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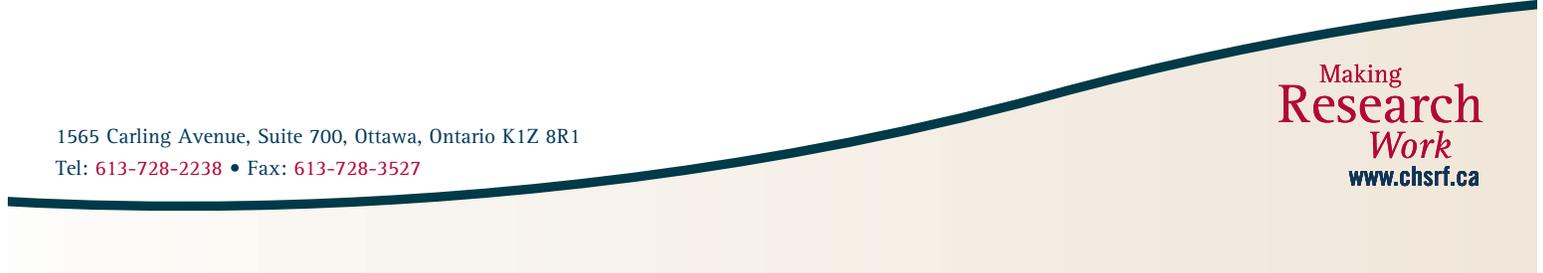


A Profile of the Structure and Impact of Nursing Management in Canadian Hospitals

Final Report for CHSRF Open Grants
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KEY IMPLICATIONS FOR DECISION MAKERS

- There is an immediate need for succession planning to ensure the future of nursing leadership. There is a cadre of very experienced and skilled nurse leaders across Canada who hold enormous responsibility for patient care within the healthcare system, but the average age of nurse leaders at all levels is between 47–51 years.
- Regardless of structure, senior nurse leaders viewed themselves as influential members of the senior management team with high levels of decisional involvement in both traditional (distinct professional departments) and program management structures. Key facilitators of role effectiveness included being part of the senior executive structure, a reporting relationship to the chief executive officer, and the inclusion of chief nursing officer in their title.
- Organizational structure had an impact on the quality of nurse leader work environments. Senior nurse leaders who felt they were more involved in decision-making and were involved earlier in the process felt more empowered, valued within the organization, supported for professional nursing practice and, ultimately, perceived a higher quality of patient care in their organizations. Senior nurse leaders' role satisfaction and influence in senior management team decisions likewise had an impact on the role satisfaction and perceptions of patient care quality experienced by middle and first-line managers.
- Nurse managers at all levels have adapted to large spans of control, but a majority recognize the need to reduce this level of responsibility. First-line managers averaged 71 direct reports (median 63, range five–264), far exceeding the benchmark found in other work settings. Despite very large spans of control, nurse leaders were very positive about their work and their abilities to be effective in their roles.
- Working relationships between all levels of management were critical to both role effectiveness and satisfaction. Transformational leadership behaviours, perceived organizational support and quality communication had an impact on the satisfaction and quality of care for each subsequent level of manager.
- Organizations have undergone significant and ongoing restructuring, which has produced barriers to role effectiveness for nurse leaders through broadened roles and functions, increased organizational size and complexity and the accompanying time and financial constraints. Access to adequate resources remains a key issue.

EXECUTIVE SUMMARY

The purpose of this study was to profile nursing leadership structures in Canadian hospitals in relation to organizational and structural characteristics of nursing management roles. Data were collected in 10 provinces from acute care inpatient units within 28 academic health centres and 38 community hospitals. Of the original 2,015 surveys, 1,164 surveys were returned for an overall response rate of 58 percent.

KEY FINDINGS

Overall, nurse leaders across the country were very experienced individuals with enormous responsibility for patient care within the healthcare system. A notable finding was the high average age (47-51 years) of nurse leaders at all levels, suggesting the immediate need for succession planning to ensure the future of nursing leadership. Despite very large spans of control, nurse leaders were very positive about their work and abilities to be effective in their roles. Roles at all levels have expanded to include responsibility for non-nursing personnel.

Senior nurse leaders felt they were influential members of the senior management team. Their decisional involvement was high in both traditional (distinct professional departments) and program management structures. Senior nurse leaders with operational/line authority were viewed by all levels of management as having higher senior management team status and greater decisional involvement in senior management decisions than those with staff authority. Perceived organizational support was an important factor at all levels of management. In addition, transformational leadership styles and satisfactory supervisor communication had an impact on lower-level managers' satisfaction and patient care quality.

NURSING LEADERSHIP STRUCTURES

The predominant senior nurse leader role configuration was operational/line authority for clinical programs with a direct report to the chief executive officer or senior vice-president (84 percent). Senior nurse leaders in academic health centres were more likely to have responsibility for allied health than senior nurse leaders in community hospitals. A smaller number of senior nurse leaders (16 percent) had staff authority, reporting directly to the chief executive officer or senior vice-president. Professional practice leader-type roles were found in 68 percent of academic health centres and 25 percent of community hospitals. Traditional distinct nursing departments were rare (20 percent) and were found primarily in Quebec and in community hospitals.

SPAN OF CONTROL

Overall, managers reported very large spans of control with considerable variation in each level. First-line managers averaged 71 direct reports, with 20 percent reporting more than 100 reports. Middle managers averaged 12 direct reports, with the majority having less than 20 reports. Senior nurse leaders also averaged 12 direct reports, with a range from two to 47. More than 50 percent of the organizations were considering a decrease in managers' span of control.

SENIOR NURSE LEADER ROLE FUNCTIONS: CHANGES, FACILITATORS AND BARRIERS TO EFFECTIVENESS

Senior nurse leaders identified four key role facilitators: part of senior executive structure; direct report to chief executive officer; inclusion of chief nursing officer in title; and operational/line authority. The main barriers to an effective role included financial and time constraints as well as increased organizational size and complexity. The most frequently reported changes during the past three years included (a) organizational restructuring and/or merging of facilities, (b) additions to the portfolio, (c) addition of the chief nursing officer role, and (d) changes in chief executive officer incumbents.

RELATIONSHIPS AMONG STRUCTURAL AND PROCESS CHARACTERISTICS AND WORK OUTCOMES

All levels of management reported moderate to high levels of:

- transformational leadership behaviour used by senior nurse leader and themselves;
- job and role satisfaction and job security;
- empowerment and organizational support;
- support for professional nursing practice;
- satisfaction with supervisor communication;
- influence in staff and policy decisions; and
- patient care quality.

Overall, nurse leaders rated these characteristics higher than those in leadership roles below them (senior nurse leaders were greater than middle managers who were greater than first-line managers). Nurse leaders at all levels agreed that access to resources was limited.

SENIOR NURSE LEADERS' FUNCTIONS AND DECISION-MAKING INVOLVEMENT AND INFLUENCE

Senior nurse leaders reported being integral members of the senior management team with high levels of involvement and influence in senior management decisions with a title and salary comparable to other executives in their organization. Those who reported more influence in senior management decisions and higher quality of senior management decisions were more likely to feel empowered and valued by the organization. They also felt greater support for professional nursing practice with a higher quality of care in their organizations.

Overall, senior nurse leaders felt that senior management decisions were compatible with existing constraints, timed to gain maximum benefit, based on an optimal amount of information, appropriately balanced between risks and rewards, with an understanding of the basis and implications of the decision by the senior team.

IMPACT OF ORGANIZATIONAL STRUCTURE ON OUTCOMES

Traditional versus Program Management

Senior nurse leaders and middle managers working within *program management* structures felt more organizational support, job security and support for professional nursing practice structure. In comparison, nurse leaders working in organizations with *traditional departmental structures* were more empowered with greater influence in staff and policy decisions and more confidence in the patient's ability to manage care after discharge.

Line versus Staff Authority

Compared to senior nurse leaders with staff authority, those with *line authority* felt they had a higher status (title and salary) within their organization, with not only more involvement in decisions but earlier involvement in the process as well. They were also more satisfied with their role and the quality of senior management team decisions. Middle and first-line managers in these organizations also felt that their senior nurse leaders were more involved in senior management team decisions with a higher status and, in addition, provided more support for a professional practice environment.

Senior nurse leaders with *staff authority* were more likely to use an enabling or "encouraging the heart" leadership style. As a result, middle managers in these organizations felt more empowered and valued by the organization. Both middle and first-line managers felt more involved in decisions than their counterparts in line authority organizations.

EFFECTS OF SENIOR NURSE LEADER WORK CONDITIONS ON LOWER-LEVEL MANAGERS' WORKLIFE

Effects of Senior Nurse Leader Variables on Middle and First-Line Manager Variables

Middle managers were more likely to report a higher quality of patient care if their senior nurse leader was satisfied with her role. First-line managers were more likely to report higher quality of patient care if their senior nurse leader reported more influence in senior management team decisions and used transformational leadership behaviours.

Effects of Middle Manager Variables on First-Line Managers

Higher middle manager perceptions of organizational support were significantly related to greater first-line manager empowerment, job and role satisfaction, organizational support and ratings of patient care quality. Middle manager self-ratings of their leadership style were significantly related to higher first-line manager perceptions of a supportive professional practice environment in the organization and higher patient care quality. Greater middle manager communication satisfaction with their supervisor was significantly related to first-line manager job satisfaction.

CONTEXT

Nursing leadership positions in Canada have decreased by 6,849 (29 percent) as result of hospital restructuring in the 1990s.^{1, 2, 3, 4, 5} Those remaining have greatly expanded areas of responsibility and spans of control⁶ with reduced visibility and availability for mentoring and support.^{5, 7, 8} While there is much speculation about the impact of changes in nursing leadership, surprisingly little is actually known about the patterns of changes in nursing leadership roles in Canada or the consequences these changes have had on leadership roles.

