describe the experiences of students in the CNL role who have submitted professional portfolios for graduation after completion of three track courses in a Model A program.

Objectives: This qualitative study had three objectives:

1. Explore the CNL experience from reflections, stories and common activities related to structure, process and outcomes in clinical practice.
2. Identify potential role-model stories and clinical outcomes.
3. Seek validation of CNL student experiences with interviews composed of persons who are new to practice CNL graduates.

Methods: An exploratory case-study approach was used to better understand the experiences from a participant's perspective. The case study method is useful to explore an experience that requires an in-depth understanding of a complex process. Schon's Theory on Reflective Practice was used as a guiding model to understand development of praxis. Additionally, an examination of quality through a theory-centered approach of structure, process and outcomes was employed in an effort to appreciate the interrelatedness of variables in the health care system. Data were analyzed from five submitted portfolios with reflective records using a constant comparative approach and triangulated with interview data.

Results: Ongoing data analysis preliminarily revealed findings that point to opportunities for the greatest impact was when care was chronic, the health care system was complex and student CNLs were empowered through personal and professional development. Conflicts of interest, both socially and professionally, were found to exist. CNL students' ongoing reflections provided strength of agency to power through these barriers.

BEING THERE
Debbie Newman, MSN, RN, CNL
Central Texas Veterans Healthcare System
Temple, Texas

In 2007 the death rate in the United States was approximately 2 million. This number is expected to rise as the “baby boomers” age. The majority of people who die in the U.S. do so in an institutional setting, even though most people would prefer to die at home. Modern medicine has increased longevity and many Americans will live for years with a chronic debilitating disease. Americans often deny and fear death. They frequently associate death with suffering. Hospice care, which began in the 1960’s, is care provided to terminally ill patients with the aim of alleviating distress due to illness-related symptoms. Hospice care was traditionally home based, but many hospitals have incorporated hospice units into their institutions. I work as a Clinical Nurse Leader (CNL) on a hospice unit in the Central Texas Veterans Healthcare System (CTVHCS). This is also where I completed my clinical hours when I was a CNL student. As a student I suspected there was a need among hospice residents and their loved ones for information concerning changes that occur as someone nears death. To determine if the need actually existed I compiled a questionnaire for residents and their families. I opted to personally administer the questions, so I could get objective, as well as subjective feedback. The objective and subjective feedback were both beneficial. I asked if they had any questions concerning what might happen at the end of life. Almost all replied “no”, but as I spoke with them they would begin to ask questions, and often became tearful. As I spoke with more residents, I realized how much they needed someone to speak with them, answer their questions, and listen to them. As I have transitioned from student to CNL on the hospice unit I realize that one of the ways I am making a positive difference on the unit is just by “being there”. I routinely visit each resident and their loved ones every morning to see if their needs are being met. I have seen positive changes in the attitudes of family members who were at one time disgruntled. I have also seen residents become more social. It warms my heart to see one of our residents faces brighten when they see me enter their room. As a CNL there will be numerous opportunities for me to make positive changes on the hospice unit, none may be more important than just “being there”.

COLLABORATING WITH AN EXTERNAL PARTNER TO LAUNCH AN ONLINE
CLINICAL NURSE LEADER MSN PROGRAM

Evelyn J. Norton MS, RN, CNL, NEA-BC
Saint Xavier University
Chicago, IL 60655

Eshanthika Wijesinha BA
Deltak edu, Inc.
Burr Ridge, IL 60527

BACKGROUND INFORMATION:

Saint Xavier University (SXU) is an independent, Catholic, comprehensive University offering bachelor's and master's degrees to a diverse population of over 5,300 students. Saint Xavier is recognized as one of the top 40 comprehensive master's universities in the Midwest by *U.S. News & World Report's America's Best Colleges 2009*. Deltak edu is an online education service provider that for the past ten years has partnered with traditional, private institutions to deliver online degree programs. Deltak edu works with institutions to expand their on-ground degree programs to an online environment, providing expertise in the areas of program development, marketing, student recruitment, and student retention.

SXU's decision to partner with an online service provider was based on several factors. Declining graduate enrollment and tuition revenue combined with limited ability to physically expand the campus led the school to look into online programming. There was a mixed response by the faculty regarding online education, ranging from enthusiasm to skepticism. The limited capabilities of the existing IT infrastructure along with a lack of capital funds to upgrade and support an online system influenced the decision to pursue an outside partner.

METHODS, PROGRAMS & PRACTICES:

This presentation will address the strategic planning, operational needs, and relationship building that was necessary to launch this program. Internal and external threats to the success of the program will be explored. Initial concerns of faculty were addressed through several avenues including discussion at staff meetings, and a survey tool to measure readiness for online instruction. Initially, faculty who expressed interest in online education were recruited for training and to develop the courses for the online track. Support for faculty included course release time to develop the new course materials, and instructional design support and training provided by Deltak edu.

OUTCOME DATA:

Outcome data to be presented include the results of the Faculty Readiness for Online Instruction survey, enrollment and retention data, and course evaluations comparing on-campus to online programs. The program has just admitted its third cohort of online CNL students. Faculty interest has increased, and enrollment is steadily growing. Lessons learned will also be presented.

SUMMARY RECOMMENDATIONS AND IMPACT:

It is our belief that nurses can advance their education and learn the skills needed to make significant positive impacts on patient outcomes at the Microsystems level using a web based curriculum from an established nursing school with a reputation for quality nursing education. Deltak edu has allowed SXU to begin this strategic initiative for developing the nursing workforce needs of today. We are still in the beginning of this partnership, and have learned valuable lessons along the way. It is anticipated that our partnership will continue to grow and that online programming will expand.

**USING A TEAM APPROACH AND INNOVATIVE METHODS TO DEVELOP A NEW
CNL PROGRAM WITH MULTIPLE PARTNERS**

**Cynthia R. King, PhD, NP, MSN, RN, CNL, FAAN
Professor and Nurse Scientist
Presbyterian School of Nursing
Queens University at Charlotte
Charlotte, NC 28213**

Developing any new nursing program is daunting, especially when it involves the first new role, clinical nurse leader (CNL) for nursing in many decades. To date, there are limited nursing schools that offer a CNL program, yet, the role is clearly having an impact in key areas where healthcare reform is desperately required (e.g. quality and safety). As with any new nursing program there are many different models for planning, implementing and evaluating the program. With the current economic, political, and social climate and intense need for healthcare reform, Presbyterian School of Nursing (PSON) at Queens University at Charlotte, made a commitment to start the first full (and certificate) CNL program in the state of North Carolina.

The School of Nursing at Queens University is fortunate to have two major health systems in the large metropolitan area of Charlotte, NC and many smaller partners. This presentation/poster will describe: 1) the partnering model used to develop and implement the new CNL program, 2) the process by which a grant was obtained by one partner to assist students to attend the program, 3) the team process used to plan the core CNL classes and residency, as well as 4) other innovative strategies utilized by the team to develop the program, specific content for classes, practicum experiences, capstone project, and preceptors. Additionally, the author/presenter will share successes, lessons learned and specific tools that have been used during the initial planning and implementation of this new CNL program.

