CHAPTER 5
Preparing Preceptors for CNL Immersions

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LEARNING OBJECTIVES
1. Define preceptor and preceptee and identify core competencies of each.
2. Define clinical nurse leader (CNL) immersion in the clinical setting and the requisites for a successful immersion.
3. Define and discuss the significance of a dedicated learning environment for the CNL’s clinical experiences and life-long learning trajectory.
4. Identify steps in developing meaningful and sustainable clinical immersion projects.
5. Provide examples of clinical immersion projects and discuss the impact on the healthcare system.

KEY TERMS
Preceptor
Preceptee
Mentor
Apprentice
Dedicated learning environment
Clinical immersion
Sustainable value
Life-long learning
Professional development

Chapter Opener Image: The life of each of these plants has much in common with our own lives. Each started from a fertilized egg, grew into an adult by obtaining energy and nutrients, as well as defending itself from diseases and pests.

Image Credit: FPO
Preceptors, Preceptees, and Core Competencies of Each

The clinical immersion experience consists of two central participants: the preceptor and the preceptee. In this relationship, the key participants incorporate the interprofessional team as essential work in the CNLs’ overall experience. The preceptor must be knowledgeable of the Clinical Nurse Leader competencies in order to ensure that experiences are offered to meet each of them during the immersion experience. The preceptor will lead, direct, teach, align competencies with clinical experiences, and mentor the student throughout the immersion. The student and preceptee must enter the relationship with an openness and commitment to learn, observe, listen, engage, as the individual transforms into the CNL. The relationship between the two is crucial for a successful and meaningful clinical immersion experience. Once the commitment is made to precept a CNL student, it is important to meet prior to the clinical immersion experience and at regular intervals. An environment where both parties feel they can openly communicate, express ideas freely, ask questions, seek understanding, and plan objectives helps to ensure a positive experience. There are 3,557 certified CNLs, and the number continues to increase annually (AACN, 2015). It is optimal to have a preceptor who has been precepted as a student. This precepted experience gives the new preceptor insight into the student (and now preceptor) experience. In this relationship, the key participants incorporate the interprofessional team as essential work in the CNLs’ overall experience. It is optimal to have a preceptor who is a certified CNL; students should seek to find a preceptor who is certified. If there are no available preceptors at the clinical site, it may be important to consider a “team” of preceptors to best facilitate the immersion experience. In some cases, the nurse manager may be the lead, with other department contacts (education, infection

**CNL ROLES**

- Educator
- Member of a profession
- Life-long learner

**CNL PROFESSIONAL VALUES**

- Altruism
- Integrity
- Human dignity
- Advocacy

**CNL CORE COMPETENCIES**

- Communication
- Advocacy
- Critical thinking
- Outcomes management
- Advocacy
- Outcomes management
control, risk management, quality, and safety) to widen the students’ experiences. In small settings, for example, free-standing skilled nursing and rehabilitation facilities, home care agencies, and hospice programs, the director of clinical services may be the best “main” preceptor, with interdisciplinary team members augmenting the overall clinical immersion experience. If a certified CNL is not available to be hands on at the site, using them as a consultant (even if they are not physically present) is advisable. This could be done telephonically through virtual classroom arrangements. The message here is to consider the microsystem and stakeholders’ needs and to be creative about how best to establish a quality precepted experiences.

The Preceptor

The preceptor can be defined as the experienced CNL who provides individual attention to the novice student’s learning needs by providing feedback regarding performance, making decisions, setting priorities, management of time and giving insight into meaningful and appropriate clinical experiences. A preceptor is a teacher, coach, tutor, instructor, professor, and any of the countless terms that mean “to instruct.” For students aspiring to be CNLs, the preceptor serves as a role model for the profession. The newness of the role in healthcare and variations of the role in practice continues to create ambiguity surrounding the role. The preceptor serves as the example of the CNL in the healthcare environment. The preceptor functions as the ambassador of the healthcare profession to the preceptee and serves as the foundational cornerstone for the clinical immersion experience for the student.

The preceptor for the CNL student should be a CNL (AACN, 2007). The white paper on the Role of the Clinical Nurse Leader (AACN, 2007) states, “an extended clinical experience, prior to graduation, mentored by an experienced Clinical Nurse Leader, is critical to the effective implementation of the role.” The reality of finding an “experienced” CNL and pairing one with every student enrolled in a CNL program can be difficult. The ideal preceptor would be a certified CNL practicing in the CNL role; however, in today’s healthcare environment, it is not feasible. It is imperative that students are placed with certified CNLs as preceptors and together work to establish the role in their own work setting. Out of necessity, many schools of nursing have resorted to coupling CNL students with preceptors who serve in other roles, such as nurse managers, case managers, or educators. If the preceptor does not recognize the role of the CNL nor understands the extent and latitude of CNL practice, the student’s experience will not be optimal. With there not being another role existing in healthcare that focuses on practices and outcomes from a general view across the healthcare continuum, the CNL immersion experience must be consistent and aligned with the core competencies of the role.

