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A STUDY OF CHIEF NURSING OFFICERS AS THE LEAD VOICE FOR THE PROFESSIONAL NURSE: A PHENOMENOLOGICAL INQUIRY

DISSERTATION

Presented in Partial Fulfillment of the

Requirements for the Degree of

Doctor of Philosophy in Nursing

Barry University

Charlene M. Ingwell

2013

A STUDY OF CHIEF NURSING OFFICERS AS THE LEAD VOICE FOR THE

PROFESSIONAL NURSE: A PHENOMENOLOGICAL INQUIRY

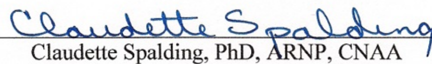
DISSERTATION

by

Charlene M. Ingwell

2013

APPROVED BY:



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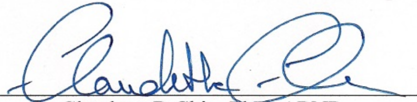

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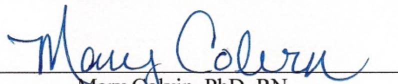

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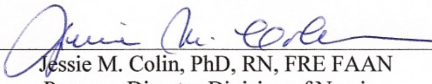

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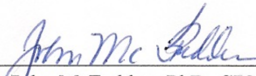

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Abstract

Background: Studies have shown job dissatisfaction, increased workload demands, poor working conditions and high patient acuity (overload) are among the challenges facing the registered nurse (RN) today. These challenges are also being faced by the Chief Nursing Officer (CNO), the lead voice for the professional nurse, in advancing the RN into a highly functioning professional practice guaranteeing, daily, the delivery of quality patient care. Today's CNO must think differently to remove the barriers in the acute care setting, providing effective practice at the point of care.

Purpose: The purpose of this study was to explore the lived experience of the CNO as the lead voice for the professional nurse in the acute care setting. This information may help determine how future CNOs will be even more successful as an effective advocate for the professional nurse and help identify the scope of the CNOs' contribution to the nursing profession.

Philosophical Underpinnings: Guided by the naturalistic inquiry paradigm, this qualitative, transcendental phenomenological inquiry (Moustakas', 1994) yielded an understanding of the human experience of the CNO as the lead voice for the RN, within their context.

Methods: This qualitative, transcendental phenomenology inquiry determined textural-structural, composite descriptions through the lens of the participants to convey an overall essence of the CNOs' lived experience as the lead voice for the RN.

Results: CNOs experience bullying and unwritten hierarchy in the Corporate Suite. They are mostly unprepared to fully communicate in financial, business terms. CNOs rose through the ranks as a result of their clinical expertise and ability to meet challenges.

Their primary focus is patient care, while the nursing workforce is essentially managed. This does not facilitate the development, growth and positive work environment for the professional nurse. Therefore quality patient care is stymied.

Conclusions: From this study of the lived experience of the CNO as the lead voice for the professional nurse, four themes emerged. The primary theme is challenging; with three essential themes of battling, morphing and relating. The demanding workday of the CNO does not leave time for strategizing or growth. CNOs realize their tenure is probably limited.

ACKNOWLEDGEMENTS

Obtaining my PhD has been a remarkable journey. Being able to see and think in a more enlightened manner is incredible, as the ability to understand more also stimulates an unquenchable thirst for further knowledge. It provides a driving force in obtaining answers to questions that have yet to be answered. This is a gift that is priceless for me and for my growth as a scientist.

Dr. Claudette Spalding, my chair and mentor. Thank you for your unwavering guidance and support during this process. Without you, it would not have been possible. My respect and admiration continues to grow. I cannot thank you enough. You are a true leader and educator!

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DEDICATION

Achieving a dream that first seemed elusive, if not impossible, is, in my world, a phenomenon that is absolutely momentous. At times it is surreal and I am most grateful for those people who were consistently there for me throughout the journey. Never wavering, never doubting and always believing.

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CHAPTER ONE

Communicating in a manner that can be heard is the art of dialogue and voice is the vehicle in which this is accomplished. Leadership is finding your true voice. In leadership, "it's not enough just to have something to say, you have to have the strength to say it out loud" (Trainer, 2003). As the leader of the professional nurse at the point of care, in the acute care setting, the Chief Nursing Officer (CNO) is the lead voice for the professional nurse, which includes; understanding the role of the registered nurse (RN) from the point of care to the board room, being able to make innovative changes for the success of these nurses, developing relationships with other healthcare leaders to represent and speak for the professional nurse and promoting understanding of their value to the healthcare industry. By influencing others (Iacono, 2009) and being a role model, a leader can pave the way. The leadership of the CNO is vital for creating a culture which supports excellent patient care services (Adams, 2011; Falter, 2012; Scott & Cleary, 2007). Excellent patient care is the deliverable product and this product is delivered by the nurse, to the patient, at the point of care.

Professional nurses, at the point of care in the acute care setting, have an unhealthy work environment. This unhealthy work environment has continued for more than 90 years (Helmstadter & Godden, 2011; Keddy, Jones, Jacobs, Burton, & Rogers, 1986; Selanders, 2012; University of Virginia School of Nursing Center for Historical Inquiry, 1930). The literature defines an unhealthy work environment as; professional nurses who feel they cannot give quality patient care, lack decision making, do not feel valued, experience mistrust between colleagues and bullying among nurses (Baernholdt & Mark, 2009; Barker & Nussbaum, 2010; Dong & Temple, 2011; Hinno, Partanen, &

Vehvilainen-Julkunen, 2011; Scott, Engelke, & Swanson, 2008). Patient care and outcomes are suffering (O'Brien-Pallas, Murphy, Shamian, Li, & Hayes, 2010).

The CNOs' leadership is required to change present processes, with the objective of consistent excellence at the point of care (Kerfoot, 2009). These nurse executives of today must think differently to remove the barriers and provide effective practice at the frontlines (Kerfoot, 2009). The CNO's strategies need to be aligned with the organization's culture and values and these plans need to be executed with a clearly defined, cost-effective outcome. Presenting new programs and being able to answer key questions about the total, net worth impact for both the nursing areas and the organization are key (Hicks, 2011; Spitzer, 2006). As the leader and advocate for the professional nurse, in the acute care setting, the CNO needs to be considered an equal partner within the executive team, for motivation to continue and to achieve the deliverable product of excellent patient care (Robert Wood Foundation & Institute of Medicine (IOM), 2011).

An exploration and discovery of the lived experience of the CNO as the lead voice for the professional nurse in the acute care setting will help shed light on this phenomenon. Presently, no qualitative phenomenological studies exist in the nursing literature on this area of interest. Hence, this phenomenological study examined the lived experience of the CNO, the lead voice for the professional nurse at the point of care in the acute care setting, in her/his role as an advocate for the professional nurse.

Background of the Study

As part of the executive team, the CNO is responsible for creating a vision, being a strategic thinker, developing the nursing workforce, writing business plans and creating an environment of quality, safe and consistent care for the patients (Kerfoot, 2009).

Simultaneously, the CNO must build strategic relationships in order to be an advocate for the professional nurse, not only at point of care, but also in the board room, where decisions are made. These responsibilities are large and varied.

The most essential part of the patient's hospital experience is the nurse. The CNO has the capacity to influence the role of the RN with the patient. The CNO is the voice of the nurse and the profession of nursing within the acute care setting. Advancing the RN into a highly functioning professional guarantees the highest standard of care being delivered every day, to each patient. This professional progression will contribute to improved patient outcomes, nurse-physician relationships and help counter the rising hospital costs challenges within the healthcare industry (Kerfoot, 2009).

CNOs need to earn respect, support and assistance in the implementation of new, innovative methods of healthcare delivery in the acute care environment. The skills required include building teamwork, along with planning, amending, communicating and implementing strategic and tactical plans, all of which are essential to their success as an innovative and effective leader (Spitzer, 2006). A Healthy Work Environment (HWE) resulting from more effective CNO leadership is the glue that may hold and sustain the much needed changes within the nursing profession; which may lead to decreased turnover and increased retention of staff nurses, decreased attrition rates of new graduate nurses, better patient outcomes and integration of the nurse as a more valued member of the healthcare team.