A CASE STUDY/DISCUSSION METHODOLOGY ORIENTATION PROGRAM
SUCCESSFULLY LAUNCHES NEW NURSES INTO PROFESSIONAL PRACTICE

Donna S. Covin, MSN, RN, CNL and Kathleen H. Seneca, MSN, RN, CNL
University Medical Center at Princeton
Princeton, New Jersey

Failure to launch a new nurse successfully from an orientation program negatively affects staff and patient satisfaction and adds financial burden to a healthcare organization. National turnover rates for new nurses range from 30-60%, costing organizations between \$62,100 and \$81,681 per new hire. Due to role transition, role stress, and role overload new nurses often leave organizations within two years of hire, or worse, leave the profession.

Utilization of a structured orientation program highlighting holistic nursing care, evidence based practice, and skill competency enhances the readiness of a new nurse to transition to professional practice. Participatory learning advances critical thinking and develops time management skills.

At the University Medical Center at Princeton (UMCP), a robust telemetry orientation program has been developed utilizing a case study/discussion methodology focusing on frequently encountered diagnosis-specific patient populations. For each diagnosis - specific learning module a set of targeted skills, competencies, and medication management are linked with related policies, procedures, and evidence based articles. To ensure consistent knowledge transfer, a primary preceptor is assigned to each newly hired nurse. To minimize role overload, patient assignments are correlated with weekly learning modules. Clinical Nurse Leaders, the unit Management Team, and the unit Nurse Educator, meet weekly with the preceptors and new nurses to monitor their progress and to provide timely feedback. A culture of evidence based practice is expected and supported, encouraging new nurses to increase their knowledge base and to continue professional learning. Mastery of nursing priorities for targeted patient populations during orientation ensures that the new nurse is prepared to function competently, confidently and independently upon completion of the program. Developing critical thinking skills during orientation hastens the shift from task driven care to holistic patient-centered care, thus enhancing nurse and patient satisfaction.

Utilizing a task driven orientation process, the previous cohort of new nurses required an extended orientation, needing a combined total of 26 additional orientation weeks, which cost the organization more than \$28,000. Their launching also required an adjusted patient assignment for the first few weeks of practice. This same cohort had a 43% turnover rate within 8 months of hire. With the new orientation process, the current cohort of new nurses has completed orientation as projected with successful launching into full patient assignments. Participation in the case study/discussion method orientation program has been enthusiastically embraced by both the preceptors and new nurses, with reciprocal learning occurring. Preceptors are now requesting to mentor the next new hire. The initial success of this program has prompted UMCP Nursing Administration to encourage the development of similar orientation programs on all other patient care units. ICU has adapted and utilized this orientation process this year. All currently employed nurses will complete the orientation reading assignments over the next year to ensure a consistent knowledge base for the care of their unit specific patient populations.

THE CLINICAL NURSE LEADER AS PRECEPTOR: ACADEMIC-
CLINICALCOMMUNITY PARTNERSHIPS IN SUSTAINING QUALITY IMMERSION
EXPERIENCES

Henrietta Brown, DNP, RN Pam Neely, MSN, RN, CNL Jennifer White, MSN, RN, CNL Linda Roussel, DSN, RN, CNL Catherine Dearman, PhD, RN University of South Alabama College of Nursing Mobile, Alabama

Academic, clinical and community partners have come together to provide quality clinical immersion experiences for CNL students. This presentation focuses on the work of an Advisory Council in preparing CNL students with CNL graduates as primary preceptors for clinical experiences. Guided by the CNL White Paper and the Kotter Change Model, partners work together to integrate course and clinical assignments that facilitate the development of CNL skills. A variety of factors will be presented including the CNL students' role in the precepting relationship such as the student as employee in the work/clinical setting and the student as new to the system. Recruitment and retention strategies will be described. Seasoned registered nurse students, as well as new graduates, and accelerated students perceptions and strategies for enhancing socialization of the role will be outlined. The CNL faculty role in the student-preceptor relationship will be addressed, particularly from the perspective of a new CNL in a preceptor role. The "grow our own" strategies will be identified as methods to sustain safe, quality experiences. The CNL preceptor's experience in being preceptor, their clinical nursing background and current role will be integrated into the presentation. With this as the backdrop, the culmination of how clinical experiences and assignments are weaved into the immersion experience makes the case for a project. Partners focus on quality, safety and nursing sensitive performance measures which serve as the centerpiece for the overall end of program competency evaluation of the CNL.

American Association of Colleges of Nursing. (2004). End of Program Competencies for the Clinical Nurse Leader. Accessed at <http://www.aacn.nche.edu/CNL/partnershipresources.htm>.

American Association of Colleges of Nursing. (2004). Working Paper on the Clinical Nurse Leader Role. Accessed at <http://www.aacn.nche.edu/Publications/docs/CNL604.DOC>

INTERVENTIONS FOR THE PREVENTION OF CENTRAL VENOUS CATHETER INFECTIONS IN A SURGICAL INTENSIVE CARE UNIT

Melinda Davis, RN, MSN, CCRN, CNL

Veterans Affairs Tennessee Valley Healthcare System
Nashville, Tennessee

Background Information: Approximately 48% of critically ill patients have Central Venous Catheters (CVCs) which put them at high risk for developing CVC infections. CVC infections lead to higher rates of mortality and morbidity, increased length of stay, and higher hospital costs. The attributable mortality for CVC infections is approximately 18%. In addition, nosocomial bloodstream infections prolong hospitalization by a mean of 7 days. Estimates of the cost of a single bloodstream infection are between \$3,700 and \$29,000. Prevention of CVC infection was identified as a process improvement goal in the Surgical Intensive Care Unit (SICU) at Tennessee Valley Healthcare System subsequent to an increase in CVC infections in the SICU from a total of 2 incidences in Calendar Year (CY) 2007 with a rate of 0.97 infections per 1000 device days, to 6 incidences in CY 2008 with a rate of 2.6.

Description of Methods: Beginning in February, 2009 several interventions have been implemented with measurable success, including formation of a unit-based Infection Reduction Team (IRT) and applications of evidence-based interventions. Current practice was evaluated and revised based on guidelines and evidenced-based interventions. The ICT made rounds each shift using a walking monitor sheet that the Clinical Nurse Leader developed to evaluate compliance with standards of practice and perform real-time teaching and coaching to staff nurses. The sheets were monitored over time for improvements in compliance. The walking monitor included practice standards such as CVC dressing change, and tubing changes. Additionally, the CNL developed a service-wide CVC Dressing Change Standard of Practice and Competency Validation tool in collaboration with infection control and the Intravenous (IV) Therapy Team. The CNL included CVC dressing change as a station at the bi-annual Nursing Skills Fair. After reviewing the literature and CDC Infection Control Guidelines, the CNL set up a trial of a central line dressing impregnated with chlorhexidine gluconate that had been shown in the literature to reduce the incidence of CVC infections.

