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On-boarding and Enculturation of New Chief Nursing Officers

Joyce A. Batcheller, DNP, RN, NEA-BC, FAAN

Given that chief nursing officers (CNOs) play a critical role in hospital organizations and require a diverse set of executive leadership and professional competencies, what competencies are most critical? What kind of support is needed for a leader who is new to this executive role? What is needed to successfully on-board an experienced leader who is new to the organization? How can a CNO demonstrate the unique value he/she brings to the executive "C" suite? The author presents findings from on-boarding 6 new CNOs by using an in-depth 360-degree process to assess competency, an on-boarding development road map, and a CNO scorecard.

Chief nursing officers (CNOs) are responsible for creating a compelling vision for the professional practice of nursing, demonstrating strategic thinking, developing the workforce, planning business, and creating safe and reliable care. Chief nursing officers establish levels of ownership and decision making within the nursing department's operational framework.[1] In addition, the CNO has been described as the "primary architect" of nursing practice and patient-care environments. Chief nursing officers are also the common voice for nursing in healthcare organizations, with levels of power and authority equal to other organizational executives.[2] This role is critical to the organization and requires a specific set of executive competencies.

Background

In 2005, an American Organization of Nurse Executives (AONE) survey reported that approximately 62% of CNO respondents indicated they anticipated making a job change in fewer than 5 years, and of those, more than 25% planned to retire.[3] In addition, 25% of respondents had either lost their jobs involuntarily or had been asked to resign.[3] According to Sullivan-Havens et al,[4] there are 4 central themes for involuntary CNO turnover: hospital financial concerns, conflict with senior leadership, appointment of a new chief executive officer, and concerns about the CNO's financial management capabilities. Other reasons for CNO turnover identified by healthcare executive recruiters include making a career move, senior leadership change, and increasing complexity of the role, reporting relationships, and personal reasons.[4] The desired qualifications for CNOs are a minimum of a master's degree, 10 years of experience in management, diversity management experience, and prior CNO experience. Specific financial and business skills, experience with the Magnet Recognition Program®, a passion for advancing nursing, and the ability to collaborate with physicians are also highly desirable characteristics. In addition, executive recruiters identified key factors they look for when recruiting potential candidates: leadership partnerships, good match with the organization, commitment to quality and patient safety, compensation package, and human resource management involvement.[5]

An organization can be negatively affected when a CNO is terminated or asked to leave. Staff unrest and loss of momentum as well as negative public perceptions when patients and families hear staff concerns are involved. In addition, focus on strategic priorities is lost in the time between a CNO resigning and a new CNO coming on board.[6] It is the CNO who participates in executive-level decision making and gives the nursing voice regarding patient-care delivery in the organization. Despite the expertise needed by the CNO, limited evidence exists about what is needed to develop and enable the enculturation of this key executive position.

Author Affiliation: Senior Vice President/System Chief Nursing Officer, Seton Family of Hospitals, Austin, Texas.
Correspondence: Ms Batcheller, Seton Administrative Offices, 1345 Philomena St, Suite 402, Austin, TX 78723 (*jbatcheller@seton.org*).
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CNO Competencies

The AONE developed a set of CNO competencies that reflect a model developed by the Healthcare Leadership Alliance in 2004. Members of this alliance include AONE, the American College of Healthcare Executives, the Healthcare Financial Management Association, the Healthcare Information and Management Systems Society, and the Medical Group Management Association. These competencies focus on 4 core areas: communication and relationship management, professionalism, business skills and principles, and knowledge of the healthcare environment. Specific behaviors and skills are associated with each of these areas and form a self-assessment tool that could provide guidance for job expectations and evaluations of nurse leaders. In addition, nurse educators can use these competencies in curriculum development and in coaching young nurse leaders with personal growth and development.[4] One challenge may be to know which skills are needed in a prioritized manner, because it is unusual for someone to be competent in all areas when he/she begins this role. Another challenge may be to determine what an individual's competencies are in relation to those expected for a given position.

Overview of On-boarding and Enculturation Strategies

The purpose of this initiative was to determine the efficacy of an on-boarding strategy for new CNOs in a large hospital system—the Seton Family of Hospitals in Austin, Texas, a ministry of Ascension Health. This system has a mature systemwide shared governance model that has been in place for more than 15 years. Four of the hospitals have achieved American Nurses Credentialing Center (ANCC) Magnet® designation and 5 Pathways to Excellence status.

The focus was on developing and enabling CNO enculturation to decrease CNO turnover. This report describes the tactics and experience of the 6 newly appointed CNOs. All 6 have a dual-reporting relationship, reporting directly to the site chief operating officer (COO) and indirectly to the system CNO. Each of the CNOs is also responsible for a systemwide specialty council, a component of the system shared governance model. Chief nursing officer roles are complex in any situation, and here, they are made more complex by the configuration of the matrix organization.