Preparation for most CNO positions is predominately on the job training. If a CNO does obtain training in leadership education, it is usually fragmented and non-standardized, in which their method of leadership is often not aligned with the overall

leadership objectives of the institution (O'Neil, Morjilian & Cherner, 2008). If the CNO is unable to strategize, plan and convince others of the vision, then this could cause conflict and frustration. Having leadership talent is not enough. Being nurtured and mentored with these talents is essential in developing the CNO for success.

Currently, the turnover of the CNO generally occurs within 3 to 5 years (Batcheller, 2010). This data has not changed since Kippenbrook's original survey study conducted in 1995. Further, executive recruiters seek CNOs with financial management skills, a minimum of a master's degree, 10 or more years of management experience and prior CNO experience. According to the literature, the pool of qualified CNO applicants is too small and, thus, the disorganization and state of flux remain (Batcheller, 2011).

If CNO turnover remains high and their skills are not further developed, then patient care outcomes will be flat, if not failing. The deliverable product will not be accomplished or delivered. According to the literature (Baernholdt & Mark, 2009; Barker & Nussbaum, 2010; O'Brien-Pallas et al., 2010), this is currently resulting in lower than standard patient care, increased turnover and decreased retention of professional nurses, fragmented processes, poor communication, increased hospital costs and poor patient outcomes.

The CNO, the lead voice for the professional nurse, has many challenges that new healthcare initiatives, nationally and locally, have not been able to successfully sustain, detrimentally affecting patient care and outcomes. Addressing these challenges will build a case for the nursing profession being recognized as a valued, integral member of the health care team, not currently experienced by the professional nurse at the point of care in the acute care setting (O'Neil et al., 2008). The cost crisis in the healthcare industry is

in need of CNOs better able to focus and determine what is needed to achieve healthcare reform. This will require a level of innovation, understanding the role of the acute care nurse and their challenges, the complete healthcare operations and the ability to communicate and build relationships in order to affect the much needed change for this reform. Financial expertise is also essential for the CNO to problem solve and create a standardized delivery of care that is both efficient and cost-effective. All these components will build a case for the nursing profession being recognized as a valued, integral member of the health care team (O'Neil et al., 2008). As the nursing leader, the CNO must act not only as the professional nurses' advocate in the executive setting, but also at the point of care. It is here, at the point of care, that the CNOs will be able to provide a foundation and build a successful practice for the professional nurse, the lynchpin of the healthcare industry.

Data from this study and/or its successors may assist in CNO effectiveness, ultimately resulting in sustained, improved patient care and outcomes. This accomplishment may encompass not only the nursing profession and the immediate healthcare facility, but also the global healthcare industry.

Statement of the Problem

An unhealthy work environment is a symptom of lack of leadership. The problem, of an unhealthy work environment among professional nurses at the point of care, has not changed significantly in over ninety years (Helmstadter & Godden, 2011; Keddy, Jones, Jacobs, Burton, & Rogers, 1986; Selanders, 2012; University of Virginia School of Nursing Center for Historical Inquiry, 1930). As a result, patient care and patient outcomes are suffering and 32% to 61% of new nursing graduates are leaving the

profession within 1 to 3 years of graduation (Florida Center of Nursing, 2010). The CNO is the professional nurse's leader. The absence of effective leadership or voice for nursing in the acute care setting is noteworthy (Robert Wood Johnson Foundation & IOM, 2011; University of Virginia School of Nursing Center for Historical Inquiry, 1930; Wong, Laschinger & Cummings, 2010). Research on the distinctive meanings and in-depth comprehension is limited about the lived experience of the CNO as the lead voice for the professional nurse at the point of care in the acute care setting. It was vital to design a qualitative study to illuminate the experiences of these individuals.

Purpose of the Study

The purpose of this study was to explore the lived experience of the Chief Nursing Officer as the lead voice for the professional nurse at the point of care in the acute care setting. This phenomenological, qualitative study used Moustakas' (1994) approach to direct this inquiry to uncover the textural (what) and structural (how) descriptions of the CNO's lived experiences. "What" and "how" it was experienced helped reveal an overall essence of the CNOs' life view in the role as the lead voice for the professional nurse.

Research Questions

In order to obtain the textural (what) and the structural (how) descriptions of the CNOs' lived experiences, the phenomenological design of Moustakas (1994) was used within this qualitative, phenomenological research study. This approach involved a minimum of at least two expansive, over-arching, research questions that focus attention on gathering data that will lead to both textural and structural descriptions (Creswell, 2007). An eventual understanding of the common experiences of CNOs within this study emerged.

Two expansive, over-arching, research questions deemed appropriate for this study were:

1. What is the lived experience as a CNO as the lead voice for the professional nurse at the point of care?
2. Why are CNOs typically identified as the lead voice?

Philosophical Underpinnings

The philosophical underpinning through which the problem was examined was the naturalistic inquiry paradigm. It framed this area of interest, the lived experience of the CNO as the lead voice for the professional nurse at the point of care in the acute care setting.

Describing, understanding and interpreting the professional lived experiences of these leaders within the nursing profession provides a philosophical framework that incorporates value bound, contexts and multiple holistic realities. This is consistent with the post-positivist viewpoint and framed this qualitative, phenomenological research study.

A naturalistic inquiry paradigm is appropriate to use when a phenomenon needs to be explored and a complex, detailed understanding is warranted. If little is known of an area and this becomes problematic, then the naturalistic, qualitative approach is indicated (Joniak, 2007; Westbrook, 1994). Since there are no qualitative studies of the lived experience of the CNO as the lead voice for the professional nurse at point of care in the nursing literature, this type of philosophical perspective was indicated to explore this complex phenomenon.

Tenets of the naturalistic inquiry paradigm are: Research can never be objectively observed from the outside; rather, it must be observed from the inside, through the direct experience of people. The researcher must choose a point of balance between observing and participating, then supplementing by interviewing. Causal links that can be established in natural science, referred to as cause and effect, cannot be made through this paradigm. This paradigm is an integrative one that includes context, perspectives, experiences, underlying motivations and factors that influence decision making and opinions. The role of the scientist is to understand and demystify social reality through the eyes of the different participants and to seek to understand, rather than explain.

The basic assumptions of the naturalistic paradigm are that realities are multiple, they are constructed and holistic. The researcher and the researched are interactive and inseparable. Only time and context bound working hypotheses in the form of idiographic or unique statements and facts are possible. All entities are in a state of mutual, simultaneous shaping, as they are interconnected, so that it is impossible to distinguish between causes and effects and inquiry is value–bound, versus the value–free inquiry of a positivist paradigm (Lincoln & Guba, 1985).

This interpretative inquiry, according to Blumer (1969), rests on three simple assertions: 1. Human beings act toward things on the basis of the meanings that the things have for them. 2. The meaning of such things is derived from, or arises out of, the social interaction that one has with one's fellows. 3. These meanings are handled in, and modified through, an interpretative process used by the person in dealing with the things he encounters (Blumer, 1969). Therefore, the formation of meanings depends on the

context in relation to the interpreter and the culture in which both are located (Joniak, 2007).

The researcher examines the complete information obtained, including the textural interviews, along with the observations noted within the interviews. Looking at the all-inclusive data, the researcher presents descriptions, themes, interpretations, or assertions that are interrelated and expresses the holistic account of the outcomes or effects. This mutual, simultaneous shaping has no direction, it simply happens as a result of the total interactions described. All elements have a relationship that activates them all and the result is shaping meaning in ways that depend on varying circumstances, or conditions (Lincoln & Guba, 1985).

The naturalistic inquiry paradigm guides the qualitative, phenomenological study seamlessly. A qualitative, phenomenological study is more adaptable to multiple realities, more open to shaping and exposing the relationship of the researcher to the respondent. This type of study is value-bound, interactive and cause/effect are meaningless - all of which are known assumptions of the naturalistic inquiry paradigm.

