

Knowledge and Influence of the Nurse Leader

A Survey of Participants from the 2005 Conference

The Institute for Nursing Healthcare Leadership



Jeffrey M. Adams, MSN, RN

Mary E. Duffy, PhD, RN, FAAN

Joyce C. Clifford, PhD, RN, FAAN

This report was made possible through the generosity of



200 Cordwainer Drive, Suite 100,
Norwell MA 02061
Tel 781.871.6770
www.navinhaffty.com

&



THE BOGART GROUP, INC.
Healthcare Systems Consultants

Nine Waterville Street, Suite 4C
Portland, ME 04101
207.899.1919
www.bogartgroup.com

A special thank you to
Dorothy Jones, EdD, RN, FAAN
Alicemary Aspell Adams, MBA, BSN, RN
Karen Poznick

TABLE OF CONTENTS

	<u>Page</u>
Title and Authors	1
Survey Sponsors	2
Perspective	4
Survey Overview	5

SECTION I: Survey Demographics & Conference Attendance Statistics

Primary Title	6
Primary Employer	7
Years of Experience	8
Employment Community	9
INHL Conference Attendance by Year	10
Number of INHL Conferences Attended	11
Required Accommodations and Location	12
Most Appealing Aspects of the Conference	13

SECTION II: Research Question Results

Survey Methodology	14
Self Reported Knowledge and Influence	15
Research Question 1:	16
Research Question 2:	17
Research Question 3:	18
Research Question 4:	19
Research Question 5:	20
Research Question 7:	21
Research Question 8:	21
Research Question 9:	22
Discussion:	23

SECTION III: Most Pressing Issues for Nurse Leaders

Most Pressing Issues for Nurse Leaders Categorized by AONE Core Competency	24
Research Question 10:	25

References	26
------------------	----

July 16, 2006

Dear Colleagues-

Nurse Leadership roles within healthcare organizations have expanded into some of the most complex in all of healthcare. The Nursing Leader continues to be charged with the delicate balance of integrating the professional goals of nursing with the mission of the healthcare organization (Burritt, 2005; Cilliers, 1989; Clifford, 1985; Scoble & Russell, 2003). In doing so the Nursing Leader strives toward continued maximization of quality of patient care, professional satisfaction of the nurse and cost-effectiveness and efficiency for the organization (Clifford, 1998).

The Institute of Medicine Report (Keeping Patients Safe – Transforming the Work Environment of Nurses) suggests that organizational nursing leadership is vital for nursing success and positive patient outcomes (IOM, 2004). Nurses have made great strides “to get to the table” and solidify their involvement in the leadership team (Ballein & Thompson, 2003; Havens, 1998). The question now is “Having gotten there now what?” Do nurses have the knowledge and influence needed to make a difference? While there are great examples of successful and influential nurse leaders within organizations, nurses have traditionally been depicted as and often describe themselves as a powerless professional group (Sullivan, 2004).

Some research has begun to define the nurse leader and her/his impact on the work environment and patient care outcomes (Ives Erickson, 2001; Poulin, 1984; Sovie & Jawad, 2001; Upenieks, 2002, 2003). The purpose of this survey is to advance this area of research, and begin to understand the knowledge and influence of the contemporary Nurse Leader within her/his organization. An additional aim is to begin to identify the most important issues nurse leaders are faced with in their current practice. The survey results provide a unique insight into the status of nursing leadership within healthcare organizations as perceived and self reported by attendees at the 2005 Executive Nurse Leadership Invitational conference held in Boston, MA.

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.

Jeffrey M. Adams, MSN, RN

Principal, The Bogart Group, Inc.
Research Associate, Institute for Nursing Healthcare Leadership
Doctoral Student, Boston College Connell School of Nursing

Mary E. Duffy, PhD, RN, FAAN

Professor & Director, Center for Nursing Research
Boston College Connell School of Nursing

Joyce C. Clifford, PhD, RN, FAAN

President & CEO, Institute for Nursing Healthcare Leadership

This document reports the results of the INHL Executive Nurse Leadership Survey distributed at the Institute for Nursing Healthcare Leadership Conference in June 2005. The report was prepared by;

Jeffrey M. Adams, MSN, RN, Principal, The Bogart Group, Inc, Portland, ME, Doctoral Student Boston College Connell School of Nursing, Chestnut Hill, MA and Research Associate, Institute for Nursing Healthcare Leadership, Boston, MA,

Mary E. Duffy, PhD, RN, FAAN, Professor and Director of the Center for Nursing Research, Boston College Connell School of Nursing, Chestnut Hill, MA

Joyce C. Clifford, PhD, RN, FAAN, President and Chief Executive Officer, Institute for Nursing Healthcare Leadership, Boston, MA

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:** *Within the context of this survey, is there a relationship between nurse leaders self reported knowledge and self reported influence?*
- RQ6:** *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?*
- RQ7:** *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?*
- RQ8:** *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?*
- RQ9:** *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?*
- RQ10:** *What are the most pressing issues for nurse leader attendees at the 2005 INHL conference?*

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

Typical survey respondents had an average (7.7 years) experience in their current employment position with 79% having less than ten years experience in their current role. The majority of respondents (78%) held care delivery management roles as Vice President/ Chief Nursing Officer, Director or Manager primarily in hospitals and/ or medical centers (77%) in major metropolitan areas (54%). About half of the respondents (46%) were attending their first INHL conference and 60% required overnight accommodations to do so. 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 (Charts 1-8 and Tables 1-6) provide more insight into the profile of the INHL conference attendees/ survey respondents.

Question 1: Your primary title is best described as

Chart 1: Primary Title of Survey Respondents (n=87)