Two of the participants had CNO experience prior to coming to the Seton system. One of these individuals started as a nursing director for a new site and later was promoted to the CNO role. The other 4 participants were internal promotions and were new to the CNO role. Each of the participants had a minimum of 5 years of nursing leadership experience. One of the participants has a PhD, and the other 5 are master's degree prepared. All of the participants hold the ANCC's board certification for nurse executive basic or advanced.

Tactic 1: Competency Assessment

Transformational leaders must lead people to where they need to be to meet the demands of the future. This requires vision, influence, clinical knowledge, and expertise in professional nursing practice as well as leadership that begins with self-knowledge and a commitment to ongoing professional developmental. For these reasons, development and involvement in a 360-feedback process became one of the tactics used.

A CNO "success profile" was created by Development Dimensions, International for the Ascension Health system in October 2008. The success profile is composed of knowledge, competencies, experience, and personal attributes. The CNO competency profile incorporates 12 leadership competencies, 6 of which are considered most critical for CNO success. In addition, 5 technical competencies are unique to the CNO role: demonstrates clinical expertise; displays commitment to quality, research, and safety; exhibits a clear understanding of clinical laws and regulations; maintains knowledge of emerging medical care; and stays abreast of current industry, market, and competitive trends.

The 6 most essential competencies for CNO success were models integrity and values, achieves value-based results, makes effective decisions, leads organizational change, demonstrates financial acumen, and inspires and engages people. These 6 were the focus of the 360-degree assessment that resulted in a report that aids the development of the CNOs.

A consultant gathered qualitative data through in-depth structured interviews with the 6 CNOs. Each of the CNOs completed this assessment and shared results with both the system CNO and their site-specific COO. The assessment provided detailed information about the nurse leader's strengths and development areas and was intended to be used to maximize self-awareness and enhancement of the nurse executive in current and future roles.

Tactic 2: On-boarding Development Road Map

In a study by Groves,[7] best-practice leadership development methods include 360-feedback process, executive

coaching, mentoring, networking, job assignments, and action learning. The Center for Creative Leadership's continuing studies of executive growth and development have confirmed and extended the adage that experience is the best teacher. A variety of leadership challenges include enduring hardships, coping with mistakes, and exposure to exceptional leaders. Each challenge can contribute to building and developing of leaders.[8] Using this model, intentional on-boarding experiences were prioritized for the first year.

For example, executive coaching was provided for practical, goal-focused, one-on-one learning. Many of the day-to-day or organizational issues were addressed by the system CNO as well as the site COO. A consultant from organizational development assisted with role transition and team building. An example of a CNO job assignment was to participate in developing the nursing strategy for the Seton system with the expertise of the Nursing Executive Center of the Advisory Board in Washington, District of Columbia.

They were involved in action learning to develop the nursing strategy for the next 5 years that went to the Board of Trustees in summer 2010. Aligning goals from the boardroom to the bedside at both the site and system level is an example of how executive coaching can be combined with a stretch job assignment. Table 1 provides other examples to illustrate the road map.

Table 1. *On-boarding Development Road Map*

Best Practices	Examples
Executive coaching	One-on-one coaching with system CNO Coaching from site COO Organizational development coach
Mentoring	External resources Team as a whole Mentoring a peer
Networking	Participation in executive meetings Participation at CNO informal dinner meetings Attendance at state and national conferences Membership in professional organizations Intentional exposure to other senior executives
Job assignments/ action learning	Involvement in nursing strategic planning New staffing bill implementation Nursing leadership academy sessions High reliability training Implementation of the nursing business intelligence system Launch of nursing informatics council

Tactic 3: CNO Scorecard

How does the CNO demonstrate the unique value he/she adds in the executive "C" suite? What can be done proactively to build confidence and the relationship between the chief executive officer (CEO), COO, and CNO? What are the most important areas a new CNO in a Magnet-designated organization must be assured are in place? With these questions in mind, the system CNO developed a CNO scorecard as a tool to assist in answering these questions. The Redesignation Self-assessment for Magnet Excellence™ tool was used in deciding which critical indicators would be included in the scorecard because 4 of the sites are Magnet designated. The tool focuses on nurse-sensitive indicators, patient safety indicators, and other metrics that the CNO can improve and align from the boardroom to the bedside. The results are color-coded red-yellow-green to indicate how well each goal is being achieved. This color-coded approach can assist the CNO in assessing which areas to focus and develop action plans for in a timely manner.

In addition, the results for all CNOs and their respective sites were displayed in a comparative chart. The goal was for the team to become comfortable with a transparent approach in sharing results and becoming more data-driven across the system.

Details of Process

Competency Assessment

Five of the original 6 candidates completed their in-depth 360-degree assessment after being in the role for a year. One CNO resigned during this period. Each participant was provided a personal coaching session with one of the consultants who conducted the assessment interviews. A second session among the consultant, the site CNO, and the system CNO was conducted. The results were shared, and plans for ongoing development were discussed. The CNOs expressed that the process was rigorous and thorough. Each of the participants agreed that the results were reflective of what they believe were their strengths and areas in which to improve. Appreciation was expressed by the CNOs for both the organization's willingness to make this kind of investment and for the overall coaching experience. Agreed-upon ongoing development opportunities were discussed in the coaching session and continue today.