The key characteristics of the naturalistic inquiry paradigm are: a constructivist world view; a holistic way of approaching reality, which is time and context bound; places a strong emphasis on "thick" description and interpretation; and it incorporates the participant's perception and perspectives. The researcher and researched have an integrated relationship, in which the researcher needs to be conscious of her/his bias and prejudices, monitoring them through the processes of data collection and analysis (epoche).

The key characteristics of the phenomenological approach, which was utilized in this study, are also comparable to the naturalistic paradigm, consisting of: the person's perception of the meaning of the event. The focus is what people experience in regard to a phenomenon and how they interpret those experiences; attempting to understand people's perceptions, perspectives and understandings of a particular situation; examining multiple perspectives of the same situation; involving a direct investigation and description of the phenomena as consciously experienced. Cause and effect are meaningless.

These parallel key characteristics of the naturalistic inquiry paradigm and the phenomenological approaches are unified. Therefore, it is evident that the naturalistic paradigm gave a foundation and support to this qualitative, phenomenological inquiry using Moustakas' (1994) approach of transcendental phenomenology.

Phenomenology

Edmund Husserl is considered the father of phenomenology. Husserl's important philosophical tenet was the life world or lived experience (Husserl, 1983). He believed that "a description of our ordinary, everyday experiences is not immediately accessible, because we take for granted most things in everyday life and fail to notice them" (Husserl, 1983).

Husserl's phenomenology is a transcendental phenomenology, which emphasizes subjectivity and discovery of the essences of experience, providing a systematic and disciplined methodology, asserting that the only thing we know for certain is that which appears before us in consciousness. The steps needed for reaching understanding of the human experience are: the researcher must become aware of all her/his preconceptions

(biases, prejudices and other prior personal conceptions) by owning up to one's subjective experiences; therefore the researcher must bracket (epoche) the text, confronting it without his or her preconceived notions; the researcher must use participant member checks to verify data interpretation and the researcher builds data clusters about the text and synthesizes these groups into a cohesive structure. By grouping and synthesizing, phenomenologists contend that the essence of an object emerges to the surface.

Clark Moustakas (1994) built on Husserl's transcendental phenomenology, by analyzing the data into themes, developing a textural description of the experiences of the participants, developing a structural description of their experiences, and developing a combination of the textural and structural descriptions to convey an overall essence of the experience (synthesis). Therefore, the researcher/participant relationship develops through a joint enterprise of exploration and understanding, allowing the researcher to use the eyes of the participant.

Martin Heidegger, a student and critic of Husserl, developed phenomenology into a hermeneutic, or interpretative, philosophy (Heidegger, 1962). There are distinct differences between the two approaches to phenomenology. Both transcendental and hermeneutic phenomenology includes description and interpretation. However, hermeneutic phenomenology emphasis interpretation with some description; while transcendental phenomenology concentrates on description with some interpretation. Bracketing is very important in qualitative research and essential in both forms of phenomenology.

Even Husserl and Moustakas have differing beliefs. In Husserl' transcendental phenomenology, the researcher's own bias, opinions and subjective beliefs cannot be totally eliminated through bracketing and epoche. In contrast, Moustakas' transcendental phenomenology contends that bracketing and epoche do allow the researcher to attain objectivity.

This qualitative phenomenological approach takes into account five foundations (see Figure 1) leading to the essential essence of the lived experience of the CNO as the lead voice for the professional nurse at the point of care: the External Foundation of phenomenology as a philosophy and research method; the Investigative Foundation of interviewing, listening, analyzing and bracketing; the Language Foundation of expressions, words and stories; the Participant Foundation of the introspection and reflection; and the Descriptive Foundation of reflective thought giving rise to meanings and emerging themes.

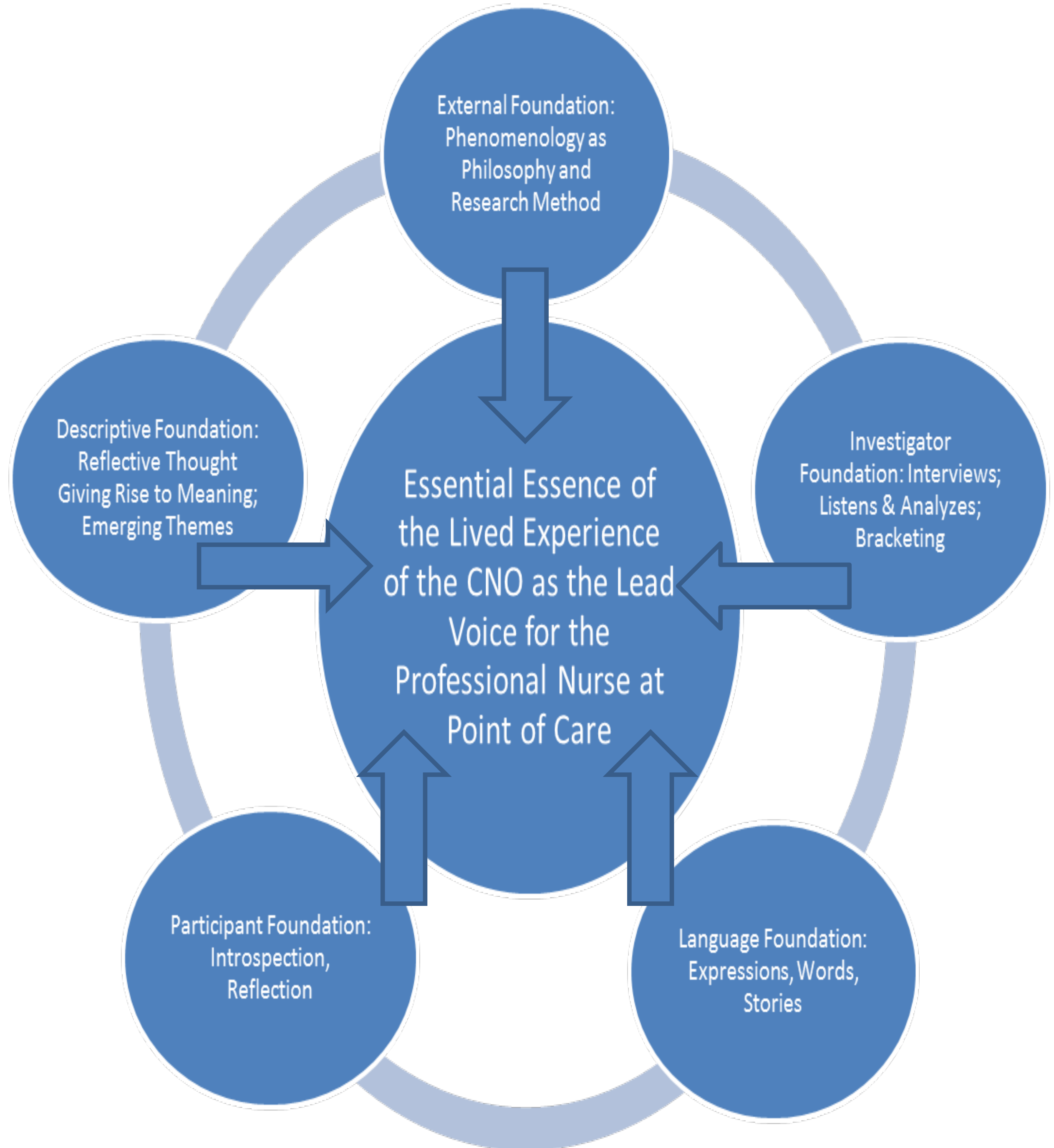

Figure 1. Ingwell (2013) adapted from Husserl's essence of phenomenology (1913).

Phenomenology is an effective method of research for the human sciences. This qualitative approach takes into account the complete context of the person in her/his situation. To tell one's own experience can illuminate that which was previously hidden. Therefore, the methodological approach for this study was a qualitative, phenomenological inquiry using Moustakas' (1994) approach of transcendental phenomenology. This inquiry uncovered the textural and structural descriptions of the CNOs' lived experiences, helping to convey an overall essence of the CNOs' life view in their role as the lead voice for the professional nurse in the acute care setting.