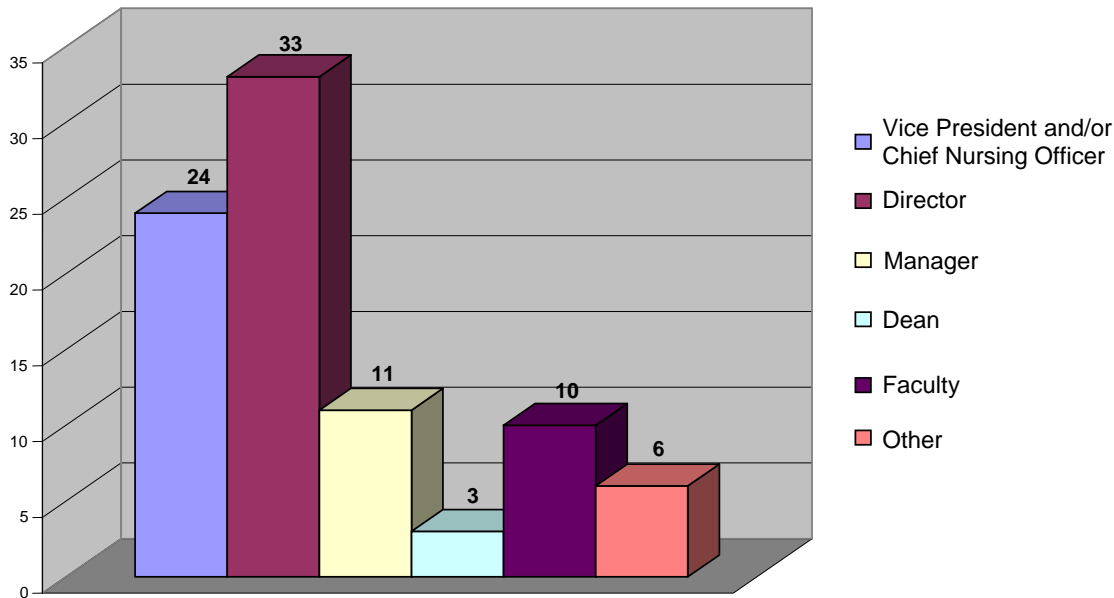


TABLE 1: Primary Title

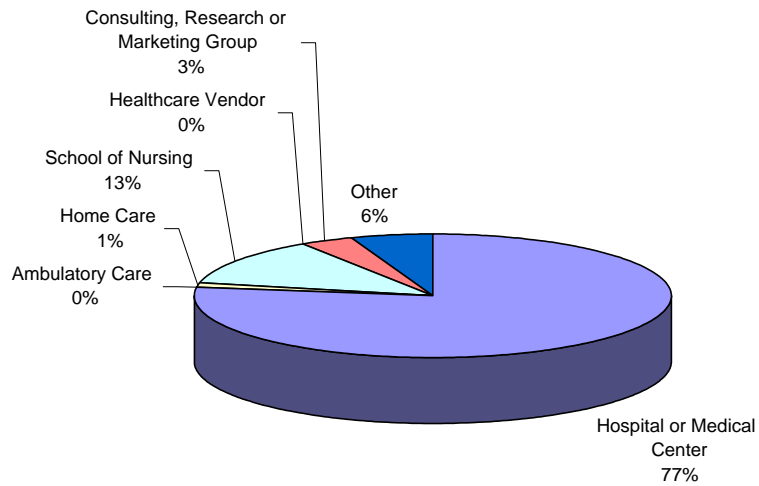
Primary Title (Response)	Frequency	Valid Percent	Cumulative Percent
Vice President/ Chief Nursing Officer	24	27.6	27.6
Director	33	37.9	65.5
Manager	11	12.6	78.2
Dean	3	3.4	81.6
Faculty	10	11.5	93.1
Other	6	6.9	100
TOTAL	87	100	

Question 2: Your primary employer is best described as:

TABLE 2: Primary Employer

Primary Employer (Response)	Frequency	Valid Percent	Cumulative Percent
Hospital or Medical Center	68	77.3	77.3
Ambulatory Care	0	0	77.3
Home Care	1	1.1	78.4
School of Nursing	11	12.5	90.9
Healthcare Vendor	0	0	90.9
Consulting, Research or Marketing Group	3	3.4	94.3
Other	5	5.7	100
TOTAL	88	100	

Chart 2: Primary Employer of Survey Respondents

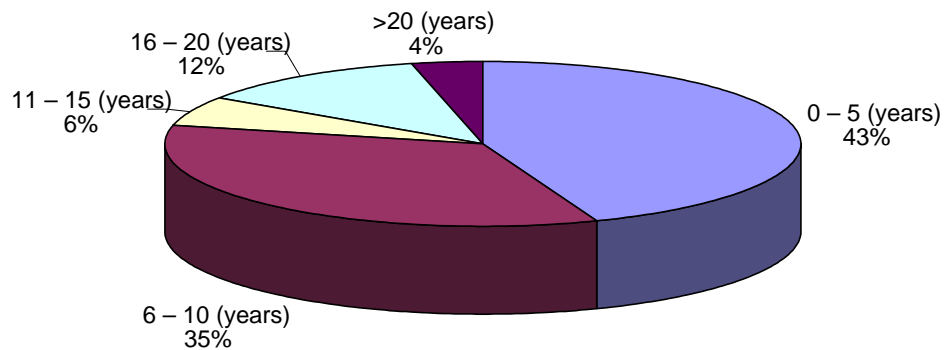


Question 3: Years experience in current role (GROUPED RESPONSES):

TABLE 3: Years Experience in Current Role

Years in Current Role (Grouped Response)	Frequency	Valid Percent	Cumulative Percent
0 – 5 (years)	37	44	44
6 – 10 (years)	29	34.6	78.6
11 – 15 (years)	5	5.9	84.5
16 – 20 (years)	10	11.9	96.4
>20 (years)	3	3.6	100
TOTAL			
	84	100	

Graph 3: Experience in Current Role (years)

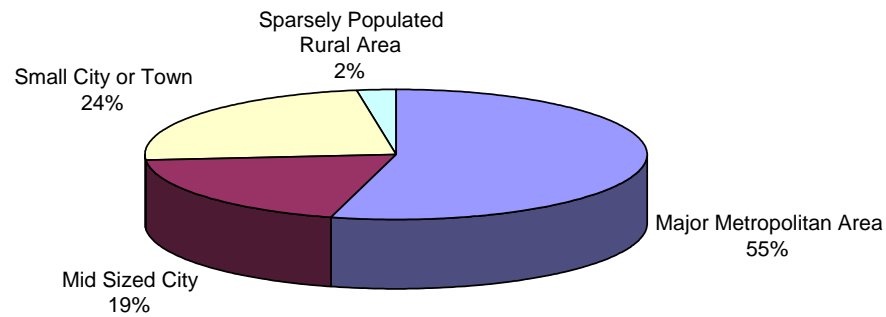


Question 4: Your employment community is best described as a:

TABLE 4: Employment Community

Employment Community	Frequency	Valid Percent	Cumulative Percent
Major Metropolitan Area	45	54.2	54.2
Mid Sized City	16	19.3	73.5
Small City or Town	20	24.1	97.6
Sparsely Populated Rural Area	2	2.4	100
TOTAL	83	100	

Chart 4: Employment Community

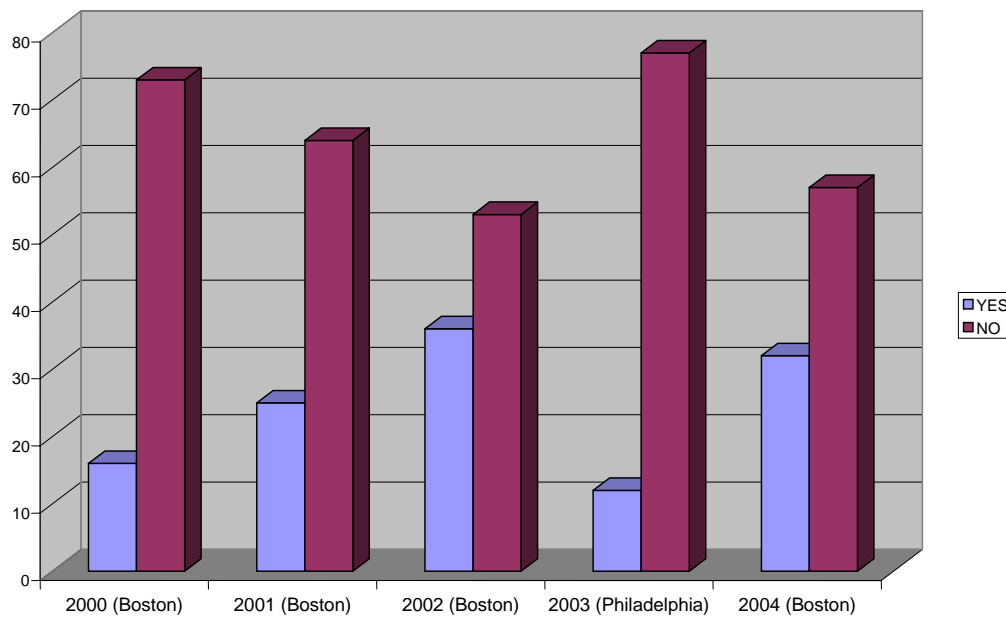


Question: Respondents Previous Conference Attendance (by year)

