Success Measures for the Nurse Leader
A Survey of Participants from the 2007 INHL Conference

The Institute for Nursing Healthcare Leadership

Report Prepared by:

- **Jeffrey M. Adams, PhD(c), RN**
- **Lisa Paulo, MSN, MPA, RN**
- **Lilia Meraz-Gottfried, BSN, RN**
- **Alicemary Aspell Adams, MBA, BSN, RN**
- **Jeanette Ives Erickson, MS, RN, FAAN**
- **Dorothy A. Jones, EdD, RNC, ANP, FAAN**
- **Joyce C. Clifford, PhD, RN, FAAN**

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About the Authors

Jeffrey M. Adams, PhD(c), RN is a Research Associate with The Institute for Nursing Healthcare Leadership, he is a Pre Doctoral Fellow with the Yvonne L. Munn Center for Nursing Research at the Massachusetts General Hospital, and a Doctoral Candidate at Boston College Connell School of Nursing. Jeff is a Principal Consultant with The Bogart Group, Inc. and will be starting Post Doctoral study at The University of California San Francisco Center for Health Professions upon graduation this summer 2008.

Lisa Paulo, MSN, MPA, RN is the Senior Administrative Director for Patient Care Services at Salinas Valley Memorial Healthcare System. She will begin doctoral study at Capella University this fall 2008.

Lilia Meraz-Gottfried, BSN, RN is a Staff Nurse at Salinas Valley Memorial Hospital. She is currently a Graduate Student at University of Phoenix.

Alicemary Aspell Adams, MBA, BSN, RN is the President of The Bogart Group, Inc. She is currently a Graduate Student at Oregon Health and Science University.

Jeanette Ives Erickson, MS, RN, FAAN is a Senior Associate of The Institute for Nursing Healthcare Leadership and the Senior Vice President of Patient Care Services & Chief Nurse at Massachusetts General Hospital.

Dorothy A. Jones, EdD, RNC, ANP, FAAN is the Director of the Yvonne L. Munn Center for Nursing Research at the Massachusetts General Hospital. Dr. Jones is also a Professor at Boston College William F. Connell School of Nursing.

Joyce C. Clifford, PhD, RN, FAAN is the President & CEO of The Institute for Nursing Healthcare Leadership.

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This document reports the results of The Institute for Nursing Healthcare Leadership (INHL) Executive Nurse Leadership Survey distributed at the INHL Conference in June 2007. We thank those who participated in this survey and all those who 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.

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Dear Colleagues- June 12, 2008

Over the past quarter century, the argument has been made that nursing leadership can and does significantly impact the organization (Clifford, 1998; Poulin, 1984) and work environment. More recently several prominent leaders' publications have taken this one step further and suggested that organizational nursing leadership is vital for enhancing nurses' work environments and positive patient outcomes (American Nurses Association, 1995; Institute of Medicine, 2004; McClure & Hinshaw, 2002) and is essential to ensure excellent patient care (American Organization of Nurse Executives, 2005). Yet we presently do not have a universally accepted measure of success for nursing leadership roles, specifically for Nurse Executives in the inpatient setting. Some would argue that Magnet recognition, and/ or the professional practice/ work environment measures are the appropriate evaluation tools.

An initial step toward identifying a measure of success for the nurse executive leader requires an understanding of the profile and role of the approximate 5000 Chief Nurse Executives currently practicing in the United States (Health Forum, 2006). A 2003, survey of 1000 randomly sampled Chief Nurse Executives (n=103) in the United States was conducted by Ballein Search Partners in conjunction with AONE. The results of the study began to develop a profile of the nurse executive leader. The average nurse executive leader is responsible for nearly 43% of the organization's operating budget, most (82%) hold the title of Vice President and 55% report directly to the CEO (The Advisory Board Company, 2003). These findings are representative of the significant strides nurse executive leaders have made in overcoming social and historical barriers "to get to the table" (Adams, Duffy, & Clifford, 2006; Sullivan, 2004).

Interestingly however despite social and historical challenges, the role and responsibilities of the nurse executive leader have developed into some of the most expansive and complex within all of healthcare (Adams et al., 2006). The nurse executive leader serves as one of the primary identifiable leaders both within the organization in which they are employed and the global nursing profession (Fedoruk & Pincombe, 2000). In this capacity, the nurse executive leader serves as the "gatekeeper" of professional nursing while striving toward the continued maximization of quality patient care, professional staff satisfaction and organizational cost-efficiency (Clifford, 1998), delicately balancing these nursing professional/ disciplinary goals while operating under political, financial and organizational constraints of the healthcare delivery system (Burritt, 2005; Cilliers, 1989; Clifford, 1985; Ives Erickson, 2001; Scoble & Russell, 2003).

Thus, nurse executive leaders continue to be evaluated differently based upon institutional specifics (such as for profit status) as well as criteria set by subordinates, peers and superiors. This balancing of goals can lead to a variation in the ability for the nurse executive leader to impact work environments. This variation makes it difficult to develop an accepted definition of "success" for those in nurse executive leadership. As Lang has suggested, "if you cannot "define" it, you cannot "measure it", control it, finance it, teach it, or put it into public policy" (International Council of Nurses, 1993) In 2005, The 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, these publications all fall short of defining how the nurse executive leadership is universally measured for success.

The purpose of this survey is to advance this area of research toward defining role clarity for the contemporary nurse leader. We feel the results provide a unique insight into the status of nursing leadership within healthcare organizations. 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 nurse executive leader, because they (you) are leading us, at what pace and in what direction cannot be left to chance.

Jeffrey M. Adams, PhD(c), RN *Lisa Paulo, MSN, MPA, RN* *Lilia Meraz-Gottfried, BSN, RN*

Alicemary Aspell Adams, MBA, BSN, RN *Jeanette Ives Erickson, MS, RN, FAAN* *Dorothy A. Jones, EdD, RNC, ANP, FAAN*

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

Typical survey respondents were 46-55 year old females from New England with a graduate nursing education. The majority of respondents (78%) held care delivery management roles as Vice President/ Chief Nursing Officer, Associate Vice President, Director or Manager primarily in hospitals and/ or medical centers (81%) in major metropolitan areas (52%). On average (62%), survey respondents had 5 years or less experience in their current employment position with 80% having less than ten years experience in their current role. Conference attendees represent membership in nearly one hundred different professional organizations and identified "applicability of topics to work" and "networking with other senior level nurses" among the most appealing reasons for attending the INHL conference. The following pages (Tables 1-20) 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
25 – 35 Years	5	3%	3%
36 – 45 Years	21	14%	17%
46 – 55 Years	87	56%	73%
56 – 65 Years	39	25%	99%
> 66 Years	2	1%	100%
	154	100%	

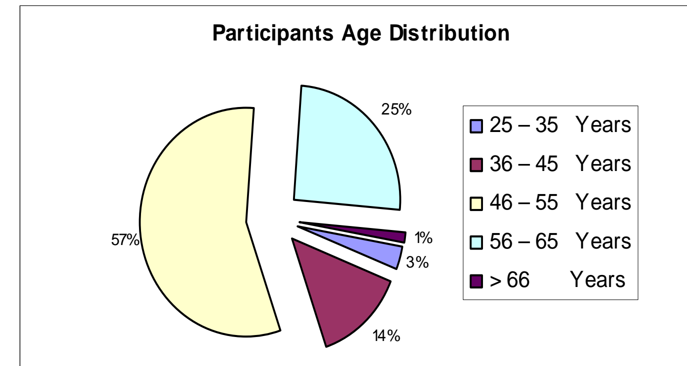

Table 2: Participant's Gender

	Frequency	Valid Percent	Cumulative Percent
Female	150	97%	97%
Male	4	3%	100%
	154	100%	