Qualitative research is the discovery of how people make sense of their social worlds, realizing that social realities exist due to the differences in the human experience. Social realities/perceptions of human behavior are context bound. Understanding social realities is achieved through rich, contextual description, including subjectivity of the participants (Creswell, 2007).

Qualitative research is used when: variables cannot be quantified; are best understood in their natural settings; are studied over time; when studying roles, groups and processes; and when the principal objective is to understand. Accordingly, the philosophical underpinnings of the naturalistic inquiry paradigm are appropriate to this study's time and place.

Importance/Significance of the Study

Illuminating, or shedding light on, the complex phenomenon of the lived experience of the CNO as the lead voice for the professional nurse has led to a better understanding of the contributions, challenges and successes of the CNO, in order to help develop a blueprint for an even more effective nurse leader. The context of the

environment, relationships, expectations and other influences can be an integral component of the success and failure of individuals and their outcomes.

This phenomenological study helped identify the true root cause of the current unhealthy work environment for the professional nurse and may allow the CNO, the nurse leader, to affect meaningful, permanent change for healthcare reform and better patient outcomes.

The identified themes of this study helped recognize what needs to be done for future CNOs to be more successful and effective as a lead voice for the professional nurse. It also discovered a need for further studies on this topic either quantitative, qualitative, and/or combination studies all important to nursing science including:

Implications for Nursing Education

Standardized leadership development curriculum and succession planning are necessary and critical for the future of an effective CNO. The healthcare industry is rapidly changing with new technology, medical reimbursement requirements, productivity metrics and fiscal responsibilities. Graduate level of education, years of experience and leadership course completion were identified as factors that significantly influence innovativeness, financial abilities, strategic thinking and building relationships with all levels of nursing leadership and professional staff nurses (Clement-O'Brien, Polit, & Fitzpatrick, 2011). Advanced education, along with clinical application with support and mentoring, are essential for the CNO. This study helped bring clarity to understanding the lived experience of the CNO as being lead voices for the professional nurse and, from the identified themes, may guide further development and education of CNOs, today and tomorrow.

Implications for Nursing Practice

High attrition rates among new graduate nurses focuses on the need for a HWE with more emphasis being placed on the transition from school to practice (IOM, 2011). Growing turnover rates of professional staff nurses is also among the CNOs' current problems, as is the requirement for the professional nurse to be culturally competent to meet the needs of a more diverse, growing patient population. Information technology needs to be more user friendly to fully benefit the professional nurse at point of care and, of course, the patient (IOM, 2011).

The decision making and innovativeness of the CNO has a tremendous impact on the professional nurses' success at point of care. In the end, this may bring success for the healthcare industry, not only by giving excellent patient care, but doing it in a cost effective manner for the patients we serve.

Implications for Nursing Research

Through identification of themes from this study, more studies may be needed to obtain data to support and answer questions that may surface from reflecting on these lived experiences. Studies addressing turnover rates of CNOs in relation to a HWE and determining what constitutes pertinent educational curriculum and succession planning for the development of a CNO may be concepts that need further exploration.

The findings of this study may require other types of methodologies for future quantitative, qualitative and/or mixed method research perspectives. These future studies may help enhance the future CNO's ability to be even more effective and influential for the success of global healthcare, as well as for the profession of nursing throughout the world.

Implications for Nursing Health/Public Policy

Addressing healthcare reform, as noted in the literature, requires a decisive, strong and visionary nurse leader, to functionally transform the healthcare system. This includes all nurses being leaders in the design, implementation, evaluation and advocacy of the new reforms (IOM, 2011).

The CNO will need to lead the leaders. She/he needs to be able to build relationships and communicate the value of the professional nurse as a true professional within the healthcare industry, as well as to the public. It is important that the professional nurse, from the point of care at the bedside to the board room, has respect and is a full partner with other colleagues within the healthcare system. Developing leadership skills should not be for the very few, but for all healthcare professionals. It is vital that the professional nurse, led by the CNO in the acute care setting, is the true lynchpin in the development of the new healthcare reform. They are the true advocates for the patient and would be, as a profession, a lead voice for the patient's well-being. The professional nurse, of course, would be taking the example and lead of the CNO, the lead voice and advocate for their well-being as professionals in the healthcare industry.

Scope and Limitations of the Study

The study consisted of CNOs working at acute care facilities within the Southeastern United States. Each participant willingly shared their lived experience for the purposes of this research.

Limitations of the study included: The principal researcher was a novice.

Chapter Summary

This chapter discussed the problem, purpose, research questions, philosophical underpinnings, significance, scope and limitations of this study - to explore the lived experience of the Chief Nursing Officer as the lead voice for the professional nurse at the point of care in the acute care setting.

An unhealthy work environment has persisted for over 90 years for the professional nurse in the acute care setting at point of care. The CNO is the professional nurse's leader. It is noteworthy that there is no effective leadership or voice for nursing in the acute care setting. Patient care and outcomes are suffering. In addition, approximately 50% of nursing graduates are leaving the profession within 1 to 3 years of graduation. This phenomenological study may help to alleviate these problems.

CHAPTER TWO

Literature Review

The purpose of this study was to explore the lived experience of the Chief Nursing Officer (CNO) as the lead voice for the professional nurse at point of care in the acute care setting. Understanding the complex phenomenon of the CNO as the lead voice for the professional nurse helped identify the scope of the CNOs' contributions to the nursing profession and helped determine how current and future CNOs may be even more effective as an advocate for the professional nurse and, inevitably, for the overall nursing profession.

When reviewing literature, it is important not just to find what has been examined, but just as important, to determine what needs to be and has not yet been done (Munhall,2012). The literature review allows the researcher to determine the significance of his or her study by defining what is existent while simultaneously focusing on new propositions for future research. Finding the gaps and inconsistencies in the current body of knowledge is essential in providing the groundwork for a current study (Creswell, 2007). This gives value to the study.

The professional nurse needs a voice in order to clear the path for their leadership, to be more effective and heard and to help transition the organizational change of the healthcare industry. When this happens, the future of the healthcare industry will be achieved with the completion of healthcare reform that is sustainable and constructive. The stage will be set for a true continuum of quality care.

A search of relevant literature was conducted to explore the phenomenon of CNOs as the lead voice for the professional nurse. Using First Search, Lilinet Online and

ProQuest Direct search engines, the following computerized databases were used for this search: ABI Inform (index of Business and Management), ArticleFirst, the Cumulative Index to Nursing and Allied Health Literature (CINAHL), Dissertation Abstracts, Educational Resource Information Center (ERIC), Health Reference Center-Academic, Medicine, Modern Language Association (MLA),and Periodical Abstracts (PerAbs: Covering business, economics, literature, religion, psychology, and women studies). A limitation was imposed to find literature published since 2007, with classics sought by reviewing citations in the published works. A random selection process delimited the profusion of theoretical references that were found. Synthesis of the literature reveals what is known and not known about the CNO as the lead voice for the professional nurse. Combination of key words used were; “voice,” “CNO,” “leadership styles,” ‘leadership attributes,” “retention and turnover of the RN” and “patient care outcomes.” Relevant research reports were examined. Selection criteria included (1) voice of nursing, in relation to CNO leadership; (2) samples of professional nurses at point of care, examining attrition rates, retention, turnover and job satisfaction; and (3) demonstration of leadership styles and methods of nurse leaders and their outcomes.

Studies outside of the acute care setting were excluded. Once meeting the selection criteria, studies were evaluated for sufficient description of the purpose, methodology, sample selection, reliable results and conclusions. Only 4 studies on the voice for nursing in relation to CNO leadership were obtained, 12 studies of the professional nurse’s attrition rates, retention, turnover and job satisfaction were acquired and 11 studies were found on leadership methods and styles. All studies were inpatient in the acute care setting.

Descriptive synthesis of the findings indicated 7 contextual areas that bring success to the nurse leader as an effective voice for the professional nurse. They are: being innovative, having authentic leadership, advanced communication skills, more leadership development, implementing transformational leadership styles, a need for a supportive and collegial work environment and reducing burnout and fatigue of the professional nurse.