TABLE 5: Previous INHL Conference Attendance By Year

Year of Conference Attended	YES	NO	NO%	TOTAL	TOTAL%
2000 (Boston)	16	73	82	89	100
2001 (Boston)	25	64	71.9	89	100
2002 (Boston)	36	53	59.6	89	100
2003 (Philadelphia)	12	77	86.5	89	100
2004 (Boston)	32	57	64	89	100

Chart 5: Respondents Conference Attendance by Year

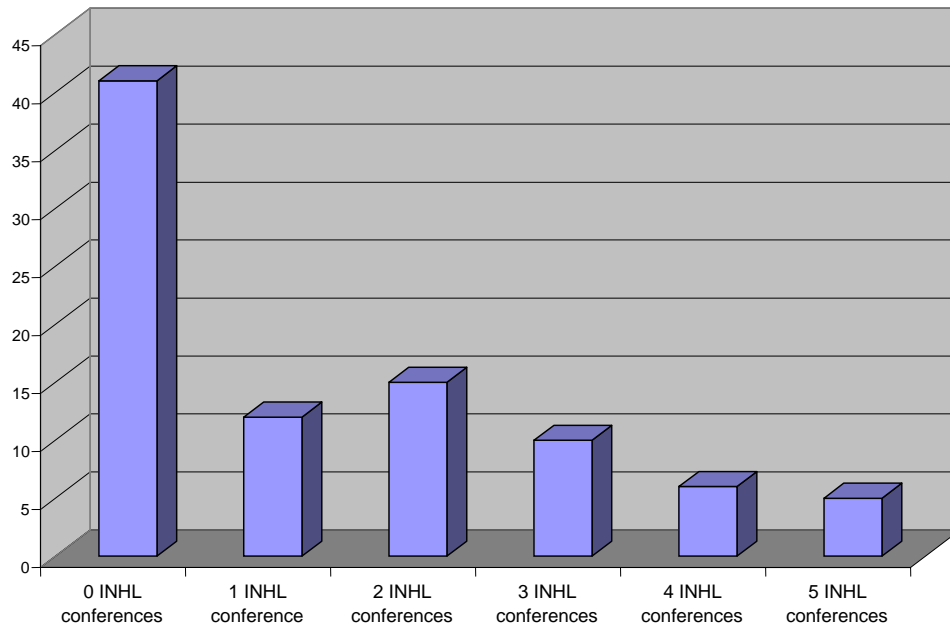


Question: Number of INHL conferences attended by 2005 attendees (n=89)

TABLE 6: Number of Previous INHL Conferences Attended

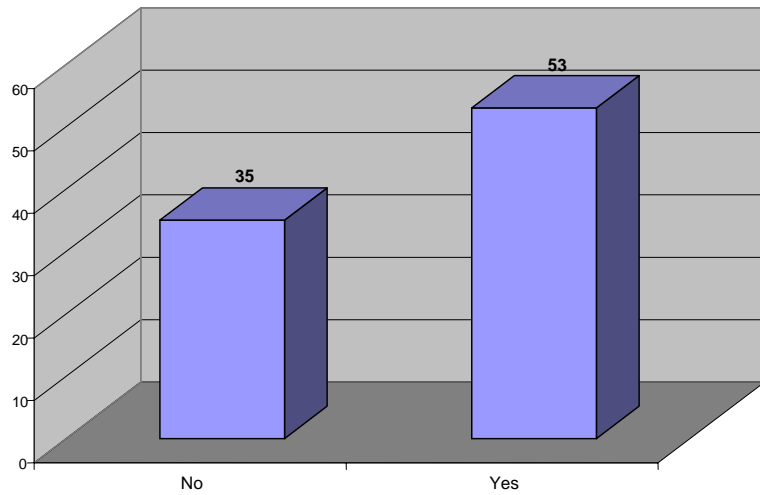
Number of Previous Conferences Attended	Frequency	Valid Percent	Cumulative Percent
0 INHL conferences	41	46.1	46.1
1 INHL conference	12	13.5	59.6
2 INHL conferences	15	16.9	76.4
3 INHL conferences	10	11.2	87.6
4 INHL conferences	6	6.7	94.4
5 INHL conferences	5	5.6	100
TOTAL		89	100

Chart 6: Number of INHL Conferences Attended by Survey Respondents



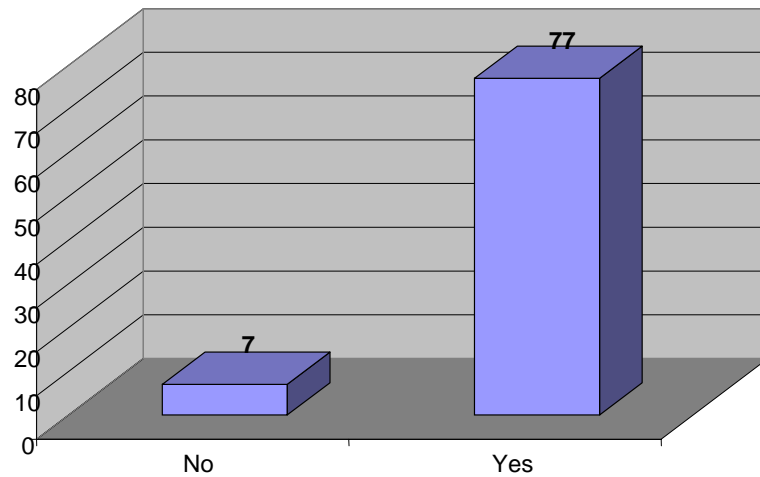
Question: Did you require overnight accommodations to attend the 2005 annual conference: (n=88)

Chart 7: Those Requiring Overnight Accommodations



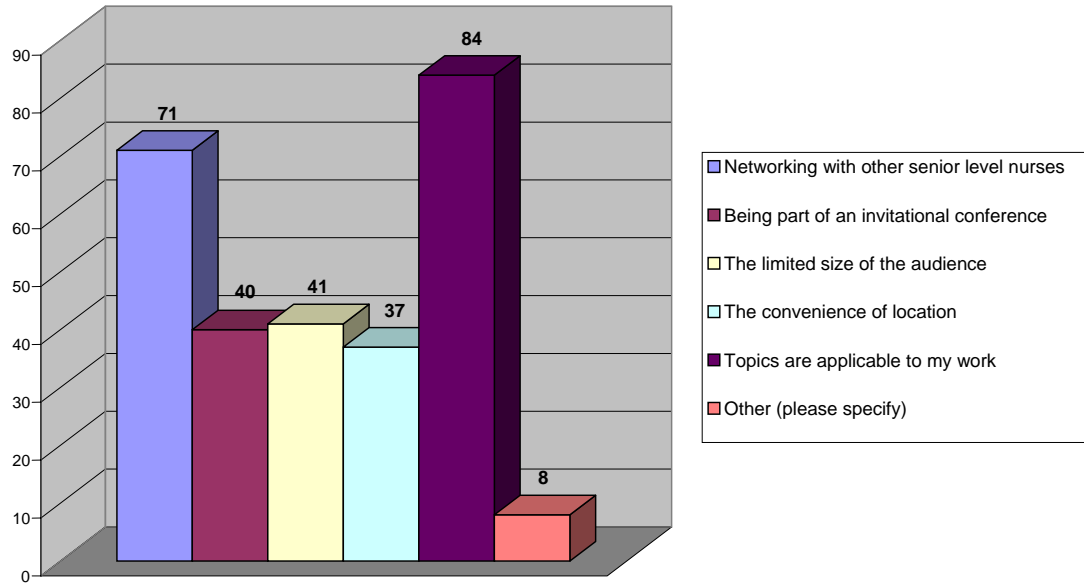
Question: Would you be willing/ able to attend if the venue was changes to another location in New England: (n=84)