Identifying qualified individuals to serve as mentors for CNL preceptees can be challenging for schools of nursing. One strategy used is to maintain certified CNLs precepting students in the CNL program is to create and maintain a database of existing CNLs, graduates of the CNL program, and contacts at organizations in the area who currently have established CNL roles. The core competencies of the a CNL preceptor include that of advocate, member of a profession, team manager, information manager, life-long learner, systems analyst/risk anticipator, clinician, outcomes manager, and educator—the roles and functions of the CNL. A competent preceptor also possesses the ability to value and recognize the significance of self-evaluation, has a willingness to serve as a role model, assists students in developing critical-thinking skills, adapts and accepts the different ways in which students learn and function, and...
provides positive reinforcement (Lichtman et al., 2003). Preceptors who are actively involved in interdisciplinary teams and practice are desirable if the preceptee is to understand, engage in, and maximize the full learning experience (AACN, 2007). Other competencies include the ability to give feedback, experience, availability of time, and a positive attitude (Huybrecht, Loecx, Quaevygaens, De Tobel, & Mistiaen, 2011). School of nursing must recognize and acknowledge the crucial role that dedicated preceptors play in ensuring the success of the CNL student and they must pursue individuals possessing such competencies and professional values as altruism, integrity, and respect and acknowledgement of human dignity. The initial meeting with the school faculty and the preceptor is important to ensure that the preceptor is an acceptable candidate to precept the student during the clinical immersion. This meeting is similar to an informal interview. Faculty must ensure there is understanding of the CNL role, a commitment to the student's success, and openness to share experiences throughout the final semesters. The support and backing that the preceptor offers to the preceptee, along with modeling successful interdisciplinary team relationships, is imperative for the student to reach his or her full potential and thrive (Goode, 2012).

The Preceptee

The CNL preceptee is a student but also should be recognized as a CNL emerging into clinical practice and understanding. The preceptee learns and develops under the direction and guidance of the preceptor, in much the same way an apprentice integrates knowledge learned from classroom instruction with on-the-job training. In the clinical immersion experience, the preceptee has the responsibility of assuming accountability for the learning process. Most schools of nursing, colleges, and universities have defined universal core competencies for students such as oral and written skills, information technology, and professional values. Core competencies that the CNL preceptee should possess, like that of the CNL preceptor, are serving as an advocate and a member of a profession, being dedicated to life-long learning, and showing commitment to professional development. Acquiring and cultivating these key proficiencies determines the level of success of the clinical immersion experience.

The preceptee should have a clear perception of their personality, including strengths, weaknesses, thoughts, beliefs, motivation, and emotions prior to entering into the immersion experience. Many times schools of nursing will assign self-awareness tests prior to the immersion, but if not completed as part of previous curriculum, it is important to perform a self-assessment prior to one's clinical immersion. The knowledge obtained by knowing oneself will assist the preceptee in interactions with members of other professions as the student works in collaboration with multiple disciplines to drive change.

There are additional behaviors the CNL preceptee can exhibit that will foster positive clinical immersion experiences, such as coming prepared for clinical days, dressing professionally, openly communicating with the preceptor, and maintaining interest and a positive attitude in all interactions. The preceptee should involve the preceptor in the didactic course of study and homework assignments so that he/she can follow along with the preceptee. He or she should actively engage in and participate in the microsystem structure by becoming a recognized team member. He or she must remember to exercise patience and recognize that the preceptor will have job responsibilities that must be juggled throughout the CNL immersion. The preceptee should communicate openly with the preceptor about what is working well and what areas may need further attention or tweaking. Positive immersion experiences with
meaningful care outcomes include establishing dedicated one-on-one time with the
preceptor to reflect on clinical experiences, review lessons learned, provide support
and guidance, and discuss alignment of the CNL competencies what has been en-
countered. This prioritizes the “student's time” and allows for ongoing communication
throughout the immersion experience.

The CNL Clinical Immersion and Requisites for a Successful Immersion

The culminating educational experience for the preceptee is the CNL clinical immi-
sion, which is a 300–400 hour concentrated practicum in which the preceptee enters
the healthcare environment and begins incorporating the knowledge and skill sets
gained throughout the educational process, including previous didactic and clinical
proficiencies. During this time, weekly opportunities to discuss experiences, ask
questions, and reflect on events with other CNL students, faculty, or mentors should
be made available (AACN, 2007). These can be in person or through virtual meetings.

Practice environments in which staff understand and have embraced the CNL role
should be given first priority for placement of CNL students embarking on the clinical
immersion experience. Requisites for ensuring successful immersions between schools
of nursing and healthcare settings include collaborative partnerships and agreements,
education about the role, thoughtful planning and pairing of preceptor and preceptee,
and support and backing of the CNL role by nurse administrators and nurse managers.
Senior leaders have the opportunity to strategically partner CNL students with strong
certified CNL preceptors to focus on key areas in need of improvement. With the
support, oversight, and commitment to the student, the immersion has the potential
to have an outcome that is meaningful to others in the organization, thus resulting
in potential replication and sustainability of the intervention once the clinical hours
are completed. If formalized more frequently, senior nurse leaders could optimize
the impact of the immersion experience for their own gain.