All of these contextual areas tended to influence and affect each other. Leadership style and development and a need for a supportive and collegial work environment were discussed in the areas of communication, innovativeness and authenticity and burnout and fatigue of nurses. Accordingly, they are not discussed separately.

Historical Context

Despite the descriptions and explanations of the numerous challenges for the CNO as a nursing leader within the acute care setting, current nursing literature regarding this topic is limited. Only 4 studies on the voice for nursing in relation to CNO leadership were obtained. All were quantitative in a self-survey format, which could possibly result in bias.

A self-survey study of 5000 CNOs conducted by the American Organization of Nurse Executives (2006) found that approximately 25% of CNOs were coerced to leave and/or terminated. Conflict with their Chief Executive Officer (CEO), family matters and job dissatisfaction were among the main causes of CNO attrition. Kippenbrook's (1995) survey study of 68 CNOs (a 40% response rate) and 47 CEOs (a 28% response rate) found differing workplace performance expectations between the CNO and CEO, which

resulted in conflict. The most frequent CNO lengths of employment were only 1 and 3 years, with CNOs noting lack of ability to affect change, CEO conflicts and insufficient number of staff nurses as their main reasons for departure. In contrast, CEOs felt that CNOs were inadequately prepared to meet performance metrics and were thus unable to perform their CNO roles. This survey did not provide effective solutions for solving the identified issues. Another CNO survey (Jones, Havens & Thompson, 2008) examined turnover and retention of 634 CNOs across U.S. hospitals. The largest percentage of CNOs reporting, 31%, had been in their current position 2 to 5 years and 60% of all the CNOs were in their first CNO position. 61% of the CNO respondents expected to change jobs in less than 5 years. 73% of the CNOs expressed concerns about the "slippery slope" of CNO turnover (p. 98). 74% of CNOs in this study reported they had a good relationship with professional nurses at point of care because they made rounds at least weekly. The professional nurses' perspective was not reported. The central premise of Clement-O'Brien, Polit & Fitzpatrick (2011) survey study revealed that the CNO, or nurse leader, with more education and experience had a tendency to be a better change agent, putting into practice more relationship and innovative methods.

Most of the studies within the last decade were not CNO centric; instead they focused on the professional nurses' attrition rates, retention, turnover and job satisfaction in relation to a HWE. Hinno, Partanen, & Vehvilainen-Julkunen (2011) study found a HWE to be the foundation for reducing turnover and promoting a positive work environment and a better self-concept for the RN. The leadership methods and style studies; e.g., Sorensen, Iedema & Severinsson (2008), discovered a central basis for a

need of professional advocacy and communication to overcome nursing barriers and articulate new nursing knowledge.

There were no studies found that examined the lived experience of the CNO as a lead voice for the professional nurse. Approximately two-thirds of the studies meeting the selection criteria were quantitative, versus qualitative, including an action research study. Understanding the actual environment of the CNO, including; their daily routine, relationships with other members of the executive team, application and understanding of leadership skills, working with their CEO and Chief Financial Officer (CFO) and the level of influence in regard to decision making within the facility, are all imperative to help reveal the CNOs' perspective.

Since there were no qualitative, phenomenological studies of the CNO, a definitive gap existed. Understanding the professional, lived experience of the CNO is a starting point. Discerning CNO performance through a phenomenological approach, as being a lead voice for the professional nurse, helped identify the scope of the CNOs' contribution to the nursing profession. In addition, it may assist in determining how CNOs will be even more successful as an effective advocate for the professional nurse and, inevitably, for the overall nursing profession. This may generate future research and shape existing practice for the global nurse leader, the CNO, as well as for the future of the nursing profession. This study began to fill the existing gap with regard to the lived experience of the CNO as the lead voice for the professional nurse at point of care in the acute care setting.

Innovativeness and Authenticity

The leader is key in preparing and affecting organizational change. The CNO is the leader of the acute care nurse and her/his influence and ideas to implement

meaningful change for the professional nurse are crucial for their success and sustainability. Organizations are more likely to continue on with the same implementation methods, which may not necessarily be the best method for the current culture (Clement-Obrien, Polit, & Fitzpatrick, 2011; Dickerson, Brewer, Kovner, & Way, 2007; Mastal, Joshi, & Schulke, 2007; & Wong, Laschinger, & Cummings, 2010).

A quantitative study (Clement-O'Brien et al., 2011) regarding innovativeness among nurse leaders sought to describe innovativeness and the rate of adoption of change among CNOs in the acute care setting and to also explore differences of innovativeness and rate of change of CNOs of magnet versus non-magnet hospitals. 261 CNOs of acute care facilities in New York State received a mailed survey, in which the response rate was 102 participants, or 41%.

The research questions that guided this study were: (1) What is the innovativeness of acute care hospital chief nursing officers? (2) What is the rate of adoption of change among acute care hospital chief nursing officers? and (3) Is there a difference in the degree of innovativeness of chief nursing officers of magnet hospitals compared with CNOs of non-magnet hospitals? The Scale for the Measurement of Innovativeness was used and it was found that graduate level of education, CNO experience and leadership development were significant factors influencing innovativeness of CNOs. Using Pearson's correlation, a meaningful relationship was found between innovativeness scale scores of the sample and their innovativeness diversity index, $r = 0.34$, $P < 0.00$. The education level, in the three-group categories, is significantly related to the willingness to change classifications ($r = 15.93$, $P = 0.04$). The average scores of the Magnet group (mean = 59.5) and the non-Magnet group (mean = 59. 88) on the innovativeness scale

score ($t = 0.21$, $P = 0.83$) were similar. The CNOs who completed more leadership courses had implemented more types of innovations and had higher innovativeness scale scores. Implications were to increase the body of knowledge in regard to this subject area; however, there was not a consistent definition of leadership development and, therefore, it could affect the results with regard to what constitutes quality in a leadership program to achieve leadership development.

The study of Wong et al. (2010) explored a theoretical model linking authentic leadership with staff nurses' trust in their manager, work engagement, unit care quality and voice behavior. This non-experimental, predictive survey design was implemented via a random sample of 280 registered nurses working in acute care hospitals in Canada. The results showed that authentic leadership significantly influenced staff nurses' trust in their manager and work engagement, which consecutively foresaw unit care quality and voice behavior. The Authentic Leadership Questionnaire (ALQ) was used to measure nurses' perception of manager authentic leadership. Each subscale was averaged to produce a total scale score between 0 and 4, with higher scores representative of higher levels of authenticity. Acceptable internal consistency has been reported, as evident by Cronbach's alphas ranging from 0.70 to 0.90. Overall, staff nurses reported higher social identification (M = 5.19, SD = 1.03) with their work units than personal identification (M = 3.49, SD = 1.46) with their unit manager and trust in the manager was moderate (M = 3.26, SD = 0.63) as was work engagement (M = 4.01, SD = 0.96). Voice behavior and perceptions of unit care quality were rated moderately high (M = 5.22, SD = 1.07 and M = 3.39, SD = 0.70, respectively). Implications of this study included; managers having positive relationships with their staff, by being authentic, can improve quality of care and

work environment conditions. Applying authenticity can support others to bring about effective change. This can help cultivate innovativeness of the professional nurse. Professional nurses want to believe their leaders are dependable, reliable and consistent. When they do, it brings empowerment to the professional nurse, as well as to the leader.

A quantitative study (Mastel et al., 2007) identified the extent to which the Chairman of the Board, CEO and CNOs of 63 U. S. hospitals were engaged in the areas of quality and patient safety at the leadership governance level and how CNOs can support board engagement in these areas. Of the 73 telephone interviews conducted, 22 were with CNOs, 29 were CEOs and 22 were with the Chairman of the Board. The results showed a significant difference between the CNOs and the Chairmen of the Board and CEOs with regard to pertinent nursing quality issues. The P-values ranged from <0.01 to <0.12. The board chairs and CEOs had limited comprehension of the quality issues of patient care and safety. The CNOs were focused on landmark reports on quality and patient safety, while the CEO and Chairman of the Board were more interested in the integration of quality planning. The study noted that CNOs were a valuable resource in the areas of patient care and safety, and they could help close the gaps and educate the importance of these pressing issues to the other board members. However, this study did not specify the actual implementation methods or innovative techniques needed by the CNO to accomplish this endeavor.