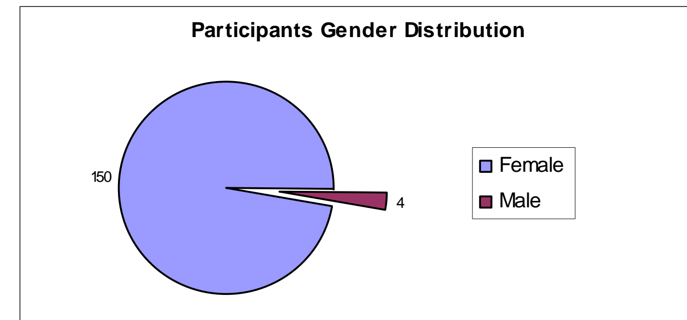

Table 3: Organization Size for Survey Respondents

	Frequency	Valid Percent	Cumulative Percent
000 – 200 Beds	36	29%	29%
201 – 400 Beds	39	31%	60%
401 – 600 Beds	15	12%	71%
601 – 800 Beds	19	15%	87%
801 - 1000 Beds	15	12%	98%
> - 1000 Beds	2	2%	100%
	126	100%	

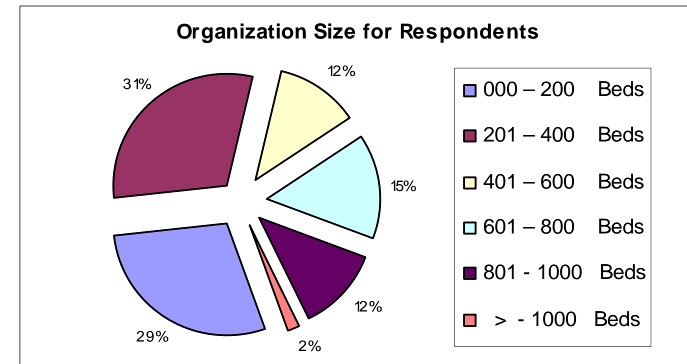

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Table 4: Primary Title of Survey Respondents

V.P./Chief Nursing Officer	41
Associate V.P.	12
Director	52
Manager	13
Dean/Faculty	12
Other	22
	152

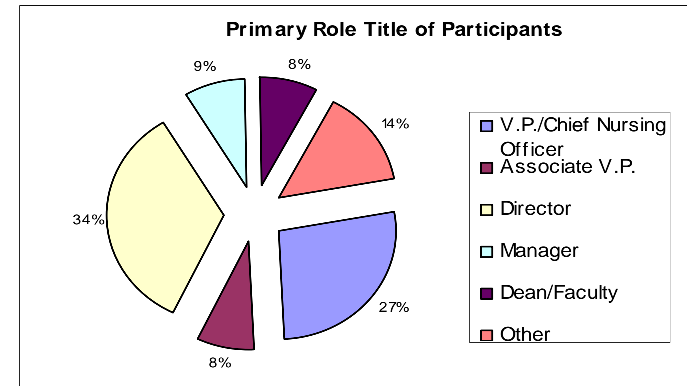

Table 5: Employment Community

	Frequency	Valid Percent	Cumulative Percent
Major Metropolitan Area	78	52%	52%
Mid Sized City	34	23%	75%
Small City or Town	34	23%	97%
Sparsely Populated Rural Area	4	3%	100%
	150	100%	

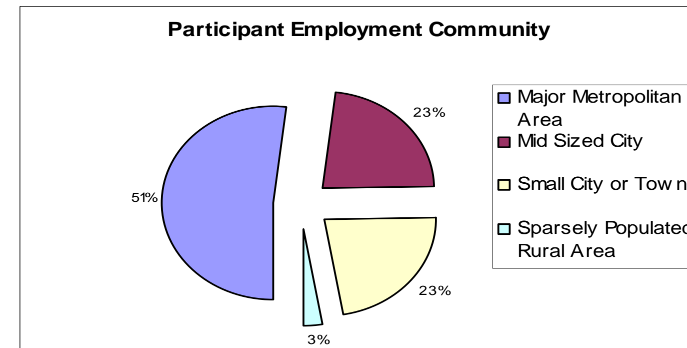

Table 6: Primary Employer of Survey Respondents

Hospital or Health Care System	130
School of Nursing	13
Ambulatory Care	10
Healthcare Vendor or Consulting Group	3
Government Agency	1
Professional Membership Organization	3
	160

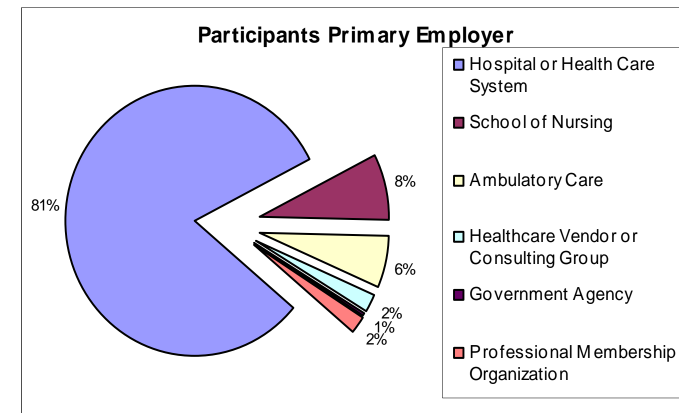

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Table 7: State of Respondent's Employment

