

Knowledge and Influence of the Nurse Leader

A Survey of Participants from the 2006 Conference

The Institute for Nursing Healthcare Leadership



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Dear Colleagues-

June 12, 2007

While healthcare organizations have a myriad of leadership roles with various responsibilities and workloads, the Nurse Executive Leader (NEL) is faced with what is likely the most complex of these roles. There are approximately 5000 nurse executive leaders in acute care settings (Health Forum, 2006) in the United States, this population of 5000 serve as the gatekeepers for the advancement of the majority (3/5) of the 2.4 million nurses practicing in the U.S. (US Department of Labor - Bureau of Labor Statistics 2007), and it is very likely that the impact of nursing executive leaders is similar throughout the international community.

In our previous report, "Knowledge and Influence of the Nurse Leader" (Adams, Duffy & Clifford 2006), we asked the questions, "Having gotten to the table now what?" and "Do nurses have the knowledge and influence needed to make a difference?" These questions were based upon existing nurse executive research which has identified the conflict and ethical dilemmas of nurse executive leaders pursuing both organizational and professional leadership goals. After a year of reflection, discussion, literature review, and experiences within acute care executive teams both in the United States and abroad, we feel it is time to officially phase out nurses celebration of "getting to the table" and ask the question... *"What is the appropriate definition and measurement of nurse executive leader success?"*

Toward this end, nursing research has made significant advancements assisting the NEL in identifying, understanding and justifying what nurses need and how this melds with the organizational mission. However, this research is not yet universally translating to practice. Just over half (56%) of CEOs and less than a quarter (21%) of staff nurses rate their CNEs as strong performers (Advisory Board Company 2003). A unified and defined measure of nurse executive leader success is necessary to understand how NELs are valued and evaluated differently by the executive peers, staff nurses and academics. There is great opportunity and benefit to standardizing the role of the CNE in for profit, not for profit, government, academic medical centers and community hospitals alike. This standardization will allow for continued consistent evaluation at an individual, national or international level and likely lead to individual improvement in personal, patient and nursing environment expectations and outcomes.

AONE took the initial steps toward developing a measure of success for the nurse executive/ leader when it released its core competencies for nurse executives (American Organization of Nurse Executives 2005). These competencies are designed as an inclusive list of skills that are useful/ necessary for nursing leadership. However, we believe it is simply not enough to identify competencies, but to set expectations of the nurse executive role for all constituents. This survey serves as a starting point toward limiting role conflict, defining "role clarity" and measuring success for the nurse executive leader through understanding self perceived knowledge and influence.

We feel it is the responsibility of INHL, AONE, nursing administration researchers, along with nurse executives, past, current and future to set a measurable definition of success. As healthcare continues to evolve, so too will the role responsibilities of the Nurse Executive Leader. As a discipline and profession, nursing must continue to advocate for and measure the success, influence and impact of the NEL, because they (you) are leading us, at what pace and in what direction cannot be left to chance.

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We thank those that participated in this survey and all those that work for the continued improvement of nursing leadership. We appreciate the wealth of knowledge nurse leaders' exhibit and look forward to being a part of the continued development of nurses as effective leaders in the ever changing and complex healthcare system. Should you be interested in discussions surrounding the development of a defined measure of success for the Nurse Executive Leader, please contact us at jeff.adams@bogartgroup.com.

This document reports the results of the INHL Executive Nurse Leadership Survey distributed at the Institute for Nursing Healthcare Leadership Conference in June 2006. The report was prepared by; Jeffrey M. Adams, PhD(c), RN, Jeanette Ives Erickson, MSN, RN, Mary E. Duffy, PhD, RN, FAAN, Dorothy A. Jones, EdD, RNC, ANP, FAAN, Alicemary Aspell Adams, MBA, BSN, RN, President, The Bogart Group, Inc. and Joyce C. Clifford, PhD, RN, FAAN.

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The study sought to answer the following research questions (RQ):

- RQ1:** *How do nurse leaders perceive their knowledge about specific management and leadership topics in comparison to non-nurse healthcare executives within their primary employment organization?*
- RQ2:** *How do nurse leaders perceive their influence about specific management and leadership topics in comparison to non-nurse healthcare executives within their primary employment organization?*
- RQ3:** *How do nurse leaders perceive their knowledge about specific management and leadership topics in comparison to fellow nurse leaders within their primary employment organization?*
- RQ4:** *How do nurse leaders perceive their influence about specific management and leadership topics in comparison to fellow nurse leaders within their primary employment organization?*
- RQ5:** *Do the total knowledge scores of Vice Presidents/ CNOs differ from the total knowledge scores of Directors and Managers in comparison to non-nurse healthcare executives?*
- RQ6:** *Do the total knowledge scores of Vice Presidents/ CNOs differ from the total knowledge scores of Directors and Managers in comparison to fellow nurse leaders?*
- RQ7:** *Do the total influence scores of Vice Presidents/ CNOs differ from the total influence scores of Directors and Managers in comparison to non-nurse healthcare executives?*
- RQ8:** *Do the total influence scores of Vice Presidents/ CNOs differ from the total influence scores of Directors and Managers in comparison to fellow nurse leaders?*
- RQ9:** *What are the most pressing issues for nurse leader attendees at the 2006 INHL conference?*
- RQ10:** *What are the most time consuming issues for nurse leader attendees at the 2006 INHL conference?*

I. Section one of this document reports the demographic and conference attendance statistics.

Typical survey respondents were 52 year old females from New England with a graduate nursing education. The majority of respondents (81%) held care delivery management roles as Vice President/ Chief Nursing Officer, Associate Vice President, Director or Manager primarily in hospitals and/ or medical centers (93%) in major metropolitan areas (49%). On average (51%), survey respondents had 5 years or less experience in their current employment position with 76% having less than ten years experience in their current role. Respondents found applicability of topics to work and networking with other senior level nurses among the most appealing reasons for attending the conference. The following pages (Tables and Charts 1-15) provide more insight into the profile of the INHL conference attendees/ survey respondents.

Table 1: Participant's Age

Participant's Age	Frequency	Valid Percent	Cumulative Percent
30 – 35 Years	2	3	3
36 – 40 Years	5	6	9
41 – 45 Years	5	6	15
46 – 50 Years	17	20	35
51 – 55 Years	30	36	71
56 – 60 Years	20	24	95
> 60 Years	4	5	100
	83	100	

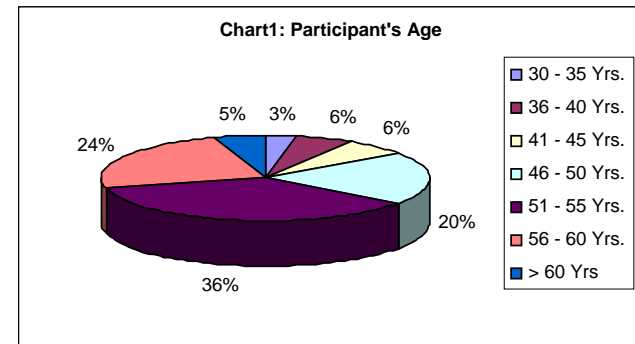


Table 2: Participant's Gender

	Frequency	Valid Percent	Cumulative Percent
Female	81	98	98
Male	2	2	100
	83	100	

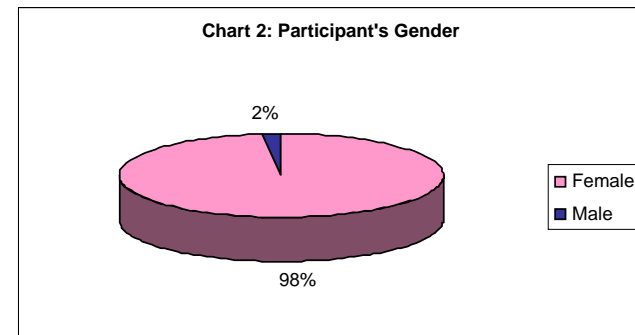


Table 3: Organization Size for Survey Respondents

	Frequency	Valid Percent	Cumulative Percent
000 – 200 Beds	15	22	22
201 – 400 Beds	19	28	50
401 – 600 Beds	17	25	75
601 – 800 Beds	11	16	91
801 - 1000 Beds	7	9	100
	69	100	