Successful immersion begins long before the CNL preceptee actually enters the
doors of the chosen healthcare environment. Academia should have already laid
the groundwork for enriching clinical immersions by educating, having dialogue,
interviewing, recruiting, and developing and nurturing relationships with potential
preceptors, especially to explain the history, framework, and competencies of the
CNL role. Non-CNL preceptors should not be chosen regularly but clearly be the
exception in rural areas where CNLs currently do not exist. In those circumstances,
closer monitoring of both the preceptor and preceptee is mandated. Candidates for
preceptor should be made aware of and understand the level of commitment and
guidance required before agreeing to serve in this role. Academia should assess and
thoughtfully consider if potential preceptors are a good fit for their institutional goals.
Once preceptors have accepted the responsibility and school of nursing faculty have
deemed these preceptors a good fit, careful pairing of student to preceptor should occur.
Successful partnerships usually have common threads, such as clearly defined
goals and purposes, awareness and understanding of each other’s roles and responsi-
bilities, and planned deliberate reviews of performance through ongoing observation,
communication, and evaluation (Hunter & Perkins, 2012). Considering personality
traits, strengths and weaknesses, and teaching and learning styles of both individuals
also contributes to effective relationships. If personality conflict exists, no matter how wonderful the individual preceptor or preceptee seems, extra challenges will resonate throughout the immersion. This will negatively impact the student’s experience.

Prior to the clinical immersion commencing and throughout the duration of the clinical immersion, regular and periodic meetings should be held between the schools of nursing, preceptors, and preceptees to ensure that a clear understanding of the CNL role is maintained and the core competencies are being achieved, and the student is progressing appropriately. When possible, on-site visits should occur, or if on-site visits are not practical for CNL programs that provide online distance learning, conference calls should be scheduled. This time should be used to evaluate progress toward and attainment of both long- and short-term goals, to discuss and remove barriers, to celebrate successes, and to chart direction. The projected course curriculum, in-class assignments, and clinical opportunities should also be reviewed.

Successful immersions require the assistance and backing of senior nursing leadership. In a qualitative study of CNLs, failure of nurse administrators to provide support to the role was identified as the chief barrier to achieving success. Moreover, nurse administrators who reinforce and uphold the role and objectives of the CNL increase the sustainability of the role (Weaver Moore & Leahy, 2012). Nurse managers also play a role in determining whether or not clinical immersion experiences are effective. Because the focus of the CNL is the microsystem, the unit manager of that microsystem must have a clear understanding of the CNL competency objectives and project goals. Unit managers who are confident and secure in their own role are much more apt to welcome and support improvement projects and embrace change processes than unit managers who are insecure or afraid of upsetting the status quo. Faculty should take time to also meet with microsystem leadership where the immersion is to occur to ensure there is understanding of the CNL role and apparent support from faculty throughout the student’s immersion. Meeting with the unit leadership prior to commitment to the microsystem would allow faculty to evaluate possible challenges and decrease negativity toward the student created by nursing leadership that might impede successful project plan implementation of the CNL. If warranted, the faculty should be prepared to intervene and facilitate.

Dedicated Learning Environment and Life-Long Learning Trajectory

Schools of nursing should partner with healthcare organizations committed to dedicated learning environments for the CNL’s clinical immersion. In a dedicated learning environment, educators and clinicians work together to create an atmosphere in which all members have a concentrated focus on teaching and learning (Fourie & McClelland, 2011). Key factors contributing to satisfying and successful student learning experiences include the quality of planning, welcome and orientation of the student to the unit, peer encouragement and teamwork, cooperation of the unit manager and charge nurses, and support of clinical and faculty preceptors (Fourie & McClelland, 2011).

When preceptees begin the clinical immersion journey, it is usually with fear and trepidation. How will I be received? Will the nurses on the unit welcome me? How can I earn the respect of staff and management? These questions are frequently asked.
by both novice and experienced CNL students. In learning environments where staff and management routinely work with CNL students, there exist clear and identifiable learning objectives, anticipated trajectories, formation, development and acquisition of CNL core competencies, and a concluding CNL project plan. Staff is acclimated to the role of the CNL student, and the student perceives that careful and thoughtful planning of this immersion was completed beforehand.

Time should be allocated early in the immersion experience for the CNL student to orient with charge nurses and staff nurses, unit secretaries, patient care associates, and the unit manager in order to learn each member’s role and how this role contributes to the overall function and purpose of the unit. Furthermore, time spent orienting with individual associates helps to create and establish relationships that enable the CNL student to work freely in the environment, become part of the “team,” and assume accountability and responsibility for unit performance, outcomes, and opportunities. This engagement and evolution of becoming a team member is beneficial to the student experience and critical for the overall success of the immersion experience, as well as the project plan implementation and sustainability.

Data about unit performance should be accessible and shared freely with the CNL student. This frequently is a challenge and delays the acquisition of relative information to perform a thorough microsystem assessment. Transparency is the hallmark of a high-reliability organization, and any attempt to cover up or hide weaknesses within the system can hinder effective and meaningful project plans. Unfortunately, health care is not a high-reliability industry like those in commercial aviation and nuclear power (Chassin & Loeb 2013). However, in our efforts to move to becoming a high-reliability organization transparency is a first step. There is a responsibility on the part of the student and faculty to ensure that any sensitive information that could in any way be disparaging to the institution remain confidential. Agreements between schools of nursing and healthcare organizations where CNL preceptees complete clinical immersions should be obtained prior to the clinical experience to ensure confidentiality. Organizations that are not willing to share necessary information and data prevent the CNL preceptee from achieving maximum results and create a culture of distrust and futility. Careful selection and partnering with institutions, providing ongoing education, and maintaining close relations promotes an environment of trust, clarity, and openness.