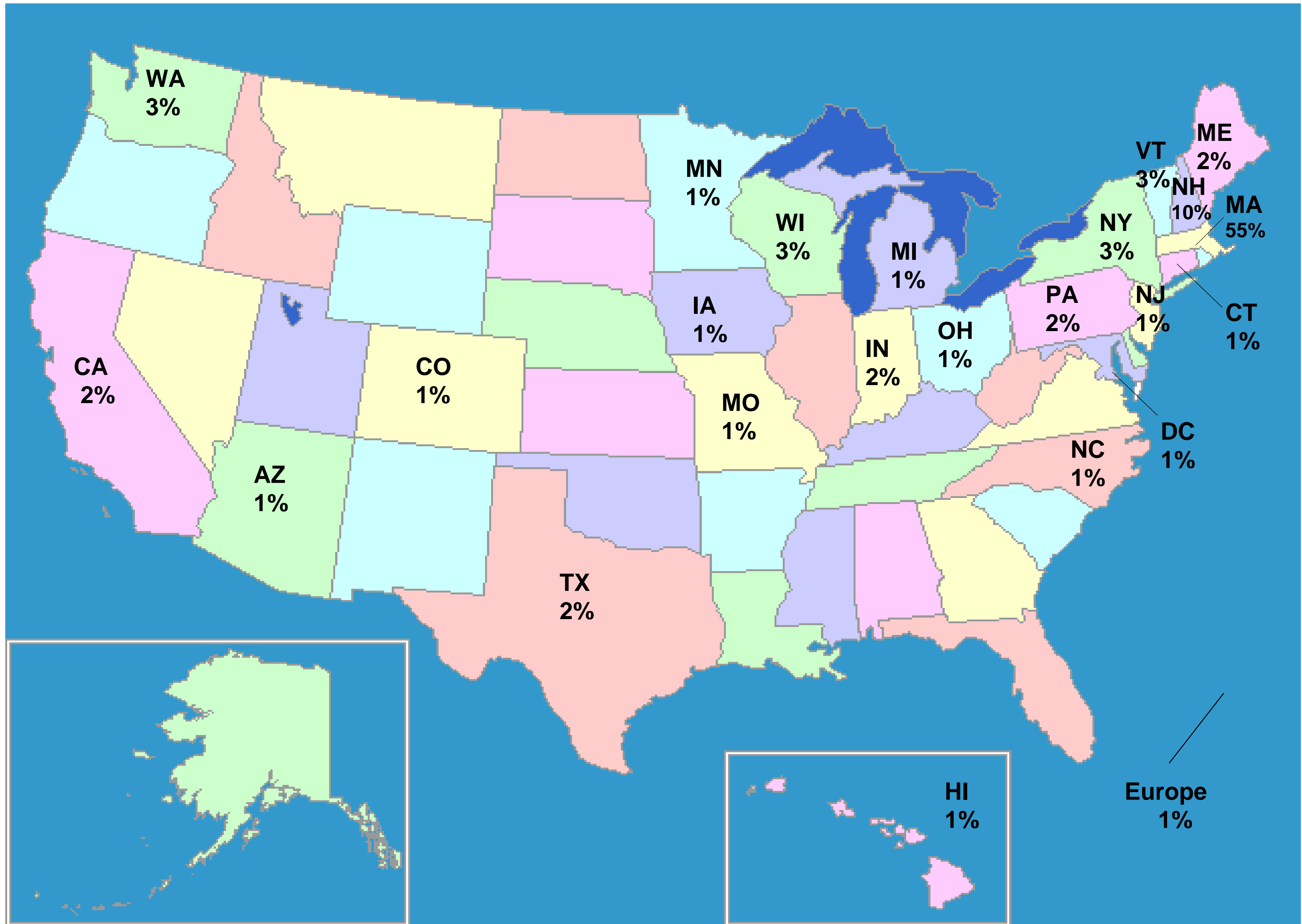

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Table 8: Highest Nursing Education Level

	Frequency	Valid Percent	Cumulative Percent
Diploma Program	3	2%	2%
Associates Degree	5	3%	5%
Bachelors Degree	19	12%	18%
Masters Degree	90	59%	76%
Doctoral Degree	36	24%	100%
	153	100%	

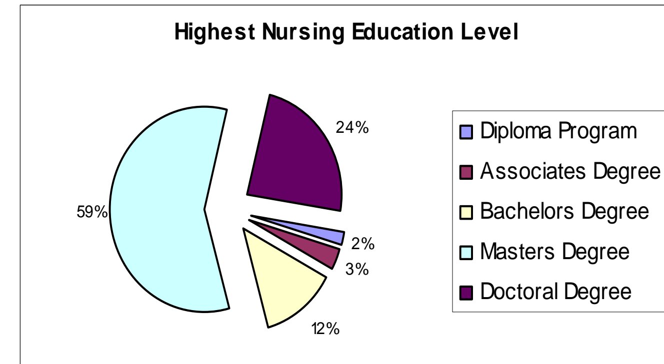

Table 9: Highest Educational Level of Any Degree

	Frequency	Valid Percent	Cumulative Percent
Associates Degree	2	1%	1%
Bachelors Degree	9	7%	8%
Masters Degree	84	62%	70%
Doctoral Degree	41	30%	100%
	136	100%	

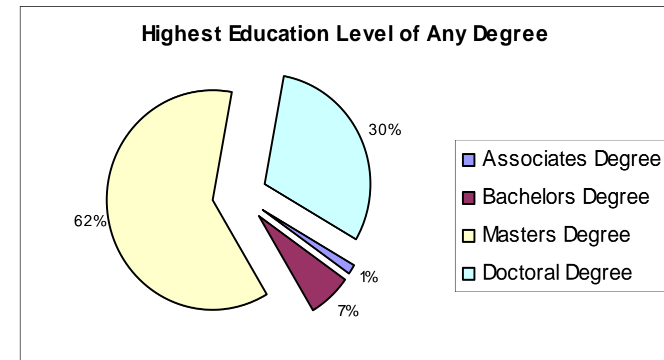

Table 10: Respondents Years Experience In Current Role

	Frequency	Valid Percent	Cumulative Percent
Years: 0 - 5	95	62%	62%
Years: 6 - 10	27	18%	80%
Years: 11 - 15	13	8%	88%
Years: 16 - 20	10	7%	95%
Years: > 20	8	5%	100%
	153	100%	

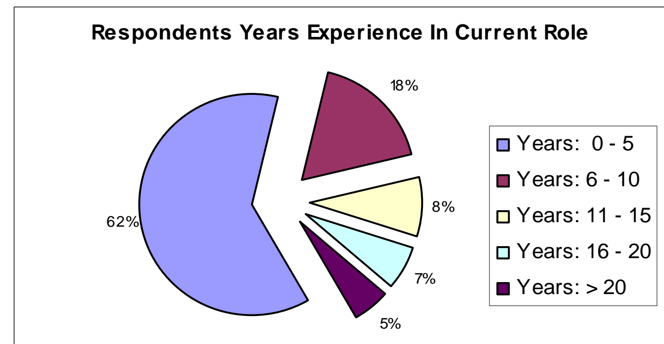

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Table 11: Number of Employers Since RN Graduation

	Frequency	Valid Percent	Cumulative Percent
01 - 03 Employers	65	44%	44%
04 - 08 Employers	37	25%	69%
06 - 08 Employers	38	26%	95%
09 - 10 Employers	6	4%	99%
> 10 Employers	2	1%	100%
	148	100%	

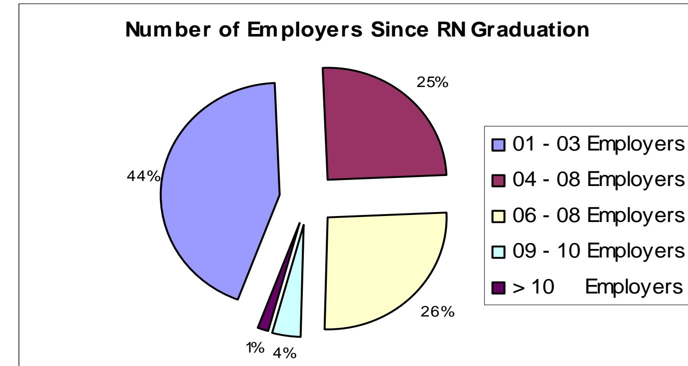

Table 12: Number of Years of Direct Patient Care Provided

	Frequency	Valid Percent	Cumulative Percent
00 - 10 Years	62	41%	41%
11 - 20 Years	49	32%	73%
21 - 30 Years	31	20%	93%
31 - 40 Years	10	7%	100%
	152	100%	

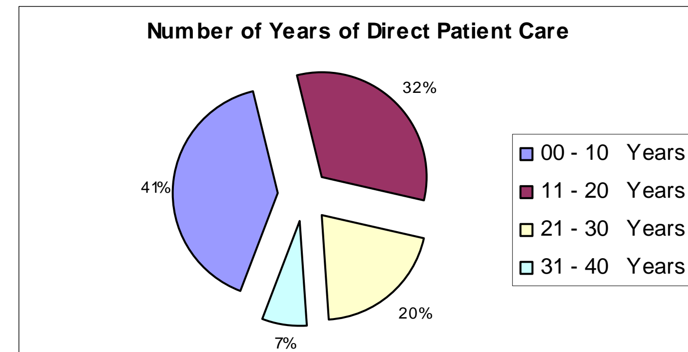

Table 13: Number of Years of Healthcare Administrative Experience

	Frequency	Valid Percent	Cumulative Percent
00 - 10 Years	62	41%	41%
11 - 20 Years	44	29%	70%
21 - 30 Years	40	26%	96%
31 - 40 Years	6	4%	100%
	152	100%	