Chart 7: Interest in Attending INHL Conference if Held at Another New England Location (n=84)



Question: What is the most appealing aspect of attending this annual conference? (n=89) (Select all appropriate answers)

Chart 8: Most Appealing Aspects of the INHL Conference



“Other” Responses:

- Consistently provides information on cutting edge of practice. Critical to those of us who work in regions with less sophistication in change.
- P&A of audience excellent questions/ dialogue (timely, current and useful topics)
- Fosters discussion across policy makers and researchers to uncover potential action
- Opportunity to revisit recharge vision as a nursing leader, to learn reshape goals as a leader in assuring healthcare needs of community in which I work.
- Planned time for interaction and thoughtful attention to exec and academic practice inclusive topics are cutting edge
- Learning new information
- Discussion/ "repatees"
- Please do not hold so close to MONE & MHA

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 an eleven 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 eleven topic areas were;

- 1) Clinical information technology clinical requirements and system selection.
- 2) Integration of standardized nursing language(s) into practice.
- 3) Development and 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 and issues.
- 8) Organizational Magnet Status Requirements.
- 9) Staffing/skill mix/ staff to patient ratio issues.
- 10) JCAHO, Leapfrog, CMS and other quality reporting requirements.
- 11) Financial management & budget development.

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 11 to identify the least knowledgeable or influential and 55 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 160 attendees, 90 (56%) sufficiently completed the survey. 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 11-item knowledge and influence scales was undertaken with the sample of valid survey respondents (n=85). Items were summed, and Cronbach's alpha internal consistency and reliability were computed on the four 11 item scales, since these were satisfactory, the four subscales were then computed. The standardized Cronbach's alpha coefficient for each the 11 item subscales were;

- Self-reported knowledge in comparison to non-nurse healthcare executives was 0.88
- Self-reported influence in comparison to non-nurse healthcare executives was 0.89
- Self-reported knowledge in comparison to fellow nurse leaders was 0.89
- Self-reported influence in comparison to fellow nurse leaders was 0.92

Finally, each respondent was asked to share the three most challenging issues they are currently dealing with in their role as a nurse leader. Directed content analysis (Hsieh & Shannon, 2005) was used to categorize the results of the qualitative "three most challenging issues" question into the identified American Organization of Nurse Executive (AONE) core competencies (AONE, 2005). Responses were categorized by core competency and skill as identified by AONE.

*** 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 7 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 11 (scoring of 1 on each specific item score) to a maximum 55 (scoring of 5 on each specific item scale).

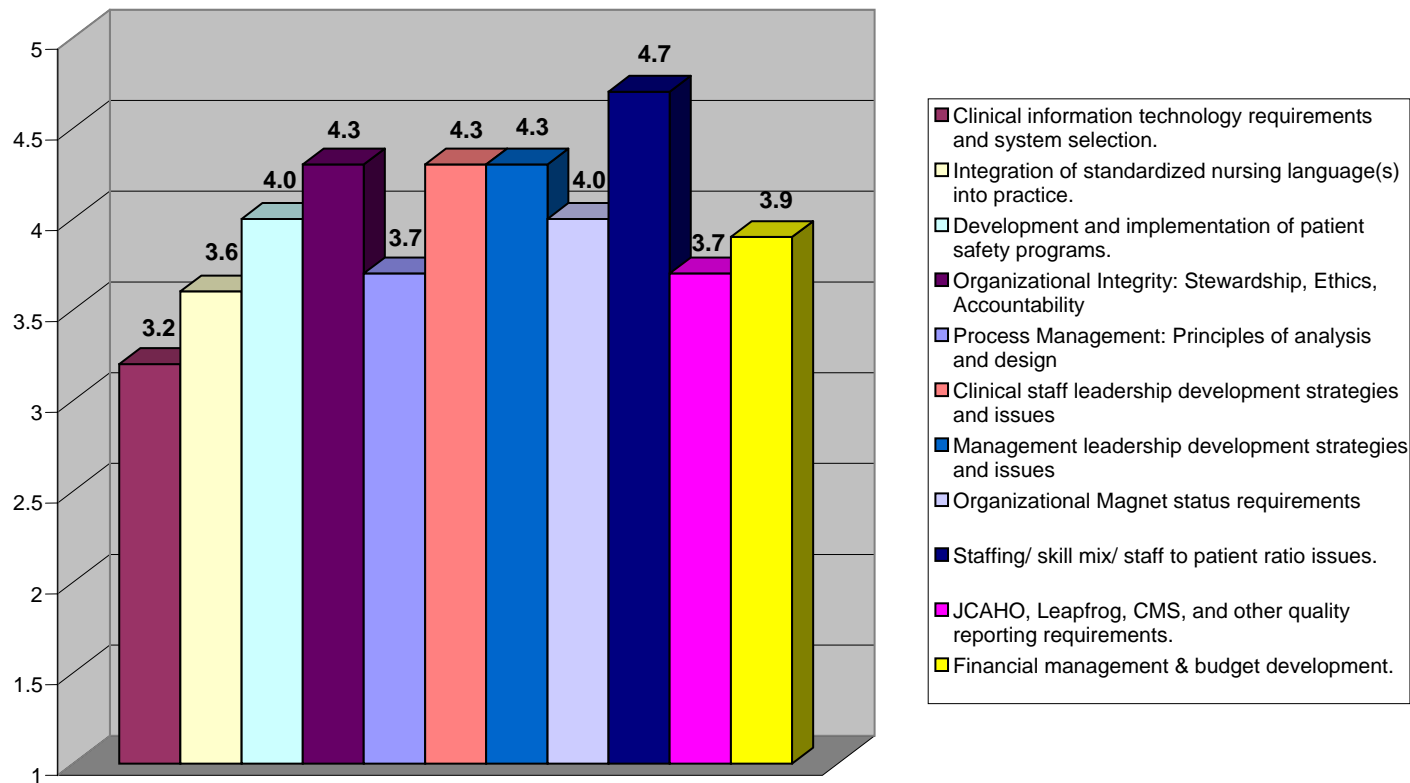
TABLE 7: Nurse Leaders Self Reported Knowledge and Influence in Comparison to Nurse and Non-Nurse Healthcare Leadership

	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 requirements and system selection.	90	3.2	1.1	87	3.2	1.1	82	3.4	1.1	80	3.4	1.1
Integration of standardized nursing language(s) into practice.	89	3.6	1.0	86	3.6	1.0	80	3.7	1.0	78	3.6	1.0
Development and implementation of patient safety programs.	90	4.0	1.0	87	3.9	0.9	81	4.0	0.9	79	4.0	1.0
Organizational Integrity: Stewardship, Ethics, Accountability	88	4.3	0.9	85	4.0	1.0	80	4.3	0.9	78	4.2	0.9
Process Management: Principles of analysis and design	89	3.7	1.1	87	3.6	1.1	80	3.9	1.1	78	3.7	1.1
Clinical staff leadership development strategies and issues	89	4.3	0.7	87	4.1	0.9	79	4.3	0.9	77	4.1	0.9
Management leadership development strategies and issues	87	4.3	0.8	85	4.1	0.9	78	4.4	0.8	76	4.2	0.9
Organizational Magnet status requirements	89	4.0	1.0	86	4.0	1.1	80	4.1	0.9	78	4.1	0.9
Staffing/ skill mix/ staff to patient ratio issues.	89	4.7	0.9	87	3.8	1.0	78	4.2	0.9	76	3.9	1.1
JCAHO, Leapfrog, CMS, and other quality reporting requirements.	89	3.7	1.0	87	3.6	1.0	80	3.9	1.0	78	3.7	1.1
Financial management & budget development.	89	3.9	0.9	87	3.7	1.0	80	4.0	1.0	78	3.8	1.1
TOTAL (min 11 - max 55)	85	43.6	6.7	80	42.0	7.5	76	44.6	7.0	74	43.0	8.3