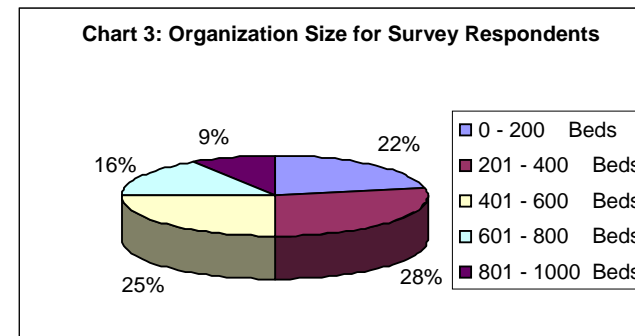


Table 4: Primary Title of Survey Respondents

Sr. V.P./Chief Nursing Officer	28
Associate V.P.	7
Director	32
Manager	2
Dean/Faculty	10
Other	6
	85

Other: Titles of Survey Respondents

- Association Executive
- CEO
- Consultant

Table 5: Primary Employer of Survey Respondents

Hospital or Medical Center or Health Care System	68
School of Nursing	10
Other	4
	82

Other: Primary Employers of Survey Respondents

- Ambulatory Care Facility
- Home Care Agency
- Health Care Vendor – Consulting Group
- Professional Membership Organization

Table 6: Employment Community

	Frequency	Valid Percent	Cumulative Percent
Major Metropolitan Area	40	49	49
Mid Sized City	17	21	70
Small City or Town	23	28	98
Sparsely Populated Rural Area	1	2	100
	81	100	

Chart 4: Primary Title Of Survey Respondents

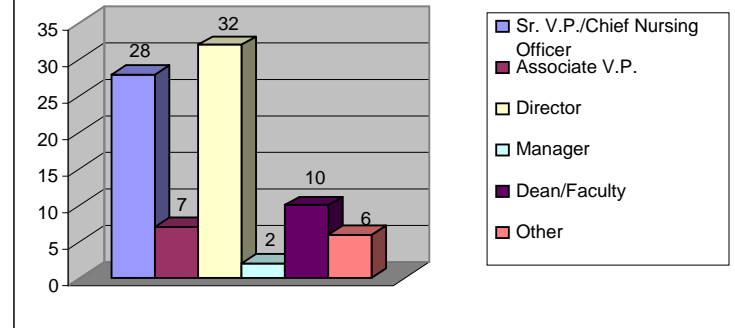


Chart 5: Primary Employer of Survey Respondents

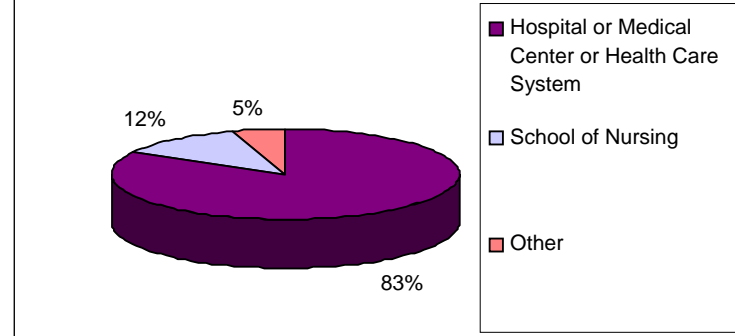


Chart 6: Employment Community

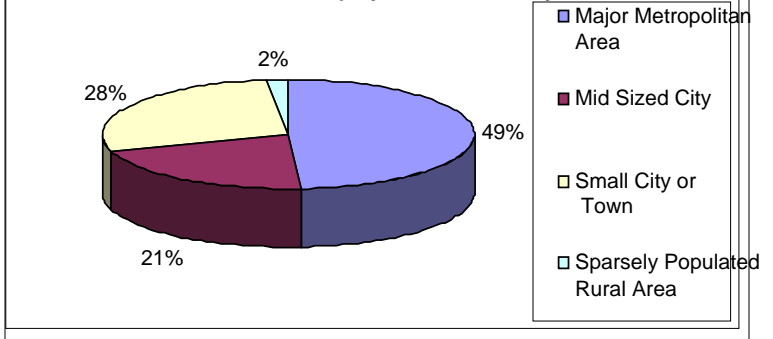


Table 7: State of Respondent's Employment

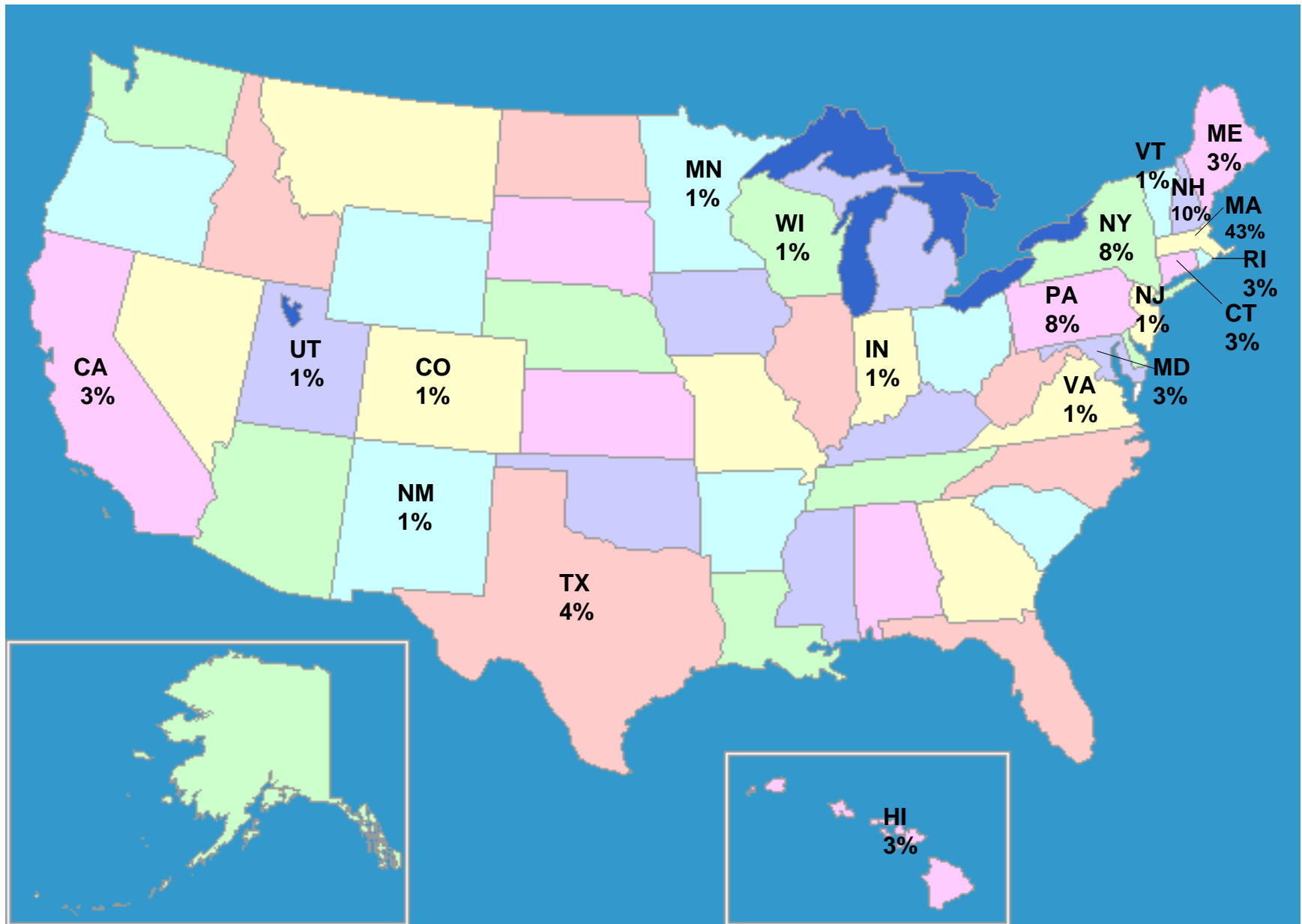


Table 8: Highest Nursing Education Level

	Frequency	Valid Percent	Cumulative Percent
Associates Degree	3	4	4
Bachelors Degree	11	13	17
Masters Degree	47	55	72
Doctoral Degree	24	28	100
	85	100	