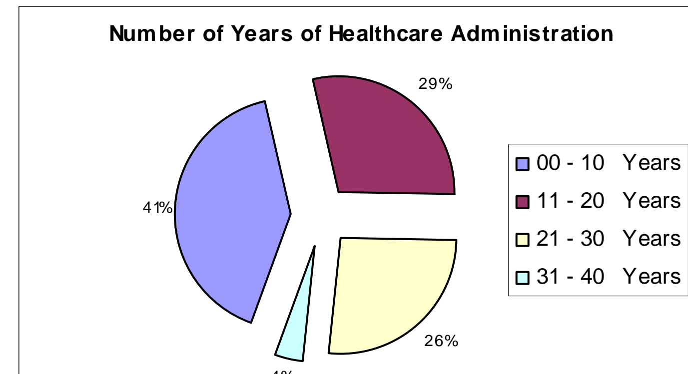

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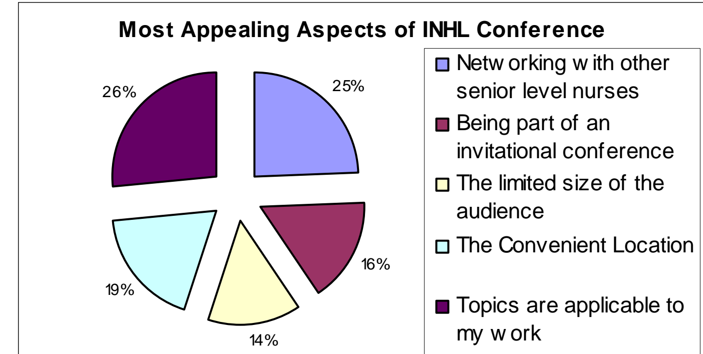
Table 14: Most Appealing Aspects of the INHL Conference

Networking with other senior level nurses	127
Being part of an invitational conference	83
The limited size of the audience	74
The Convenient Location	96
Topics are applicable to my work	137



Other Comments

Topics provide self development
Speakers and topics are at levels rarely found.
National issues; Practice leaders together
Excellent faculty
INHL Fellowship
Outstanding quality of conference, excellent speakers
Quality of presenters
Speakers reputation
To hear cutting edge research
Reasonable schedule ending at 1630
Hearing what executives from all over the country say
Design of conference with pauses for audience engagement

Table 15: Top Five Professional Organizations of Respondents

	Frequency
Sigma Theta Tau (STT)	98
American Organization of Nurse Executives (AONE)	82
Massachusetts Organization of Nurse Executives (MONE)	45
American Nurses Association (ANA)	41
American Association of Colleges of Nursing (AACN)	15

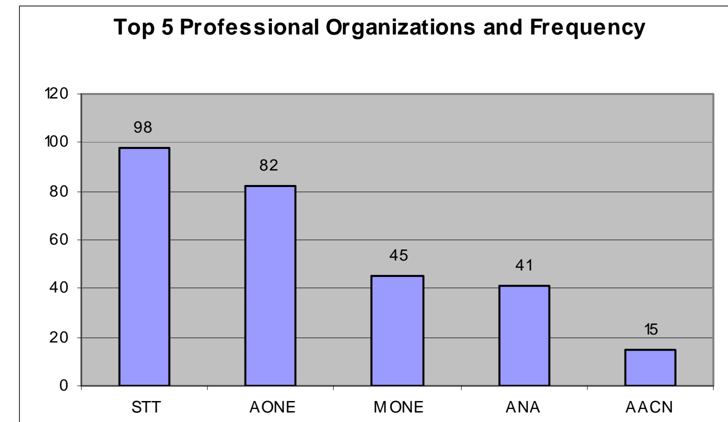


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Table 16: Participants Requiring Overnight Accommodations

	Frequency	Valid Percent	Cumulative Percent
Yes	73	48%	48%
No	79	52%	100%
	152	100%	

Table 17: Participants Willing to Attend in Another Boston Location

	Frequency	Valid Percent	Cumulative Percent
Yes	138	91%	91%
No	13	9%	100%
	151	100%	

Table 18: Participants Willing to Attend if in New England Location

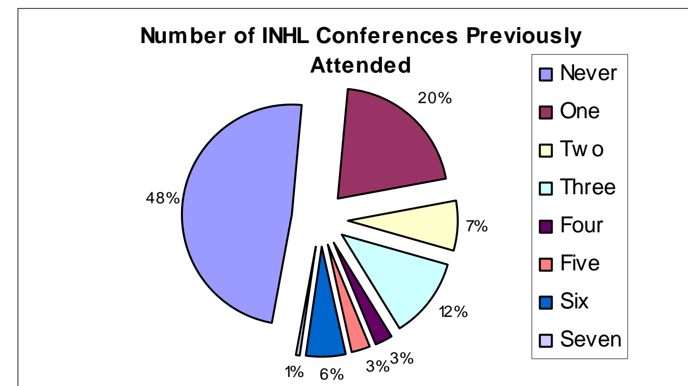
	Frequency	Valid Percent	Cumulative Percent
Yes	135	91%	91%
No	13	9%	100%
	148	100%	

Table 19: Country of Employment

	Frequency	Valid Percent	Cumulative Percent
USA	146	99%	99%
Other	1	1%	100%
	147	100%	

Table 20: Number of INHL Conferences Attended

	Frequency	Valid Percent	Cumulative Percent
Never	75	49%	49%
One	32	21%	69%
Two	11	7%	77%
Three	18	12%	88%
Four	4	3%	91%
Five	4	3%	94%
Six	9	6%	99%
Seven	1	1%	100%
	154	100%	



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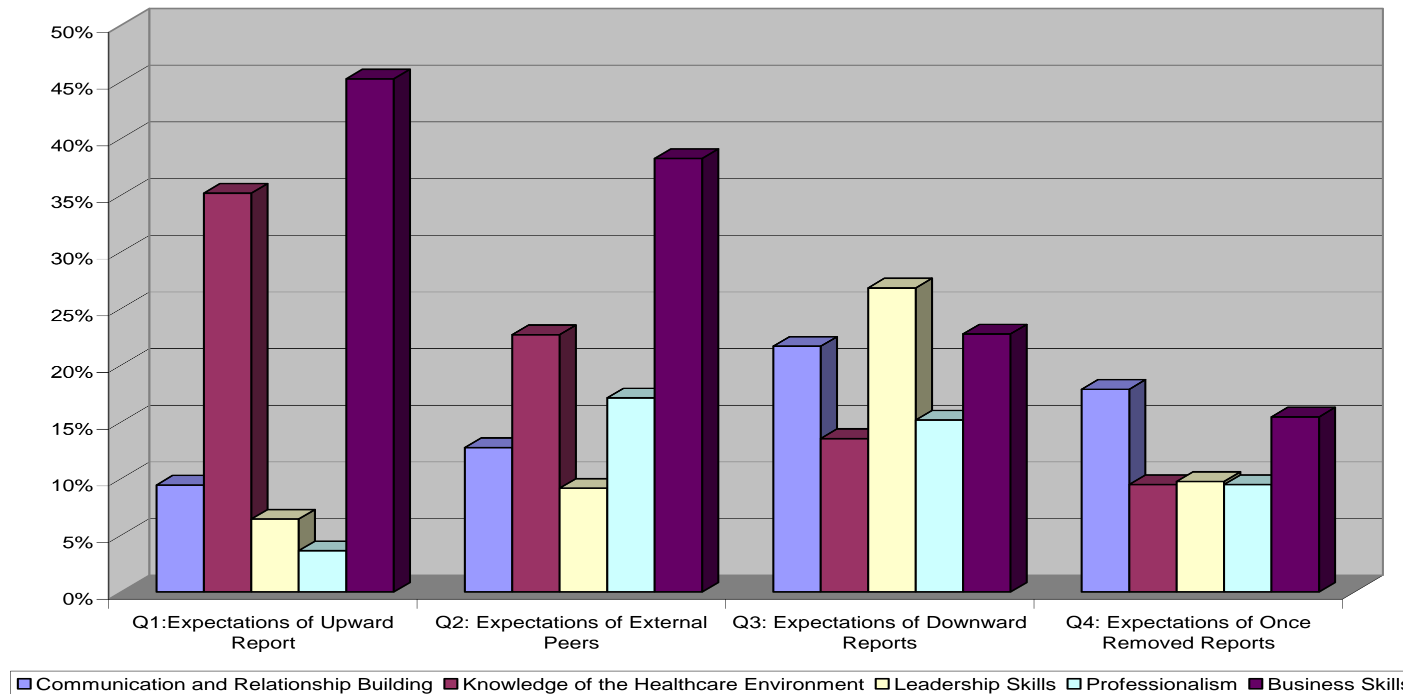
II. Section two of this document identifies the criteria used to measure nurse executive leader success by differing constituencies as identified by survey respondents (RQ) 1-4