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 43.6 ± 6.7 (possible range 11 minimum – 55 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 Clinical information technology requirements and system selection as the topic they were least knowledgeable about (score 3.2 ± 1.1). In contrast, these nurse leaders identified Staffing/ skill mix/ staff to patient ratio issues as the topic they had the greatest knowledge about (score 4.7 ± 0.9). The remaining item mean scores all fell between 3.6 and 4.3. (See Table 7 and Chart 9)

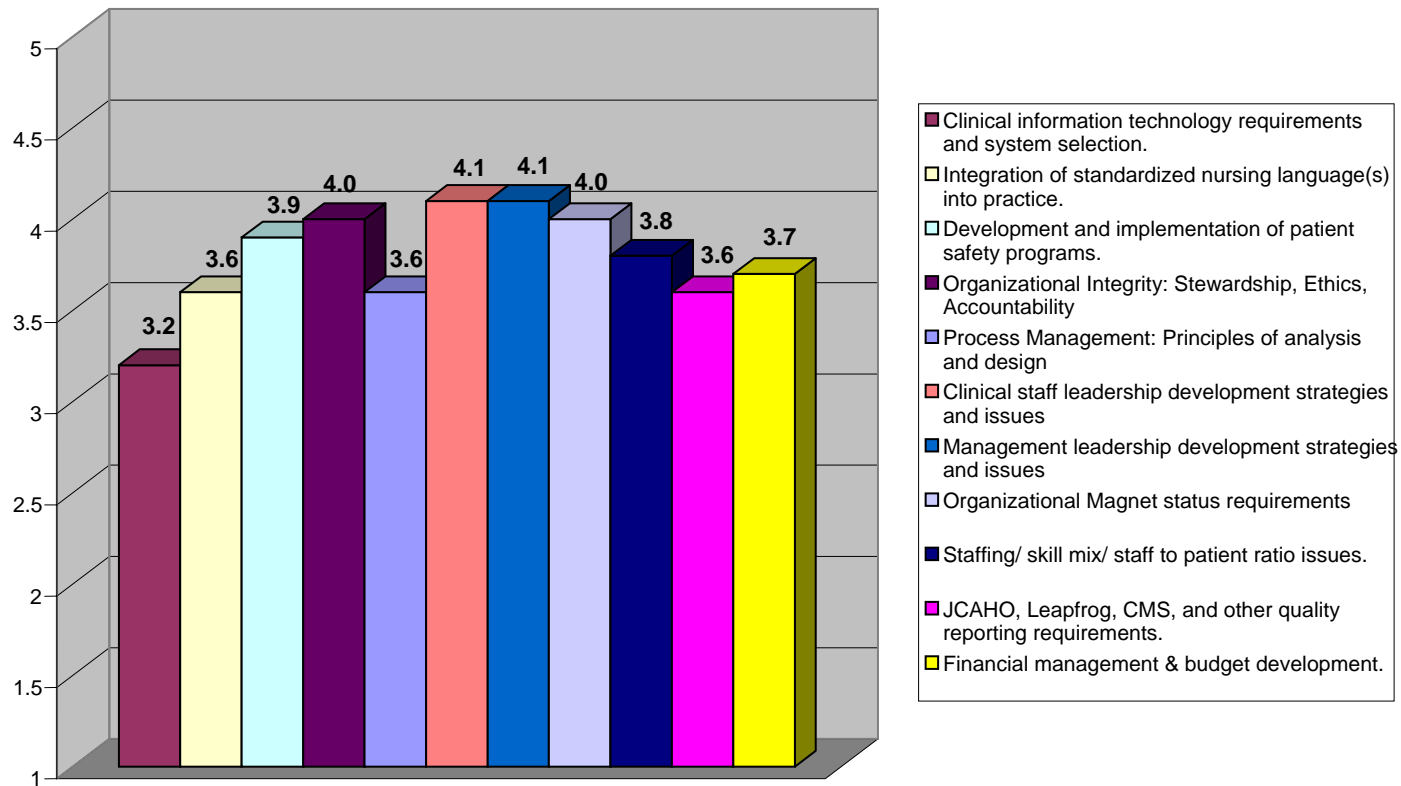
Chart 9: Self-perceived Knowledge in Comparison to Non-nurse Healthcare Executives



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 42.5 ± 7.0 (possible range 11 minimum – 55 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 Clinical information technology requirements and system selection as the topic they were least influential about (score 3.2 ± 1.1). In contrast, these nurse leaders identified Clinical staff leadership development strategies and issues (score 4.1 ± 0.9) and Management leadership development strategies and issues (4.1 ± 0.9) as the topics they had the most influence about. The remaining item mean scores all fell between 3.6 and 4.0. (See Table 7 and Chart 10)

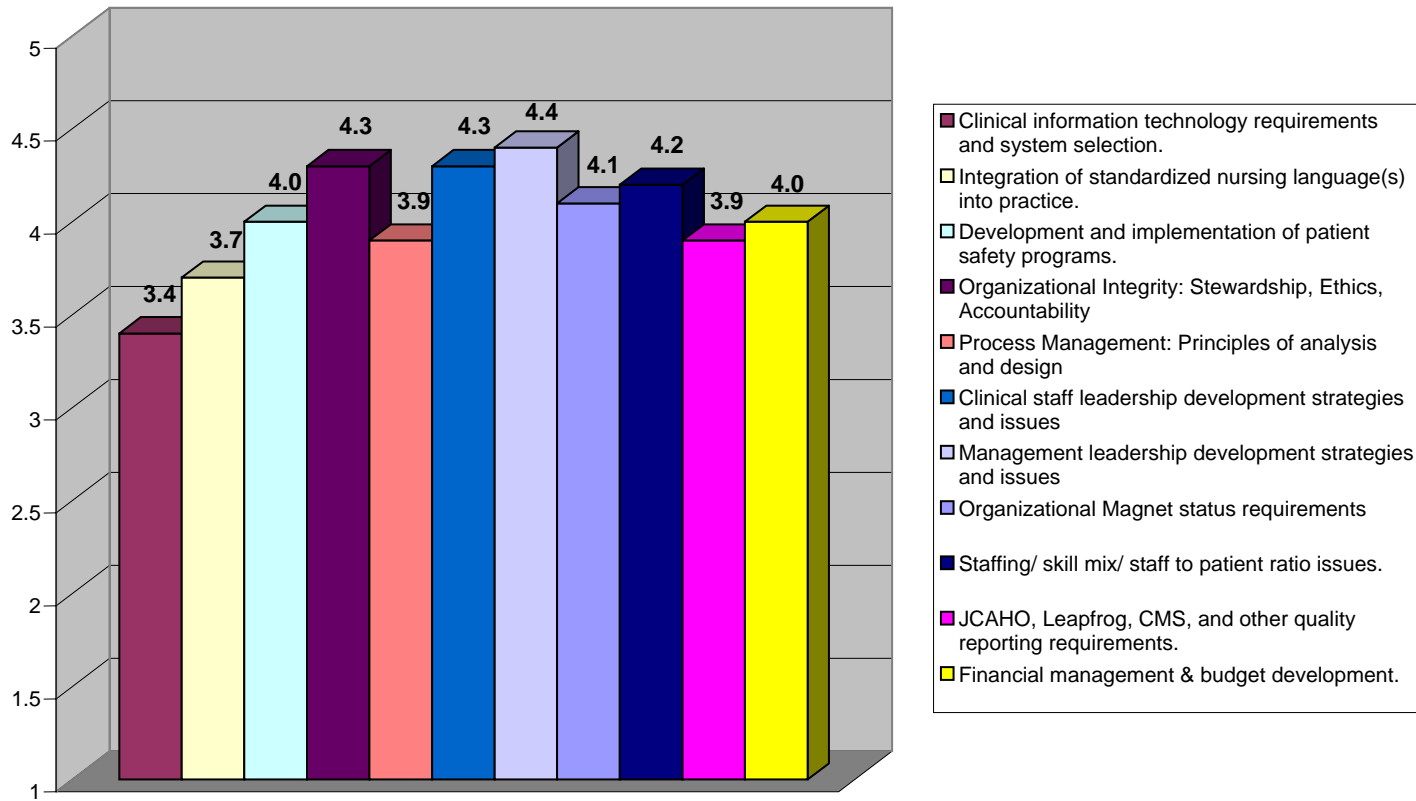
Chart 10: Self-perceived Influence in Comparison to Non-nurse Healthcare Executives