With the cost of approximately $5,000 per CNO, the assessment should be conducted only after the CNO has been in his/her role about a year. In addition, waiting that long allows for familiarization with the role and the institution and thus enhances the success and utility of the assessment. Five of the 6 CNOs

were internally promoted. They all agreed that feedback from the assessment process was reflective of how their team and others view them in their "new identity" and not as a result of their previous role.

Flexibility in the on-boarding strategy is needed in a dynamic organization. For example, during the first year of this on-boarding process, 1 CNO resigned, and another CNO had a change in both the COO and president at her site. A third CNO led the opening of a new facility in October 2009.

The 6 individual CNOs beginning at the same time had multiple advantages. It provided opportunities for team building and peer support as the individuals transitioned into their new roles. In addition, providing developmental activities for the whole team was more cost-effective. It was helpful that an outside consulting firm provided a workshop on time management, organizational skills, and tactics that assist the executive to have a "paperless" desk.

On-boarding Developmental Road Map

Taking the time to plan things such as developmental training, projects, presentations, exposure to senior executives, and board members has been beneficial. The term "road map" has been used to illustrate that it will take time for a new CNO to assimilate into his/her new role. New CNOs need to be given adequate support when they start and be able to prioritize goals. To be successful, a new CNO needs to assess and build relationships with many different leaders and unit staffs. Systems, tools, and technology that are used in finance, staffing, and tracking patient outcomes are additional examples of what a new person may need to learn.

Priorities will need to be developed and mutually agreed upon between the hospital/system CNO and COO. Expectations and timelines for achieving results and/or completing certain projects need to be realistically negotiated. For example, the CNO who was leading the opening of a new hospital needed to spend the majority of her time at her site with her team. Intentional plans were made to ensure that she was updated on system-level meetings so she could focus on her site. The new CNO who recently started will not participate in any system or specialty meetings for the first month. This was an agreed-upon approach between the site COO and the system CNO. The goal is to ensure the CNO has sufficient focused time to meet with her new team, round on all shifts, spend time in clinical areas with staff to learn how care is organized, and meet with key physicians.

CNO Scorecard

Each CNO is currently working with the nursing leadership at her respective site to align focus on the indicators that are being monitored on the CNO scorecard. Improvements in certain areas are already being seen. One example relates to patient loyalty. The 4 specific areas affecting loyalty that nurses can impact directly include patients' perceptions regarding pain management, patient education, listening to concerns, and courtesy and respect. Two sites are already seeing improvement in their patient-loyalty scores with this kind of intentional focus. The metrics that are being monitored will be realigned as needed as the CNO group completes the overall system nursing strategy.

The development of the CNO scorecard has stimulated interest in developing comparable scorecards for the COO and the vice president of medical affairs for each of the sites. Although the primary focus for each of the individuals would be slightly different, the interdependencies would be more apparent, which could lead to enhanced teamwork. The data highlighted on the CNO scorecard have been readily available in a variety of different places. The Seton system has invested in the implementation of a nursing business intelligence system and the development of unit-based nursing dashboards to provide each unit with this kind of information for alignment purposes.

In addition, the results for all of the sites have been displayed in a transparent manner for a number of years. The scorecard is different in that it helps to prioritize areas that need focus, celebrates areas of success, and, most importantly, gives clarity on what a CNO should be able to positively impact. The scorecard heightens the level of accountability the individuals have in these roles. This approach is aligned with the greater focus the Magnet Commission and ANCC have taken with the Magnet redesignation process. The eighth domain of Magnet is dedicated to empirical outcomes, which this tactic supports.[1]

If an organization does not have a culture of transparency, these kinds of tactics could be seen as a threat. In addition, if an organization does not have adequate information systems, these kinds of data may be difficult to track and report. Realistic timelines for improvement need to be negotiated between the CNO and the COO. Some of the metrics may be easier to impact than others.

Conclusion

The CNOs have stated that the in-depth assessment process has allowed them to learn more about themselves and to enhance their professional potential. The on-boarding development map with intentional planning and timing of what the priorities are for a new CNO was useful. The road map concept helps to illustrate that it is important to mutually

prioritize what a new CNO must spend time on in a prioritized manner. It visually represents a journey and certain milestones to be reached as time in the role progresses. The CNO scorecard illustrates unique contributions the CNO role adds to the C suite. Aligning the development of goals and action plans that yield positive results will certainly assist in demonstrating the value of the CNO role.

How can this approach be adopted by other CEOs/COOs? Will this type of approach assist in clarifying what a CEO or COO must do to ensure their CNO is successful? As a reformed healthcare system rolls out, the CNO role becomes even more critical. Using business intelligence and metric tools such as those described in this review, CNOs can stand ready to lead the way. Perhaps the on-boarding and enculturation of new CNOs through the use of specific tactics can assist new CNOs to acclimate to the organization and role so that they may more quickly and effectively provide the important leadership for the backbone and the greatest number of employees in healthcare organizations—the nurses.

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