A total of one thousand three hundred and fifteen unique concepts were identified as qualitative responses to the four research questions pertaining to measurement of success by varying constituencies as perceived by nurse leaders. Using directed content analysis (Hsieh & Shannon, 2005) these concepts were categorized by respective AONE core competencies (American Organization of Nurse Executives, 2005).

Table 21: Reponses by Role Relation	Communication and Healthcare Environment	Knowledge of the Healthcare Environment	Leadership Skills	Professionalism	Business Skills
Q1:Expectations of Upward Report	44	164	30	17	211
Q2: Expectations of External Peers	32	57	23	43	96
Q3: Expectations of Downward Reports	80	50	99	56	84
Q4: Expectations of Once Removed Reports	66	35	36	35	57



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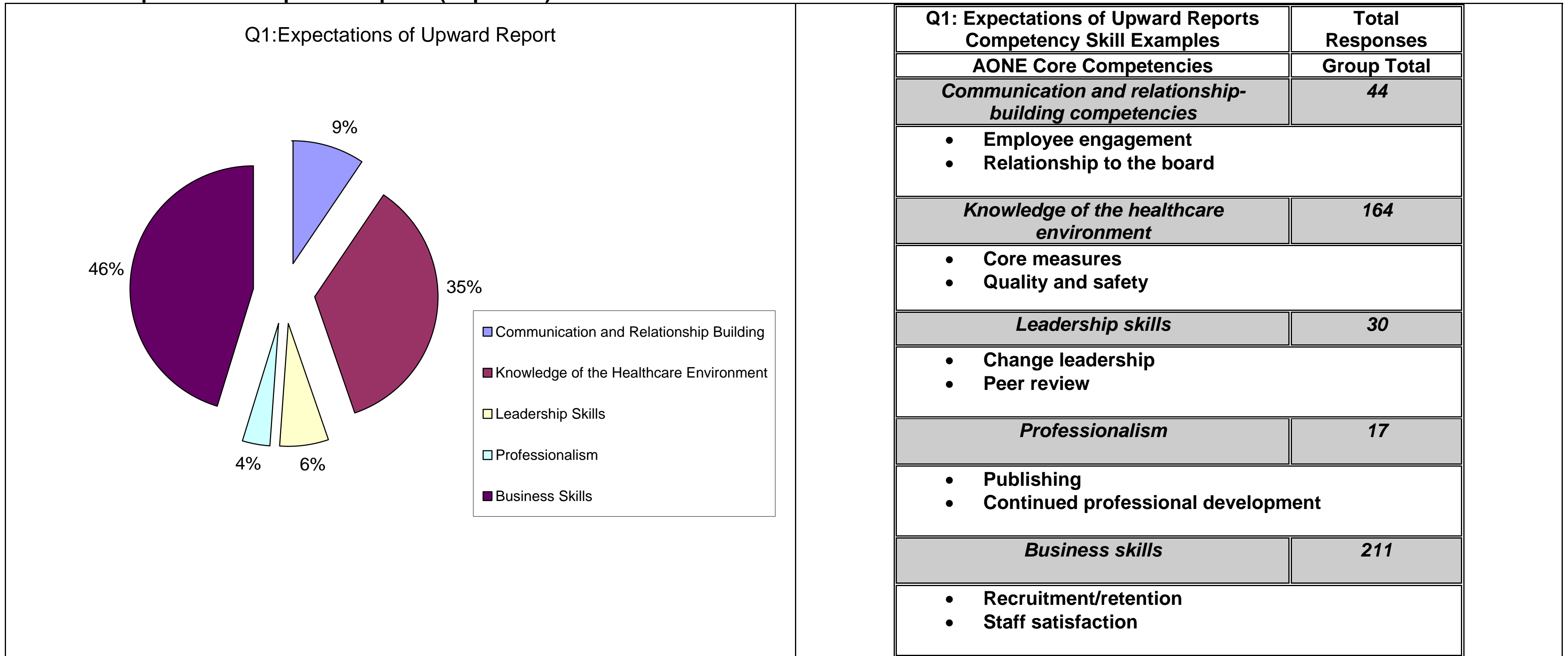
RQ 1: What are the criteria used measure success by nurse executives when they are evaluated by the person to whom they report directly?

Table 22: Expectation of Upward Reports (Superiors)



Q1: Expectations of Upward Reports Competency Skill Examples	Total Responses
AONE Core Competencies	**Group Total**
Communication and relationship-building competencies	***44***
• Employee engagement • Relationship to the board	
Knowledge of the healthcare environment	***164***
• Core measures • Quality and safety	
Leadership skills	***30***
• Change leadership • Peer review	
Professionalism	***17***
• Publishing • Continued professional development	
Business skills	***211***
• Recruitment/retention • Staff satisfaction	

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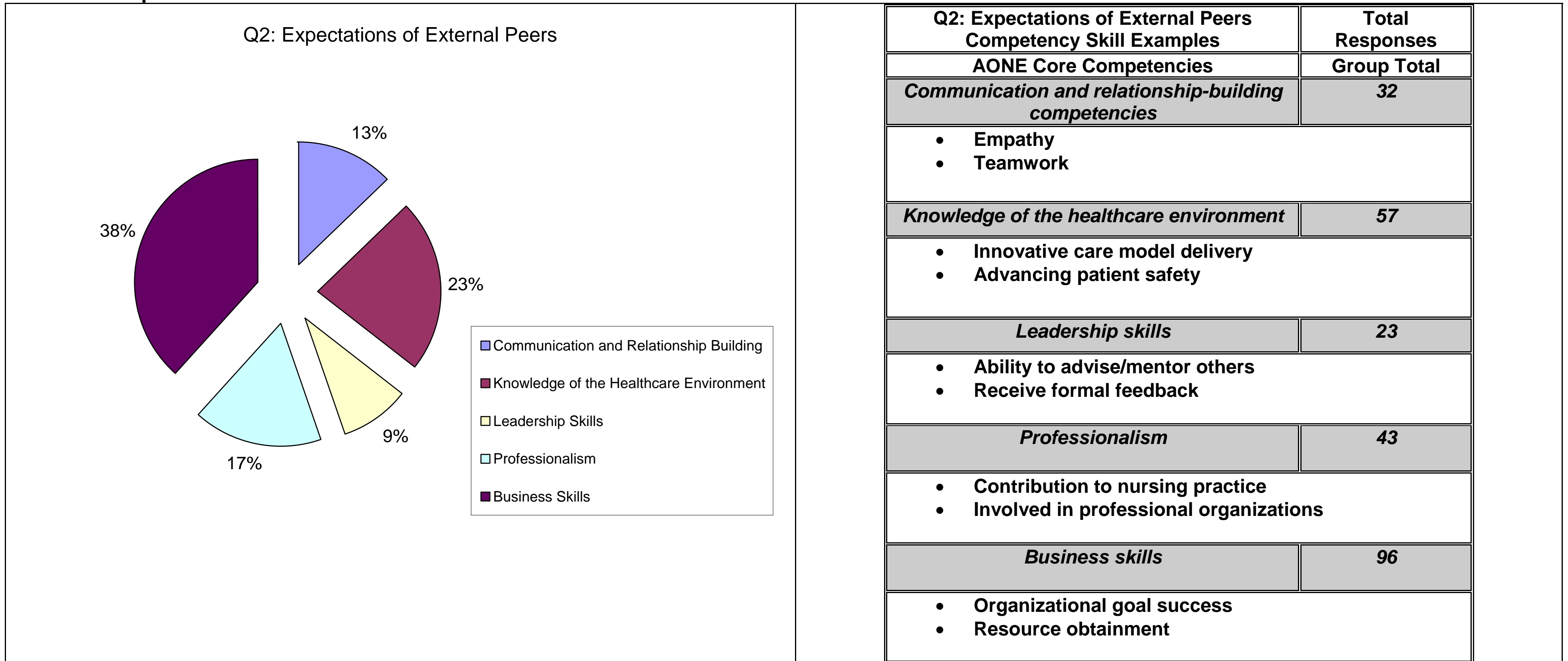
RQ2: What are the criteria used to measure success as nurse executive by nurse peers outside of their own organization?