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 44.6 ± 7.5 (possible range 11 minimum – 55 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 Clinical information technology requirements and system selection as the topic they were least knowledgeable about (score 3.4 ± 1.1). In contrast, these nurse leaders identified Management leadership development strategies and issues as the topic they had the greatest knowledge about (score 4.4 ± 0.8). The remaining item mean scores all fell between 3.7 and 4.3. (See Table 7 and Chart 11).

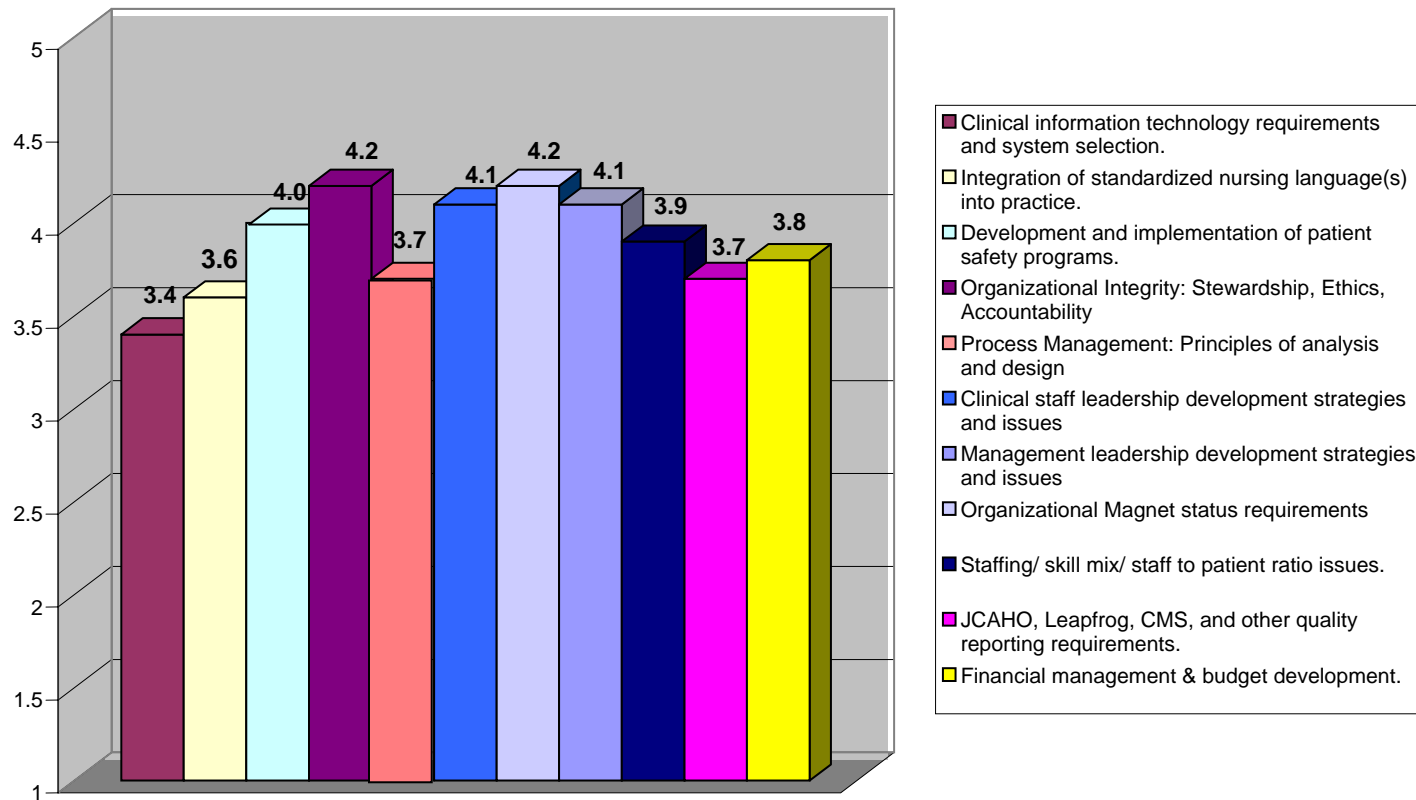
Chart 11: Self-perceived Knowledge in Comparison to Fellow Nurse Leaders



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 43.0 ± 8.3 (possible range 11 minimum – 55 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 Clinical information technology requirements and system selection as the topic they were least influential about. (score 3.4 ± 1.1). In contrast, these nurse leaders identified Management leadership development strategies and issues (score 4.2 ± 0.9) and Organizational integrity: stewardship, ethics and accountability (4.2 ± 0.9) as the topics they had the greatest influence. The remaining item mean scores all fell between 3.6 and 4.1. (See Table 7 and Chart 12).

Chart 12: Self-perceived Influence in Comparison to Fellow Nurse Leaders



Discussion

The respondents to this survey responded as 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 7) with the exception of the topic “Staffing/ skill mix to patient ratio issues.” 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 every topic with the exception of staffing/ skill mix to patient ratio issues. This is somewhat concerning, and identifies opportunity and need for knowledge and/ or confidence development for nurse leaders.

Another interesting finding is the identification of “Clinical information technology requirements and system selection” as the topic where nurse leaders self reported knowledge and influence as lowest in comparison to both non-nurse executives and fellow nurse leaders. Information Management & Technology was also infrequently (5% of all responses) identified as one of the most pressing issues in the qualitative responses (see Research Question 10 page 24). While this is anecdotally not a tremendously surprising finding, it is an important one as hospitals and healthcare organizations will continue to increase spending on information technology (HIMSS, 2005), and many have identified the impact and value that clinical informatics provides toward care delivery, patient safety, workforce management and decision support (Adams, 1998; Androwich et al., 2003; Graves & Corcoran, 1989; Simpson, 2005).

For questions RQ5-RQ10, 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=68).

RQ5: Within the context of this survey, is there a relationship between nurse leaders self reported knowledge and self reported influence?

As Table 8 shows, there is a significant positive relationship in every instance. Correlations were high and positive indicating that knowledge and influence were significantly related regardless of the comparison group. Thus, as reported knowledge scores increased, influence scores increased in the same direction.