### Developing Meaningful and Sustainable Clinical Immersion Projects

The culminating assignment for the CNL student is the clinical immersion project. The clinical immersion project is the pinnacle of the preceptee's existence. Requiring the CNL student to complete a process or quality improvement project provides the student with a means to demonstrate all objectives, course work, competencies, and experiential learning acquired throughout the CNL program of study. Thus, the project is scheduled at the end of the learning experience, after the CNL has acquired the knowledge and developed the necessary skill set to execute such a challenge. Diligently checking off the CNL competencies day by day empowers the CNL student with the skill set and knowledge necessary for implementing a successful project. Conducting the microsystem assessment and performing a gap analysis homes in on gaps and
inconsistencies seen as opportunities within the microsystem that can be potential project plan ideas.

Common mistakes made among CNL students are attempting to identify a project plan too early in the clinical immersion experience or selecting a project that is so broad or far reaching that there is not sufficient time or resources to allow for adequate education, implementation, and measurement. There are ordered steps, which if applied correctly and adhered to, can ensure successful project plan implementation. Identifying and selecting the appropriate project plan, setting measurable and attainable goals, developing a realistic step-by-step timeline for implementation and evaluation, and summarizing events are key factors for accomplishing desired targets.

Identifying and Selecting a Project Plan
Identification and selection of an appropriate project plan is the most important decision in implementing a successful process or quality improvement change. It is also the most difficult step of the endeavor. Many times preceptors or unit leaders have projects for the student to take on prior to the student’s completion of the microsystem assessment. Many students also enter into the healthcare setting with their own ideas and agendas for what the project plan will be and how it will be implemented before they even become familiar with the culture or goals of the organization and microsystem. Both are missteps and usually result in failure.

Seven steps that safeguard effective project plan selection include (1) completing an overview of the organization, (2) recognizing the importance and value of the introductions and orientations to the facility, (3) listening, (4) conducting thorough literature researches, (5) seeking feedback, (6) determining buy-in, and (7) alignment with organizational priorities.

Step 1
Complete an overview of the designated healthcare organization prior to entering the clinical immersion setting. Formulate an impression by driving by the facility, talking to people, asking questions, and conducting online searches to determine the history, development and progress, and purpose of the institution. Go to the cafeteria, waiting room, or coffee shop and observe and listen. Learn the mission, vision, and values of the organization and discern if those values line up with your own. If not, know that going in and be prepared for situations that may prove challenging during the immersion experience. Commit the mission, vision, and values to memory or save them to a location where they can be reviewed throughout the year and assess periodically if the organization “walks the walk” of the vision. Conduct a self-evaluation and see how your time spent there will impact the organization and also how time spent at the organization will impact you. Students who complete some degree of background homework first usually are able to begin contemplating project plan ideas; they also experience a much less stressful transition into the clinical setting.

Step 2
Acknowledge the value and importance of introductions and orientation to the clinical immersion setting and microsystem. Introductions to personnel during the orientation period is the time when the CNL student learns the who, what, and where of
obtaining information and support, and serves as the formative time for establishing underpinnings necessary for building and developing interdepartmental relations. Spend time shadowing individuals of various roles in the microsystem to gain insight and mutual respect from team members. Sit at the unit secretary’s desk, talk, look, and listen. Spending time with and learning the roles of key personnel in other departments enables the CNL student to identify the “go-to” people and resources readily available. This will also show frontline staff that you respect their role on the team and value their opinion enough to get to know them. This will be beneficial as project plan ideas arise and project plan implementation evolves. Orientation with associates in the microsystem helps form alliances and bonds that will be instrumental as the time for project plan identification and implementation approach. Attending organizational, multidisciplinary, and interdisciplinary team meetings, as well as unit meetings within the microsystem, provides a plethora of information pertaining to goals and objectives for future reference for project ideas.

**Step 3**

The most important undertaking for developing meaningful and sustainable clinical immersion projects is to just simply listen. What is everyone talking about? What is the organization talking about? What are the leaders talking about? What are you hearing as you spend time with infection control, outcomes managers, nursing leadership, and quality? What are the associates talking about? Are there resounding themes and topics being heard over and over again? Are any of these themes being discussed locally? Nationally? Do these recurring themes apply to the microsystem where you are completing your clinical immersion? Do you personally have a passion for these themes? Listen until you can identify the aims of the organization, pinpoint objectives of the chief nurse officer and director of nursing, and ascertain the goals and aspirations of the unit manager, CNL, and associates of the microsystem. Then begin a list of possible project plan ideas and continually add to this list as the clinical immersion progresses. Ensure that someone is talking about something dealing with your project that matters. What you choose to pursue must matter to someone or it is not worth doing. Take in everything. Listen to everyone and above all, do not try to establish the project plan too early. Be patient. Allow the course work, guided curriculum, and clinical time to develop, and project plan ideas will emerge.

**Step 4**

Conduct literature reviews and research the recurring themes that have been identified. Determine if studies have already been done in this area and if there are any evidenced-based best practice standards for the project plan ideas. Review as much literature as necessary until the point of saturation occurs. Afterwards, conclude if the project plans offer sustainable value and can be successfully implemented within the microsystem. Consider the costs involved and determine if the project plan requires capital, manpower, supplies, or resources that simply may not be available. Ensure that the scope of the project is not so large that it cannot be implemented or evaluated within the time constraints of the immersion. Determine if the project plan creates or reduces work for associates. Ascertain if the manager, CNL, or associates have an interest in this idea or a burden for this process improvement. If the project produces positive results, who and how will it be sustained? Once the research has been
completed and thoughtful contemplation given to all contributing factors, eliminate those ideas that are not feasible, and hold onto those ideas that remain possibilities.