Outcomes Data: The number of CVC infections and infection rates were measured and benchmarked using the National Nosocomial Infection Surveillance (NNIS) method. Total number of CLI cases per calendar year decreased from 6 CLIs in the Calendar Year 2008 with an infection rate of 2.6, to 1 CLI in 2009 so far with an infection rate of 0.45.

Summary Recommendations: The results support continuation of the aforementioned interventions that have been effective in reducing CVC infection cases, continuing to seek out and use evidence-based literature to guide nursing practice, and to continue to monitor patient outcomes to evaluate effectiveness.

Impact: Several practice changes have been adopted since implementation of the process improvement initiative with measurable success including (a) continuation of ICT “spot checks”; (b) continuation of instruction and competency validation for CVC dressing changes at the bi-annual Nurse Skills Fair; (c) adoption of the chlorhexidine gluconate-impregnated CVC dressing as the dressing of choice for central lines.

EMOTIONAL COMFORT: PATIENT HEALING IS BOTH PHYSICAL AND EMOTIONAL

Judith Ann Tinelli, BSN, RN, ONC
University of Pittsburgh School of Nursing
Pittsburgh, PA

The Code of Ethics for Nurses (2001) states that nurses “practice with compassion, respect, recognizing the inherent dignity, worth and uniqueness of every individual”. Nursing literature states that quality care refers to the development of nurse-patient relationships based on closeness, connecting and professional intimacy. In a high tech world with the nurse performing many tasks, the patient’s emotional needs and personal goals are rarely assessed and treated. In relationship based care the nurse optimizes the personal control of the patient and utilizes mutual goal setting. In effect, the nurse becomes the facilitator of the care of the patient, acknowledging their emotional comfort, instead of being the director of their care experience.

A pilot program for addressing patient’s emotional needs was developed to create dialogue and better personalize the patient’s care experience. The baseline data was evaluated through the Press Ganey scores. ‘Staff addressed emotional needs’ for the 3rd and 4th quarter of 2008 on an inpatient rehabilitation unit of a community hospital and were reported at 82.2 (national average 84). This score is only in the 34th percentile nationally. The pilot utilized an assessment tool that identified the patient’s emotional needs and goals. The philosophy of the ‘I am’ pilot was that emotional needs can be influenced by every encounter during a patient’s hospitalization. The pilot enrolled 53 of the 98 patients admitted between May and August 2009. The inter-professional healthcare team members were recruited and lead by the clinical nurse leader student. The effectiveness of the pilot was evaluated through the Press Ganey scores. The Press Ganey reported a 91.7 score for the first month of the ‘I am’ pilot program.

The evaluation of the pilot is ongoing with the hope that the ‘I am’ pilot will become the standard practice on the rehabilitation unit. This presentation will discuss the development and implementation of the micro-system project. Barriers and facilitators to the pilot implementation will be discussed. Qualitative data gathered from the inter-professional healthcare team members, as well as, quantitative data related to meeting the emotional needs of the patient will be shared.

There has been a transformational drive for nurses to address the emotional needs of their patients through relationship based care models. The ‘I am’ program restores the art of nursing by giving our patients emotional comfort and having the nurse ‘be the facilitator’ of the patient’s care experience. We can then heal our patients in mind, body and spirit.

3:30 p.m.

Royal Palms 1

CNL: Role in Acute Psychiatric Transformation to Recovery Focus

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Royal Palms 2

How Do My Genes Look? CNL Students Practice Patient-Centered Genetics Care

P. Bicknell, Ed. D. MSN, RN, ACNS-BC, CNL; C. Bradley, RN; A. Gresko, RN;

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Royal Palms 3

Quantifiable Outcomes of the CNL

Barbara Bonnah, MSN, RN, CNL; Michelle Sheets, MSN, RN, CNL; Jennifer Kareivis, MSN, RN, CNL; Pamela Abraham, MSN, RN, CNL; Judd Strauss, MSN, RN, CNL; Marianne Sweeney, MSN, RN, CNL Student

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Royal Palms 4

Innovative Solutions to Assist Patients with Success Outside of the Hospital

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Royal Palms 5

Top Ten Reasons to Take Your CNL Program Online

Ola Fox, DNS, GNP, BC, CNL

Spring Hill College

Mobile, AL

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Royal Palms 6

Selected CNL Student Immersion Projects

Joan M. Pryor McCann, PhD, RN, CNS, CNL

Otterbein College

Westerville, OH

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Pacific Salon 4***Outcomes Focused Residency Experience: A Case Study***

Cindy Costanzo PhD, RN, CNL

Creighton University

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Pacific Salon 5***Transformational Leadership at the Microsystem Level***

David R. Hughes MSN, RN, CNL

Central Texas Veterans Health Care System

Temple, TX

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Pacific Salon 6***A CNL Designed Tool to Help Reduce the Duration of Indwelling Urinary Catheterization***

Denise A. Foster, CNL, MS, RN & Mary Catherine Rawls, RN-BC, MS, ONC

Dartmouth Hitchcock Medical Center

Lebanon, NH

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Pacific Salon 7***The CNL Role Impacting the Geriatric Evaluation and Management Clinic***

Kim Hall, RN, MSN, CNL and Mary Mather, RN, MSN, CNL

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CNL: ROLE IN ACUTE PSYCHIATRY TRANSFORMATION TO RECOVERY FOCUS

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Department of Veteran Affairs, VISN 23 CIH
Des Moines, Iowa

VISN 23 CIH Acute Psychiatry Care Unit began the transformation from a medical maintenance model to the Recovery Model for Veteran's care. The CNL role has been instrumental in this transformational process. Currently this a case study, including observational and participative information. Further transformation is required prior to collecting data and reporting Veteran outcomes. This is a work in progress, and further work is required to develop a dissertation and report statistical outcomes.

The Acute Psychiatry Care Unit formed a committee to assist with the transformation that was comprised of an interdisciplinary team: CNL, nursing staff, social worker, psychology, recreation, chaplain services, peer support, management, suicide prevention, and the psychiatrist. The CNL is the facilitator of this committee with support from the Recovery Coordinator. This group began meeting in May 2009. Monthly meetings promote teamwork, and ensure a Recovery approach is used throughout program development. The committee has developed a unit specific mission and vision to help guide future decisions. Recovery focused groups have begun to be implemented on the unit. Interdisciplinary team (IDT) meetings are held daily that include planning and coordination of services with the Veteran. A Veteran Resource guide has been developed that is strength based and promotes the Recovery philosophy. A Strength, Needs, Abilities, Preferences work sheet is completed by each Veteran upon admission and used to guide the IDT process, and individual work towards recovery.