TABLE 8: Correlation between Total Knowledge and Influence Scores in Comparison to Nurse and Non-nurse Leadership

Pearson <i>r</i> Correlation(s)	Total knowledge compared to non nurse execs	Total influence compared to non nurse execs	Total knowledge compared to fellow nurse leaders	Total influence compared to fellow nurse leaders
Total knowledge compared to non nurse execs	1.00			
Total influence compared to non nurse execs	0.74	1.00		
Total knowledge compared to fellow nurse leaders	0.88	0.69	1.00	
Total influence compared to fellow nurse leaders	0.64	0.83	0.80	1.00

TABLE 9: 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	23.0	46.0	4.3	32.0	43.9	5.8	9.0	40.4	9.2
Total influence compared to non nurse execs	21.0	45.4	5.8	32.0	42.7	6.2	8.0	35.0	8.9
Total knowledge compared to fellow nurse leaders	20.0	46.7	4.4	28.0	45.6	5.4	8.0	41.4	9.7
Total influence compared to fellow nurse leaders	19.0	46.2	5.5	28.0	44.6	6.8	8.0	35.8	8.3

RQ6: *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?*

Yes, (see Chart 13 and Table 9) the mean self reported total knowledge score of the Vice President/ CNO (46.0) was higher than that of the Directors (43.9) and Managers (40.4) when comparing themselves to non-nurse healthcare executives.

RQ7: *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?*

Yes, (see Chart 13 and Table 9) the mean self reported total knowledge score of the Vice President/ CNO (46.7) was higher than that of the Directors (45.6) and Managers (41.4) when comparing themselves to fellow nurse leaders.

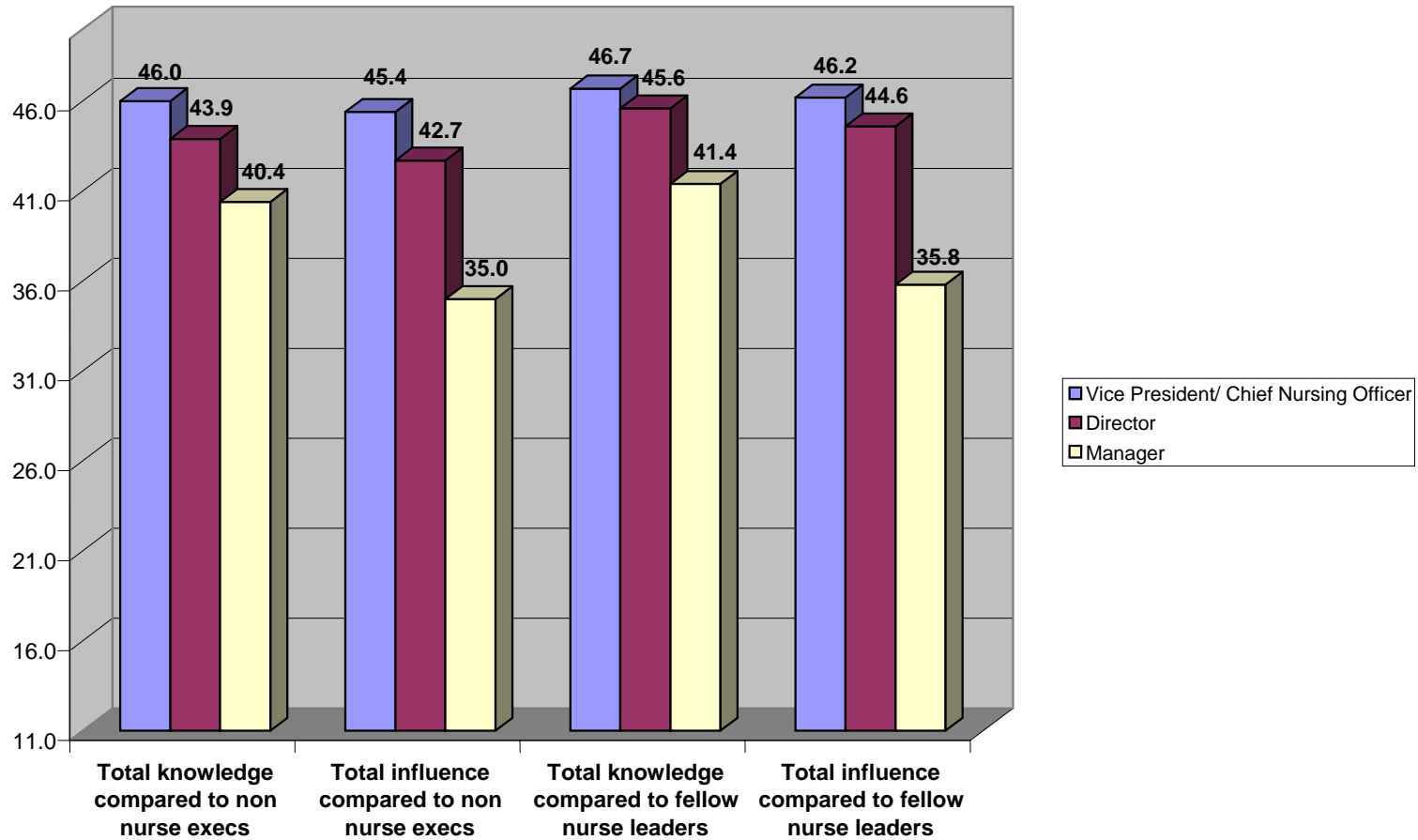
RQ8: *Do the total influence scores of Vice Presidents/ CNOs differ from the total influence scores of Directors and Managers in comparison to non-nurse healthcare executives?*

Yes, (see Chart 13 and Table 9) the mean self reported total influence score of the Vice President/ CNO (45.4) was higher than that of the Directors (42.7) and Managers (45.0) when comparing themselves to non-nurse healthcare executives.

RQ9: *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?*

Yes, (see Chart 13 and Table 9) the mean self reported total influence score of the Vice President/ CNO (46.2) was higher than that of the Directors (44.6) and Managers (35.8) when comparing themselves to non-nurse healthcare executives.

Chart 13: Self Reported Total Knowledge and Influence Scores in Comparison to Fellow Nurse Leaders and Non-nurse Healthcare Executives



Discussion

An important finding is the identification of a correlation between knowledge and influence within this population. This means that if knowledge increases, influence about that topic is highly probable to also increase. This is supportive of previous influence research (French & Raven, 1959; Kipnis, 1976; Kipnis, Schmidt, & Wilkinson, 1980; Yukl & Falbe, 1990; Yukl & Tracey, 1992) which suggests that knowledge is a component of influence.

Additional Pearson correlations were computed between years of experience and self reported knowledge and influence in comparison to both nurse and non-nurse leaders. In all cases there was no relationship (maximum $r = 0.02$) between years of experience in current role and any other variable.

When the sample was split, Vice Presidents/CNOs ($n=24$), Directors ($n=33$) and Managers ($n=11$) were isolated. It was identified that both knowledge and influence scores followed a hierarchical trend. This means that the total knowledge and influence scores of the Vice President/CNO were higher than both the Director and Manager (See Table 9 & Chart 13). Following this trend, the Director total scores were higher than that of the Manager. It is not surprising that organizational hierarchical position impacts one's influence, although identifying that those with higher professional position self report a higher level of knowledge on specific topics does cause for some interesting follow up questions. Future research will aim to explore the cause of this trend. Could it be that there is;

- A) a natural (advancement of the fittest) order in that the most knowledgeable advance up the professional ladder?
- B) a confidence in self reporting knowledge that is associated with hierarchical position?
- C) an additional confounding factor(s) such as education level or specialization of work that causes one to self report lower knowledge scores?