New governance structures, systems of care and organizational models have radically changed nursing leadership structures.^{7, 9, 10, 11, 12} Up until the early 1990s, most hospitals had traditional functional departmental structures, with each discipline having a departmental structure and control over its own human resources and budget.¹³ During the restructuring of the 1990s, program management structures replaced departmental structures.¹⁴ In program management, distinct professional departments were eliminated and care was organized around populations of patients for whom care was provided by a multi-disciplinary team.¹⁵ Currently, in many hospitals hybrid or mixed structures exist, in that program management has been implemented but organizations continue to retain central departments for corporate services such as human resources, financial management, information services, etc.¹⁴

Many chief nursing executives have gained a wider scope of responsibility beyond nursing services while others no longer have line responsibility over nursing services.^{10, 16, 17} Some claim these changes provide opportunities for nurse leaders to demonstrate their leadership skills and play a greater role in decision-making within the new multidisciplinary program structures. However, others argue these changes diminish communication links between senior nurse leaders and other nursing personnel at lower levels of the organization and deprive nurses of disciplinary leadership representation at the policy-making level in the organization.^{5, 7, 17} Ties between clinical staff and administrators are potentially weakened, threatening both nurse job satisfaction and the quality of patient care.¹⁷

Several documents^{5, 9, 16, 18, 19} have emphasized the importance of strong nursing leadership in hospital settings to ensure that effective structures are in place with nursing input into patient care process issues. All warn of an impending shortage of nurse leaders in Canada and the need to understand and address the forces that contribute to this situation.

PURPOSE

The purpose of this study was to profile nursing leadership structures in Canadian hospitals in relation to organizational and structural characteristics of nursing management roles.

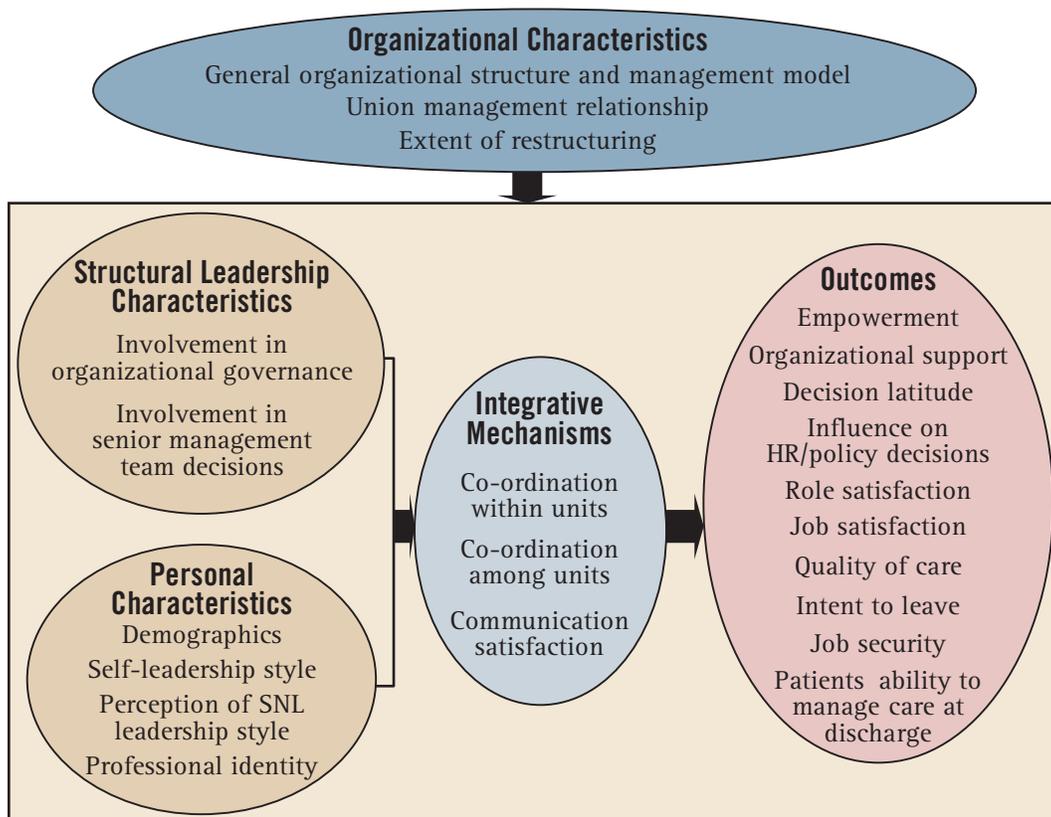
This study had three objectives:

- 1) Describe nursing leadership structures at senior, middle and unit levels of management.
- 2) Examine relationships among structural and process characteristics of nurse leader roles and work-related outcomes.
- 3) Examine the effect of senior nurse leader role characteristics on middle and first-line managers' work.

CONCEPTUAL MODEL

A conceptual model (figure 1), based on a review of the nursing, health services and organizational theory literature, was developed to guide this study. In the model, we posited three sets of propositions. First, structural characteristics of each level of management (senior, middle and first-line) affect their own outcomes. Second, structural and individual leadership characteristics of each level of management affect their own outcomes through integrative mechanisms, such as effective co-ordination and communication. Third, structural and individual characteristics of senior nurse leaders affect the outcomes of middle and first-line managers. In addition, the overall organizational and management structures are seen as the context that moderates these relationships.

FIGURE 1: CONCEPTUAL MODEL



Within this framework, structural characteristics of senior nurse leaders, such as role configuration, scope and intensity of decisional involvement, and span of control, influences their perceptions of role effectiveness, influence in the organization and job satisfaction. The scope and intensity of senior nurse leaders' involvement in strategic decision-making has been shown to increase their perceptions of influence in the organization.^{20, 21} Large spans of control hinder organizational performance where high levels of communication are necessary for effective accomplishment of work.²² A recent study by Doran et al.⁶ found that a large span of control reduces the effect of positive leadership styles on staff satisfaction and patient satisfaction. These structural characteristics of senior nurse leaders in combination with individual characteristics, such as supportive leadership styles, influence whether or not formal integrated mechanisms are in place to ensure effective co-ordination and communication among levels in the organization to support professional nursing practice. In turn, these conditions have an impact on lower-level managers' perceptions of decisional authority, their ability to be effective and job satisfaction.

Integrative mechanisms, such as shared governance structures, professional practice models and strong communication mechanisms, promote engagement in organizational affairs and facilitate autonomous nursing practice, leading to greater satisfaction and organizational commitment.^{23,24,25} The quality of manager/subordinate communication, including that of senior nurse leaders, is strongly related to subordinate job satisfaction.^{26,27} Supportive leadership styles, in particular transformational styles, also affect the quality of communication and ultimately subordinate satisfaction, commitment and productivity.^{28,29,30,31,32}

Finally, organizational factors, including organizational structure (multi-hospital system, merger status, integrated delivery system), management model (program management, departmental), unionization status, and labour-management relations, as well as the extent of restructuring can have an impact on any of the proposed relationships in the model. For instance, program management structures are associated with both positive outcomes, such

as increased interdisciplinary teamwork and decisional involvement, flexibility and fewer adverse patient events,³² and negative outcomes, such as sense of isolation from peers, increased workload and job dissatisfaction.³³

IMPLICATIONS

In this study, three key nursing leadership issues were identified: succession planning, span of responsibility/control and the gap between managers' satisfaction and the satisfaction of front-line workers.

Succession Planning: The average age of nurse leaders at all levels was high (47-51 years), suggesting the immediate and urgent need for succession planning to ensure the future of nursing leadership. Several national reports,^{5,18,19} including a Canadian Health Services Research Foundation³⁴ report outlining the priorities for nursing leadership, have emphasized the promotion of movement between roles (clinician to manager) and encouraged succession planning for nurse leaders. Much needs to be done to attract nurses to leadership positions.

Policy makers and organizational leaders can use the results of this study to create evidence-based plans and decisions in the recruitment and retention of individuals in nursing leadership roles. Improving recruitment measures is especially important given that the younger generation of nurses places a higher value on a work-life balance and is less likely to apply for management positions, which require long hours and often do not offer compensation that accurately reflects workload. Organizations should reassess their current compensation levels and consider changing these levels to be fair and reflective of managers' additional responsibility and workload. Organizations and nurse leaders should ensure they have definitive plans for succession planning. Actively promoting leadership roles, as well as defining and creating a better understanding of roles and responsibilities at each level of management will provide nurses with the opportunities to know what to expect as managers. Knowledge about the differences in leadership structures and attributes at different levels of the organizational hierarchy can better prepare nurse leaders for making these transitions.

In addition, a systemic, deliberate, multi-level approach to career development should be created with educational support to teach standardized leadership training. Currently, there is little time to develop personal goals in areas such as research or education and to branch outside their own networks to gain empowerment in a larger sense. All levels of management should have access to financial resources and flexibility to pursue educational and mentorship opportunities that allow for long-term development of professional practice. Knowledge gained from this study can be incorporated into leadership education and training programs to prepare future nursing leaders for the complexities of healthcare leadership.

Span of responsibility/control: Overall, managers reported very large spans of control with considerable variation in each management level. Based on study findings, higher numbers of direct reports can result in both negative and positive outcomes. At the senior nurse leader level, higher numbers of direct reports predominantly had a negative impact, while middle and first-line managers with higher numbers of direct reports had greater job dissatisfaction but more influence in staff and policy decisions. Most participants stressed the need to redefine span of control beyond the number of direct reports. Other suggested factors to be considered include the number of units, programs and sites, the level of clinical and administrative resources available, the level of external demand and changing realities.