Psychology is currently developing a pre and post interview for Veterans to measure hope, and future outcomes. Currently fidelity is being researched to ensure the pre and post interview is accurate in obtaining the desired outcome measurement of hope. Veteran and staff satisfaction data will be used to determine outcomes, with a goal of increasing both scores.

The goal is to positively impact Veteran outcomes, promote hope, and coordinate continuing care. As the Acute Psychiatric population changes in demographics, change and transformation are required to meet current psychiatric needs. The Recovery Model has been chosen by VHA as the model of choice for care. The CNL role has been instrumental in the promotion of Recovery, and is an excellent fit for the Mental Health Service line. The CNL role is integral to increasing patient outcomes, and staff satisfaction. The role elements of the CNL are utilized proficiently and effectively in Acute Psychiatry, providing excellent opportunities for the CNL role to flourish.

HOW DO MY *GENES* LOOK? CNL STUDENTS PRACTICE PATIENT-CENTERED GENETICS CARE

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A. MacLennan, RN, M. Rafferty, RN, K. Welsh, RN
LaSalle University School of Nursing and Health Sciences
Philadelphia, PA

Background: Genetic competencies are required for all RNs in practice today. Increased patient quality and safety, as well as satisfaction, have been demonstrated with patient-centered care, care where the patient's needs and values are paramount in the planned health care interventions. CNLs are uniquely poised at the point of service, the clinical microsystem, as lateral integrators of care, to move forward a patient-centered genetic care agenda. There is a need to build curricular experiences that will assist CNL students to develop the skills to forward this agenda.

Purpose: The purpose of this presentation is to describe an interactive learning exercise designed to assist CNL students to develop knowledge, skills and attitudes directed toward effective genetic care that is patient-centered.

Methods: Using a case and commentary model, students take on individual roles of 1) patient 2) significant other 3) Clinical Nurse Leader 4) staff nurse 5) genetic counselor. Students develop each of their assigned roles through preparation that includes: literature review, evidence-based practice searches, listening to podcasts, interviews with genetic experts and conversations with patients and health profession colleagues. The exercise culminates in a CNL led Roundtable Discussion where a CNL student is responsible to facilitate a patient-centered genetic care conference. The student assigned to the patient role presents his "case" and genetic dilemmas that call for intervention from health care staff. This *patient* illustrates a genetic pedigree, shares results from a home genetic testing kit, identifies significant family history of risk and questions his genetically-linked medical diagnosis. The "commentary" is provided by the student assigned to the role of his significant other who contributes social and ethical concerns related to insurance, finances, work discrimination, and privacy issues. Other commentary is added by the student roles as staff RN and genetic counselor; each respond to the patient/family issues as the exercise moves along. These health professional roles require their own level of prior research and simulated patient interaction. The experience ends with a debriefing of lessons learned, planning for actual experiences in future practice and ways to improve care that is truly patient-centered.

Discussion and Conclusions: As a work in progress, this exercise involves extensive preparation to build knowledge of genetic concepts relative to patient concerns. It provides an active learning strategy for CNL students to practice essential communication skills, group facilitation, information gathering, delivery of genetic care practices, patient-centeredness and developing an aptitude for collaboration and patient advocacy. Verity is substantiated with use of a faculty designed study guide of pertinent questions for each role played in the exercise. In addition, students use a faculty prepared annotated bibliography with web links that direct students in each role to web-based tools and literature that are seminal and evidence-based.

Implications: Future lessons may be assigned to groups rather than individual students and video-taped to facilitate role play for larger numbers of students in class. Requiring interviews of genetic experts validates the level of knowledge needed and allows students to gain insight into an area of practice where little experience is available, yet future practice is certain.

Abstract

QUANTIFIABLE OUTCOMES OF THE CLINICAL NURSE LEADER

Barbara Bonnah, MSN, RN, CNL, Michelle Sheets, MSN, RN, CNL, Jennifer Kareivis, MSN, RN, CNL, Pamela Abraham, MSN, RN, CNL, Judd Strauss, MSN, RN, CNL and Marianne Sweeney, MSN, RN, CNL Student
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Background: Hunterdon Medical Center (HMC), a 176 bed non-profit community hospital, was one of few hospitals in the nation to pilot the Clinical Nurse Leader (CNL) program. The CNL role was created by the American Association of Colleges of Nursing (AACN) and adopted at HMC beginning in 2005. By September 2008, HMC had a total of five full-time certified CNLs, with three staffed on a 48 bed medical-specialty unit and two on a 29 bed step-down telemetry unit. A 34 bed surgical specialty unit was also staffed with a CNL student functioning as a CNL.

Objective: Our aim is to illustrate the correlation between implementation of the CNL role and improved patient outcomes.

Methods: Outcomes data preceding CNLs staffed to recommended patient ratios were compared to the year when the CNLs were adequately staffed full-time in their respective units.

Measurable indicators such as length of stay (LOS), patient satisfaction, fall rates, hospital-acquired pressure ulcers, hospital-acquired infection rates and Registered Nurse (RN) turnover rates for the three nursing units were examined. Some of the interventions instituted by the CNLs included daily patient rounds to address patient and family questions and concerns, education of staff regarding the use of the Braden Scale, pressure ulcer prevention interventions, proper peri-care of patients with catheters and the falls prevention protocol. CNLs also participated in weekly measurement of wounds and wound prevalence studies conducted quarterly on the nursing units. CNLs collaborated with staff nurses about the care of their patients and inquired about patients' skin care measures daily. Prevention of hospital-acquired illnesses through initiatives such as indwelling urinary catheter removal within three days or when no longer medically indicated and daily rounding on patients to ensure that catheter stabilizers are in use was instituted. Referrals to supportive services such as cardiopulmonary rehabilitation, physical therapy and palliative care were initiated by the CNLs. CNLs also participated in weekly length of stay meetings with members of the hospital administrative team and biweekly interdisciplinary rounds to discuss patients' discharge plan. Daily call backs were conducted on all patients discharged from the nursing units. Infection control data and other measurable nursing quality indicators were reviewed at monthly staff meetings and data were posted for staff to visualize.

Results/Conclusion: After the institution of the CNL role, the average LOS for the two nursing units fully staffed with CNLs decreased from 6.497 to 5.426 per 1000 patient days and overall patient satisfaction rose from 84.87% to 85.77%. Also the falls rate per 1000 patient days decreased from 2.585 to 2.116. The percent of patients with hospital-acquired pressure ulcers decreased from 4.28% to 1.18% with the presence of the CNLs and the average monthly hospital-acquired urinary tract infections decreased from 5.08 to 3.58 per 1000 patient day after the CNLs. The average *Clostridium difficile* rate decreased from 1.295 to 0.552 per 1000 patient days and RN turnover rate decreased from 1.997 to 1.408. Preliminary data will be posted for the surgical specialty unit staffed with CNL student. Since the institution of the CNL role at HMC, clinical outcomes have markedly improved and can be associated with interventions and projects they have initiated at the organization.