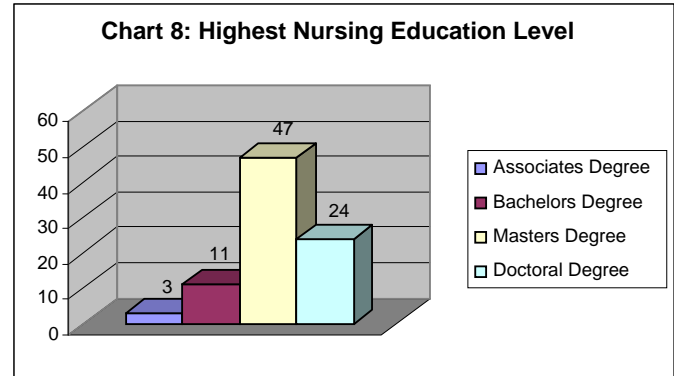


Table 9: Highest Educational Level of Any Degree

	Frequency	Valid Percent	Cumulative Percent
Associates Degree	1	1	1
Bachelors Degree	3	4	5
Masters Degree	49	61	66
Doctoral Degree	27	34	100
	80	100	

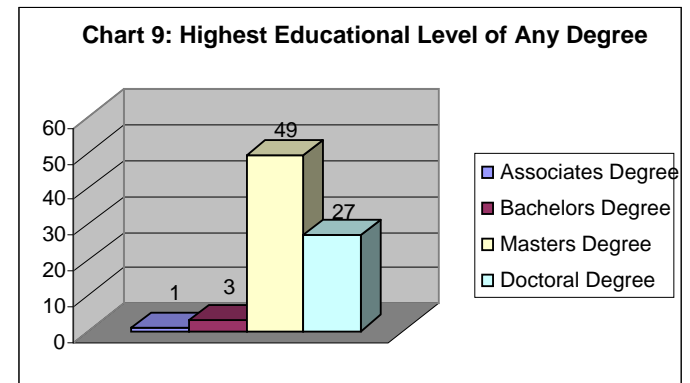


Table 10: Country of Employment

	Frequency	Valid Percent	Cumulative Percent
USA	80	94	94
Other	5	6	100
	85	100	

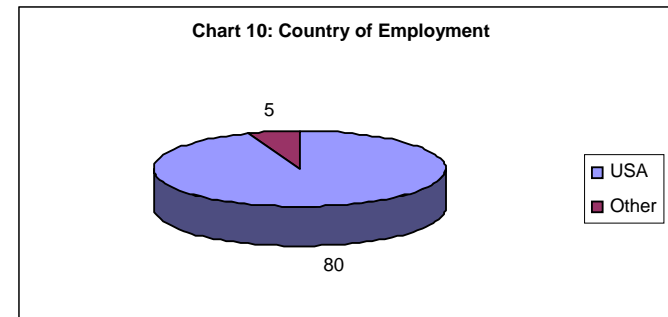


Table 11: Respondents Years Experience In Current Role

	Frequency	Valid Percent	Cumulative Percent
00 - 05 Years	44	51	51
06 - 10 Years	21	25	76
11 - 15 Years	9	11	87
16 - 20 Years	5	6	93
> 20 Years	6	7	100
	85	100	

Chart 11: Experience in Current Role (Years)

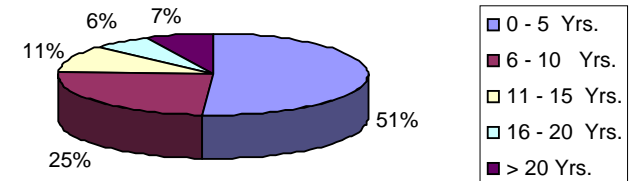


Table 12: Number of Years of Direct Patient Care Provided by Respondents

	Frequency	Valid Percent	Cumulative Percent
00 - 10 Years	36	42	42
11 - 20 Years	28	33	75
21 - 30 Years	14	17	92
31 - 40 Years	6	8	100
	84	100	

Chart 12: Years of Patient Care Provided by Each Respondent

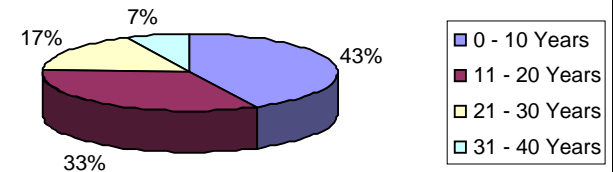


Table 13: Number of Employers Since RN Graduation

	Frequency	Valid Percent	Cumulative Percent
01 - 05 Employers	50	59	59
06 - 10 Employers	29	34	93
11 - 15 Employers	3	4	97
16 - 20 Employers	1	1	98
> 20 Employers	2	2	100
	85	100	

Chart 13: Number of Employers Since RN Graduation

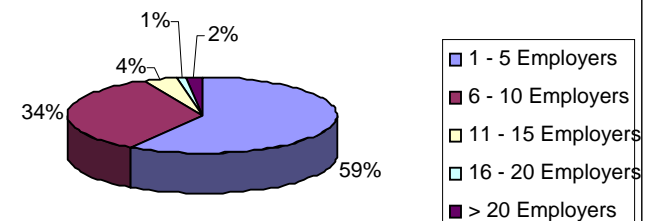


Table 14: Number of Years of Health Care Administrative Experience

	Frequency	Valid Percent	Cumulative Percent
00 - 10 Years	27	31	31
11 - 20 Years	33	39	70
21 - 30 Years	21	25	95
31 - 40 Years	4	5	100
	85	100	

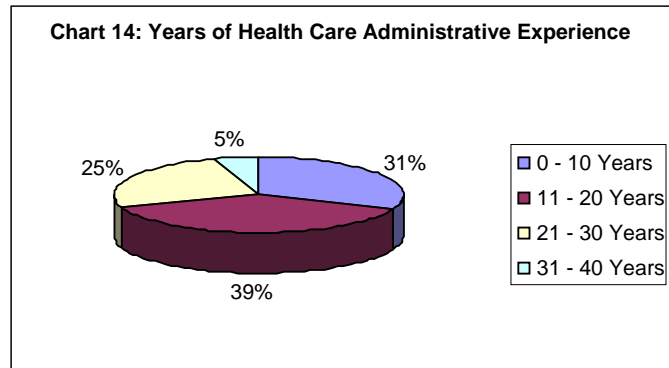
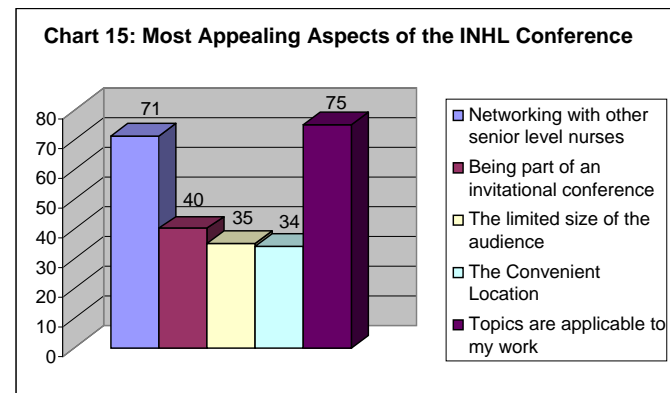