Table 23: Expectation of External Peers



Q2: Expectations of External Peers Competency Skill Examples	Total Responses
AONE Core Competencies	**Group Total**
Communication and relationship-building competencies	***32***
• Empathy • Teamwork	
Knowledge of the healthcare environment	***57***
• Innovative care model delivery • Advancing patient safety	
Leadership skills	***23***
• Ability to advise/mentor others • Receive formal feedback	
Professionalism	***43***
• Contribution to nursing practice • Involved in professional organizations	
Business skills	***96***
• Organizational goal success • Resource obtainment	

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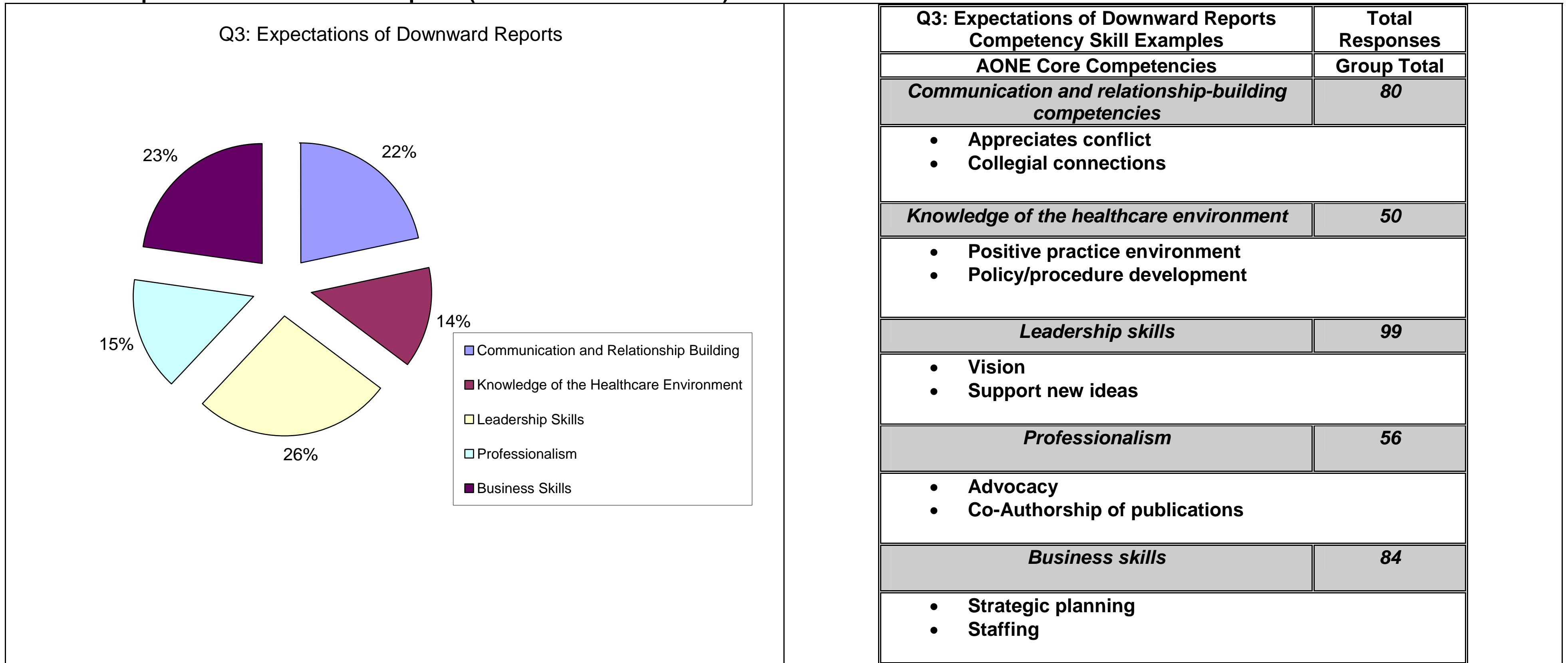
RQ3: What are the criteria used to measure success as nurse executive by direct report nurse subordinates?

Table 24: Expectation of Downward Reports (Immediate Subordinates)



Q3: Expectations of Downward Reports Competency Skill Examples	Total Responses
AONE Core Competencies	**Group Total**
Communication and relationship-building competencies	***80***
• Appreciates conflict • Collegial connections	
Knowledge of the healthcare environment	***50***
• Positive practice environment • Policy/procedure development	
Leadership skills	***99***
• Vision • Support new ideas	
Professionalism	***56***
• Advocacy • Co-Authorship of publications	
Business skills	***84***
• Strategic planning • Staffing	

