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**I Have the CNL Power – Faculty Category**

I have had the privilege of being a nurse for many years (too many to admit to). I have practiced in a variety of positions, in three states and across the continuum of care. I enjoyed every step in the process but felt like I hit my stride when I became a clinical nurse leader (CNL) in 2008. I piloted the CNL role in three institutions before I moved to the academic arena. Now as the director of the MSN in Clinical Leadership at Rutgers School of Nursing in Newark New Jersey I enjoy mentoring/educating students through the process of moving from a staff nurse to a clinical leader.

This is no easy transition, and although some students complete it with alacrity, others eventually make it with stubborn reluctance. Learning to appreciate the full impact of all aspects of the patient which includes not only their medical state, but also their insurance status, healthcare literacy and living conditions. The move away from seeing the patient as a set of tasks to complete takes time and perseverance. I now see the student's achievements as a reflection of my own, similar to a parent watching their children spread their wings, and I vicariously live through their celebrations.

Please allow me to take a few minutes of your time to celebrate the meaningful impact that five of my recent graduates had as a result of their projects. A short sample of student impact at one month post implementation include:

1. Initiation of an electrolyte drink two hours prior to outpatient joint arthroplasty to reduce length of stay (LOS). Post implementation, there was a 6% reduction in unplanned overnight admissions and a reduction of one hour 20 minutes LOS for same day patients. With an estimated savings of $50,400.

2. Initiation of a post hospital discharge phone call for heart failure patients using a script for consistency of calls made by the discharge nurse, with a focus on ensuring compliance with medications, understanding of side effects of medications, follow up appointments and self-management strategies. Thirty-day readmission was reduced by 3.25% and seven day by 1.6%. Financial impact extrapolated to 12 months would result in a cost avoidance of $864,000.

3. A student noted that the length of stay for post stroke patients was significantly higher when an MRI was completed beyond the first 24 hours of admission (6.38 days vs 3.34 days). A protocol was initiated to increase the number of MRIs under 24 hours of admission. As a result, here was a 50% reduction in delayed MRI and a reduction in LOS to 5.3 (for MRI over 24 hours) and 2.03 (for MRI under 24 hours). Financially the implications noted a cost saving of over $1.9 million based on a 10-12k/night cost.

4. A systematic bedside report was initiated to standardize the shift change hand-off on a telemetry unit. The student noted a 51% reduction in Medical Emergency Team (MET) calls and Code Blues within the first two hours' post hand-off post implementation. The financial impact of MET and Code Blue costs are difficult to capture, however, at a minimum, the project saved $1,873.

5. A reduction in emergency room visits for discharged patients from the Neonatal Intensive Care Unit (NICU) was initiated through a structured post discharge phone call. As a result, there was a 27.5% reduction in emergency room visits with a cost savings of $37,200.