Table 15: Most Appealing Aspects of the INHL Conference

Networking with other senior level nurses	71
Being part of an invitational conference	40
The limited size of the audience	35
The Convenient Location	34
Topics are applicable to my work	75

Other: Most Appealing Aspects of the INHL Conference

- New ideas, information and challenges
- Opportunity to share my thoughts and ideas
- Quality of presenters
- Quality of speakers
- Service and education mix
- The high level of topics and speakers



II. Section two of this document reports the results of research questions (RQ) 1-9. Survey Methodology

The following methodology was used in the development and evaluation of the survey tool. Nursing administration content area specialists identified areas of management and leadership pertinent to the nurse leader. Those areas were then consolidated and organized into a thirteen item scale and used to identify the self reported knowledge and influence of the contemporary nurse leader respondents in comparison to both non-nurse healthcare executives and fellow nurse leaders within their primary work organization. The thirteen topic areas were;

- 1) Clinical information technology clinical requirements and system selection.
- 2) Integration of standardized nursing language(s) into practice.
- 3) Implementation of patient safety programs.
- 4) Organizational integrity: stewardship, ethics, accountability
- 5) Process management: principles of analysis and design.
- 6) Clinical staff leadership development strategies and issues.
- 7) Management leadership development strategies
- 8) Organizational Magnet status requirements.
- 9) Staffing: skill mix/& patient ratio issues.
- 10) Quality reporting: JCAHO, CMS, NDNQI, etc.
- 11) Financial management & budget development.
- 12) Health care policy
- 13) Clinical practice (direct care delivery)

The rating scale was scored one through five. A score of one being the lowest self perceived knowledge or influence in comparison to nurse and non-nurse leaders. Thus, total scale scores would pose a minimum of 13 to identify the least knowledgeable or influential and 65 the most knowledgeable or influential in comparison to fellow nurse leaders or non-nurse healthcare executives.

Attendees at The Institute for Nursing Healthcare Leadership (INHL) national invitation conference in June 2005 provided a purposive sample of nurse leaders. Of the 180 attendees, 76 (42%) sufficiently completed at least one section of the survey in its entirety. The results of this were tabulated and statistically analyzed. Demographic information (primary title, primary employer, years of experience and employment community) were also identified as valuable to include for collection and analysis.

A preliminary psychometric evaluation of each of the 13-item knowledge and influence scales was undertaken with the sample of valid survey respondents (n=76). Cronbach's alpha internal consistency reliability were computed on the four 13 item scales. Since these were satisfactory i.e., (>.70) the four subscales were then formed. The standardized Cronbach's alpha coefficients for the subscales were:

- Self-reported knowledge in comparison to non-nurse healthcare executives was 0.90
- Self-reported influence in comparison to non-nurse healthcare executives was 0.91
- Self-reported knowledge in comparison to fellow nurse leaders was 0.85
- Self-reported influence in comparison to fellow nurse leaders was 0.91

Finally, each respondent was asked to answer two qualitative questions; 1. What are the three most challenging issues you are currently dealing with in your role as a nurse leader? 2. What three issues you are currently dealing with in your role as a nurse leader consume the greatest amount of your time? Directed content analysis (Hsieh & Shannon 2005) was used to categorize the results of these questions into the identified American Organization of Nurse Executive Core Competencies (AONE 2005).

*** Caution should be exercised, due to the small sample size, no further psychometric analysis were completed due to the small sample size in this study.*

Table 16 reports the mean specific item scores, standard deviations and the total subscale scores and standard deviations. The specific item rating was scored 1 for the lowest score and 5 was the highest score. Thus, the total subscale scores could range from a lowest possible score of 13 (scoring of 1 on each specific item score) to a maximum 65 (scoring of 5 on each specific item scale).

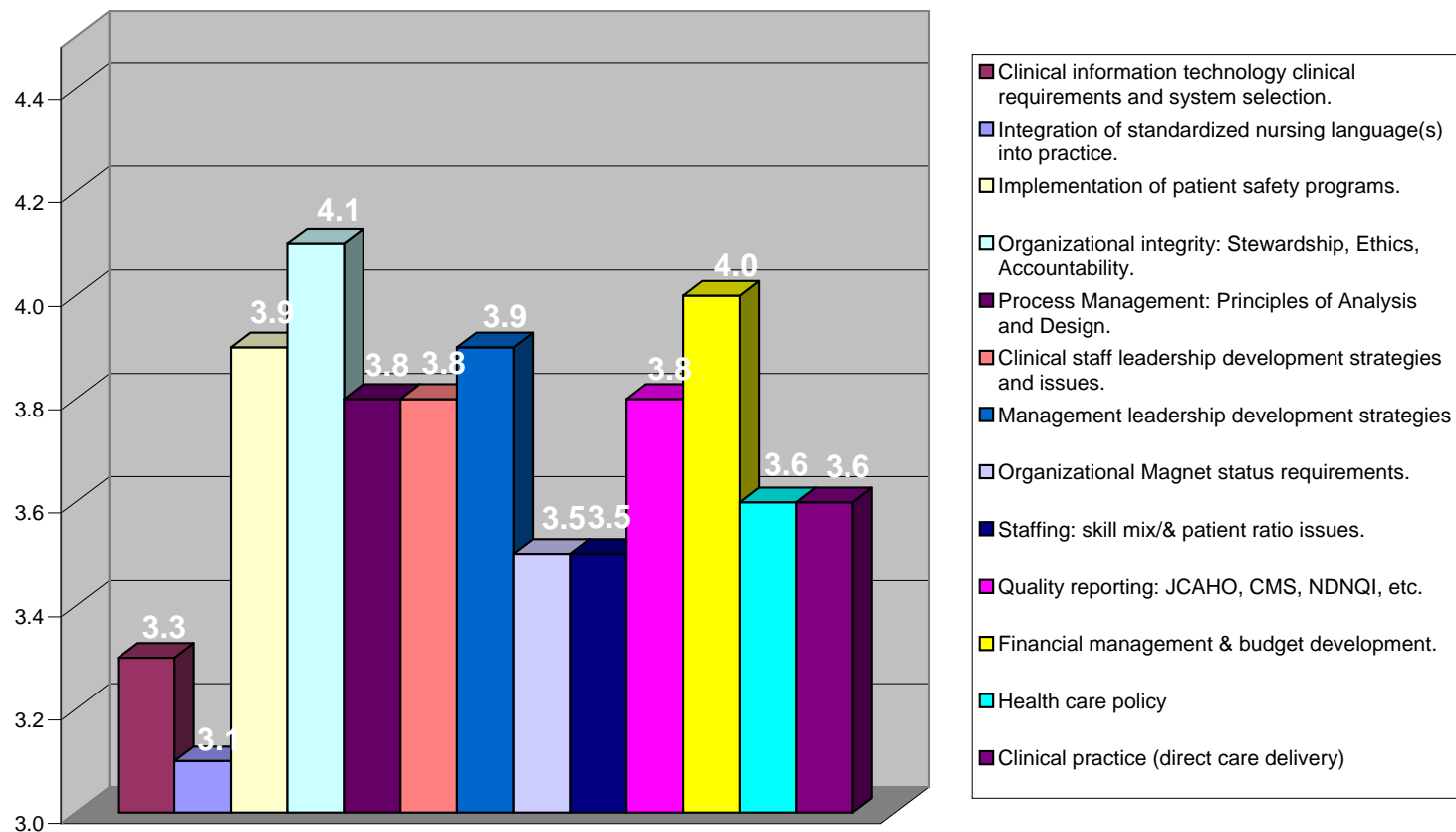
TABLE 16: Nurse Leaders Self Reported Knowledge and Influence in Comparison to Nurse and Non-Nurse Healthcare Leadership