These studies exhibited the value of the CNO's knowledge and that a higher level of education influences more innovative thinking. Nurse leaders in the acute care setting who demonstrate innovativeness and authenticity provide a better work environment for

the professional nurse at point of care, resulting in better patient outcomes, along with a voice for nursing.

The literature, however, does not specify any actual innovative approaches developed by CNOs impacting the professional nurse in the acute care setting. There were also no studies of CNOs' authenticity or innovativeness with regard to their impact, sustainability and/or effect upon the HWE of the professional nurse. Therefore, a gap existed, as there were no CNO studies on specific innovative and authentic approaches having a lasting effect on the professional nurse at point of care. This phenomenological study began to help determine factors currently existing that stymie innovative, authentic and lasting CNO methods and tactics for the professional nurse at point of care. This, in turn, may lead to further studies, either quantitative, qualitative and/or mixed methods, regarding specific strategies for the CNO of today and tomorrow.

Communication

The CNO needs to move beyond dependence on current clinical models in order to have professional nurses become more skilled, multidisciplinary team members. This will require high level communication and advocacy for nurses to take their place as equal partners in health care. Speaking up about organizational issues and suggesting changes to operating procedures may cause risk to the person speaking; however, when spoken effectively this could be viewed as constructive (Whiting, Maynes, Podsakoff, & Podsakoff, 2012).

According to Sorensen, Iedema, & Severinsson's (2008) study, a higher level of communication is the method of professional advocacy which operationalizes new nursing knowledge. This 3 year, qualitative, ethnographic study of an Intensive Care

Unit (ICU) in Sydney, Australia examined nursing leadership in the context of contemporary healthcare and its potential contribution to its organization and management. 34 nursing managers, senior nurses, novice, intermediate and experienced nurses were interviewed. Professional barriers in the workplace, fragmentation of clinical systems and clinical and administrative disconnect were found, all preventing the professional nurse from articulating a new model for end-of-life care. Three sub-themes were identified: nursing care at the end of life; barriers to enacting nurses' professional role; and opportunities for nursing leadership in the organization. Achieving the end-of-life care goals involved structured communication at key points in the patient's trajectory of care. Yet, no structured routines were evident in the unit. Without this level of collaboration, nurses could not anticipate treatment or prepare patients and families for their experiences. In this study, the excerpts presented and discussed suggested that nurses were systematically excluded from contributing information that was crucial to patient decision making and quality of care. The question that arose in this study is "What can nurses do about it?" Nurses must find a way, institutionally, to overcome the barriers that prevent them from enacting their professional model of care, as they deem it appropriate. This will entail enabling and encouraging nursing staff to communicate and negotiate interpersonally, socially and organizationally, as well as clinically, which is imperative to regain the trust of patients, families and the wider population.

A case study (Valentine, Kirby, & Wolf, 2011) of a health care system developing a platform for change focused on the partnerships between the CNO and CFO in addressing challenges of quality patient care, safety and financial performance. This study found that communication at a higher level also involves understanding and

appreciating financial constraints and the importance of balancing them with expected outcomes. This knowledge needs to be communicated to the CFO from a nursing perspective, as well as to professional nurses, so all can understand the complete presentation of the healthcare industry and the roles of the professional nurse within this portrait. With ever increasing pressure to cut costs, the partnership and collaboration between nursing and finance needs to take on these new challenges. This partnership has historically been strained and does not always come easily due to differences in focus, priorities and inadequate communication, listening and hearing. A strong CNO-CFO partnership is needed. This case study illustrated effective communication between the CNO and CFO, resulting in the development of benchmarks, a functional nurse staffing council, an evaluation process of patient acuity and classification systems to prevent inequitable patient assignments.

Another study (O'Brien-Pallas et al., 2010) also examined the strength of communication. Nurses and unit managers were surveyed, medical records and human resources databases were assessed and nurse turnover was observed in Canadian hospitals, with the focus on the impact and key determinants of nurse turnover. The study was guided by the Patient Care System and Nurse Turnover Model, which conceptualized nursing turnover as a throughput factor, using both repeated cross-sectional and longitudinal components, executed over 2 waves. 4,481 nurse respondents, or 88.97%, participated in the first wave and 3,844 nurse respondents, or 90.16%, took part in the second wave.

The relationships between system inputs (nurses, characteristics of patients, nursing unit and the organization) and system outputs (patient, nurse and organizational

outcomes) occurred after interacting with the throughput (environmental complexity, staff utilization and turnover rate). These results were then fed continuously back to the entire patient care system. Nine different units were represented from a large sample of hospitals. A higher level of ambiguity and role conflict were associated with high turnover rates, P-value less than 0.05. Increased role conflict and higher turnover rates were associated with mental health issues, P-value less than 0.05. Higher turnover rates were associated with lower job satisfaction, P-value less than 0.05. Higher turnover rate and higher level of role ambiguity were associated with an increased likelihood of medical error, P-value less than 0.05. The overall mean of annual turnover rates across units was 19.9%. ICU at 26.7%, surgical at 20.8% and pediatrics at 20.8% were the highest units in terms of professional nurse turnover.

Reasons for leaving were lack of team support (poor working relationships with nurse managers), professional ineffectiveness (lack of autonomy and decision making related to the organization and patient care) and inability to give competent care. The implication, that communication and a supportive practice setting in which role responsibilities are understood by all members of the team, are essential in promoting nurse retention.

According to these studies of nurse managers, high level communication and effective advocacy with other healthcare professionals are required for a healthier nurse work environment and more competent patient care. In addition, the single CNO study concluded that communication at the highest organizational levels involves understanding and appreciating current financial realities, so that the CNO may advocate in the board room, where decisions are made for the professional nurse at point of care.

Further, nurse turnover and retention rates were also affected by the communication skill of the nurse manager and the professional nurses' ability to voice.

From these studies, it is known that effective communication, advocacy, collaboration with other disciplines and the ability to afford competent patient care provides a healthy work environment for the professional nurse in the acute care setting, which also reduces turnover and increases retention. None of these studies were phenomenological in nature, to understand the lived experience of the lead voice of the professional nurse, the CNO, to discover and explore, in order to understand this phenomenon.

Burnout and Fatigue of the Professional Nurse

In spite of the poor outcomes in patient care, professional nurses continue with the same processes. For the professional nurse to feel safe to speak up, a positive work environment is a must, as is being able to trust the leader, in order to follow their lead and example (Cowin & Hengstberger-Sims, 2006; Mackusick & Minick, 2010; Robert Wood Foundation & IOM, 2011).

Barker & Nussbaum (2011) cross-sectional, online survey studied the relationships between dimensions of fatigue and performance of registered nurses. An online survey measured mental, physical and total fatigue dimensions; acute and chronic fatigue states; and performance. 745 out of 1,006 registered nurses completed the survey, in which the findings showed mental fatigue levels were higher than physical fatigue levels. Fatigue levels were negatively correlated with performance. Work environments, positive and negative, were associated with perceived levels of fatigue (low and high). Cronbach's alpha values ranged from 0.72 to 0.91, with P less than 0.0001. The study

indicated that by improving the work environment, it may be possible to reduce fatigue levels and the rates of medical errors.

Another study, Baernholdt & Mark (2009), wanted to determine whether there are differences in hospital characteristics, nursing unit characteristics, the nurse work environment, job satisfaction and turnover rates. This cross-sectional research was done both in rural and urban hospitals. This secondary data analysis examined differences between these rural and urban hospitals, in a subsample from the Outcomes Research in Nursing Administration (ORNA-II) project. The random sample consisted of 97 hospitals in the United States representing 194 nursing units. The results showed that job satisfaction and turnover rates, in both rural and urban nursing units, are associated with nursing unit characteristics and the work environment. The P-value ranged from less than 0.04 – 0.01 in all characteristics, including the differences between rural and urban hospitals. By creating better support services and a work environment that supports autonomous nursing practice, burnout/turnover among registered nurses can be reduced.