Step 5
Share the results of the microsystem assessment conducted and seek feedback. Discuss project plan ideas, how they were identified and arrived at, and the results of your literature review with your designated preceptor at the clinical facility. Identify the goals and expected outcomes of each project plan idea, as well as limitations, anticipated obstacles, potential barriers, and roadblocks collectively. Be flexible and open minded. Trust your preceptor and foster open communication so that both preceptor and preceptee can talk through whether or not the microsystem is ready for and open to this change process. Allow time for interactive discussion, questions, dialogue, and careful and deliberate consideration. Allow time after the initial conversation for both parties to mull over thoughts and views expressed, and make an appointment to revisit these project plan ideas at a later date. Time spent away from the discussions for processing thoughts and exploring new ideas produces fruitful and insightful results.

Step 6
Determine buy-in. The most excellent project plan ideas can crumble and deteriorate if buy-in isn’t obtained prior to implementation, and while it would be unrealistic to expect support and backing from the entire team within the microsystem, it is essential that buy-in exist among key stakeholders. The unit manager, preceptor, appointed and derived leaders within the unit, and the CNL student should all believe in the project plan selected and share in the development and implementation of the identified goals.

Step 7
Are the project plan goals aligned with the microsystem, organizational, and system level priorities? Alignment is everything to a meaningful project. If one chooses a project that is not meaningful to someone then in fact the entire immersion experience although completed will not have the optimum impact for the greater good of the microsystem and thus will not be sustained. It is imperative that the project plan align with the organizational goals and if possible show the financial savings to the institution. It is very difficult to reject or discount actions that will directly impact finance and improve desired aims.

Set Measurable and Attainable Goals
Setting measurable and attainable goals is essential for implementing a successful project or quality improvement change process. It is important to be realistic in what one can hope to accomplish or achieve in the time frame allotted. Change is slow, and sustained change requires a conscience effort of others to practice a rote task or behavior differently than might have been practiced the same way for years. Establishing a baseline time frame for education and implementation and a due date for measuring results allows the CNL preceptee to see the degree of improvement and success. Selection of the baseline data is critical and requires careful thought and realistic planning. For example, a project aim statement to reduce central line–associated
bloodstream infections (CLABSIs) by 50% over a 2-month period as compared with the previous year may not be practical if the microsystem only had 4 CLABSIs last year and 3 CLABSIs this year. With the baseline data selected in this example, you have already failed at your project goal. Furthermore, a 2-month period of measurement should not be compared to a year’s worth of data. Instead, when selecting a baseline, consider the amount of time you have for project implementation and measurement. If you are lucky enough to have an entire quarter of a year (3 months) for project implementation, then select a quarter of data from a previous time frame as the baseline. If you only have 1 month to implement a project and measure results, consider getting an average of the last 6 or 12 months and set a goal to reduce or improve performance by a certain percentage of that number.

Selection of attainable goals must also be considered. There is a tendency for CNL students to set their sights high and aspire to lofty goals that usually cannot be reached within the designated time allotted. Avoid the tendency to “conquer the world” and instead, set your sights on improving one small piece of it. Change is more easily accomplished when it is simple, entailing one or two steps that do not require additional work, or even better yet, reducing extraneous efforts or tasks. Do not belittle any project idea that creates additional time for a nurse, decreases steps in work flow, or helps to improve an overall goal, even if the project is but one small step in the change process.

Develop a Step-by-Step Time Line

Developing a realistic step-by-step time line is imperative. Be smart and think through everything going on in your life throughout the clinical immersion experience. Create a calendar and include every day of the week, including weekend days, that runs until the clinical immersion is complete. Plug in test dates and assignment due dates for classwork, any events required outside of clinical time, clinical days, and work days. Divide readings so that there is approximately the same amount of material to read on a daily basis. Then add important personal events such as birthdays or holidays, children’s events if you are a parent, and extracurricular activities you may participate in such as hobbies or church events, until a clear picture emerges delineating the expected time and obligations required to meet and fulfill deadlines. Remember to include some downtime and strive to maintain some type of balance between work, home, and school. You must take time to take care of you. Remind yourself that while free time will be minimal, it is only temporary.

Once the calendar is completed, plan an outline with an accompanying time frame for project plan goals. Ask your preceptor to help you with your planning. Often students create timelines for projects without considering other projects, mandatory education, or activities already planned by unit leadership for staff. Coordinating your project time line with the preceptor who is knowledgeable of the “other” priorities being pushed to the staff will aide you during implementation. Work backwards for project plan due dates. Determine the time frame you will want to collect and analyze all concluding data and plug this into your calendar. Then determine how long the project plan or process change needs to be in effect after education is provided and all concluding data and plug this into your calendar. Then determine how long the project plan due dates. Determine the time frame you will want to collect and analyze all concluding data and plug this into your calendar. Then determine how long the project plan or process change needs to be in effect after education is provided and mark that time. Consider the time required to educate your team about the project plan, and remember that some healthcare settings offer “7 on/7 off” shifts, which will require 2 weeks of education before implementation. Once all data is added to the master calendar, you will be able to identify a due date for project plan selection.
Implementation and evaluation of the project plan is usually the time when the hard work ceases and the oversight and reinforcement begins. Observing daily for compliance, reinforcing objectives and collecting and logging data as often as possible becomes the focus of the remaining clinical days. Meetings with the preceptor should occur regularly, and findings, deviations, barriers, and successes should be discussed. Do not be afraid to tweak the project plan along the way if unforeseen obstacles occur that hinder project goal attainment.