	RQ1: Self-perceived knowledge in comparison to non-nurse healthcare executives			RQ2: Self-perceived influence in comparison to non-nurse healthcare executives			RQ3: Self-perceived knowledge in comparison to fellow nurse leaders			RQ4: Self-perceived influence in comparison to fellow nurse leaders		
	N	Mean	(SD)	N	Mean	(SD)	N	mean	(SD)	N	Mean	(SD)
Clinical information technology clinical requirements and system selection.	60	3.3	1.0	57	3.6	1.0	76	3.8	0.8	76	3.9	0.9
Integration of standardized nursing language(s) into practice.	60	3.1	1.6	57	3.2	1.3	76	3.9	0.8	76	4.0	1.0
Implementation of patient safety programs.	60	3.9	1.0	57	3.8	1.0	76	4.3	0.7	76	4.4	0.7
Organizational integrity: Stewardship, Ethics, Accountability.	60	4.1	0.9	57	4.0	0.9	76	4.4	0.8	76	4.3	0.7
Process Management: Principles of Analysis and Design.	60	3.8	0.9	57	3.7	0.9	76	3.9	0.8	76	4.0	0.8
Clinical staff leadership development strategies and issues.	60	3.8	1.2	57	3.7	1.1	76	4.4	0.8	76	4.4	0.7
Management leadership development strategies	60	3.9	1.0	57	3.9	0.9	76	4.2	0.9	76	4.3	0.8
Organizational Magnet status requirements.	60	3.5	1.4	57	3.6	1.4	76	4.2	1.0	76	4.4	0.8
Staffing: skill mix/& patient ratio issues.	60	3.5	1.4	57	3.5	1.2	76	4.4	0.9	76	4.4	0.9
Quality reporting: JCAHO, CMS, NDNQI, etc.	60	3.8	1.1	57	3.6	1.0	76	4.2	0.8	76	4.2	0.9
Financial management & budget development.	60	4.0	1.0	57	3.8	1.0	76	4.0	0.8	76	3.9	0.9
Health care policy	60	3.6	1.1	57	3.5	1.0	76	3.7	0.9	76	3.8	0.9
Clinical practice (direct care delivery)	60	3.6	1.3	57	3.7	1.3	76	4.3	0.9	76	4.4	0.8
TOTAL (min 13 - max 65)	60	47.8	10.3	57	47.8	10.0	76	53.7	6.6	76	54.5	7.6

RQ1: How do nurse leaders perceive their knowledge about specific management and leadership topics in comparison to non-nurse healthcare executives within their primary employment organization?

Respondents to this survey self reported their total knowledge in comparison to non-nurse healthcare executives as 47.8 ± 10.3 (possible range 13 minimum – 65 maximum). Each of the specific topic items mean scores were greater than the midpoint score of 3.0. Nurse leaders, when comparing themselves to non-nurse healthcare executives identified “Integration of standardized nursing language(s) into practice” (score 3.1 ± 1.6) and “Clinical information technology clinical requirements and system selection” (score 3.3 ± 1.0) as the topics they were least knowledgeable about. In contrast, these nurse leaders identified “Organizational integrity: stewardship, ethics and accountability” (score 4.1 ± 0.9) and “Financial management & budget development” (score 4.0 ± 1.0) as the topics where they had the greatest knowledge. The remaining item mean scores all fell between 3.5 and 3.9. (See Table 16 and Chart 16)

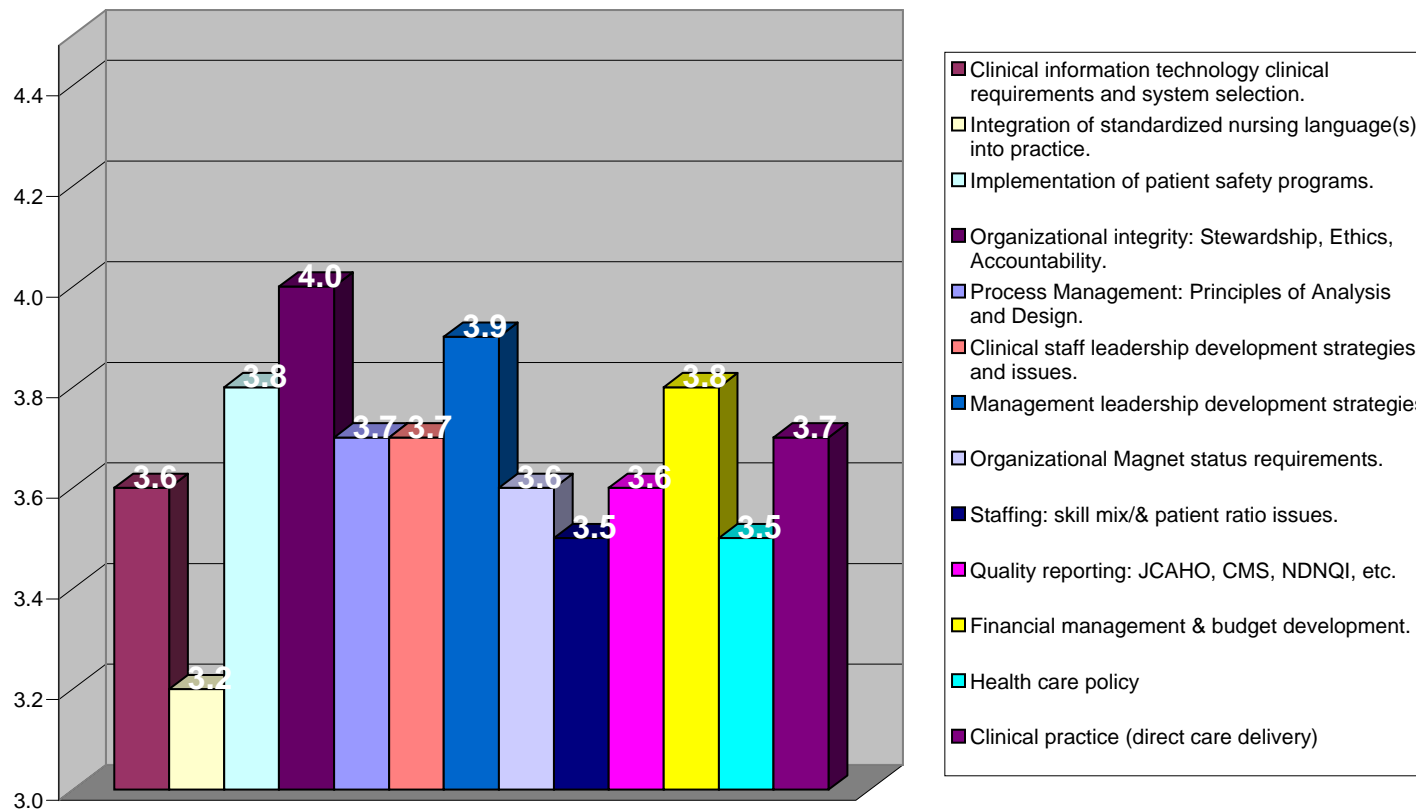
Chart 16: Self-perceived Knowledge in Comparison to Non-nurse Healthcare Executives



RQ2: How do nurse leaders perceive their influence about specific management and leadership topics in comparison to non-nurse healthcare executives within their primary employment organization?