Innovative Solutions to Assist Patients with Success Outside of the Hospital
Suzanne VanBoening, MS, RN, CNL
Mary Lanning Memorial Hospital
Hastings, Nebraska

Purpose: Utilizing the Clinical Nurse Leader role to transition clients with a mental health diagnosis from a long-term state psychiatric facility to reside in a community based level of care appropriate for their level of functioning.

Target Population: Consumers in Nebraska with mental health issues that require nursing home or assisted living level of care that would otherwise reside in a state regional center.

Problem: The stigma of placement at a state hospital adds to the difficulty in finding a community based facility willing to accept these clients. These clients end up living at a state hospital even though their mental illness is stable and could be treated adequately in the community. In 2004 a decision was made to close two of the three state psychiatric hospitals in Nebraska. Both of these issues make it very difficult place clients into the one remaining facility. Clients currently wait 3-6 months for placement at the state hospital.

Proposal: In 2007 Mary Lanning, a private hospital with a psychiatric unit, identified an opportunity to help with this issue. A proposal was made for Mary Lanning to assist the state in placement of patients living in state facilities to appropriate facilities in the community. Mary Lanning staff would select each client and would take these clients one at a time into their facility. Mary Lanning's excellent reputation in the community would allow them to place these clients into an appropriate level of care. Mary Lanning would also provide follow-up care for these clients. The state government would pay Mary Lanning a fee for this service. This was the first time in the state of Nebraska that a contract of this nature that included both government and private organizations working together.

Intervention: Clients are assessed by Mary Lanning staff for eligibility into the program. Clients who are accepted receive psychiatric care and a management plan developed to meet the unique needs of each client. Clients inpatient length of stay varies from 3-11 weeks. The CNL initiates, coordinates, and accompanies the client on pre-placement visits. After 4-10 pre-placement visits the client is discharged to facility and the CNL continues to visit the client for 4-10 times. The role of the CNL is to trouble-shoot problems with staff, provide support to the client, and adjust the management plan as necessary. On-going consultation and training with the CNL is available.

Goal: Patients would be placed in a community based facility and not require rehospitalization during the first 30 days.

Results: Four clients have been part of this program. These clients had lived at the state hospital for 3-18 years. Three out of four clients have been placed successfully in the community and continue to live at their assisted living facilities. It costs between \$1,000-\$2,000 a month to stay at a mental health assisted living facility. Its costs between \$500-\$700 a day at an inpatient level of care.

Policy Implications: Contract was renewed for another year. Currently, we continue to be the only hospital that is working on taking patients out of the state hospital.

TOP TEN REASONS TO TAKE YOUR CLINICAL NURSE LEADER PROGRAM ONLINE
Ola Fox, DNS, GNP, BC, CNL
Spring Hill College
Mobile, AL

Early outcomes reported by first adopters of the CNL role raise awareness of the potential for improved quality and safety at the microsystems level when the nationally recognized role competencies and expectations of the CNL role are integrated into the care delivery model. Through formal, standardized education programs and national certification, the CNL represents a promising opportunity for nursing education and practice to partner to take a leadership role in implementing quality improvement and patient safety initiatives across all healthcare delivery settings. One way to remove barriers to education of CNLs is delivering CNL programs via the Internet. This presentation offers ten reasons for offering Internet based CNL programs.

SELECTED CNL STUDENT IMMERSION PROJECTS

Joan M. Pryor McCann, PhD, RN, CNS, CNL, Director of the CNL Program
Otterbein College
Westerville, Ohio

This is the second year for our post baccalaureate Master's level CNL Program. We graduated 3 MSN/CNLs in December 2008, and will be graduating 9 new MSN/CNLs in December 2009. These students have all completed their immersion experience in very diverse settings, some with our partner institutions and some in non-partner institutions. Several students chose to work in community settings, including a small town health department and a complex urban inter-medical center consortium. Others went to in-patient areas including acute care hospitals in small towns (with less than 300 beds) to large urban medical centers with 700 or more beds. In-patient microsystems included medical surgical units, maternity units and psychiatric placements. This diversity fueled interesting comparisons among the students when presenting and discussing their microsystem assessments and when deciding upon and discussing their clinical immersion projects. Projects included: piloting a 12 bed hospital unit in a small medical center which plans on implementing this hospital wide; piloting a change in care of newborns involving the use of a special isolette bed which led to the hospital purchasing those isolettes; piloting patient interdisciplinary rounding on a unit in a system that wants to institute the CNL role hospital wide; presenting various kinds of staff education programs on evidence-based practice and patient safety initiatives including SBAR communication; instituting an evidenced-based bipolar protocol for an inpatient psychiatric unit; setting up easy computer access to high quality patient education websites for a rural health department staff; piloting a medication quiet zone for RN's when are preparing medications; and piloting the role of a discharge nurse in a small rural institution. Besides completing the usual background research, methodological plan and getting appropriate committee write offs on the immersion project, project guidelines demanded much more. Students were also required to evaluate the impact of their projects on patient outcomes in the short and long term, to look at the financial implications of their projects, to develop a project in which they would "leave something behind" at the institution and to present their projects in a public forum. The first group of graduates decided to have an evening of presentations and invited staff from their immersion institution and the department of nursing faculty and students. This year's group decided on an evening poster presentation at which the entire Otterbein College community will be invited as well as their immersion institution personnel. The project guidelines have been gradually adapted to cover a diversity of settings and project focus. The formal papers that accompany the projects are bound and placed in the institution's library for use by other scholars interested in the area. Although it is difficult for faculty to direct this many individual student projects that must be completed within the same two quarters, we are confident that our CNL SNs are making an positive impact on the patient care outcomes in their immersion setting. This is one way we continue the journey of making the CNL role available to patients and indispensable to health care institutions in our area.

OUTCOMES FOCUSED RESIDENCY EXPERIENCE: A CASE STUDY

Cindy Costanzo PhD, RN, CNL

Creighton University

Omaha, Nebraska

Purpose: Describe an outcomes focused clinical nurse leader (CNL) residency experience using a case study approach. **Background Information:** The Clinical Nurse Leader program (model BSN to MS) was established at Creighton University, Omaha, Nebraska in 2006. The first student cohort was admitted in January 2007. The CNL program of study has 36 college credits with 510 clinical practicum hours and 300 intensive residency hours. **Description:** The CNL residency practicum experiences were from January 2009 to May 2009. The residency experiences were designed based on the CNL end program competencies. The process for the clinical experience involved: a meeting between micro system stakeholders and the CNL student; identification of key goals and outcomes specific to clinical, cost, satisfaction, and innovation; revision and validation of the outcomes with the stakeholders; and a midterm and final evaluation of the outcomes. **Summary:** The course objectives, description, and methodology are described and discussed. The student's progression through this experience is described with specific information related to the teaching methodology, student's key learning's, and the micro system's outcomes.