Policy makers and decision makers can use the results of this study to assist with the development of an online survey collecting information annually about span of control/responsibility and best practices related to supports for managers (for example, innovative ways that managers cope with a large span of control). Organizations and nurse leaders should ensure a manageable span of control, which allows managers to have time to support staff nurses and be available for mentoring/support and development. Support should be provided for managers in carrying out both clinical and administrative aspects of

the role – both from administrative personnel and from upper management. Similar recommendations were made in the Canadian Nursing Advisory Committee report.⁵

Gap between managers' satisfaction and satisfaction of front-line workers: The results of this study highlighted the importance of a positive organizational environment at all levels of the organization. Working relationships between all levels of management are critical to both role effectiveness and satisfaction. Interestingly, nurse leaders rated their work environment higher than each subsequent role below them (senior nurse leaders were greater than middle managers who were greater than first-line managers). In addition, perceptions about the relationship to the senior management team differed according to management position: senior nurse executives felt they were able to influence budgetary allocations, participate in decisions, and act at the board level. However, middle managers did not feel the same degree of integration and first-line managers felt even less. Many participants felt that while they were informed, they could not necessarily influence senior management decisions.

This study provides important information for decision makers on the essential factors that influence nursing leadership role effectiveness and positive work environments for nurse leaders. Barriers to role effectiveness for nurse leaders include broad roles and functions, increased organizational complexity, and large spans of control with time and financial constraints. Because fiscal pressures are expected to continue and the need for organizations to restructure in response is a constant reality, a sound evaluation of what changes in senior leadership roles produce the most positive outcomes is essential to guide future restructuring.

Creating a position on the senior executive team for a representative from all first-line managers may provide them with the opportunity to add input and disseminate information among other managers and sustain or increase communication between the different levels of management. Transformational leadership behaviours, perceived organizational support and quality communication had an impact on the satisfaction and quality of care for each subsequent level of manager. The degree of empowerment that participants feel in their job is positively influenced by their autonomy and ability to make clinical and practice decisions; they feel disempowered by decisions that are mandated externally.

APPROACH

To address the proposed objectives, a mixed-methods design was used in this study with both quantitative (survey) and qualitative approaches (interviews, document analysis). The two phases of the study are described below.

PHASE ONE

Hospital Sample

To obtain a comprehensive description of nursing management structures in Canada, data were collected from 28 academic health centres and 38 community hospitals in 10 provinces. Academic health centres were selected from the members of the Association of Canadian Academic Healthcare Organizations identified in the 2002 Guide to Canadian Healthcare Facilities.³⁵ To obtain a sample of community hospitals with greater than 100 beds, hospitals were selected according to the following rules: 1) each academic health centre was identified by its health authority or, in Ontario where there were no health authorities, by geographic region; 2) for each health authority/geographic region with a selected academic health centre, a complete list of community hospitals was created and a community hospital was randomly selected from this list. If there was only one community hospital, that hospital was selected; 3) in cases where there were no available community hospitals within the same health authority/geographic region, the search was extended to neighbouring health authorities/geographic regions; and 4) since there were no academic health centres in Prince Edward Island, to allow for full national representation, an additional community hospital was randomly selected from all community hospitals in this province.

Manager Sample

During 2004, primary data were collected at each site through a mail survey of nursing leadership roles, including senior nurse leaders, middle managers, first-line managers, professional practice leaders and chief executive officers. Of the original 2,015 surveys, 1,164 surveys were returned for an overall response rate of 58 percent. Participants included all individuals who worked in roles that met the following criteria:

COMPARISON OF RESPONSE RATES						
	Total		AHC		Community	
	n	%	n	%	n	%
SNL	63	95.5	30	100.0	33	91.7
MM	231	60.2	148	57.8	83	64.8
FLM	788	53.9	515	50.1	273	63.2
PPL	30	75.0	21	87.5	9	56.3
CEO	52	81.3	22	75.9	30	83.3

Senior Nurse Leader: the nurse who held the most senior nursing leadership position in the hospital or regional health authority with direct responsibility for nursing; for example, chief nursing officer, chief nurse executive, vice-president patient care.

Middle Manager: nurses or non-nurses in positions with line responsibility for nursing and acute care patient areas, including outpatient or ambulatory care areas in addition to inpatient care areas; for example, managers or directors. There was at least one level of management below their level and one level above.

First-Line Manager: nurses or non-nurses in positions with line responsibility for nursing and acute care patient units with staff nurses reporting directly to them; for example, co-ordinators. There was no level of management below them; however they may have charge nurses, supervisors or team leaders who reported directly to them.

Professional Practice Leaders: nurses in staff positions with responsibility for nursing within the hospital or regional health authority; for example, professional practice leaders, chief of nursing. This category did not include clinical nurse specialists, nurse practitioners or nurse educators.

Chief Executive Officer: the individual who held the title of president or chief executive officer within the hospital or regional health authority.

Instruments

Several self-report standardized measures were used to measure each of the variables in the conceptual model in figure 1. Appendix A outlines each measure in detail. Most measures included items rated on Likert scales, with a high score representing a high level of the construct. Open-ended questions were used to identify role changes, barriers and facilitators to role effectiveness as well as information on the organization of nursing services. Each senior nurse leader also provided organization charts, job descriptions and reporting structures for their hospital or regional health authority. Professional practice leaders and chief executive officers were surveyed to gain their perspectives on the role of the senior nurse leader within their organizational structure.

PHASE TWO

Interviews

During the fall of 2005, a purposive sample of 21 senior nurse leaders was selected from the 49 senior nurse leaders who consented to participate in an interview at the time the initial survey was conducted. At least one senior nurse leader from a community hospital and one from an academic health centre per province was selected where possible. All interviews

were conducted by telephone and lasted approximately 30 to 45 minutes. Participants were asked five questions based on themes generated by the research team from the survey data analysis. The full report is available in Appendix B.

In 2006, a purposive sample of four chief executive officers (two from community hospitals, two from academic health centres) was selected from the four regions in Canada: Western provinces, Ontario, Quebec and Atlantic provinces. Chief executive officers with nursing backgrounds and senior nurse executive role experience were specifically selected to discuss the senior nurse leader role from their perspective. The sample was chosen from a list of community hospitals and academic health centres generated by the research team. The full report is available in Appendix C.

Focus Groups

During the fall of 2006, the Registered Nurses' Association of Ontario conducted three separate focus groups with 47 managers to validate the study's findings and develop recommendations. The invitation to participate in the focus groups was open to all members of the Nursing Leadership Network of Ontario working as first-line, middle or senior nurse leaders in a hospital setting. Participants were asked how the study results fit with their own worklife perceptions. The full report is available in Appendix D.

Invitational Symposium

In early 2007, an invitational symposium was held in Ottawa, Ontario to share the study results with nursing leaders, stakeholders and policy makers from across the country. Eighty-three participants attended, including senior nurse leaders, middle managers, first-line managers, representatives of national organizations, provincial nursing officers, study contributors from academic health centres and community hospitals, and representatives of the "next generation" of leaders. Through a combination of small group and plenary work, symposium participants identified key issues and actions to address each issue. The full report is available in Appendix E.

Analyses

Quantitative survey data were analyzed using SPSS 14.0 for Windows.³⁶ Responses were analyzed by hospital type (academic health centre or community hospital) and level of management. Organizational charts and descriptive statistics were used to profile the characteristics of nurse leaders (objective 1). A series of regression analyses were used to test the relationship between the structural characteristics of each level of management (senior, middle and first-line) and their own outcomes, controlling for overall organizational characteristics (objective 2). Finally, HLM 6³⁷ was used to test the effect of structural and personal leadership characteristics of senior nurse leaders on middle and first-line manager outcomes and middle manager characteristics on first-line manager outcomes (objective 3). Data from interviews, focus groups, open-ended questions and symposium were content analyzed for key themes and sub-themes.

RESULTS

A notable finding was the high average age (47-51 years) of nurse leaders at all levels, suggesting the urgent need for succession planning to ensure the future of nursing leadership. These results are similar to other studies recently conducted with senior nurse managers.^{19,38} When grouped into age categories, the results show that there were very few senior nurse leaders below the age of 45, with a similar age distribution in the middle and first-line manager groups. Most nurse leaders were between 46 and 55 years of age while only a small percentage of first-line (2.2 percent) and middle managers (6.3 percent) were between 26 and 35 years of age.

Current nurse leaders were also very experienced individuals with 11 to 21 years of management experience. More than 80 percent of senior nurse leaders had at least 15 years of management experience, with 100 percent having at least five years. In contrast, 45 percent

of middle managers and 30 percent of first-line managers had more than 15 years, while 10 percent of middle managers and 36 percent of first-line managers had less than five years of management experience. Interestingly, 39 percent of managers with less than five years of experience were 45 to 55 years of age, suggesting that individuals are not becoming managers until they are over 40 years of age.

AGE CATEGORIES BY MANAGEMENT LEVEL			
	Senior Nurse Leader	Middle Manager	First-line Manager
26-35	-	2.2%	6.3%
36-45	17.7%	32.0%	32.7%
46-55	69.4%	53.1%	50.0%
Over 55	12.9%	12.7%	11.0%

Overall, managers reported very large spans of control with considerable variation in each management level. Senior nurse leaders averaged 12 direct reports, with a range from two to 47. Middle managers also averaged 12 direct reports, with most having less than 20 reports. First-line managers averaged 71 direct reports, with 20 percent reporting more than 100 reports. In a national study by O'Brien-Pallas et al.,³⁸ chief nursing officers working in hospitals reported an average of 49 direct reports while senior managers reported 105 direct reports. In contrast, in a study with unit managers, Doran et al.⁶ found that managers averaged 77 direct reports, with a range of 36 to 151. Subsequently, units with managers who reported a large span of control had higher levels of staff turnover and lower patient satisfaction. The large spans of control also reduced the positive effect of managers' leadership styles on staff satisfaction and patient satisfaction.⁶

MANAGEMENT EXPERIENCE CATEGORIES BY MANAGEMENT LEVEL			
	Senior Nurse Leader	Middle Manager	First-line Manager
0-5	-	10.5%	36.0%
5.01-10	6.7%	20.1%	16.7%
10.01-15	10.0%	24.0%	17.1%
15.01-20	38.3%	24.0%	16.2%
Over 20	45.0%	21.4%	14.1%

OBJECTIVE 1: DESCRIBE NURSING LEADERSHIP/MANAGEMENT STRUCTURES AT SENIOR, MIDDLE AND UNIT LEVELS OF MANAGEMENT.