Respondents to this survey self reported their total influence in comparison to non-nurse healthcare executives as 47.8 ± 10.0 (possible range 13 minimum – 65 maximum). Each of the specific topic items mean scores were greater than the midpoint score of 3.0. Nurse leaders, when comparing themselves to non-nurse healthcare executives identified “Integration of standardized nursing language(s) into practice” (score 3.2 ± 1.3) as the topic they were least influential about. In contrast, these nurse leaders identified “Organizational integrity: stewardship, ethics, accountability” (score 4.0 ± 0.9) and “Management leadership development strategies” (3.9 ± 0.9) as the topics where they had the most influence. The remaining item mean scores all fell between 3.5 and 3.8. (See Table 16 and Chart 17)

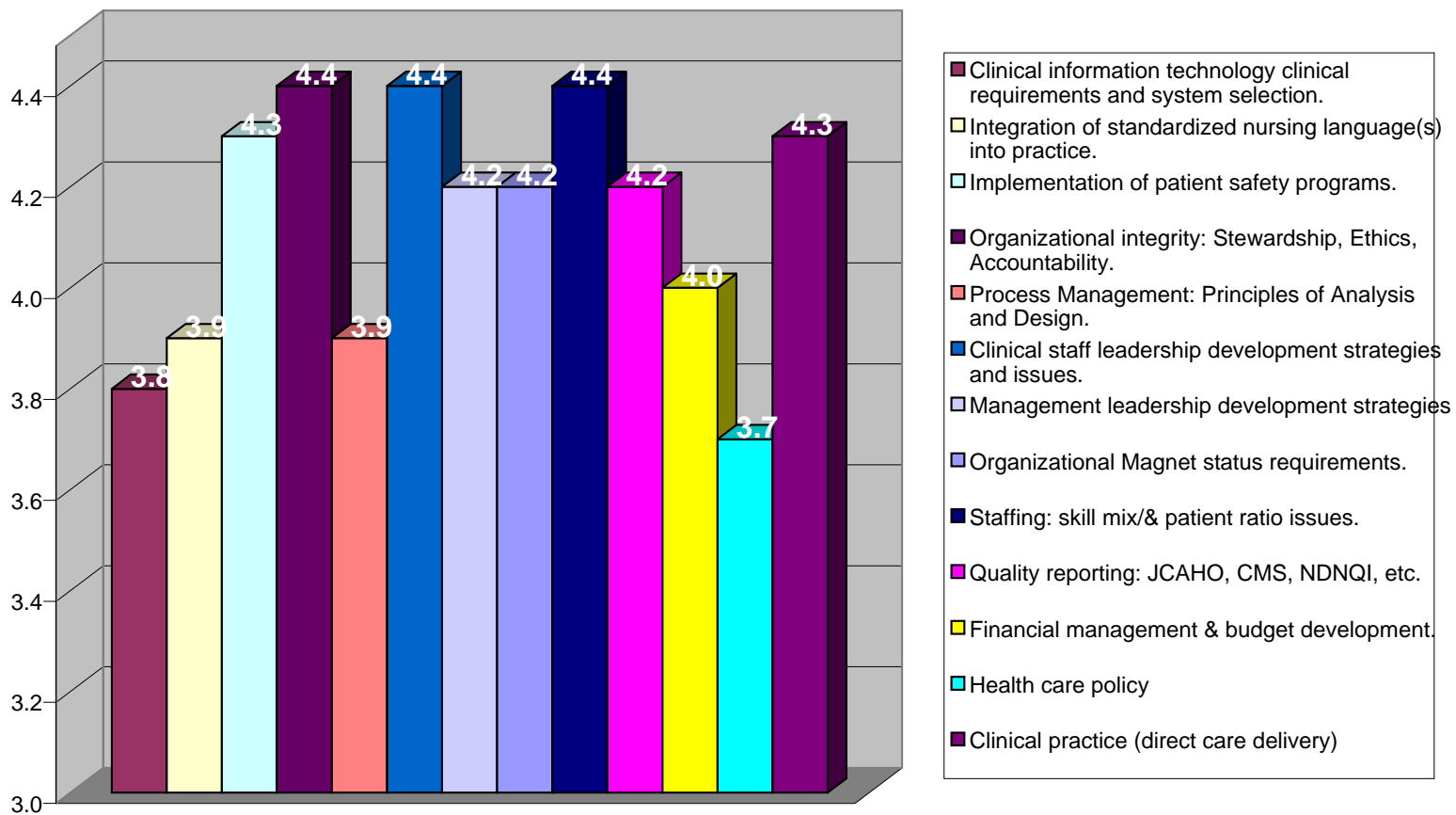
Chart 17: Self-perceived Influence in Comparison to Non-nurse Health Care Executives



RQ3: How do nurse leaders perceive their knowledge about specific management and leadership topics in comparison to fellow nurse leaders within their primary employment organization?

Respondents to this survey self reported their total knowledge in comparison to fellow nurse leaders as 53.7 ± 6.7 (possible range 13 minimum – 65 maximum). Each of the specific topic items mean scores were greater than the midpoint score of 3.0. Nurse leaders, when comparing themselves to fellow nurse leaders identified “Health care policy” (score 3.7 ± 0.9) as the topic they were least knowledgeable about. In contrast, these nurse leaders identified “Staffing: skill mix & patient ratio issues” (score 4.4 ± 0.9), “Organizational integrity: stewardship, ethics, accountability” (score 4.4 ± 0.8) and “Clinical staff leadership development strategies” (score 4.4 ± 0.8) as the topics where they had the greatest knowledge. The remaining item mean scores all fell between 3.7 and 4.3. (See Table 16 and Chart 18).

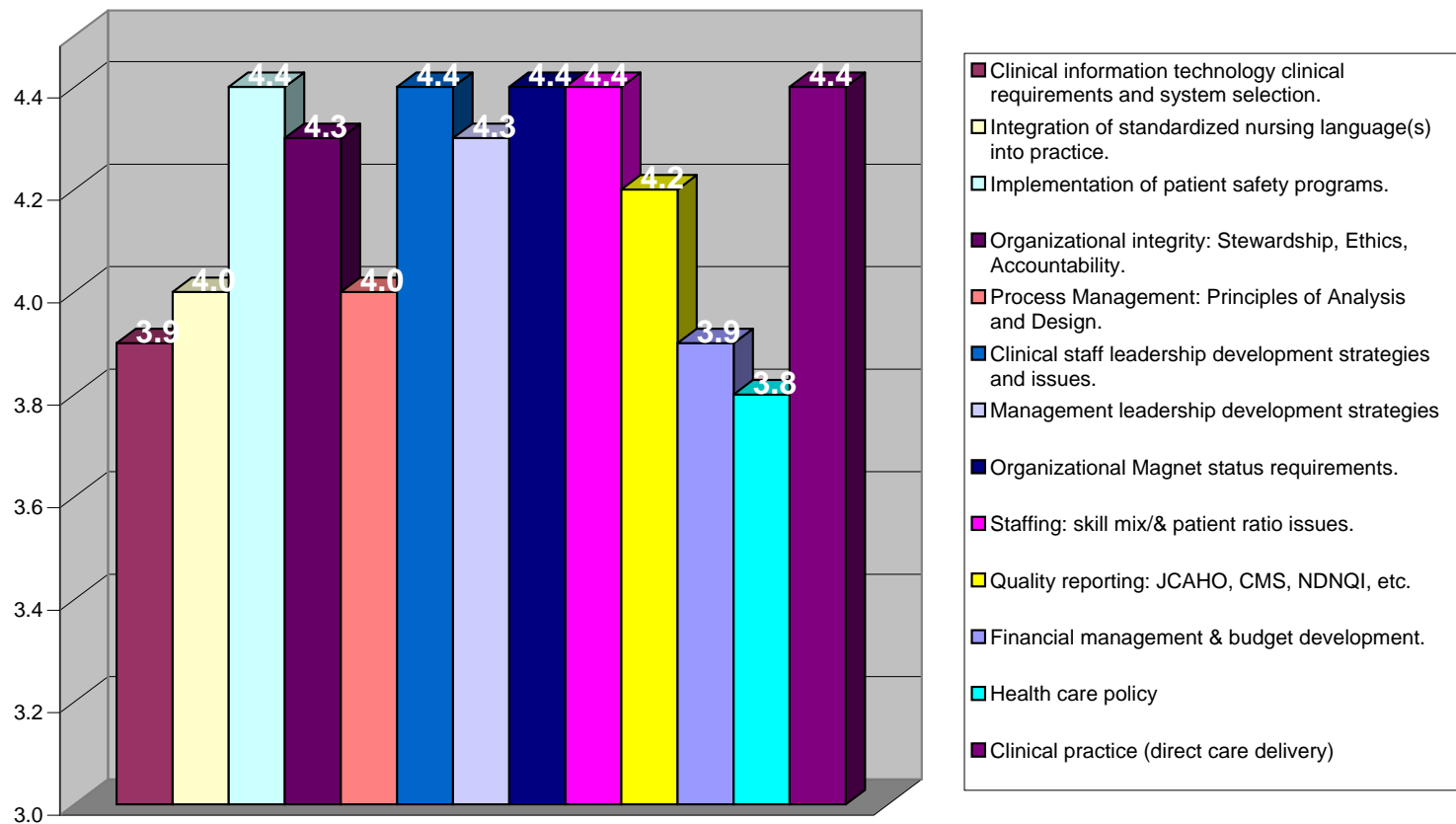
Chart 18: Self-perceived Knowledge in Comparison to Fellow Nurse Leaders



RQ4: How do nurse leaders perceive their influence about specific management and leadership topics in comparison to fellow nurse leaders within their primary employment organization?