TRANSFORMATIONAL LEADERSHIP AT THE MICROSYSTEM LEVEL

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Central Texas Veterans Health Care System
Temple, Texas

Transformational Leadership principles are being embraced throughout society as a new wave of leaders assumes their place at the helm of industry and government. Nurses are spreading a culture of change and shaping the future of nursing in the twenty-first century by using clinical pathways to standardize evidence based practice across the care continuum. By shifting the dynamic of nursing management from traditional, transactional styles to transformational leadership, Nurse Leaders can realize untapped resources within their staffs. At the microsystem level, transformational leadership theory finds fertile ground for growth and expansion as nurses learn to "work smarter, not harder". The author chose transformational leadership as the conceptual basis for his CNL clinical immersion project and the beginning of his tenure as a new Clinical Nurse Leader on an acute medicine unit. Patient care quality and satisfaction measures on the unit are increasing as nursing staff are allowed to discover their empowerment and evidence based practice principles are introduced. This presentation describes the process of a paradigm shift in leadership style initiated by a new Clinical Nurse Leader and the effect it has had, and continues to have, on one acute care clinical microsystem.

A CNL DESIGNED TOOL TO HELP REDUCE THE DURATION OF INDWELLING URINARY CATHETERIZATION

**Denise A. Foster, CNL, MS, RN & Mary Catherine Rawls, RN-BC, MS, ONC
Dartmouth Hitchcock Medical Center
Lebanon New Hampshire**

Background/Objectives: The duration of catheterization (DOC) with an indwelling urinary catheter (IUC) is the major risk factor for the development of a catheter associated urinary tract infection. Several recent studies have shown that nurse-led initiatives were effective at reducing the DOC. After extensive investigation, observation and collaboration, a student CNL and her MSN preceptor implemented an intervention that helped nursing personnel keep track of how long an IUC had been in place and measured its impact on duration of catheterization.

Methods: A simple bright yellow sticker was designed that requested three pieces of information: did the patient have an IUC, the date the IUC was inserted, and the number of days the IUC had been in place. A statement to “Please consider if the IUC is still necessary” was written at the bottom of the sticker. The sticker was placed at the top of the Nursing Notes section of the daily nursing flow sheet. Nurses were expected to answer the questions on a daily basis about the presence of an IUC, the date of the IUC insertion, and the current number of DOC days. Baseline data about the DOC was collected from a 30-bed general surgery unit at an academic medical center for 3 weeks prior to the placement of the stickers on the daily flow sheet. Thirteen short training sessions for the nursing staff were held by the CNL after the baseline data had been collected to inform the nursing staff about the reason for the stickers and how to complete them. Using the same data collection method, data about the DOC was then collected for a three-week period following the implementation of the stickers.

Results: After the implementation of the stickers, the mean DOC for patients on the study unit was significantly decreased from 4.5 days to 2.8 days ($p = 0.01$). There was also a difference in the number of patients who were catheterized for only 1 day. In the pre-intervention group 10 of 66 (17%) patients were catheterized for 1 day only, while in the post-intervention group 35 of 83 (42%) were catheterized for 1 day only.

Conclusions: This project supports previous findings that nurse-led initiatives to reduce the duration of catheterization are effective and that a simple, easy-to-use intervention can result in a significant and immediate reduction in the duration of indwelling urinary catheters. The CNL role provided the critical link for translating and modifying nursing initiative, knowledge and process into a simple tool that significantly reduced the duration of catheterization.

THE CLINICAL NURSE LEADER ROLE IMPACTING THE GERIATRIC EVALUATION
AND MANAGEMENT CLINIC

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South Texas Veterans Health Care System
San Antonio, Texas

Purpose: Enhancing patient safety by decreasing care fragmentation.

Evidence: The elderly are at increased risk due to complex medical conditions, limited resources, polypharmacy and fragmentation of care. Tools such as the clinical microsystem assessment tool (MAT) identify fragmented care.

Background/Significance: National Patient Safety Goals include “improving medication safety”. CNLs identified that veterans did not understand medication instructions evidenced by numerous telephone calls with questions. The current process in the GEM clinic does not include an exit interview with patients prior to leaving the clinic.

Methods/Strategy: The GEM CNL utilized the MAT to identify systems practices that could contribute to error.

Practice Change: The CNL’s identified the need for an exit interview tool and a telephone log to monitor calls regarding the needs of the patient. The patient interview tool is completed at discharge to determine if veterans understood treatment recommendations, and medication use and side effects.

Evaluation/Results: Implementation of the exit interview tool resulted in an increase in medication adherence, veteran identification of medication side effects, and a decrease in telephone calls to the clinic with questions.

Recommendations: The CNL is a lateral integrator of care who is able to anticipate risk and coordinates care. The CNL is a change agent that can modify processes at the point of care by combining evidence based practices resulting in increased patient safety.

4 p.m.

Royal Palms 1

Incorporation of the Clinical Nurse Leader in Public Health Practice

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Royal Palms 2

Initiation of Remote Telemetry Cardiac Monitoring on a Medical-Surgical Unit

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Royal Palms 3

Microsystem Outcomes of a Dedicated Education Unit for CNLS

V. F. Engle, PhD, RN, FAAN; S. Webb, DNSc, RN; M. Gill, MSN, RN; L. McKeon, PhD, RN
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Memphis, TN
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Royal Palms 4

No session

Royal Palms 5

Incorporating the Microsystem Assessment into a Model C CNL Program

Angela Jukkala, PhD, RN; Sylvia Britt, DSN, RN; Margaret Armstrong, ME, RN, CNL student;
Rachel Duncan, BS, RN, CNL student; Velinda Block, MSN, RN
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Birmingham, AL
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Royal Palms 6

CNLs Perceptions About the Role and Implications for Sustainability

Linda Weaver Moore, PhD, RN, CNS, CNL and Cathy Leahy, MSN, MEd, RN, CNL
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Pacific Salon 4

Marjory D. Williams, PhD, RN; Karen Spada, MSN, MPH, MHA, FNP; Linda Wolf, RN, MSN,
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Pacific Salon 5

Creating the CNL Preceptor Role

Mary Catherine Rawls, RN-BC, MS, ONC & Denise A. Foster, CNL, MS, RN
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Pacific Salon 6

Positive Outcomes Since Implementing the CNL Role at Thornton IMU

Miriam Bender MSN, CNL; Leslie Bartlett BSN; Jody Polyniak BSN; Kathy Ryan BSN
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Pacific Salon 7

Improving Patient Satisfaction Indicators: Pain

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Background Information

A micro-system organizational assessment was conducted of the Alabama Department of Public Health's pandemic influenza planning efforts or more specifically the 72-Element Template for pandemic influenza (PI). The role of the Clinical Nurse Leader (CNL) was used to provide evaluation while promoting progress and improvement of planning efforts within the PI planning micro-system. AACN determined that the role would vary across the various levels of healthcare (AACN, 2007). However, application of the CNL role within public health has been limited. Gaps and recommendations for improvement of PI planning efforts were identified by the CNL in an organizational assessment which led to the development of a strategic plan. The strategic plan was the basis of the master's level CNL clinical immersion project. Discussions and planning for the final summation of this project through an article illustrating applications and fulfillment of the CNL Role Functions in the environment of public health are ongoing.