III. Section three of this document identifies the most pressing issues identified by survey respondents (RQ10)

TABLE 10: Most Pressing Issues Identified by Nurse Leaders Grouped by AONE Competency

AONE Core Competencies	Group Total	Competency Skills	Item Total
Communication and relationship-building competencies	31	Effective communication	1
		Relationship management	4
		Influence behaviors	3
		Ability to work with diversity	4
		Shared decision making	3
		Community involvement	0
		Medical staff relationships	10
		Academic relationships	6
Knowledge of the healthcare environment	48	Clinical practice knowledge	1
		Patient care delivery models and work redesign knowledge	13
		Healthcare economics knowledge	0
		Healthcare policy knowledge	4
		Understanding governance	5
		Understanding of evidence-based practice	3
		Outcome measurement	5
		Knowledge of and dedication to patient safety	6
		Understanding of utilization/ case management	3
		Knowledge of quality improvement and metrics	7
Knowledge of risk management	1		
Leadership skills	35	Foundational thinking skills	1
		Personal journey disciplines	0
		The ability to use systems thinking	4
		Succession planning	21
		Change management	9
Professionalism	25	Personal and professional accountability	14
		Career planning	2
		Ethics	0
		Evidence-based clinical and management practice	3
		Advocacy for clinical enterprise and for nursing practice	6
		Active membership in professional organizations	0
Business skills	77	Understanding of healthcare financing	19
		Human resource management and development	34
		Strategic management	12
		Marketing	1
		Information management and technology	11

RQ10 What are the most pressing issues for nurse leader attendees at the 2005 INHL conference?

Two hundred sixteen written responses to this qualitative question were reviewed and using directed content analysis were identified as relating with AONE competency skills. The top ten competency skills and percentage of the responses identified as the most pressing issues by nurse leaders are identified in Table 11.

Table 11: Top Ten Most Pressing Issues

Competency Skill	Number of Responses	Percentage of Responses (out of 215 total responses)
1) Human resource management and development	34	16%
2) Succession planning	21	10%
3) Understanding of healthcare financing	19	9%
4) Personal and professional accountability	14	6%
5) Patient care delivery models and work redesign knowledge	13	6%
6) Strategic management	12	6%
7) Information management and technology	11	5%
8) Medical staff relationships	10	5%
9) Change management	9	4%
10) Knowledge of quality improvement and metrics	7	3%
TOTAL OF TOP TEN RESPONSES	150	69%

While there was a diversity of responses covering all of the AONE competencies and the majority of competency skills, “Human resource management and development” which includes topics such as staffing, workforce planning, recruitment and retention and employee satisfaction (AONE, 2005) was the single skill issue identified as most pressing (16%) by nurse leaders. “Succession planning,” covering topics such as promoting nursing management as a desirable profession, conducting periodic organizational assessments for succession planning, serving as a professional role model, establishing mechanisms for identifying staff with leadership potential, and develop a succession plan for one’s own position (AONE, 2005), was identified as the second most reported competency skill (10%).

The AONE Competency grouping Business Skills (understanding healthcare financing, human resource management and development, strategic management, marketing and information management and technology) (AONE, 2005) were identified as containing 36% of the reported most pressing issues. The AONE Competency grouping Knowledge of healthcare environment (clinical practice knowledge, patient care delivery models and work design knowledge, healthcare economics knowledge, healthcare policy knowledge, understanding of governance, understanding of evidence-based practice, outcome measurement, knowledge of and dedication to patient safety, understanding of utilization/ case management, knowledge of quality improvement and metrics, and knowledge of risk management) (AONE, 2005) were identified as the group containing the second most (22%) reported pressing issues.

REFERENCES

- Adams, J. M. (1998). Health information systems: improving nursing care and cutting costs. *MedSurg Nursing*, 7(5), 308.
- Andrewich, I. M., Bickford, C. J., Button, P. S., Hunter, K. M., Murphy, J., & Sensmeier, J. (2003). *Clinical Information Systems: A Framework for Reaching the Vision*: American Nurses Publishing.
- AONE. (2005). AONE Nurse Executive Competencies. *Nurse Leader*, 3(1) 50-56.
- Ballein, K. M., & Thompson, P. A. (2003). *Why Senior Nurse Executives Matter: A National Survey of Nurse Executives*. Oak Brook, IL: Ballein Search Partners.
- Burritt, J. E. (2005). Organizational turnaround: the role of the nurse executive. *The Journal of nursing administration*, 35(11), 482-489.
- Cilliers, G. J. (1989). The expected leadership role of nursing administrators. *Nursing administration quarterly*, 13(3), 47-54.
- Clifford, J. C. (1985). The Nurse Executive in the Institution's Leadership. *World Hospitals*, 21(4), 28-30.
- Clifford, J. C. (1998). *Restructuring: The Impact of Hospital Organization on Nursing Leadership*. Chicago: American Hospital Publishing, Inc. & American Organization of Nurse Executives.
- French, J. R. P., & Raven, B. (1959). The bases of power. In D. Cartwright (Ed.), *Studies in social power*. Ann Arbor, MI: Institute of Social Research.
- Graves, J. R., & Corcoran, S. (1989). The Study of Nursing Informatics. *Image: Journal of Nursing Scholarship*, 21, 227-231.
- Havens, D. S. (1998). An update on nursing involvement in hospital governance: 1990-1996. *Nursing economic\$,* 16(1), 6-11.
- HIMSS. (2005). *16th Annual HIMSS Leadership Survey*. Ann Arbor, MI: Healthcare Information and Management Systems Society.
- Hsieh, H.-F., & Shannon, S. E. (2005). Three approaches to qualitative content analysis. *Qualitative Health Research*, 15,, 1277-1288.
- Institute of Medicine. (2004). *Keeping patients safe: Transforming the work environment of nurses*. Washington, DC: National Academies Press.
- Ives Erickson, J. (2001). *Chief Nurse Executive role in integrated delivery systems: A national survey of Chief Nurse Executives*. Boston, MA: Robert Wood Johnson Executive Nurse Fellowship Program.
- Kipnis, D. (1976). *The powerholders*. Chicago: University of Chicago Press.
- Kipnis, D., Schmidt, S. M., & Wilkinson, I. (1980). Intraorganizational influence tactics: explorations in getting one's way. *Journal of Applied Psychology*, 65(440-452).

- Poulin, M. A. (1984). The nurse executive role: a structural and functional analysis. *The Journal of nursing administration*, 14(2), 9-14.
- Scoble, K., B., & Russell, G. (2003). Vision 2020, Part I: Profile of a Future Nurse Leader. *JONA*, 33(6), 324-330.
- Simpson, R. L. (2005). Patient and nurse safety: how information technology makes a difference. *Nursing administration quarterly*, 29(1), 97-101.
- Sovie, M., & Jawad, A. (2001). Hospital restructuring and its impact on outcomes. *The Journal of Nursing Administration*, 31(12), 588-600.
- Sullivan, E. J. (2004). *Becoming influential: A guide for nurses*. Upper Saddle River, NJ: Pearson Educational, Inc.
- Upenieks, V. (2002). *The interrelationship between and meaning of power and opportunity, nursing leadership, organizational characteristics of magnet institutions, and clinical nurse job satisfaction*. Unpublished Dissertation/ PhD, University of Washington, Seattle, Washington.
- Upenieks, V. (2003). Nurse Leaders' Perceptions of What Compromises Successful Leadership in Today's Acute Inpatient Environment. *Nursing Administration Quarterly*, 27(2), 140-152.
- Yukl, G., & Falbe, C. M. (1990). Influence tactics and objectives in upward, downward, and lateral influence attempts. *Journal of Applied Psychology*, 75, 132-140.
- Yukl, G., & Tracey, J. B. (1992). Consequences of tactics used with subordinates, peers, and the boss. *Journal of Applied Psychology*, 77, 525-535.