Respondents to this survey self reported their total influence in comparison to fellow nurse leaders as 54.5 ± 7.6 (possible range 13 minimum – 65 maximum). Each specific topic item mean scores were greater than the midpoint score of 3.0. Nurse leaders, when comparing themselves to fellow nurse leaders identified “Health care policy” (score 3.8 ± 0.9) as the topic they were least influential about. In contrast, these nurse leaders identified “Implementation of patient safety programs” (score 4.4 ± 0.7), “Clinical staff leadership development strategies” (score 4.4 ± 0.7), “Clinical practice (direct care delivery)” (score 4.4 ± 0.8), “Organizational Magnet status requirements” (score 4.4 ± 0.9), and “Staffing: skill mix & patient ratio issues” (score 4.4 ± 0.9) as the topics where they had the greatest influence. The remaining item mean scores all fell between 3.9 and 4.3. (See Table 16 and Chart 19).

Chart 19: Self-perceived Influence in Comparison to Fellow Nurse Leaders



Discussion

The respondents to this survey identified being both more knowledgeable and influential when comparing themselves to fellow nurse leaders than when comparing themselves to non-nurse executives within their organization. This is also supported on an item by item basis (Table 16) with the exception of the topic “Financial management & budget development.” This suggests that the nurse leader respondents to this survey identify non-nurse healthcare executives as more knowledgeable and influential than fellow nurse leaders on nearly every survey topic. This is somewhat concerning, and identifies opportunity and need for knowledge, competence and influence enhancement for nurse leaders.

Another interesting finding is the identification of “Integration of standardized nursing language into practice” as the topic where nurse leaders self reported knowledge and influence as lowest in comparison to non-nurse executives. This is somewhat of a surprising finding, as NELs perceive themselves as more knowledgeable and influential with fellow nurses than with non-nurse executives who seemingly have less exposure to standardized nursing language. This however is an important finding as hospitals and healthcare organizations continue to focus resources on nursing and clinical information systems. As organizations select, design and build clinical information systems it is important to approach these projects from the well quoted perspective “If you cannot name it, you can’t control it, finance it, research it, or put it into policy”(Lang & Clark 1997). A standardized language for nursing can aid in the articulation of nursing clearly and efficiently conveying what clinicians do, easily tracking care across clinicians and settings, evaluating effectiveness of care and generating data to support policies for appropriate resource allocation. This finding also leads us to the question “What is the relationship between the NELs level of topic knowledge and influence within the non-nurse executive and nurse leader communities?”

For questions RQ5-RQ8, the data file was split and only those with primary titles of VP/CNO, Director and Manager were included in the sample making a sample size (n=58).

TABLE 17: Total Knowledge and Influence Scores for VPs/CNOs, Directors and Managers in Comparison to Nurse and Non-nurse Leadership

	Vice President/ Chief Nursing Officer			Director			Manager		
	N	Mean	(SD)	N	Mean	(SD)	N	mean	(SD)
Total knowledge compared to non nurse execs	20	49.0	12.0	25	47.0	9.1	1	NA	NA
Total influence compared to non nurse execs	19	50.4	12.1	28	46.0	8.2	1	NA	NA
Total knowledge compared to fellow nurse leaders	25	55.8	6.1	26	54.3	5.2	2	NA	NA
Total influence compared to fellow nurse leaders	23	58.2	5.1	31	54.7	5.8	2	NA	NA

RQ5: Do the total knowledge scores of Vice Presidents/ CNOs differ from the total knowledge scores of Directors and Managers in comparison to non-nurse healthcare executives?

The mean self reported total knowledge score of the Vice President/ CNO (49.0) was higher than that of the Directors (47.0) when comparing themselves to non-nurse healthcare executives. Due to a small N (N=1) Managers were not assessed when comparing themselves to non-nurse healthcare executives. (see Chart 20 and Table 17)

RQ6: Do the total knowledge scores of Vice Presidents/ CNOs differ from the total knowledge scores of Directors and Managers in comparison to fellow nurse leaders?

The mean self reported total knowledge score of the Vice President/ CNO (55.8) was higher than that of the Directors (54.3) when comparing themselves to fellow nurse leaders. Due to a small N (N=2) Managers were not assessed when comparing themselves to fellow nurse leaders. (see Chart 20 and Table 17)

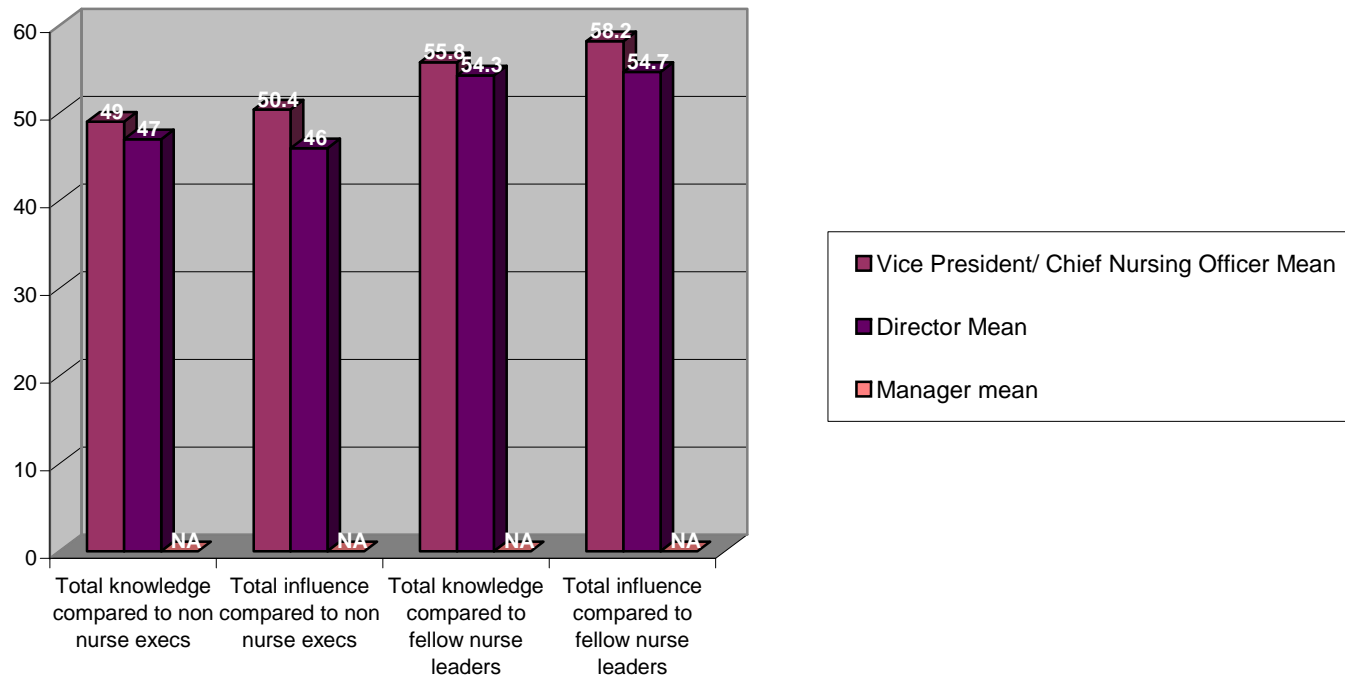
RQ7: Do the total influence scores of Vice Presidents/ CNOs differ from the total influence scores of Directors and Managers in comparison to non-nurse healthcare executives?