Summarize Findings and Results

Finally, summarize findings and results of the project plan. Go back to the baseline and demonstrate progress made toward goal attainment and trends noted; do not forget to include unforeseen barriers that presented roadblocks along the project’s course. Consider using graphs, pie charts, run charts, or line charts. Brief summaries with picture boards and educational material developed to promote project plan goals are interesting to the reviewers and should be included in the summary.

Examples of Clinical Immersion Projects and Impact on the Healthcare System

Exemplars of CNL clinical immersion projects can be located in various books and textbooks written for the CNL, poster presentations from previous CNL summits, CNLA regional conferences, CNLA chapter meetings, CNL conferences via the Web, and from the Clinical Nurse Leader Association (CNLA) website. Additionally, ongoing monthly continuing education units (CEUs) provided by the CNLA offer a variety of CNL topics, including projects CNLs or former CNL students have completed or are presently working on within their organization. The book Project Planning and Management: A Guide for CNLs, DNPs, and Nurse Executives (Harris, Roussel, Dearman & Thomas, 2015) is an excellent resource for guiding the CNL student through project plan selection and implementation. Networking with other CNL students and CNLs also can provide ideas for meaningful and sustainable clinical immersion projects. Several venues to network have been created through schools of nursing or CNLA chapter development. Some organizations that employ several CNLs have weekly or monthly meetings to discuss current projects. It is for students to ask about network opportunities within their clinical setting.

An example of a successful clinical immersion project conducted in one acute care hospital setting was to improve patient outcomes by reducing the number of catheter-associated urinary tract infections (CAUTIs) within a microsystem. According to the APIC Guide to the Elimination of Catheter-Associated Urinary Tract Infections (2008), a CAUTI event can cost $44,043 per hospital stay. CAUTIs can also create discomfort for the patient, and they are associated with increased length of stay, mortality, and morbidity (Centers for Disease Control and Prevention, 2012).

Because the CNL is responsible for a cohort of patients within a microsystem, drilling down on each CAUTI event to determine if the cause of the CAUTI was related to insertion, maintenance, or both was a meaningful way to improve patient outcomes and significantly impact the healthcare system by reducing hospital-acquired
infections and increasing reimbursement rates for high-achieving performance. Knowledge gained from drilling down to the root causes of how and why the infections occurred allowed the CNL preceptor and preceptee to identify and focus on areas for improvement. The first step to eliminate risk of acquiring a CAUTI is to eliminate the use of catheter line days. The CNL and preceptor decided to adopt and revise a checklist that was being used in the intensive care setting. This checklist would focus on key elements related to safety and quality care expected to be reviewed daily on every patient. One element addressed was presence of a urinary catheter. Nurses completed the checklist at the time of handoff from shift to shift. Then when rounding with the interdisciplinary team, the nurse would “run the list” or review the checklist. This brought the need for a urinary catheter in the discussion immediately. At first, staff complained that it was just one more thing to do, however, after a few weeks realized it took only 5 minutes of their time and provided a consistent picture of the patient during rounding with the physician daily. This checklist, revised by the CNL student, is still being used in this microsystem. The checklist indirectly positively impacted the communication surrounding central line catheters, as well, resulting in a significant decrease in central line days for the same microsystem. This team just recently celebrated 700 days CAUTI free.

Another example of a CNL project that directly impacted a healthcare system was to improve the patient experience related to pain management in a postsurgical acute care unit. The Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) Survey is a standardized tool used by hospitals to evaluate patients’ perception in regards to hospital care received; it is also used as a scorecard, rewarding hospitals with financial incentives for high ratings (HCAHPS, 2012). There are eight domains addressed in the HCAHPS survey; the category related to pain management was one of the lowest percentiles for this one microsystem. To improve the patients’ perception of how frequently his/her pain was managed during the hospitalization. Plans of action were developed, including having the nurse focus during hourly rounding on only “potty” and “pain,” communicating nonpharmacological measures to possibly alleviate pain without requiring medication, and using the primary white board to identify the patient’s acceptable pain score, last time medication was given, and when the patient can have the medication again based on the physician order. The innovative intervention created and used was a pain specific white board for patients who were requiring more than one medication to manage their postsurgical pain. This board provides a location to list every medication, when it was given, when it can be given again, if nonpharmacological interventions help alleviate pain, and if so what interventions work, as well as a location for the patient to request to awakened to assess pain needs throughout the night. Education was provided to all staff including the “why” in all messaging. Audits were completed by the student to ensure that after being educated the staff were using these boards and incorporating them into their daily workflow. Feedback from patients, families, and staff were also obtained during the intervention phase. The focus on pain management for the team, use of the pain boards, offering nonpharmacological interventions to reduce pain, and rounding to ensure compliance resulted in consistent improvement in the pain management HCAHPS domain. Variability in this domain has decreased and 4 months later scores remain greater than the 75th percentile. This microsystem has been recognized for their sustained improved scores by senior leadership.
Summary