An overall picture of the nursing leadership structures was determined by reviewing organizational charts and survey responses. The results showed a variety of nursing leadership structures that differed in the following ways: configuration of senior nurse leaders' roles; presence or absence of a distinct nursing department; and the number of first-line, middle and senior levels of management.

Configuration of Senior Nurse Leaders' Role

Most senior nurse leaders had experienced significant role changes in the previous three years, with several additions and revisions made to their portfolios. Based on their experiences, the senior nurse leaders identified four key features of their role that were deemed essential to represent and influence the interests of nursing in their organizations: reporting directly to the chief executive officer; being a member of the senior leadership structure; having chief nursing officer in their title; and having operational/line authority.

In this study, two major role configurations were identified: (1) those with line authority and (2) those without line authority. However, there was a great deal of variation within each of these major groupings.

Line Authority Configurations

Similar to the study by O'Brien-Pallas et al.³⁸ most senior nurse leaders (84 percent) had operational/line authority for clinical programs (n=55). Within this group, two subcategories were identified:

- (1) Senior nurse leaders reported directly to the chief executive officer with or without chief nursing officer in their titles (n=48). This reporting structure was twice as likely to occur in community hospitals (73 percent versus 12 percent). More than half (67 percent) of the senior nurse leaders in this group had chief nursing officer in their title. Most (75 percent) of these were employed in Ontario (47 percent) and Quebec (28 percent) and were distributed equally across academic health centres (44 percent) and community hospitals (56 percent). Of the remaining 33 percent of senior nurse leaders without chief nursing officer in their titles, most were employed in community hospitals (87 percent). There were no geographical differences in this pattern.
- (2) Senior nurse leaders reported to a senior vice-president or executive director, with or without chief nursing officer in their titles (n=7). This configuration was most common in the West (71 percent) and 43 percent had chief nursing officer in their titles. Those who did not were all from the West, primarily Alberta.

No Line Authority Configuration

Sixteen percent of the senior nurse leaders (n=11) did not have operational/line authority for clinical programs, but all had line responsibility for professional practice personnel. Most reported directly to the CEO, the remaining to a senior vice-president. All had chief nursing officer in their titles, and all but one reported they were members of the senior management team. Sixty-four percent were employed in organizations located in the western provinces of Alberta, Manitoba and British Columbia; the rest were from Ontario, Quebec and the Atlantic provinces.

Traditional Distinct Nursing Departments

Traditional distinct nursing departments (20 percent) were rare, with 77 percent present primarily in community hospitals and predominantly in organizations (61 percent) in the province of Quebec. Senior nurse leaders in academic health centres were more likely to have responsibility for allied health than senior nurse leaders in community hospitals. Organizations without a distinct nursing department had implemented program management or hybrid/mixed organizational structures and reported a wide range of nursing management levels.

Respondents who indicated there was no distinct department of nursing reported that chief nursing officer, professional practice leader or director positions and/or nursing committees had replaced the traditional departments. Nursing practice councils and regular meetings with all levels of managers were described as key to ensuring organizational alignment on nursing and patient care issues. Professional practice leader-type roles were found in 68 percent of academic health centres and 25 percent of community hospitals. Resources for nursing education and development were prevalent in both academic health centres and community hospitals, while resource support for research was only within academic health centres.

Levels of Management

Organizations reported anywhere from two to five levels of nursing management. Most (65.2 percent) organizations reported three levels of management with one level of first-line, one level of middle, and one level of senior management. Almost 20 percent reported four levels of management. These structures were found predominantly in academic health centres (84.6 percent) and consisted of one level of first-line, one level of middle and two levels of senior management, with the first level of senior management reporting to a second

level of senior management, such as a vice-president reporting to an executive vice-president or chief operating officer. Interestingly, 50 percent of academic health centres had two senior levels of nursing management in their organizational structures. Two large regional health authorities reported five to six levels of management with two levels of first line management, one or two levels of middle management, and two levels of senior management. One academic health centre in Ontario reported two senior levels of management, with no middle management and one level of first-line management. In each of these cases, the second level of senior managers was directors or assistant directors of nursing with a large number of first-line managers reporting to them. The remaining organizations had two levels with no middle management. These sites were smaller hospitals found mostly in Ontario (n=2), Quebec (n=3) and the Prairie provinces (n=2).

OBJECTIVE 2: EXAMINE RELATIONSHIPS AMONG STRUCTURAL AND PROCESS CHARACTERISTICS OF NURSE LEADER ROLES AND WORK-RELATED OUTCOMES.

The results of this study highlighted the importance of a positive organizational environment at all levels of the organization. All levels of management reported moderate to high levels of:

- transformational leadership behaviour used by senior nurse leader and themselves;
- job and role satisfaction and job security;
- empowerment and organizational support;
- support for professional nursing practice;
- satisfaction with supervisor communication;
- influence in staff and policy decisions; and
- patient care quality.

Overall, nurse leaders rated these characteristics higher than those in leadership roles below them (senior nurse leaders were greater than middle managers who were greater than first-line managers). Nurse leaders at all levels agreed that access to resources was limited. Important factors at all levels of management were perceived organizational support and communication satisfaction with immediate supervisor.

Senior Nurse Leaders' Functions and Decision-Making Involvement and Influence
Senior nurse leaders reported being integral members of the senior management team with high levels of involvement and influence in senior management decisions and a title and salary comparable to other executives in both traditional (distinct professional departments) and program management structures. Overall, senior nurse leaders felt that senior management decisions were compatible with existing constraints, timed to gain maximum benefit, based on an optimal amount of information, appropriately balanced between risks and rewards, with an understanding of the basis and implications of the decision by the senior team.

Across all management levels

Empowerment and organizational support associated with greater:

- senior nurse leader transformational leadership behaviour;
- satisfaction with supervisor communication; and
- support for professional nursing practice.

Satisfaction with supervisor communication associated with greater:

- influence in human resource and policy decisions; and
- satisfaction with job and role.

Support for professional practice associated with greater:

- job satisfaction; and
- quality of patient care.

Senior nurse leaders perception of a comparable salary and title to similar roles within the organization was associated with their levels of perceived organizational support, role satisfaction, influence in decision-making in staff and policy decisions, and support for professional practice. Those who reported more influence in senior management decisions and higher quality of senior management decisions were more likely to feel empowered and valued by the organization. They also felt greater support for professional nursing practice with higher quality of care in their organization.

Middle managers stated they felt empowered with the autonomy to make decisions within the capacity of their portfolio area. However, fewer middle managers felt they had the ability to ultimately influence decisions at the senior management table, but they did feel they could present their case to senior management. This feeling of empowerment was not as strong among first-line managers. This group stated that although they may have felt it was appropriate to approach their immediate supervisors, the amount of contact they had with senior management varied widely. Many participants also clearly expressed their feeling that the extent of their influence depended largely on budgetary issues.

Impact of Organizational Structure on Outcomes

Traditional versus Program Management

Senior nurse leaders and middle managers working within program management structures felt more support from the organization, secure in their job, and support for professional nursing practice structure. In comparison, nurse leaders working in organizations with traditional departmental structures were more empowered with greater influence in staff and policy decisions and more confidence in the patient's ability to manage care after discharge.

Line versus Staff Authority

Senior nurse leaders with operational/line authority were viewed by all levels of management as having higher senior management team status and greater decisional involvement in senior management decisions than those with staff authority. Compared to senior nurse leaders with staff authority, those with line authority felt they had a higher status (title and salary) within their organization, with not only more involvement in decisions but earlier involvement in the process as well. They were also more satisfied with their role and the quality of senior management team decisions. Middle managers and first-line managers in these organizations also felt that their senior nurse leaders were more involved in senior management team decisions with a higher status and, in addition, provided more support for a professional practice environment.

Senior nurse leaders with staff authority were more likely to use an enabling or "encouraging the heart" leadership style. As a result, middle managers in these organizations felt more empowered and valued by the organization. Both middle managers and first-line managers felt more involved in decisions than their counterparts in line authority organizations.

Transformational Leadership Behaviours

Greater reported use of transformational leadership behaviours at work was associated with greater perceptions of access to empowering work conditions across all three levels of management. At the middle and first-line manager level, it was linked to higher levels of perceived organizational support, influence over staff and policy decisions, job satisfaction, support for professional practice, high quality of care on their units, communication satisfaction and co-ordination within and among units.

Middle and first-line managers who perceived their senior nurse leader as demonstrating high levels of transformational leadership behaviours reported higher levels of perceived organizational support, empowerment, communication satisfaction, job satisfaction, influence over human resource and policy decisions, decision latitude, support for professional practice, confidence in patient ability to manage care at discharge, and co-ordination within and among units and were less likely to leave the organization.

Span of Control

Senior nurse leaders with higher numbers of direct reports reported lower levels of empowerment, less support for professional practice, job dissatisfaction, less influence in staff and policy decisions, intent to leave, less confidence in patient ability to manage discharge care but increased quality of care during past year and job security. Middle managers with higher numbers of direct reports had greater job dissatisfaction but more influence in staff and policy decisions and higher quality of care on units. First-line managers with higher number of direct reports reported greater influence in staff and policy decisions and greater decision latitude.

