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

My healthcare facility does not formally recognize the role of a CNL. In fact, while most hospitals in Illinois and Indiana don't offer a CNL position to registered nurses who qualify, they prioritize those who hold the title because of the unique set of skills we can bring to the facility and patients we serve. This is especially true for me working in inpatient oncology at one of the largest healthcare systems in Northwest Indiana. Not only does a nursing job in oncology require compassion, precision, and excellent critical thinking skills, all qualities expected of any nurse, it also requires the ability to assess risk in patient groups, independently implement evidence-based interventions, and evaluate patient outcomes given those interventions. Without my training as a CNL, I would not feel nearly as confident in achieving these tasks each shift and contributing to the successful care of patients often going through some of the most challenging times of their lives.

During the first four months of the pandemic, various types of cancer screenings declined by 56% to 85%. While these numbers did rebound slightly in the following months for some screenings, it is still estimated that these delays could result in an additional 10,000 excess deaths, an increase of approximately 1% from what we expected with appropriate screening and treatment[1]. This means that patients are often coming in with advanced diagnoses, fewer treatment options, and poorer health statuses. On my unit in particular, this is what we're seeing. Patients and families are often seeking hospice and palliative care due to the delay in their diagnosis and the resulting advanced disease and poor or terminal prognosis. In some cases, patients were aware of their diagnosis, but were unable to seek treatment or procedures or were fearful of leaving their home and catching COVID in an immunocompromised state. While many of our oncologists are supportive of their choices to pursue end-of-life care, many are also quick to encourage treatment in an effort to regain as much stolen lifetime as possible. This leaves patients feeling vulnerable and confused about their options and uncertain of how they should proceed. A skilled, autonomous Clinical Nurse Leader, like myself, has been the perfect solution to this problem.

I recently cared for a patient newly diagnosed with acute myeloid leukemia. She completed chemotherapy and a clinical trial at a major university hospital and continued to see an oncologist at our facility for intermittent check-ups and more urgent matters. She came to the emergency department at my facility under the advice of her local oncologist for persistent fevers, expecting to be transferred back to the university hospital. After several days in the ICU, she was transferred to our floor in anticipation of discharge. She immediately expressed concern over the lack of communication she had received from the time she was admitted, the inability of her ICU nurses to convey her concerns to the rest of the team, and her persistent concern with trusting these providers to adequately treat her moving forward. How could she pursue further treatment if she couldn't even get her team of doctors to address that she felt a cold coming on?

I pulled a chair to the bedside and explained that while I might not solve every problem, I wanted to hear her concerns, address what I could, and refer where I couldn't. After a lengthy conversation, we established that her biggest qualm was that her care team was large in magnitude, but no one seemed to

be on the same page. She could tell her nurse one thing, but the doctor never got the message. Her infectious disease doctor would give her one piece of information while the internal medicine doctor told her the complete opposite. How could someone even consider life-altering treatment, like a stem cell transplant, when they couldn't even get the same information from all of their healthcare providers? The patient had very specific goals of care and was not amenable to any other treatment unless these were factored in. She was accepting of the fact that she would die someday, but she wanted to do it on her own terms, and she couldn't do that without some critical pieces of information about her diagnosis and treatment. I discussed with her the concept of palliative care to meet this incredibly valuable need and placed a referral. I expressed how critical it was for her to not only make sure her needs were met but that her questions were adequately answered. I empowered her to be bold and take charge of conversations with her healthcare team while also taking note of her most important concerns and presenting them to the oncologist myself. As a result, additional meetings were set with the patient and her partner to discuss actual patient outcomes, not just statistics, and a conversation was had between both of her oncologists highlighting her concerns and goals.

As the patient expressed physical concerns, such as physical discomfort, issues with sleep, and depression, we discussed what treatments she previously used, what was successful, and what was not. These were than brought to the healthcare team, discussed, and interventions executed. Meetings were set with members of the healthcare team to discuss the plan of care and everyone was brought to the same page with the patient's goals and the current and tentative treatment plan. Without the confidence and skills instilled in me via my CNL education, many of these things may not have been accomplished and the patient may have continued to face hardships in her care.

A nurse is a listener, a critical thinker, a teacher, and so much more. A CNL takes it one step further as a collaborator, decision-maker, and evaluator. Without those capabilities, I would not have been as large of a contributor to this particular patient's care, bringing the healthcare team together for her benefit and ensuring her goals were established and met. While I was not hired as a CNL, my skills as such are critical on my unit and the care of every patient I encounter.

[1]Kelkar, A.H., Zhao, J., Wang, S., & Cogle, C.R. (2022). Impact of the COVID-19 pandemic on colorectal and prostate cancer screening in a large U.S. health system. *Healthcare, 10*(264). https://doi.org/10.3390/healthcare10020264