Outcome Data and Description of Methods

The strategic plan's goal was to provide a standardized mutually acceptable approach for the areas and the state regarding PI planning. This goal was accomplished through the CNL by improvement of the 72-Element Template that was used for county PI planning while progressing toward inclusion of all-hazards. Two main objectives were incorporated to complete the stated goal. The first objective was to improve communications, provide education, and elicit input for improvement and progress. Secondly, input from all eleven public health areas was needed to incorporate best-practices. These input derived ideas for improvement and documented lessons learned were shared with the entire PI planning team by the CNL.

A primary quantitative planning score was calculated by a Center for Emergency Preparedness (CEP) analyst. This score was compared to a score calculated after implementation of the strategic plan providing measurable data for evaluation of the improvements. The qualitative assessments conducted by the CNL revealed that significant changes to the 72-Element Template would need to be made for progression to continue. Also during this time, updated guidance from CDC was received combining general medical emergency preparedness planning with PI. This CDC recommendation combined planning efforts from a single focus on PI to an all-hazards/pandemic perspective. In light of these significant occurrences, upper management agreed to the rewriting of the 72-Element Template to include several important measures: all-hazards planning, best practices incorporation, explanations of requirements, and input from area core team staff. Improvement measures were a direct result from the data that was collected from the root cause analysis.

The process of compiling best practices from each area was continuous throughout this project. Each area has different strengths and weakness. Utilizing the CNL to facilitate the sharing of strengths from the areas will help to reach the overall goal of creating a standardized mutually acceptable approach for the state regarding PI planning while progressing toward all-hazards. Collaboration on all levels of planning is essential to ensure success for this and future projects. The process of emergency planning is never-ending and there is always room for improvement. The CNL can potentially serve as the outcomes measurement specialist and a leader in problem solving for public health emergency medical planning.

MICROSYSTEM OUTCOMES OF A DEDICATED EDUCATION UNIT FOR CNLS
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BACKGROUND: Nursing education has been challenged to partner with the health care delivery system to design and evaluate innovative models for clinical education and practice that generate cost-effective quality outcomes to address the needs of a rapidly growing diverse population. The University of Tennessee Health Science Center College of Nursing and Methodist University Hospital (MUH) have partnered for a new model of clinical education, the Dedicated Education Unit (DEU), in our 2-year accelerated Master's-entry CNL program. This study evaluates the impact of the DEU on DEU microsystem patient and staff nurse outcomes.

A DEU is a microsystem (patient unit) that is developed as an exemplar teaching-learning environment for CNL education through the collaborative efforts of staff nurses of the practice partner, nursing administrators of the academic and practice partners, and nursing faculty. The DEU provides students with a positive clinical learning environment that maximizes student learning outcomes, uses proven teaching-learning strategies, and capitalizes on the expertise of both clinicians and faculty. Our DEU is an exemplar 44-bed neuroscience, orthopedic and medical surgical unit at MUH. This DEU differs from prototype DEUs in that our hospital does not have magnet status, and that selected staff nurses with BSN and diploma education serve as Clinical Teachers (CT) under the direction of doctorally-prepared CON faculty.

College of Nursing faculty co-teach with DEU staff nurse CTs. In addition to their MUH Preceptor Training, CTs attend a 2-day Workshop on the CT role; the CNL role and competencies; adult learning; teaching-learning techniques; and student evaluation. The Workshop also includes theoretical and applied content on how to assist students achieve QSEN competencies for: a) patient-centered care, b) teamwork and collaboration, c) health informatics, d) evidence-based practice, e) quality, and f) safety. The CTs are taught to use PDAs to facilitate evidence-based practice. Nursing faculty are present with students on the DEUs, responsible for student evaluation, and are available to CTs for problem solving.

METHODS: This quasi-experimental design study evaluates baseline and quarterly follow-up data for 1-year on the DEU microsystem patient and staff nurse outcomes using existing records. Patient outcome data include: a) Balanced Score Card (hip, knee and stroke appropriate care scores; HAC never events; length of stay; medical response and code calls); and b) Shared File (patient fall rates; medication error rates). Staff nurse outcome data include: a) Service Excellence (patient loyalty; RN engagement, productivity, turnover, and vacancy rates); and b) Professional Development (education; skill mix; Studer Group Differentiating Staff score; governance activities). Patient and staff nurse outcome data will be analyzed using repeated measures ANOVA to identify if changes in DEU microsystem outcomes have occurred.

OUTCOMES: Data collection is currently in progress. Baseline, first quarter, and second quarter DEU microsystem patient and staff nurse outcome data will be analyzed and presented.

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INCORPORATING THE MICROSYSTEM ASSESSMENT INTO A MODEL C CNL PROGRAM

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Introduction: The Model C CNL curriculum offers students with a degree outside of nursing the opportunity to pursue licensure as a registered nurse and complete a CNL program of study in a 2-year time frame. The curriculum is divided into two distinct components: pre-licensure and CNL. At the end of the first phase, students are eligible for licensure as a RN. At the same time, they begin course work to prepare them for the multi-faceted role of the CNL. Theory and practicum course development was guided by the 9 roles required of the beginning clinical nurse leader: advocate, professional, team manager, information manager, systems analyst/risk manager, clinician, outcomes manager, educator and lifelong learner.

Faculty Vision: To prepare students to effectively impact both quality and safety at the unit level, the microsystem assessment process was incorporated into the CNL curriculum. Starting with the first CNL practicum (Fall), students would conduct steps 1 and 2 of the microsystem assessment, with Steps 3 and 4 occurring during the second CNL practicum course (Spring). During the clinical immersion experience (Summer) students complete step 5, conducting ongoing evaluation of the intervention and making necessary changes.

Student Reality: As students participating in a Model C CNL curriculum, our unique position as both novice nurses and graduate nursing students created two distinct subsets of challenges when conducting a microsystem assessment. While the uncertainty experienced during the transition from supervised clinical instruction to self-directed, independent graduate practicum is likely a challenge for all graduate nursing students, being a novice nurse in a clinical setting intensified this feeling. Second, limited understanding of health care organization operation, structure, and function on a day to day basis made it difficult to understand the relationships between health care professionals and microsystems within the macrosystem. As a direct result during the first weeks of the CNL practicum, we felt as if we were not equipped with the necessary skills to comprehend and implement a microsystem assessment even though we possessed the knowledge.

Opportunities to Celebrate: Once students developed a sense of ownership of the knowledge and skill required to conduct a microsystem assessment they identified very creative methods of conducting the assessment with the limited resources accessible as students.