OBJECTIVE 3: EXAMINE THE EFFECT OF SENIOR NURSE LEADER ROLE CHARACTERISTICS ON MIDDLE AND FIRST-LINE MANAGERS' WORK.

Effects of Senior Nurse Leader Worklife Factors on Middle and First-Line Manager Variables

Middle managers were more likely to report a higher quality of patient care if their senior nurse leader was satisfied with her role. First-line managers were more likely to report higher quality of patient care when their senior nurse leader reported more influence on senior management team decisions and used transformational leadership behaviours.

Effects of Middle Manager Worklife Factors on First-Line Managers

Higher middle manager perceptions of organizational support were significantly related to greater first-line manager empowerment, job and role satisfaction, organizational support and ratings of patient care quality. Middle manager self-ratings of their leadership style were significantly related to higher first-line manager perceptions of a supportive professional practice environment in the organization and higher patient care quality. Greater middle manager communication satisfaction with their supervisor was significantly related to first-line manager job satisfaction.

CONCLUSION

Nurses in leadership positions in Canada currently are a very experienced group who are responsible for a wide scope of administrative activities. However, the results of this study highlight the importance of successful planning, given the limited variation in age across three levels of management averaging 52 years of age with a large cohort approaching retirement. In addition, the large spans of control of nurse managers are a concern or a potential threat to effective management. If nursing management jobs are to be seen as attractive opportunities to other nurses, they must be seen as doable. Large spans of control that limit manager involvement with their staff due to unreasonable workloads diminishes the attractiveness of these roles and aggravates the impending nurse manager shortage. Our results provide valuable information that can be used by hospital administration and policy makers to create a sustainable nursing workforce.

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APPENDIX A: DESCRIPTION OF MEASUREMENT INSTRUMENTS

KEY CONCEPTS	VARIABLES	SOURCE	INSTRUMENT	# ITEMS	PSYCHOMETRICS
Organizational Characteristics	General structure/management model	Nurse Executives Middle Managers First-line Managers	Nurse Executive Questionnaire (Wong 2003, adapted from Havens, 2001; Clifford 1998)	43	New Instrument, preliminary face and content validity
	Unit-management relationship	Nurse Executives Middle Managers First-line Managers	Union-Management Relationship Scale (Angle & Perry, 1986)	3	Cronbach alpha = .78 (Angle & Perry, 1986)
	Extent of restructuring	Nurse Executives Middle Managers First-line Managers	Degree of implementation of restructuring activities (Wong 2003, adapted from Havens, 2001)	28	New Instrument, preliminary face and content validity
Integrative Mechanisms	Communication & Coordination Mechanisms	Nurse Executives Middle Managers First-line Managers	Communication & Coordination Questionnaire (Shortell, et al., 1994)	8	Cronbach alpha: Communication = .64 Coordination = .75
		Nurse Executives	Communication Satisfaction Subscale (Puttie, et al., 1990)	7	Cronbach alpha: .90
Structural Leadership Characteristics	Leader roles/responsibilities/span of control	Nurse Executives	Organization of Nursing Characteristics; Nursing Involvement in Organizational Governance; Span of Control (Wong 2003, adapted from Havens, 2001; Clifford 1998)	22	New Instrument, preliminary face and content validity
		Middle Managers First-line Managers	Program/Portfolio Characteristics; View of SNL's Role in Nursing Involvement in Organizational Governance (Wong 2003, adapted from Havens, 2001; Clifford 1998)	64	New Instrument, preliminary face and content validity

KEY CONCEPTS	VARIABLES	SOURCE	INSTRUMENT	# ITEMS	PSYCHOMETRICS
Structural Leadership Characteristics	Decisional Involvement	Nurse Executives	Participation in Strategic Decision-Making Scale (Banaszak-Holl et al., 1999)	26	Cronbach alpha = .74 to .81
		Chief Executive Officers	Revised Participation in Strategic Decision-Making Scale (Banaszak-Holl et al., 1999)	32	Original instrument Cronbach alpha = .74 to .81 Revised version: preliminary face and content validity
		Middle Managers First-line Managers	Index of Centralization - Hierarchy of Authority Subscale (Hage & Aiken, 1967)	5	Cronbach alpha = .82 - .91 (Ashmos, 2000; Schminke et al., 2002)
Individual Characteristics	Nurse Executive socialization and occupational image	Nurse Executives	Nurse Executive Profile (Krugman, 1989)	7	Construct validity established Cronbach alpha = .85 (Krugman, 1989)
	Leadership Style	Nurse Executives Middle Managers First-line Managers	Leadership Practices Inventory (Posner & Kouzes, 1994)	30	Cronbach alpha: Challenge: .80 to .90 Inspire: .87 to .92 Enable: .75 to .89 Model: .77 to .90 Encourage: .87 to .93 (Kouzes & Posner, 1992)
	Demographics	Nurse Executives Middle Managers First-line Managers	Demographic Questionnaire developed by researchers	7	
		CEO		6	

KEY CONCEPTS	VARIABLES	SOURCE	INSTRUMENT	# ITEMS	PSYCHOMETRICS	
Outcomes	Influence on Decisions	Nurse Executives Middle Managers First-line managers	Index of Centralization - Participation in Decision-Making Subscale (Hage & Aiken, 1967)	4	Cronbach alpha: .74 to .81 (Schminke et al., 2002)	
	Role Satisfaction	Nurse Executives Middle Managers First-line managers	Work Alienation Scale (Aiken & Hage, 1966)	6	Cronbach alpha: .77 (Bennett, et al., 2000)	
	Perceived Quality of Nursing Care Intent to Leave Job Security	Nurse Executives Middle Managers First-line managers	Nursing Work Index - Revised (Aiken, et al., 2002)	13	Cronbach alpha: .96 Content, Criterion-related and construct validity established (Aiken, et al., 2002)	
	Empowerment	Nurse Executives Middle Managers First-line managers	Conditions of Work Effectiveness - II (Laschinger, et al., 2001)	19	Cronbach alpha: .79 to .82	
	Job Satisfaction	Nurse Executives Middle Managers First-line managers	Global Job Satisfaction Survey (Quinn & Shepard, 1974)	6	Cronbach Alpha - .82 (Greenglass, Burke, & Fiksenbaum, 2002)	
	Role Effectiveness	Nurse Executives Middle Managers First-line managers	Alienation from Work Scale (Aiken & Hage, 1966)	6	Cronbach alpha: 0.77 (Bennett et al., 2000)	
	Organizational Support	Nurse Executives Middle Managers First-line managers	Organizational Support Scale (Eisenberger, 1986) Nursing Work Index - Revised (Aiken, et al., 2002)	8 10	Cronbach alpha: 0.74 - 0.95 (Eisenberger et al. 1997)	

APPENDIX B: REPORT OF INTERVIEWS WITH SENIOR NURSE LEADERS

By Professor Carol Wong, RN, PhD (c), Co-Principal Investigator

PURPOSE

The purpose of the qualitative component of this study was to interview a purposively selected subset of senior nurse leaders to compare similarities and differences in perceived benefits of roles that are configured with line and staff accountability and to gain a more in-depth picture of the impact of changes in these roles. Interviews validated and expanded on themes generated from survey data.

INTERVIEW METHODS

A purposive sample of 21 Senior Nurse Leaders was selected from the 49 Senior Nurse Leaders who consented to participate in an interview at the time the initial survey was conducted. Written consent was then obtained for each interview. Selection of interviews was based on a need to ensure at least one Senior Nurse Leader from a community hospital and an academic health sciences centre per province where possible from the list of those who agreed to participate. All interviews were conducted by telephone, lasted approximately 30 to 45 minutes and were tape recorded with subject consent. All subjects were asked 5 questions and responses were content analyzed for key themes and sub themes. Questions were based on themes from survey data analysis and were generated by the research team and the project advisory committee.

PROFILE OF SENIOR NURSE LEADERS INTERVIEWED

The 21 Senior Nurse Leaders participating in the interview process were all female with an average age of 50 years. The Senior Nurse Leaders have been in the role in their current organization for approximately 5 years with an average of 21 years of management experience and 30 years in the nursing profession. The majority of Senior Nurse Leaders were prepared at the graduate level (52% masters, 5% PhD). Most Senior Nurse Leaders had Chief Nursing Officer and Vice-President in their title (76%), had line authority (76%) and functioned within a mixed program management and traditional structure (71%). Slightly over one half of the Senior Nurse Leaders interviewed reported to the Chief Executive Officer (with or without Chief Nursing Officer in their title) (57%). There was proportionate representation across hospital types (52% academic health centers, 48% community hospitals) and provinces (2 per province with the following exceptions: 3 from each of Ontario, Manitoba and Nova Scotia and 0 from PEI).

FINDINGS

Interview themes are described below according to the questions posed:

How does the structuring of your role influence your ability to represent and influence the interests of nursing at senior decision-making levels and in the organization as a whole?

Interviewees reported four major factors that facilitate the Senior Nurse Leader in representing nursing in the organization: (a) the Senior Nurse Leader is part of the senior executive structure; (b) the reporting relationship should be to the Chief Executive Officer; (c) the term chief nursing officer should be in the role title; and (d) the Senior Nurse Leader has operational or line authority. Several respondents emphasized that the scope of the Chief Nursing Officer role is seen as broader than nursing. One additional theme mentioned by 5 respondents was the attendance or presence of the Senior Nurse Leader at board or board subcommittee meetings such as patient care as an important way to influence organizational decision-making.