- The preceptor and preceptee are the two key players in the CNL clinical immersion experience. Both have core competencies that facilitate the mutual success of each other.
- Clinical immersion sites that partner with academia and understand the role of the CNL foster an enriching learning environment and help pave the way for future CNL immersions.
- Dedicated learning environments where CNL preceptees are welcomed and routinely complete clinical rotations instill life-long learning trajectories and shape professional development. Meaningful and sustainable CNL immersion projects can be identified and implemented by following established guidelines.
- Identifying and selecting the appropriate project plan, setting measurable and attainable goals, developing a realistic step-by-step time line for implementation and evaluation, and summarizing events are key factors for achieving project plan success.
- Examples of former successful CNL projects can be located through CNL books, textbooks, websites, organizations, and networking. Hard work is rewarded with success.

Reflection Questions

1. How are core competencies of the CNL preceptor and the CNL preceptee alike? How are they different?
2. What requisites are important to you for achieving success in the clinical immersion experience?
3. What barriers could prevent you from achieving success in the clinical immersion experience?
4. Why is it important for a CNL or member of a profession to commit to life-long learning?
5. What do you feel constitutes meaningful and sustainable clinical immersion projects?

Learning Activities

1. Complete a self-evaluation to determine your preferred methods of communication and feedback and be prepared to discuss these methods with your preceptor. Ask your preceptor about his/her preferred method of communication and ascertain what type of feedback he/she needs to maintain open lines of communication and exchange of ideas. Work together to establish means and frequency of communication acceptable to both parties.
2. Identify your strengths and weaknesses in your roles as student, preceptee, nurse, and a member of a profession. In one column list strengths, and in the other column list weaknesses. Identify ahead of time strategies for handling weaknesses that are part of your individual makeup prior to the clinical immersion experience, acknowledging that these weakness will be magnified during peak times of stress, fatigue, and weariness.
3. Assess your ability to organize and prioritize events in your life. Pinpoint events and triggers that cause you to go astray and lose focus. Research ways to minimize these triggers. Think of events in your past that made you want to give up and quit, and analyze those events to identify the mitigating factors that caused these feelings and/or actions. Develop an action plan to recognize when these situations are threatening and how to prevent and halt their progression.

References


The Clinical Nurse Leader and Clinical Nurse Specialist: Partners in Quality Care

■ Donna M. Meador

Although the National League of Nursing (NLN) first advocated the clinical nurse specialist (CNS) in the 1940s, it took many years to advance the role. With the advent of the clinical nurse leader (CNL), many concerns have been raised among healthcare leaders regarding overlapping of duties between these two roles. In an effort to clarify the roles, the American Association of Colleges of Nursing (AACN) published the Working Statement Comparing the Clinical Nurse Leader and Clinical Nurse Specialist Roles: Similarities, Differences and Complementarities in 2004. One major difference between these specialties is that the CNL is educated as a generalist and the CNS as an expert (AACN, 2004). In addition, the CNS has the ability to practice as an Advanced Practice Nurse (APRN) (AACN, 2004). The CNL is not eligible to board as an APRN.

While the CNS and CNL roles are unique, in many cases their objectives are similar. Both coordinate care for patients, advocate for quality, and serve as a mentor to staff. They are partners in providing safe, high-quality care and can augment each other in this endeavor. For example, the CNL may identify a gap in a microsystem. He or she can then enlist the assistance of the CNS to translate evidence-based practices, formulate a plan, and advocate for change in a clinical specialty. The CNL and CNS would then work together to test the modifications and share the knowledge at the unit level. Another example includes the identification of a knowledge deficit among staff on a medical unit regarding new insulin preparations and dosages. The CNL consults with a CNS who specializes in diabetes management who provides an evidence-based in-service to staff.

On-going collaborative efforts by all team members will continuously foster quality and safe care for patients. The complimentary actions by CNLs and CNSs are no exception. Embracing the partnership and recognizing the contributions of the CNL and CNS results in positive outcomes in an era of constant change within healthcare systems.

Reference


EXEMPLAR

The CNL as a Mentor

■ Bridget Graham

In February 2011, our hospital opened a 32-bed acuity-adaptable senior adult unit (3 Lacks). Staff members who had a passion for working with senior adults were hired...
for the unit. The majority of staff that was hired was competent in medical–surgical nursing but did not have any intermediate experience. In fact, fewer than 12% of the staff members were intermediate competent. CNLs and the unit's clinical nurse specialist (CNS) teamed together to develop and execute registered nurse (RN) intermediate education in order to provide the professional development, education, and coaching required to ensure safe and excellent patient care.

Our first objective was to determine the minimum competencies for an RN to be considered intermediate trained. The criteria were as follows:

- RNs must understand, verbalize, and demonstrate the use, effects, and monitoring requirements for the vasoactive drips used on our unit.
- RNs will understand, verbalize, and demonstrate the use of hemodynamic monitoring.
- RNs will recognize the signs/symptoms of and care for patients with respiratory and cardiac failure.
- RNs will understand, verbalize, and demonstrate continuing assessment and reassessment of the intermediate patient.
- RNs will verbalize and demonstrate the knowledge and ability to access additional resources during their shift (e.g., rapid responder, e-library, unit literature, CNLs, and CNS).
- RNs will complete 3 Lack's specific intermediate competency checklist.