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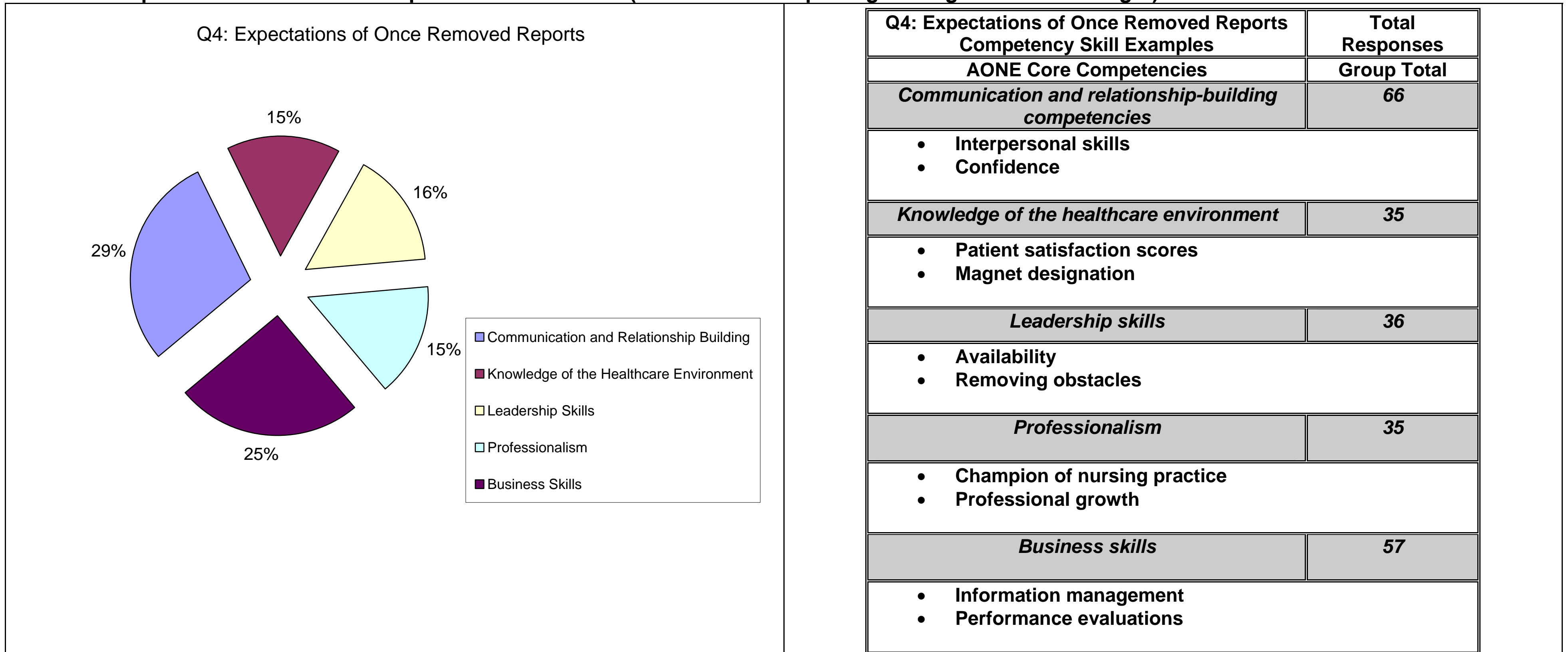
RQ4: What are the criteria used to measure success as nurse executive by nurse subordinates reporting up through another manager?

Table 25: Expectation of Downward Reports Once Removed (Subordinates Reporting Through Another Manager)



Q4: Expectations of Once Removed Reports Competency Skill Examples	**Total Responses**
AONE Core Competencies	**Group Total**
Communication and relationship-building competencies	***66***
• **Interpersonal skills** • **Confidence**	
Knowledge of the healthcare environment	***35***
• **Patient satisfaction scores** • **Magnet designation**	
Leadership skills	***36***
• **Availability** • **Removing obstacles**	
Professionalism	***35***
• **Champion of nursing practice** • **Professional growth**	
Business skills	***57***
• **Information management** • **Performance evaluations**	

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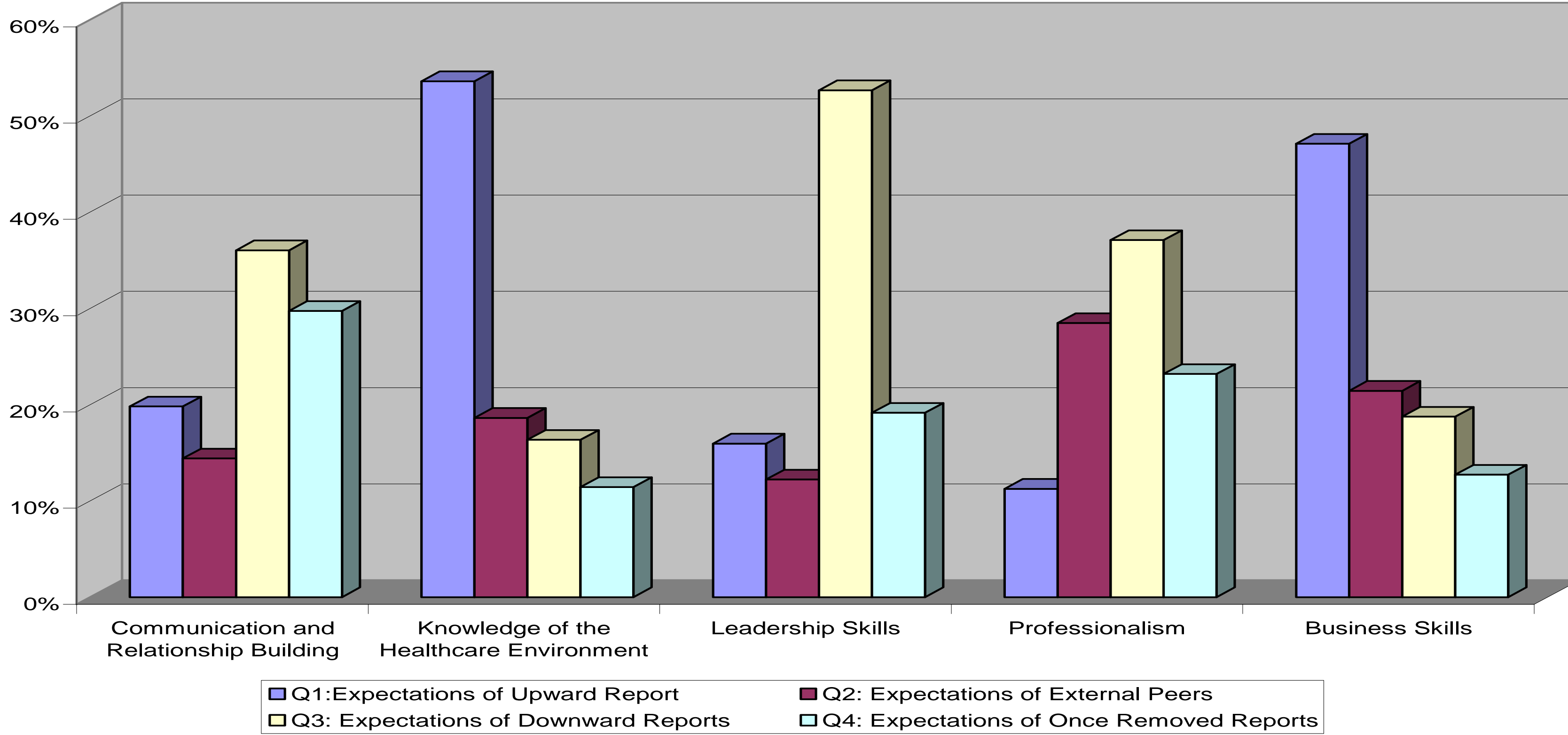
Table 26: Distribution of Responses by AONE Leadership Competencies

Table 26: Reponses by AONE Competencies	Q1:Expectations of Upward Report	Q2: Expectations of External Peers	Q3: Expectations of Downward Reports	Q4: Expectations of Once Removed Reports
Communication and Healthcare Environment	44	32	80	66
Knowledge of the Healthcare Environment	164	57	50	35
Leadership Skills	30	23	99	36
Professionalism	17	43	56	35
Business Skills	211	96	84	57



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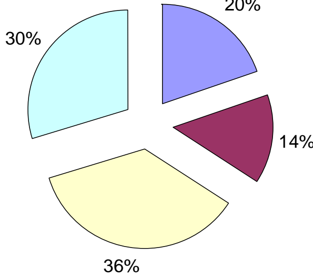
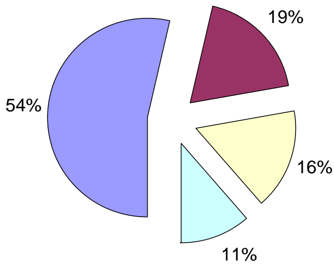
Distribution of Responses by AONE Leadership Categories