Given the scope of your role, how do you address/fulfill the voice for nursing?

a. What mechanisms or strategies do you use to keep abreast of nursing issues in your organization?

An overall pattern of both internally- and externally-focused mechanisms (with respect to their organization) was observed in the responses to this question. The majority of mechanisms described reflected internal mechanisms as opposed to external. The most frequently mentioned internal methods included: (a) participation in nursing council meetings, (b) regular meetings with managers, (c) formal and informal meetings with nursing staff, (d) having an infrastructure of professional practice roles, and (e) regular reviewing of staff meeting minutes and intranet communication. The presence of site, organizational or regional Nursing Professional Practice Councils was identified by more than 50% of interviewees and the Senior Nurse Leader role in those councils ranged from chairing meetings to attending regularly or by invitation or to meeting with staff nurse council leaders. Regular meetings and site visits with managers in their portfolios for planning purposes, networking and and/or to address issues were essential to keeping up to date on nursing concerns. In addition, both formal and informal meetings with staff included attending orientation sessions, holding open forums, developing regular social/educational evening "get-togethers" with staff nurses and scheduling regular luncheons with groups of nurses. One Senior Nurse Leader described a project whereby she met with groups of nurses by unit across her organizations to bring to light their wishes, concerns, questions and visions for their practice. The information produced was used in the planning of work environment change initiatives. Some interviewees mentioned having an infrastructure of professional practice leader/consultant roles as an important way to put attention and focus on nursing and nursing issues. Finally Senior Nurse Leaders indicated that regular review of staff meetings helped to stay in touch with the concerns of practicing nurses. They also used intranet communication and other media to profile nursing accomplishments and communicate nursing initiatives.

Membership on regional, provincial or national committees, task forces and associations was frequently identified as an external mechanism by which Senior Nurse Leaders could keep current on nursing issues regionally, provincially and nationally. Some specific examples included involvement in the Academy of Chief Executive Nurses (ACEN) group and participation on provincial leadership councils. Networking was described as a very important strategy for fulfilling their organizational responsibility to nursing. Linking with colleges and universities and attending conferences were also identified as external mechanisms to stay current on nursing issues. Some respondents emphasized the idea that it is not only Senior Nurse Leader responsibility to be the voice for nursing and that the Senior Nurse Leader needs to ensure and facilitate nurses speaking up for nurses.

b. What resources do you have to fulfill the professional nursing practice aspect of your role?

When asked about resources for nursing professional practice, participants provided a variety of responses which were organized according to the following themes: (a) special project roles, (b) professional practice leader roles, (c) nursing education roles, (d) nursing professional practice councils, (e) funding for education and (f) advanced practice nurses. Four participants specifically mentioned that they had no professional practice roles while the most frequent responses described a diversity of special project roles to manage everything from workforce initiatives to evidence-based guideline implementation to development of standards and documentation systems. Half of participants indicated they had roles devoted to professional nursing practice with a range of titles from leader, consultant, director, manager, coordinator and facilitator. Support for education was evident in dedicated education roles and funding directed to support nurses' continuing education/professional development. Nursing professional practice councils were also mentioned as a key mechanism for addressing nursing practice issues and Senior Nurse Leaders directed time support for staff nurse council chairs and members. A few participants highlighted the role of advanced practice nurses and clinical nurse specialists as key resources for practice issues. Only 2 participants identified having research roles.

How would describe the degree and nature of contact/communication you have with other levels of patient care management in order to seek or share information on issues that you may need to address? In regional health authorities and other large merged organizations in which leaders' portfolios are dispersed across geographical sites, it can be challenging to maintain regular contact and communication with first-line and middle managers in order to seek or share information on issues and planning initiatives. In response to the above question, Senior Nurses Leaders reported using a variety of both formal and informal methods to keep the level of communication high. A majority of the responses reflected formal mechanisms such as: (a) regular monthly portfolio meetings with managers, (b) planned meetings with managers of other portfolios, (c) attendance at key committees, (d) organization-wide leadership forums, (e) reliance on other nursing roles to facilitate communication on nursing issues, (f) manager planning sessions and (g) unit level meetings. Many Senior Nurse Leaders mentioned how challenging it is in program management structures to keep in contact with managers not in their own portfolio but with whom they must ensure regular contact in the interest of creating organizational continuity for nursing and patient care issues. Several mentioned relying on formal regular meetings to ensure effective communication. Attendance at key committee meetings such as Senior Management, and Medical and /or Professional Advisory were often described as key opportunities to ensure consistency of communication. The use of organization-wide leadership forums was often mentioned as a necessary mechanism to bring managers together in today's large regionalized healthcare facilities. Several Senior Nurse Leaders described the effectiveness of holding large manager planning sessions several times per year as integral to facilitating communication and alignment on key organizational issues. The issue of standardization of care practices across sites to ensure consistency of access to and quality of care was stressed as a new priority in merged or regionalized systems.

Although less frequently mentioned, 50% of Senior Nurse Leaders described the importance of informal strategies for facilitating effective communication. Participants stressed an open and informal organizational structure as integral to good communication. The importance of building relationships one-on-one over time was described by 2 experienced Senior Nurse Leaders as necessary to create influence through relationships rather than by authority.

Think about the last time your role was restructured or changed in a significant way, what was the impact on you and how you carry out your role or your ability to provide leadership?

(Probes for clarification: When did it occur, what prompted it, and what was the change?)

The average length of time since a role change had been experienced was 3.06 years with a range of 6 months to 7 years. The most frequently reported changes experienced included: (a) organizational restructuring and/or merging of facilities, (b) additions/revisions to the Senior Nurse Leader portfolio, (c) addition of the Chief Nursing Officer role and (d) changes in Chief Executive Officer incumbents. In terms of the impact of these changes, six participants indicated that no major role impacts had occurred for them and that there was some sense of stability in their organizations. The most frequently identified impacts were: (a) increased workload and responsibility, (b) uncertainty about the impact of changes, (c) experienced sense of loss of either the nursing or operational component and (d) reporting relationship changes. For one person new to her role, the move from a staff to line authority role was a key adjustment. On the other hand, the upcoming move from a traditional to a program management structure will mean a change to a staff role for another nursing leader. However, this imminent change was viewed positively as an opportunity to spend more time on professional practice issues and to create a more equal power base for negotiation with other managers on nursing issues. The concern raised with the traditional structure was that nursing had more power than other departments causing conflicts for effective collaboration. Another experienced leader expressed concern about a recent reporting change that included a matrix situation. The implications of reporting relationships for the Senior Nurse Leader/Chief Nursing Officer role are very important as mentioned under question 1. Increased visibility of the nursing role at the senior management level was a positive impact of role change for another participant.

What are some key factors unique to your organization that (a) facilitate and/or (b) interfere with how you carry out your role?

The role facilitators described by Senior Nurse Leaders were largely relationship-oriented in nature while barriers to role enactment were mainly structural. Key facilitators included: (a) supportive Chief Executive Officer, (b) other supportive relationships, (c) a strong, supportive organizational culture, (d) small or manageable organization size, (e) stability of the senior management team, (f) regionalized structure and (g) longer Chief Nursing Officer tenure in the organization. The salient supportive role of Chief Executive Officers was described as one in which the incumbent demonstrates clear leadership, promotes teamwork, creates reasonable role expectations and is a responsive listener. Other key supportive relationships included nurses who value the Chief Nursing Officer role, a community that values health care, effective links with educational facilities and a supportive human resources director. Three participants stressed the importance of a strong organizational culture in which collaboration is valued, open communication is modeled throughout the organization and there is a clear direction set involving people in the process. A stable senior management team with effective group dynamics in which conflict is acknowledged and constructively managed was identified as another facilitator of the Senior Nurse Leader role. Experienced Senior Nurse Leaders with longer tenure in their respective organizations emphasized the value of an established track record for leadership and a large network of contacts as instrumental to successful role implementation. The regionalized structure was described as facilitating coordination across sites and sectors and ensuring an effective strategic planning process both of which facilitate the Senior Nurse Leader role. However, one Senior Nurse Leader mentioned that the regional structure could have positive and negative effects depending on the issue at hand. A similar statement was made about the medical power/authority within an organization as being either a facilitator or barrier to effective Senior Nurse Leader role implementation.

As mentioned earlier, barriers to successful Senior Nurse Leader role enactment were primarily related to structural features of the role and/or organization. The major themes were: (a) role structure, (b) span of control, (c) financial pressures, and (d) political agendas. Role structure issues described included lack of clear authority in the role, inadequate or lack of infrastructure to do the role, the sheer volume of work to be done and matrix reporting for the Chief Nursing Officer role. Although span of control is very much part of role structure, it was identified as a separate theme given this was a key variable investigated in this study. The main concerns identified by participants were the fact that the span was often too large and/or responsibility extended over several sites and a broad geographical area, as is often the case in regionalized systems. Senior Nurse Leaders explained that this creates a challenging new aspect to nursing leadership roles in terms of how to ensure visibility and success in the role. There is limited if any evidence as to the impact of span of control on senior leader effectiveness. Financial pressure was cited as a factor that can interfere with role enactment because of an ongoing requirement to rationalize services when the demands are often much greater than the resources available. Three participants highlighted multiple and sometimes conflicting political agendas and/influences that play a role in organizational decision-making and also affects the Senior Nurse Leader role. This was described as occurring on several levels of government, local, regional and provincial. Some other barriers mentioned by individual participants included a variety of concerns including: the time consuming nature of partnering and collaborating requirements; insufficient time for face to face communication with key stakeholders; maintaining an effective relationship with the Chief Executive Officer when there are differences in perception of issues that affect nursing and patient care; and the impact on group dynamics when the senior management team is not physically based on the same site.

What are three current top priorities for nursing or patient care in your organization?