Rudman & Gustavsson (2011) prospective longitudinal study using the national cohort of 1,153 nurses within the Longitudinal Analysis of Nursing Education (LANE) study, identified and compared change trajectories in burnout symptoms of new graduate nurses 4 times annually; the last year of nursing education and the first, second and third years post-graduation. 997 participants were studied. Results showed that increased burnout levels were accompanied by depressive symptoms and plans to leave the nursing profession. Approximately every fifth nurse experienced high burnout levels during the first three years after graduation from nursing school and the majority of nurses in the second year post graduation suffered stress with increased levels of burnout. A

relationship was found between younger age (< 25) and early career burnout, while new graduate nurses age 35 and greater were less likely to experience burnout in the first 3 years post-graduation. Lack of clinical preparation, values not in alignment with the work culture and performance based self-esteem were also factors affecting burnout among the new graduates. A younger, less clinically prepared recent graduate is 2.5 times more likely to experience burnout than an older, less clinically prepared graduate. P-values ranged from 0.001 to 0.944.

These articles in the literature highlight that adequate clinical preparation along with a positive work environment, even a perceived one, are required for the professional nurse at point of care to reduce mental and physical fatigue and burnout levels. Medical errors may be reduced.

This literature did not offer effective, specific solutions for the needs identified to combat fatigue and burnout of the professional nurse. Again, none of the studies were phenomenological in nature, to help explain this complex, little known phenomenon of leadership or voice for the professional nurse at point of care in the acute care setting and why it is silenced. A study of the lived experience of the CNO, the lead voice for the professional nurse at the point of care in the acute care setting, began to fill this gap.

Experiential Context

Given this author's decades of experience in the hospital and corporate setting, some preconceptions and biases, both positive and negative, regarding CNOs are inevitable. The role of CNOs is certainly valued for their potential impact for the individual, professional nurse and the nursing profession. Awareness of the numerous, often conflicting roles and responsibilities of the CNO is part of this author's experience.

However, based on this experience, some CNOs have demonstrated ineffective leadership while others have been very effective in their leadership. Not every CNO has been educated and motivated to the full extent that this leadership position demands. I believed that this investigation was warranted as to why this might be happening. I bracketed my biases, meaning the focus of the study was placed in brackets, so that everything else was set aside, or separated, in order for the research to be rooted in the topic and question. Disciplined, regular and determined efforts, placing aside my preconceptions of CNOs lived experiences as the lead voice for the professional nurse, allowed the study to guilelessly develop to its fullest extent, unaffected by the author's personal and professional involvements (Moustakas, 1994). No prior opinions or views influenced the investigator.

Researcher reflexivity required constant reflection of my understandings of my own experiences, as well as the phenomenon at hand, in order to move beyond my inherent beliefs and bias (Finlay, 2009). I reflected and journaled my own bias and assumptions prior to the study, as well as continuously, throughout the study, during data collection, including before and after each interview and analysis. This allowed an openness to discover the essence of the CNOs lived experiences. It was a never ending practice throughout the research process.

Chapter Summary

This chapter provided a review of the literature pertinent to the study. There were no CNO studies on specific innovative and authentic approaches having a lasting effect on the professional nurse at point of care in the acute care setting. Nursing leadership has been silent, though the literature consistently notes the need for a voice and advocacy for the professional nurse. Patient care outcomes, attrition rates and possible medical errors are all affected, per this literature review. General areas needing improvement are mentioned in the literature; however, the specific tactical and strategic plans are not suggested there. Root cause of the problem had not been identified; hence the lack of meaningful, long- term improvement for the professional nurse at point of care in the acute care setting.

CHAPTER THREE

Methods

The purpose of this study was to explore the lived experience of the CNO as the lead voice for the professional nurse, in order to gain a better understanding of how CNOs demonstrate being a lead voice for the professional nurse. This information may help determine how future CNOs may be even more successful as an effective advocate for the professional nurse and inevitably for the overall nursing profession.

To comprehend, or understand, a phenomenon is considered an accomplishment in all facets of living. For example; understanding the working of a V engine, the electrical system of the human heart, or the human reproductive system, is an achievement that can spark further exploration of knowledge. These future discoveries could, for example, include safer, more advanced medications, or, perhaps, a more sophisticated engine that is more durable and lasts longer. The qualitative method of phenomenology as a philosophy is our hope for understanding in this world (Munhall, 2012). To understand the meaning of events and experiences of people would allow us to be more conscious of the particulars of each experience, at the same time recognizing the similarities (Munhall, 2012). By distinguishing individuals, groups, abstract concepts and providing rich textural data that builds on what is currently known, the respect of health researchers is achieved. The basis of phenomenological research is to reduce individual experiences of a phenomenon that can be described as the universal essence, or core (Creswell, 2007). This essence consists of “what” they experienced and “how” they experienced it in a conscious state (Moustakas, 1994). The development of the

description of these essences within their experiences is crucial to phenomenology, rather than explanations or analysis (Moustakas, 1994).

Advancing the RN into a highly functioning professional practice that guarantees quality patient care being delivered every day is essential. Two research questions had been deemed appropriate for this study in accordance with Moustakas' design, as all-encompassing to guide this phenomenological research, in order to obtain the textural (what) and the structural (how) descriptions of the CNOs' lived experiences. These two expansive, over-arching research questions were: (1) What is your lived experience as a CNO as the lead voice for the professional nurse at point of care? (2) Why are CNOs typically identified as the lead voice? The CNO of today and tomorrow must identify and overcome specific obstacles in the acute care setting, to be operationally more effective for the professional nurse and, ultimately, the patient population. This study helped identify the needed building blocks for the development of CNOs, as well as spark future research for the development of nursing leadership.

Research Design

Application of the naturalistic paradigm was implemented in the natural setting, or context, of each individual in the study. The ontological belief of the naturalistic paradigm is that realities are wholes that cannot be understood separately from their contexts, nor can they be divided for independent study of each solitary part.

The researcher was the primary data gathering instrument. Each individual's reality is socially constructed within their own unique, contextual interpretation. The researcher valued the participant's own interpretations of reality, maintaining that knowledge emerges from achieving a deep understanding of the data and the context in

which it is embedded. They set aside their own prejudgments as much as possible, through epoche, in order to see the phenomenon for the first time and are open to its entirety.

Multiple sources of data are used in order to allow new insights and categories to emerge. These multiple sources include text data, in verbal, print, or electronic form; obtained from narrative responses, open ended questions, structured and/or semi-structured interviews, observations, or print media, such as articles, books, or manuals (Hsieh & Shannon, 2005).

Inductive data analysis is an ongoing process, in which the collection of individualized information affects the analysis of the data, which in turn affects the gradual unfolding of understanding (Westbrook, 1994). Data analysis involves “working with data, organizing it, breaking it into manageable units, synthesizing it, searching for patterns, discovering what is important and what is to be learned, and deciding what you will tell others” (Bogdan & Biklen, 1992). This analysis can be performed on a daily basis in order to identify insights, questions and gaps that can be further pursued.

Participants’ meanings are the person’s perception of the meaning of an event. The focus is what the participants experience in regard to a phenomenon and how they interpret those experiences.

The emergent design is flexible, or changes, due to the results of the inquiry. This ability to change inquiry questions in relation to the participant’s answers allows the researcher to seek understanding of the phenomena within its distinctive context. If that context should change, the researcher will reevaluate their impression of the phenomena and, as a result, change their understanding of the researched experience.

The researcher is looking through the theoretical lens of the researched. They are involved in the research and see the world from the participant's eyes and experiences. The integration of both the researcher and the researched is vital in order to obtain understanding of the phenomena.

The researcher examines the complete information obtained, including the textural interviews, along with the observations noted within the interviews. Looking at the all-inclusive data, the researcher presents descriptions, themes, interpretations, or assertions that are interrelated and express the holistic account of the outcomes or effects. This mutual, simultaneous shaping has no direction; it simply happens as a result of the total interactions described. All elements have a relationship that activates them all and the result is shaping meaning in ways that depend on varying circumstances or conditions (Lincoln & Guba, 1985).