Opportunities for Improvement: Curriculum changes to better prepare future students to conduct the assessment are needed. Changes will include presenting didactic content regarding microsystem assessment and professional communication prior to the first CNL clinical practicum.

CNLS' PERCEPTIONS ABOUT THE ROLE AND IMPLICATIONS FOR SUSTAINABILITY

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The purpose of this presentation is to present findings from an exploratory study that focused on understanding the experience of Clinical Nurse Leaders (CNLs) as they transitioned to practice. Due to the fact that the CNL is a newly developed role, no previous studies were uncovered that examined the perceptions of CNLs regarding the implementation of the role into the existing health care system. The findings from this study contribute to the knowledge base in nursing regarding this newly created role. After obtaining IRB approval, demographic and qualitative data were collected with a 24-item questionnaire. The questionnaire was developed by the researchers based upon review of the extant literature and expertise in the CNL role. CNLs were recruited from an email list generated by the 2009 AACN CNL Summit. Forty-nine CNLs who were currently practicing in the role or who had recently practiced in the role were invited to participate via email. Twenty-three individuals completed the questionnaire accessed through *Survey Monkey*, an online data collection system. One additional respondent, who was no longer practicing in the CNL role, completed only the initial questions as directed in the questionnaire. A thematic analysis was conducted on data retrieved from the qualitative, open-ended questions. Essential themes were determined. Findings presented will include CNL perceptions regarding: the introduction of the role; the most influential persons involved in the implementation of the role; challenges and barriers to the role; diversity in the execution of the role and key responsibilities; essentials and modifications needed to enhance role success; and key characteristics and positive aspects of the CNL role. Based upon study findings, the researchers will present implications for sustaining the CNL role in the current health care environment.

Clinical Nurse Leader Traineeship Successes and Lessons Learned

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The clinical agency based Clinical Nurse Leader (CNL) Traineeship described in this presentation was developed at the Central Texas Veterans Health Care System (CTVHCS) to support the national strategic initiative of implementing the CNL role across all patient care delivery environments in the VA. A business case analysis was submitted to health care system leadership to obtain support for the traineeship pilot proposal. Key elements of the proposal included projections of future returns on the investment, as well as strategies for addressing the challenges to clinical agencies in primarily rural settings of partnering with academic programs offering the CNL master's curriculum. Critical elements of the pilot included strategic partnering, thoughtful competitive selection of trainees, engagement of advanced practice nurses as preceptors, and a series of workshops for trainees, preceptors, nurse managers, and nursing administration. CTVHCS has recently celebrated the placement of five certified CNLs on medical telemetry, respiratory, oncology, acute surgical, and hospice units as a result of the traineeship. While the implications of such a traineeship for workforce development are obvious, the potential for organizational development was among the lessons learned from the initial pilot. This presentation includes recommendations for preparing complex health care organizations for implementation of the CNL role.

Creating the CNL Preceptor Role
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Background/Objectives: Precepting a student in a Clinical Nurse Leader (CNL) program was a new undertaking for our institution. Expectations, responsibilities and the uncertainty of successful outcomes were overriding factors in developing a program to meet the unique needs of the students while incorporating the preceptor role into the activities of the Clinical Nurse Specialist.

Methods: An approach designed to meet the specialized needs of the adult learner, often in a second career, was designed. An immersion into the role of the staff nurse with a focus on collaboration, critical thinking and advocacy skills utilizing Benner's novice to expert framework occurred in the first semester. In their capstone experience, students, now novice RNs, developed quality improvement projects benefitting the in-patient care unit while providing a conduit for their learning and growth. Using reflection, advocacy, flexibility and relationship-building from the first semester, a quality improvement project served as the vehicle for problem-solving, realistic understandings, expectations and experiences. Students explored the strategies and tactics of the CNL role in improving patient outcomes in a healthcare system.

Results: Hands-on experiences were gained and understandings of the functions of the CNL leadership role in an acute-care setting were acquired. The quality improvement project won an award, the CNL student was hired and the program became established in a Magnet accredited academic medical center.

Conclusions: Applying principles of precepting to a new situation can result in a satisfying and productive experience for all involved parties. Sharing these learnings could expedite

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Thornton IMU is a high acuity 26-bed unit in the UCSD Medical Center, with a complex patient population. Staff work 12-hour, 3-day weeks. Medical teams responsible for the patient's care turn over approximately every 2 weeks. This environment does not promote continuity of care or regular communication between members of the patient's care-giving team, which can easily effect the quality of care patients receive. The clinical nurse leader (CNL) role was implemented on TIMU in May 2009 to ensure high quality, patient centered care on TIMU through effective and pro-active communication at all levels regarding patient's care.

There are 2 CNLs on the unit (each caring for 13 pts) Mon-Fri 0700-1530. There are 3 CNLs total, one CNL rounding off the role 1 week/month to work as a staff RN and on CNL projects. The responsibilities of the CNL include daily pt rounding and daily multidisciplinary rounding with the MD team and/or any other disciplines involved with a patient's care. The CNLs help the staff RNs to update patient care plans, defining measurable outcomes including discharge criteria. The CNLs break the staff RNs daily for lunch. This gives the CNL another opportunity throughout the day for hands-on patient care and to assess any unmet needs. The CNLs have started projects after assessment of unit-based problems. Current projects include: RN education about specific patient population needs (such as info sheets and tailored standardized care plans); an IRB approved bedside report project which includes creating a video showing best practice and tracking its effectiveness at improving change-of-shift communication between RNs and the patient; defining and implementing a quality resource RN role to continue on with patient-centered care after the CNLs have gone for the day; a unit welcome brochure; creation of a patient communication board to easily relay information between patient, RN, MD and nursing assistants regarding patient needs; collaboration with unit CNE regarding staff competencies; and ongoing data collection and analysis regarding patient outcomes on the unit.

The CNL role has been in place for 5 months as of September 30, 2009. In that time, Press-Ganey nurse-sensitive scores have increased dramatically. For the category "Nurses kept you informed", scores have jumped 19%, from an average of 55% to 74%. In the categories "Skill of the nurse", "Nurses sensitivity to pain", and "Nursing attention to special needs", average scores have increased 18%. For the category "Overall nursing satisfaction", scores have increased 16%, from an average of 62% to 77%. The unit trend for falls is down, decreasing 17% since May, as tracked by eQVR reporting. Preliminary results from staff RN surveys show they feel they have more support caring for their patients since implementation of the CNL role (analysis to be completed by November). Other outcomes that will be tracked as data comes in are: Joint Commission compliance scores, skin issues and unit audit data. MD teams have expressed an interest in the role and many have stated informally that they feel the daily communication with nursing staff has become an important part of their rounds.

We are still fine-tuning the CNL role to make it as productive and effective as possible, using outcomes data as our guide, and with our ultimate goal being to ensure care is patient centered and quality driven.