The most frequently stated priorities included: (a) recruitment and retention initiatives, (b) addressing staffing, skill mix and scope of practice issues, (c) improving the quality of the work environment, (d) patient safety projects, (e) leadership succession planning and development, and (f) redesigning models of care delivery. Given the current national and international concern about nursing shortages, it is understandable that recruitment and retention was the most frequently identified nursing priority. Organizations were focusing on the following concerns and strategies to address the problem: hard to fill vacancies in specialty areas, reducing overtime, developing retention strategies and hiring extra new graduate nurses. The other top priority mentioned as frequently as recruitment and retention was a combination of three related issues, staffing, skill mix and scope of practice. Senior Nurse Leaders mentioned pressure to change skill mix in order to address budget constraints as well as increasing staffing ratios in order to respond to increasing workload pressures. Several Senior Nurse Leaders mentioned wanting to pilot test an Ontario initiative called the 80/20 project in which nurses have 20% of their time fully supported for education and research while 80% is their direct service time. Ensuring the full scope of practice for Registered Nurses (RNs) and Licensed/Registered Practical Nurses (LPNs/RPNs) was also described as key to increasing nursing care available to patients. The continuing need to rationalize the resources required to deliver safe patient care was frequently identified and in particular, concern about being able to create the 70% full-time and 30% part-time mix of nursing staff recommended in Ontario was expressed.

Another top priority was the need to improve quality of work environment, specifically addressing nurses' workload, strengthened orientation for new staff including enhanced mentoring by expert nurses, the challenges of a multigenerational workforce and the staff stress and fatigue issues associated with an increased pace of change and turbulent health care work environments. Closely associated with healthier work environments is the requirement to increase issue patient safety by targeting reduction of medication errors and other patient occurrences and in general promoting a climate of safety. About 25% of participants identified the need for leadership development and succession planning and emphasized that attention must be paid to replacing the expertise of nurse managers who will be retiring and the importance of the visible presence of effective leaders in care settings. Some participants specifically mentioned that nurses with graduate degrees in health and/or business administration were prime desired recruits for patient care management roles. Another 25% of participants indicated that the development and/or redesign of models of care were a key priority in their organizations. Specifically, they described the need to modernize delivery systems, to develop a more relationship-centred and service-oriented approach to care and to strengthen the bridge between hospital and community. One leader eloquently highlighted the importance of the nurse-patient relationship in care models and that nurses leaders must "restore and sanctify the salience" of this element in patient care. Some of the other priorities mentioned included implementing evidence based practice guidelines and the electronic patient record and order entry initiatives, developing and/or expanding nursing councils across sites, building capacity for nursing research, and addressing patient access to care issues, entry to practice and maintenance of competencies for nurses working in rural/remote areas.

SUMMARY

In keeping with study quantitative descriptive findings, Senior Nurse Leaders identified four key features of their role (reporting directly to the Chief Executive Officer, member of senior leadership structure, Chief Nursing Officer in their title, and line authority) that were deemed essential to represent and influence the interests of nursing in their organizations. Nursing practice councils and regular formal and informal meetings with all levels of patient care managers were described as key to ensuring organizational alignment on nursing and patient care issues. The majority of Senior Nurse Leaders had experienced significant

changes in their role in the last three years on average and additions and revisions to their portfolios including the addition of the Chief Nursing Officer title and responsibilities were most often experienced. Organizational contextual features significantly influence how Senior Nurse Leaders conduct their work. Role facilitators were largely relationship-oriented in nature while barriers to role enactment were mainly structural. Key priorities for nursing in the organizations of Senior Nurse Leaders interviewed included: recruitment and retention, addressing staffing, skill mix and scope of practice, creating healthier work environments, increasing patient safety, leadership succession planning, and redesigning models of care delivery.

The full report can be found on the study website at www.nursingleadershipstudy.ca.

APPENDIX C: REPORT OF INTERVIEWS WITH CHIEF EXECUTIVE OFFICERS

By Professor Carol Wong, RN, PhD (c), Co-Principal Investigator

As an important supplement to this study, we were interested in talking to Chief Executive Officers, who are nurses and were previously in senior nurse executive roles, to get their views on senior nurse leader roles and nursing priorities from their perspective as Chief Executive Officers.

INTERVIEW METHODS

A purposive sample of three Chief Executive Officers (one from community hospital, two from academic health centre) was selected from the three regions in Canada: Western Provinces, Ontario, and Atlantic Provinces. The sample was chosen from a list of community hospitals and academic health centres generated by the research team. The sites were not necessarily from sites that were part of the study. All interviews were conducted by telephone, and lasted approximately 30 to 45 minutes. All subjects were asked 7 questions and responses were content analyzed for key themes and sub themes. Questions were based on themes from survey data analysis and were generated by the research team and the project advisory committee.

PROFILE OF CEOs INTERVIEWED

The tenure of Chief Executive Officers interviewed ranged from 2 to 15 years and all had held either Nursing Director, Vice President or Chief Nursing Officer positions prior to becoming a CEO. Two of 3 interviewees indicated becoming a CEO was the culmination of their personal career planning processes while another stated she did not consciously pursue this career path but was encouraged to apply for the position. At an early point in the latter's career, "others saw that I had management potential" and encouraged her to take on leadership roles at the unit and director levels then as CEO of an organization and eventually regional CEO role. A key goal of one of the interviewees was the opportunity to create a culture for a whole organization, not just a portfolio, and the chance to create greater alignment of goals and values throughout an organization. This individual also moved through various unit manager, nursing director, and vice president roles prior to becoming a CEO for a grouping of hospitals. Another interviewee wanted to be a CEO and described her career as an entire progression toward this. Concerned that change was not occurring in previous organizations and roles, the desire to "make a difference" was central to her motivation to become a CEO. This CEO described the authority to "effect change" as a key challenge because as the CEO, "the buck stops here" when it comes to accountability for change.

FINDINGS

Interview themes are described below according to the questions posed.

How do you see your role as CEO?

The role of CEO was perceived by interviewees as: (a) providing leadership for the overall strategic directions of their organizations, (b) creating transparency of communication to internal and external stakeholders including the public, and (c) developing one integrated culture throughout their organizations. One subject elaborated on the role by stating, "I am responsible for the overall strategic directions (both short-term and long-term) for the region in collaboration with the board and staff" and for "providing leadership to make that happen throughout the organization". From the communication perspective, the CEO must make those directions "transparent" for everyone including the community. Another described the role of the CEO as responsibility for change through the creation of one culture and developing and implementing the strategies to do that. A third interviewee characterized her focus as a priority for the total picture of the organization and all the people in it all the time and ensuring "all the pieces go together".

CEOs described some of the key differences from their senior nurse leader roles as the following: the CEO role affords much more influence on decisions that affect nursing

worklife and the environment; although there are “more politics to pay attention to” as a CEO, there is a more collaborative relationship with physicians; and in the CEO role there is a sense that the “...the ceiling has been removed” and there are no limits on what can be done.

How do you view your relationship to nurses and nursing now?

All respondents reported their personal identification with and value for nursing but they also emphasized the need to be perceived as not valuing one profession over another in their organizations. One stated that initially it was difficult to respond to this question because “...[I do] not have a lot of day to day contact with nurses and it is important to ensure I am perceived to support all disciplines equally” and “hide biases”. This theme was reiterated by another interviewee who said, “I am still a nurse and highly value nurses and nursing” but she cannot value one discipline over another in this role and must communicate that every role is important and essential without a status hierarchy. Another described continuing to have close connections with nursing colleagues and often being asked to speak at nurses’ association meetings.

Has your perspective on the CNO/Senior Nurse Leader role changed since you became a CEO and if so, how?

Responses to this questions centered around the CEOs’ perceptions of how the CNO role should be structured for maximum effectiveness. One interviewee discussed an “inherent power struggle between MDs and RNs” and the long history of nurses having “to take orders from MDs” and then expecting them to be on equal playing fields when they must collaborate on issues. She stated that this situation “needs the CEO leading” and the senior nurse must also be present. Another CEO reiterated the importance of the CNO being in a line role and cited differing experiences with structuring of the CNO role in her organization. At first, the CNO had all clinical programs and the professional practice disciplines but this was too large a workload even with a Director of Professional Practice under the CNO. Now all VPs have some programs and the CNO has some clinical programs and Professional Practice and she feels this ensures the line accountability and a reasonable workload. As for the remaining CEO, in her organization, the CNO has a staff not a line role because the organization is small but there is a senior nurse in a VP role for acute care so “nursing never gets dropped”. This CEO was clear that she expects the CNO to take a full leadership role with equal responsibility and support.

What do you see as the key priorities of the CNO role in your organization?

Each interviewee described three different priorities as follows: (a) one reported that the development and nurturing of key relationships especially between the CNO and the head of medicine were essential in moving the system to integration. In addition, ensuring the provision of patient care through adequate staffing and stability and effective continuing education programs for nurses and other staff, contributing key input into policy decision-making and participating in planning and policy activities at the provincial and national levels are all priorities for the CNO in her organization. (b) Another CEO emphasized the importance of a line role for the CNO to enable integration of nursing initiatives into all units and at the executive level nursing needs to “be at the table to position issues more strategically”. (c) Lastly, one CEO felt strongly that the CNO role was essential to ensure nursing issues never get dropped in the organization.

How do you evaluate the effectiveness of the CNO role?

In one organization, the CEO evaluates effectiveness based on the normal performance appraisal process, results of regular staff surveys, and observations of the CNO’s behaviour in regular meetings individually and with the executive group looking to see “how well he/she supports the rest of the team”. In another organization, role accountability agreements are the basis of evaluation. Every role is viewed as essential and the CEO looks for alignment of nursing with organizational goals and the outcomes of nursing and organizational initiatives. The CEO of the third organization described how the VP does the CNO’s evaluation through 360-degree feedback mechanisms in which nurses, peers, superiors

and some patients have input. The achievement of specific goals and objectives with timelines and reports from Nursing Council are also used as evaluative data.