The mean self reported total influence score of the Vice President/ CNO (50.4) was higher than that of the Directors (46.0) when comparing themselves to non-nurse healthcare executives. Due to a small N (N=1) Managers were not assessed when comparing themselves to non-nurse healthcare executives. (see Chart 20 and Table 17)

RQ8: Do the total influence scores of Vice Presidents/ CNOs differ from the total influence scores of Directors and Managers in comparison to fellow nurse leaders?

The mean self reported total influence score of the Vice President/ CNO (58.2) was higher than that of the Directors (54.7) when comparing themselves to fellow nurse leaders. Due to a small N (N=2) Managers were not assessed when comparing themselves to fellow nurse leaders. (see Chart 20 and Table 17)

Chart 20: Self Perceived Total Knowledge and Influence Scores for VPs/CNOs, Directors and Managers in Comparison to Nurse and Non-nurse Leadership



Discussion

When the sample was split, Vice Presidents/CNOs (minimum n=19), Directors (minimum n=25) and Managers (minimum n=1) were isolated. Due to the low number of Manager responses, this population was excluded. However within the VP/CNO relationship, it was identified that both knowledge and influence scores followed a hierarchical trend which is again supportive of our previous findings. This means that the total knowledge and influence scores of the Vice President/ CNO were higher than the Director scores in both 2005 and 2006 and the Manager scores in 2005 (See Table 17 & Chart 20) and (Adams, Duffy & Clifford 2006).

III. Section three of this document identifies the most pressing issues identified by survey respondents (RQ) 9-10

Two hundred twenty seven written responses to the qualitative “most challenging issue” question and one hundred seventy nine written responses to the “most time consuming” question were reviewed and using directed content analysis (Hsieh & S. E. Shannon 2005) were identified as relating with AONE competency skills. The most pressing and time consuming issues identified by nurse leaders are identified in Table 18.

RQ9: What are the most challenging issues for nurse leader attendees at the 2006 INHL conference?

Nurse leader respondents most frequently identified issues within AONE competency category Business Skills as the most challenging issues within their current roles.

RQ10: What are the most time consuming issues for nurse leader attendees at the 2006 INHL conference?

Nurse leader respondents most frequently identified issues within AONE competency category Business Skills as the most time consuming issues within their current roles.

Table 18: Issues Identified as Most Pressing and Requiring Greatest Amount of Nurse Executive Leaders (NEL) Time

Pressing Issues for NEL Competency Skill	Total Responses	NEL spends most time Competency Skill	Total Responses
AONE Core Competencies	Group Total	AONE Core Competencies	Group Total
<i>Communication and relationship-building competencies</i>	27	<i>Communication and relationship-building competencies</i>	15
<ul style="list-style-type: none"> • Academic faculty partnerships; curriculum development; placements • Physician-Practice collaboration • Union Environments/Union Partnerships 		<ul style="list-style-type: none"> • Academic affiliations and partnerships; clinical site access (competition); alliances with other hospitals • Union relationships; communicating effectively with all partners • Nursing voice within the organization/role clarity 	
<i>Knowledge of the healthcare environment</i>	47	<i>Knowledge of the healthcare environment</i>	21
<ul style="list-style-type: none"> • Implementing and promoting patient quality, safety and satisfaction • Using and measuring evidence for practice • Advancing professional practice with knowledge; patient education; impact of curriculum education 		<ul style="list-style-type: none"> • Quality Improvement; promoting evidenced based practice; safety • Increased work intensity • Educational networking; integration of clinical information technology 	
<i>Leadership skills</i>	47	<i>Leadership skills</i>	35
<ul style="list-style-type: none"> • Promoting change; reframe thinking to implement innovative practice models; "...raising the bar". • Leadership development- recruit and retain a leadership team • Preparing leaders for the future 		<ul style="list-style-type: none"> • Promoting change; communicating the vision; developing "centers of excellence"; staff satisfaction • Leadership development of nurses, associate • Chiefs, nurse managers; current and future • Creating leadership team • Personnel problems and issues 	
<i>Professionalism</i>	11	<i>Professionalism</i>	21
<ul style="list-style-type: none"> • Increased accountability; care coordination • Professional commitment to standards; magnet status • Impact of Technology and documentation 		<ul style="list-style-type: none"> • Implementing a professional practice model; patient care delivery redesign • Staff Competency ; achieving and maintaining Magnet status • Implementing research /evidenced based practice 	
<i>Business skills</i>	89	<i>Business skills</i>	87
<ul style="list-style-type: none"> • Resources: allocation (staffing), growth recruitment (shortage), retention, development • Resources: allocation (staffing), growth recruitment (shortage), retention, development • Strategic Planning – vision; innovation, "doing more with less". • Fiscal balancing – financial growth 		<ul style="list-style-type: none"> • Resource - adequacy and workforce supply faculty; Capacity Management; nurse recruitment • Resource - adequacy and workforce supply faculty; Capacity Management; nurse recruitment • Generating new revenue streams (e.g. Grants and innovative projects); allocation of resources • Budget constraints and fiscal management/ variance 	

Discussion

Findings from the two questions that asked nurse leaders to describe what issues are currently dealing with and those issues that consume "... the greatest amount of their time" seem to yield similar responses although in some cases the frequency with which they were noted varied. The issue which most leaders identified as most pressing and the one they spent the most time with focused on the AONE Core Competency of **Business Skills**. Within this competency financial balancing of the budget; recruitment and retention of a stable workforce and the impact of the faculty shortage were often noted. In addition, issues related to the identification of new revenue sources; and strategic planning were noted often. The impact of information management and technology were also cited frequently. Leaders were not only concerned with adequacy of the workforce but preparation, staffing and ratios.

Competencies associated with **Knowledge of the Health Care Environment** and **Leadership Skills** were often noted as very important and of areas concern to nurse leaders. Of note was the need for continued development of the current work force; advancing new opportunities to promote career mobility and fostering change were essential. Leaders often noted the challenges currently and in the future, around succession planning and role development of potential leaders.

Changes in academic curriculum, along with the inadequate number of faculty and nurses prepared at advanced levels to fill future leadership roles were seen as important areas for consideration and future planning. Links to introducing changes in professional practice models while attending to quality and safety, were noted as potential areas for vision and growth. The AONE core competencies related to **Professionalism** was less cited by nurse leaders as a as critical concern by nurse leaders, but when mentioned addressed issues around orientation, mentoring and competency development. **Communication and Relationship Building Competencies** were seen as important especially around establishing academic faculty partnerships, physician recruitment and relating with the Union. Many nurse leaders believed it was important to cultivate an environment where nursing's voice could be heard and active participation in organizational decision making was supported.

Summary and Future Direction

The results of this survey mirror the 2006 INHL Knowledge and Influence Report (Adams, Duffy & Clifford 2006). Thus, it is not tremendously surprising that issues concerning Business Skills are the most concerning and time consuming for nurse executive leaders. It is also supportive of the concept that organizational hierarchical position impacts ones ability to be influential. This inevitable leads us to question the role of Business Skills in Nurse Executive practice and the value of defining nurse executive practice as a means to promote professional influence within the organization. This study provides an interesting launching point for continued research toward defining Nurse Executive Leader practice and her/ his influence on work environments and patient outcomes. Follow-up INHL research will aim to understand...

- A) other factors (in addition to knowledge), that can aid in one being influential.
- B) nurse executive leaders knowledge, influence and the relationship to work environments
- C) additional confounding factor(s) such as education level or specialization of work that causes one to self report higher or lower knowledge scores.
- D) NELs level of specific topic knowledge and influence within the non-nurse executive and nurse leader communities
- E) psychometric evaluation of the nurse executive leader knowledge and influence tool.

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