All nonintermediate RNs will have telemetry/EKG classes and 4 hours of didactic intermediate training.

A unit-specific intermediate competency tool was developed, which was to be completed by the end of training. This served as a record of completion. Charge nurses were the priority group to receive intermediate training. All RNs were paired with a CNL or the CNS for three 8-hour shifts. We worked one on one at the bedside to ensure education and monitor progress. The CNLs and the CNS worked the schedule of the nurse, whether it was days or nights. After 3 shifts, the RN and/or the CNL and CNS could determine the need for continued education. Training would continue if the RN required additional education. Intermediate education binders were also placed on the unit as a resource for staff.

When we began our training and mentoring, only 11.76% of our RN staff members were intermediate trained. Currently, 76% of our RN staff members are intermediate trained. The CNLs and the CNS continue to mentor staff. We have increased the level of trust between staff and the CNLs/CNS. RNs who have completed intermediate training verbalize that they feel empowered to teach new RNs on the unit intermediate skills.

By training our staff to care for the intermediate patient, we have prevented transfers to a higher level of care. Hand-offs to RNs on a higher level of care were decreased by 32%.

The financial impact of training the nurses was minimal. One-on-one training and mentoring with CNLs or the CNS came at no additional cost to the unit. We paired with staff on their already budgeted shifts and therefore incurred no cost.

The financial impact of training the nurses was minimal. One-on-one training and mentoring with CNLs or the CNS came at no additional cost to the unit. We paired with staff on their already budgeted shifts and therefore incurred no cost.

The CNLs on 3 Lacks played an instrumental role in the mentoring and training of intermediate RNs for the new unit. Through collaboration, education, evidence-based practice for seniors, and application of clinical skills, the CNLs impacted patient safety
on the unit and helped to ensure a higher standard for the level of care expected. Working closely with the RNs fostered the growth of knowledge and skills for the bedside nurse.

**EXEMPLAR**

**CNL Preceptor Role Satisfaction on a Dedicated Education Unit**

Sherry Webb and Tommie Norris

**Aim:** To describe CNL preceptor role satisfaction

The role of the preceptor is critical to the achievement of the end-of-program competencies for Model C master’s entry-level CNL students. Preceptor role satisfaction ensures preceptor continuity for students in adult health, pediatrics, acute care, leadership, target population diagnosis, and clinical leadership practicum courses.

Expert staff nurses on the dedicated education unit (DEU) were selected by the nurse manager, trained by the faculty at the university, and evaluated as DEU preceptors by students and faculty. Surveys of the DEU preceptors indicated overwhelming satisfaction with their role in working with CNL students, and preceptors expressed interest in serving in future courses. They believed that they provided realistic clinical opportunities, which helped students achieve their course outcomes, and they were proud of their students’ successes. The DEU preceptors valued the relationships that they formed with their students and faculty and believed that the DEU partnership bridged the gap between academia and practice. They reported that they learned about quality, safety, risk reduction, and evidence-based practice from the students, which made them interested in returning to college to advance their education. Faculty served as ambassadors of the college and provided letters of recommendation for the CNL program. In addition, the DEU preceptors became more interested in pursuing achievement in the hospital’s clinical ladder program for advancement. DEU preceptors received recognition from their colleagues, nursing leadership, hospital staff, patients, and families through verbal feedback, hospital newsletters, performance appraisals, and site visits by other organizations. Six clinical teachers received the preceptor of the year award presented during the College of Nursing Alumni Day awards celebration. DEU preceptor satisfaction is critical to the success of CNL student education.

**EXEMPLAR**

**Preceptors’ Use of Portfolios for Career Advancement**

Tommie Norris and Sherry Webb

**Aim:** To prepare preceptors on dedicated education units

Portfolios can be organized to showcase achievement of career advancement criteria. Preceptors working with CNL students assigned to dedicated education units (DEUs) were impressed by the portfolios prepared by their students. Faculty were interested in facilitating the development of the preceptors’ portfolios as one way to express...
gratitude to the preceptors for sharing their expertise and role modeling professional nursing. Faculty worked with preceptors to develop portfolios that would demonstrate achievement of specialized skills and career advancement criteria established by the employer. In an informal survey, DEU preceptors reported that their portfolios helped them to feel prepared for their annual evaluations, impressed their supervisors, and provided evidence of meeting advancement criteria. Preceptors also reported that portfolios proved to be a great vehicle for retaining records of continuing education needed for certification renewal. All portfolios developed by preceptors contained an updated resume. Faculty provided a template that enabled preceptors to “click and insert” demographic information, work experience, education, and honors/awards. The portfolios were individualized and contained various sections such as evidence of achieving certification including basic CPR, advanced cardiac life support, and/or pediatric advanced life support. Continuing education (CE) hours earned in pursuit of life-long learning or as a requirement for employment (such as fire safety or HIPAA) were included. Membership in professional organizations and leadership positions was incorporated. Nurses returning to college to advance their education included transcripts of completed coursework, and many included examples of assignments such as quality improvement projects. Development of educational tools and patient pamphlets were included as examples of innovative practice. Of course, an agency always strives for patient satisfaction, and preceptors were encouraged to include “thank you” letters/notes from patients and peers providing evidence of patient-centered care or teamwork.