How do you think the CNO role is best structured for effectiveness?

Two out of three CEOs stated that the CNO should have line authority and the other stated the role should have staff authority largely based on the small size of her respective organization and the need to have someone totally assigned to this role. Again 2 out of 3 said it is absolutely essential that the CNO be part of senior management team while the other stated the CNO reports to a VP who brings the issues to senior management and this works well in her organization. In addition, 2 out of 3 confirmed that the reporting line for the CNO role should be to the CEO while the other was satisfied that in her organization the reporting line is to a VP who is a nurse. Additional comments about structure made by one CEO included the fact she does not have specific discipline heads in her organization as she does not think “it promotes integration” in that separate departments tend “to promote competition between disciplines”. For the same reason, her organization does not have the program management model. Another CEO also emphasized the importance of integration but with the provision that everyone, including nursing, has a voice. In this CEO’s organization, nurses work in integrated teams not separate departments but it is important that “nurses stand up and be nurses” and listen to others in the team as all professions function at their full scope.

What do you see as the key priorities for nursing in your organization?

Key themes in the responses to this question included the current priority in the CEOs’ organizations for mentorship, continuing education and succession planning. One CEO recounted: implementing mentorship and creating an environment to retain good nurses and “nurses need to help us do that” by coming up with ideas about improving worklife; and leadership succession planning by looking for natural leadership qualities in individuals early in their careers and providing mentoring. This CEO was also concerned about barriers in the current climate, which may make it unacceptable to identify individuals for management promotion. In the current politically correct environment one, leaders need to be concerned about the “optics” of doing so as it may be seen as favouritism.

Skill development, enhancing patient safety, empowering staff and culture change were the priorities identified by another interviewee. Last, another elaborated on the importance of succession planning by identifying young people who may want a career in management. This CEO added that ensuring leadership development for managers, providing support for newcomers through orientation and mentoring; continuing development for nurses already in the system; and implementing effective nursing recruitment and retention strategies to recruit the very best, create the kind of worklife needed and find ways for nurses on the brink of retirement to stay in the system.

SUMMARY

All interviewees acknowledged both the authority and the challenge that the CEO role affords them in making major organizational changes including improvements in the quality of patient care and in the working environment for nurses and other professionals. There was also agreement among them about the importance of their nursing backgrounds in shaping their perspectives on healthcare but they also cautioned how critical it is for them to value all professions and working groups equally in order to achieve organizational goals. There was validation among the majority of CEOs that the CNO role should have line authority and participate in policy making at the senior management level. Finally, the priorities for nursing outlined by CEOs in these interviews mirrored some of the recommendations from the Canadian Nursing Leadership Study, specifically, the salient need for nursing leader succession planning in organizations, the implementation of effective leadership development programs for nurses at all levels and attention to recruitment and retention strategies that include changes in nursing worklife.

APPENDIX D: EXECUTIVE SUMMARY OF FOCUS GROUPS

*By Doris Grinspun, RN, PhD(c), O. Ont., Executive Director, RNAO
Kate Melino, BA, Research Assistant, Health and Nursing Policy, RNAO*

The invitation to participate in the focus groups was open to all members of the Nursing Leadership Network of Ontario working as first-line, middle or senior managers in a hospital setting.

A total of 47 nurses participated in three focus groups. The full report can be found on the study website at www.nursingleadershipstudy.ca.

KEY FINDINGS

Three major themes arose out of all discussions, though discussed from various standpoints:

1. Influence and impact

- Focus Groups #1 and #2, conducted with senior nurse managers, showed that the majority of participants identified with the overall study findings. Participants in these two sessions stated that they felt empowered and they had autonomy to make decisions within the capacity of their portfolio area. While fewer participants felt that they had the ability to ultimately influence decisions at the senior management table, there was general agreement that they felt welcome to present their case to senior management.
- This feeling of empowerment was not as strong among participants in Focus Group #3, conducted with nurse unit managers. This group stated that although they may have felt it was appropriate to approach their immediate supervisors, the amount of contact they had with senior management varied widely. Many participants also clearly expressed their feeling that the extent of their influence depended largely on budgetary issues.

2. Span of control

- Overly large span of control was identified as a major problem in all three focus groups, for senior, middle, and nurse unit managers. Participants reported spans of control that reached across program areas, clinical areas, and sites; several participants stated that they had more than 80 people who reported directly to them.
- Participants stated that span of control was influenced by many factors in addition to direct reports. Amongst the most important: the number of units, programs and sites they needed to oversee, the level of clinical and administrative resources they had available, the level of external demand and changing realities.
- The availability of time as a resource was a major factor in influencing participants' span of control. Participants felt that it was difficult to plan and manage proactively as their time was often taken up by the need to plan reactive measures.

3. Succession planning

- All participants expressed concern for succession planning in nursing administration, with the most marked concern being given to the position of nurse unit manager. Participants stated that with positions such as professional practice leader and clinical nurse specialist seen as more appealing and growing in popularity and remuneration, there was a sense that much has to be done to attract nurses to management and make the position more palatable. Participants felt that a perceived lack of job security and inferior quality of worklife added to making these positions unattractive to other nurses.

- Nurses felt that improving recruitment measures was especially important given that the younger generation of nurses appears to place higher value on a work-life balance and is less likely to apply for management positions which require long hours and, often, do not offer compensation that accurately reflects workload.

RECOMMENDATIONS

- 1) Redefine span of control to include not only direct reports, but also the following factors:
 - a) Size of budget that they are responsible for
 - b) Number of distinct units for which they are in charge
 - c) Number of clinical areas within the units for which they are in charge
 - d) Number of support staff (if any)
 - e) Number of disciplines of staff who report to them
 - f) Number of sites
 - g) Number of unions
 - h) Culture of the organization – decentralized HR
 - i) Time as a resource
 - j) External demands (e.g., MOHLTC)
- 2) Provide support for managers in carrying out both clinical and administrative aspects of the role—both from administrative personnel and from upper management.
- 3) Create roles such as team leaders to whom first-line management can delegate, and work toward implementing these positions even within organizations with a “flattened” management structure. These roles would also assist in mentoring and succession planning.
- 4) Define and create understanding of roles and responsibilities at each level of management.
- 5) Create a position on the senior executive team for a representative from all first-line managers to add input and disseminate information among nurse unit managers, and sustain or increase communication between middle and senior management.
- 6) Offer compensation for managers that is fair and appropriate by ensuring that salaries are reflective of their additional responsibility and workload, and publicize management salaries so that nurses can know what to expect as managers.
- 7) Acknowledge that the issues in succession planning are largely tied up with those related to managing span of control, and ensure that both concerns are addressed.
- 8) Look at structural measures to address succession planning, and push for government dedication and funding for these efforts.
- 9) Provide managers with the financial resources and flexibility to pursue educational and mentorship opportunities that allow for long-term development of professional practice and build empowerment and autonomy.
- 10) Create networks to share resources between large and smaller sites.
- 11) Offer alternate work schedules aimed at improving quality of worklife.
- 12) Implement standardized leadership training and high school outreach programs.

APPENDIX E: EXECUTIVE SUMMARY OF INVITATIONAL SYMPOSIUM

Facilitated by: On Management Health Group

Dr. Heather Laschinger and Professor Carol Wong of the University of Western Ontario recently completed the study titled "A profile of the structure and impact of nursing management in Canadian hospitals". On February 4th 2007 an invitational symposium was held during which the research team shared the results of this study with those nursing leaders from across the country in a position to address issues raised by the research. Using the research results as a basis for discussion, symposium participants identified three key nursing leadership issues to discuss. In order of priority, these issues were:

1. Succession Planning (tied for first)
2. Gap between managers' satisfaction; and the satisfaction of front line workers (tied for first)
3. Span of responsibility/control

Through a combination of small group and plenary work, participants identified a framework to guide action-planning discussions. Additional points to consider during discussions were also noted (for example, consider difference across provinces, where more knowledge is needed, and implications for education). The following actions for each issue were proposed:

SUCCESSION PLANNING

- Actively promote leadership roles
- Create a systemic, deliberate, multi-level approach to career development
- Develop an organizational plan for succession planning (system)
- Leaders conscientiously and deliberately build age diversity across their leadership team
- Develop and implement the education support structure to teach leadership and management
- Develop a Canada wide consortium to address employment models
- Create a sense of urgency around the issues

GAP BETWEEN MANAGERS' SATISFACTION AND SATISFACTION OF FRONT-LINE WORKERS

- Develop a pan-Canadian framework to allow implementation of clinical leadership models
- Create mutual gain processes for younger and older nurses to identify areas of shared interest
- Create opportunities for nurses to build leadership capacity through 'stretch' opportunities
- Nurse leaders guarantee protected time for staff nurses for professional development and increased participation in decision-making

SPAN OF RESPONSIBILITY/CONTROL

- Conduct online survey to collect information about current span of control/responsibility, and best practices relating to supports for managers (eg. innovative ways that managers cope with large span of control).
- Bring national groups together to discuss actions to change the role of leadership/management to ensure support for staff nurses.
- Ensure a manageable span of control allowing a manager to have time to support staff nurses and be available for mentoring/support and development
- Consider all responsibilities and demands of managers when examining span of control.

Actions proposed were either at the individual or national policy levels. In several cases, participants were challenged to act on the proposed directions within their own spheres of influence. Several key national organizations stepped forward and committed to working together to address issues raised and actions proposed that were very broad in scope. The full report can be found on the study website at www.nursingleadershipstudy.ca.