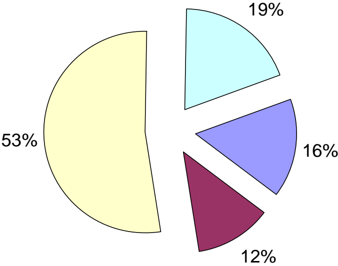
Communication and Relationship Building



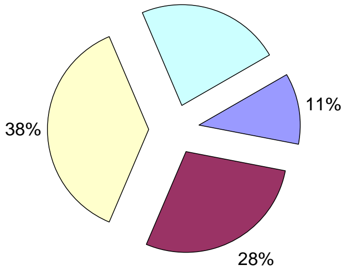
Knowledge of the Healthcare Environment



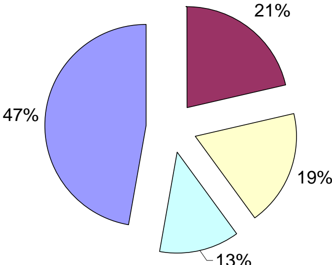
Leadership Skills



Professionalism



Business Skills



- Q1: Expectations of Upward Report
- Q2: Expectations of External Peers
- Q3: Expectations of Downward Reports
- Q4: Expectations of Once Removed Reports

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Findings

Findings from the four questions aimed at understanding nurse leaders' perceptions of how various constituency groups measure nurse leader success. Within responses for each constituency group, ***Business Skills*** ranked either as the most (Question 1 & 2) or second most (Question 3 & 4) identified competency area. The change in emphasis on ***Business Skills*** and ***Knowledge of the Healthcare Environment*** as one descended hierarchical position is of particular interest. Respondents identified 47% of their responses as being related to ***Business Skills*** when describing measurement of their success by superiors, as compared to 21% by peers, 19% by direct reports and 13% by reports once removed. This trend following hierarchical position was consistent when respondents identified the perceived measures of success by superiors whereas 54% of responses fell into the category of ***Knowledge of the Healthcare Environment***, versus 19% for the peer, 16% direct reports and 11% reports once removed (See Table 26). It is difficult to draw specific conclusions based on these trends although, the findings do suggest a variance in expectations by differing constituency groups as perceived by nurse leaders. Interestingly the two constituency groups with the most senior hierarchical position were perceived as placing the greatest emphasis on ***Business Skills*** when measuring nurse leader success as opposed to ***Leadership Skills*** and ***Communication and Relationship Building*** which were perceived as the primary competency measure of success by direct reports and once removed reports respectively (See Table 26).

Additionally, there was an obvious distribution discrepancy between survey respondents' perceived expectations of superiors and their perceived expectations of subordinates within the same organization (RQ1, RQ3 and RQ4). The AONE Core Competencies ***Business Skills (47%)*** and ***Knowledge of the Healthcare Environment (54%)*** were the competency expectations overwhelmingly identified by survey respondents when identifying the expectations by their superiors. The responses to expectations of downward reports (RQ3) and downward reports one removed (RQ4) are much more evenly distributed (See Table 26).

The variance in the total number of responses by question was also an interesting finding. Respondents identified 466 individual line item concepts (35% of total responses) (n=1315) when answering Question One (Expectations of Superiors). Within Question Two (Expectation of Peers) 251 individual line item concepts (19% of total responses) were identified and whereas Question Three (Expectations of Downward Reports) received 369 responses (28% of total responses) and Question Four (Expectations of Once Removed Reports) respondents identified 229 line item concepts (17% of total responses). While more research needs to be completed to substantiate any underlying causes of this variance, it can hypothesized that the expectations of upward report may be more readily accessible for recall or are much clearer/ definable, thus the greater number of overall responses to this question.

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Discussion

The state of Chief Nursing Executive (CNE) education, role and practice in the United States is at a critical juncture. A 2005 study, funded by the American Organization of Nurse Executives found that approximately 40% of CNEs have "turned over" at least one time during their career, with approximately 62% of the CNE respondents reporting that that they anticipate making a job change in less than 5 years (Jones, Havens, & Thompson, 2008). This high turnover rate is often associated with a lack of role clarity, undefined expectations and a lack of measures of success for many CNEs. Results from this study support the hypothesis that there is a discrepancy surrounding "success" for nurse executives as defined by different constituencies (superiors, peers or subordinates). Compounding this problem, recruiters and recruitment firms charged with filling these vacancies, use varying criteria when seeking CNE candidates causing significant role and disciplinary confusion. Drawing upon findings from this study, current and future nurse executives, leaders and researchers must uniformly define the Nurse Executive role to best influence and structure expectations for self, staff, superiors and peers. A uniformly accepted definition will also guide educational preparation, potentially increasing Nurse Executive role clarity, job satisfaction and reducing turnover.

Today, Nursing Administration education provides fewer opportunities for formal discovery and knowledge dissemination, making the emphasis on maximizing the knowledge and skills of current and future Nurse Executives that much more important. While educational criteria for Nursing Administration has been identified (Dienemann & Aroian, 1995), preparation for the role of nurse executive has been diverse. Career paths for CNEs do not always include formal executive or internship training. Rather staff work experiences are highly valued when filling the role of CNE. This is significantly different than experiences expected of other members of the "C-suite".

After nearly a decade of downward trends in enrollment and total number of nursing administration programs, the Council for Graduate Education in Administrative Nursing (CGEAN) is just starting to report anecdotal increases in numbers (Herrin, Jones, Krepper, Sherman, & Reineck, 2006). However, CGEAN also reports a growing concern surrounding the new shift toward Doctor of Nursing Practice (DNP) as preparation for CNE and leadership roles. This could result in Nurse Executives seeking alternative educational routes such as a non-nursing masters programs (MBA or MHA) due to time constraints in their current leadership role and confusion as to the direction of the discipline (Herrin et al., 2006). Today, many nurse executives are faced with a continued spiral of uncertainty in nursing educational preparation, professional role expectations, a defined measure of success and perceived organizational and professional value. These same nurse executives are tasked with leading the organization and profession. They must maximize their skills to influence these systems and right the ship.

The nurse executive's responsibilities of organizational administrator and professional ambassador permit them to work toward the simultaneous betterment of both the organization and the profession. While the CNE may develop organizational goals to that end, resource management and financial needs can compromise their implementation. As a leader of the nursing profession, the CNE also knows that nursing care and all patient care are difficult concepts to isolate as independent elements that can be quantified in strictly monetary terms. The ability of the CNE to influence the system leadership and support nursing's ability to increase its visibility within an organization is critical and helps the CNE better articulate practice goals and resources.

Two previous INHL Reports by Adams and colleagues (2006; 2007) found that nurse leaders identify non-nurse healthcare executives as more knowledgeable and more influential than fellow nurse leaders within their same organization. The 2007 study also identified that when nurse executives and directors groups were isolated, both aggregate groups self identified as being less knowledgeable and influential than non-nurse healthcare executives (Adams et al., 2007). The study of nurse executives and her/his influence within the organization can be significantly enhanced by identifying characteristics that support patient outcomes, and enhance the staff perceptions of the work environment. Additionally, the relationship between and among organizational structure and administrative support/ characteristics can be enhanced by a CNE and the executive leadership focus on achieving desired outcomes. There is great opportunity and benefit to standardizing the role of the nurse executive leader in for-profit and not-for-profit, academic medical centers and community hospitals alike. This standardization of core competencies and constituent expectations of the CNE role will allow for consistent evaluation at national or international levels, all for the betterment of patient and nursing environments. To accomplish these goals, it will be important to create and adhere to a unitary focus within the discipline of nursing and to define universally accepted expectations for those in the CNE role.

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