An effective method of research for the human sciences is phenomenology (Lincoln & Guba, 1985). This qualitative approach takes into account the complete context of the person in her/his situation. To tell one's own experience can illuminate that which was previously hidden. Therefore, the methodological approach for this study was a qualitative, phenomenological inquiry using Moustakas' (1994) approach of transcendental phenomenology. This inquiry uncovered the textural and structural descriptions of the CNOs' lived experiences, helping to convey an overall essence of the CNOs' life view in the role as the lead voice for the professional nurse.

Moustakas' (1994) qualitative, phenomenological process is:

- Epoche - setting aside prejudgments and having an unbiased, receptive presence during the interview

- Bracketing the topic or question
- Horizonalization - every statement has equal value
- Delimited meanings - meanings that stand out as invariant qualities of the experience
- Invariant qualities and themes - nonrepetitive, nonoverlappng constituents clustered into themes
- Individual textural descriptions (what was experienced) - an integration, descriptively, of the invariant, textural constituents and themes of each participant
- Composite textural description - an integration of all the individual textural descriptions into a group or universal textural description
- Vary possible meanings
- Vary the perspectives of the phenomenon - from different vantage points, such as opposite meanings and various roles
- Free fantasy variations - consider freely the possible structural qualities or dynamics that evoke the textural qualities
- Construct a list of structural qualities of the experience (how it was experienced)
- Employ universal structures as themes - time, space, relationship to self, to others; bodily concerns, causal or intentional structures
- Individual structural descriptions - for each co-researcher, integrate the structural qualities and themes into an individual structural description of the experience

- Intuitively - reflectively integrate the composite textural and composite structural descriptions to develop a synthesis of the meanings and essences of the phenomenon or experience (Moustakas, 1994, p. 180).

Implementation of this approach provided: a natural environment; private, semi-structured, one-on-one interviews; implementing a non-judgmental, bracketing process; and requiring member checks to confirm interpretative texts. This allowed open dialogue to obtain the essence of the lived experience of the CNO as the lead voice for the professional nurse at point of care in the acute care setting.

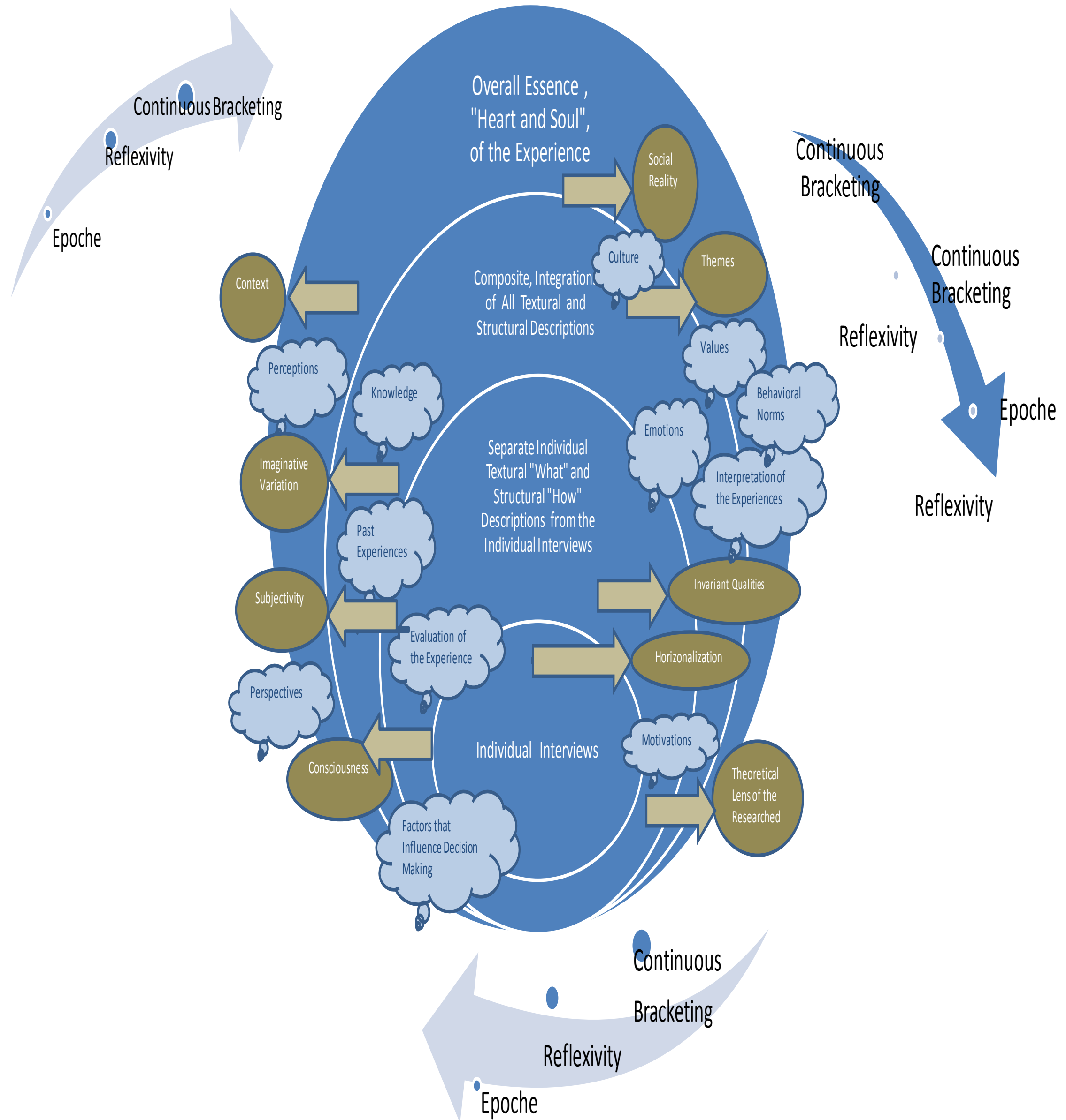

Figure 2. Ingwell (2013) adaption of Moustakas' (1994) transcendental phenomenology.

Throughout Moustakas' Transcendental Phenomenological process (see Figure 2) epoche, bracketing and reflexivity were performed by the researcher. During the one on one semi-structured interviews, horizonalization was implemented, meaning "every statement will have equal value" to the researcher (Moustakas, 1994, p. 180). After each interview, data analysis began; verbatim transcriptions by the researcher, immersing themselves in the data, going back and forth from the audio tapes to the transcript, identifying delimited meanings and invariant qualities (meaning non-repetitive, non-overlapping constituents), which were then clustered into themes. Member checks confirmed the accuracy of the transcripts.

After each interview, the researcher composed both an individual textural description ("what" was experienced) and an individual structural description ("how" it was experienced). Free fantasy variations and perspectives, looking at the phenomenon from different vantage points, empowered the researcher to consider myriad possibilities of "how" this phenomenon occurred; i.e. the structural account.

Once saturation occurred, meaning no new information was revealed, six additional interviews took place, for confirmation. After saturation, composite textural and structural descriptions were written by the researcher, from all of the individual textural and structural descriptions. These composite textural and structural descriptions were then integrated and synthesized to uncover the overall essence, or meaning, of the lived experience of the CNO as the lead voice for the professional nurse at the point of care in the acute care setting. This was Moustakas Transcendental Phenomenological process.

Sample and Setting

The population for this study was CNOs in acute care settings within hospital facilities in the Southeastern United States. Consistent with the methodology of qualitative inquiry method, this researcher interviewed participants who have experienced the phenomenon being investigated; CNOs as the lead voice for the professional nurse (Creswell, 2007). As CNOs are identified by a number of titles in the acute care settings of different hospital organizations, they were identified for purposes of this study as the most senior nurses operationally responsible for the nursing services within the participating hospitals. The criterion sample included CNOs throughout the Southeastern region of the United States who have experienced the phenomenon being studied (Creswell, 2007). This purposive sampling method was used to gain additional diverse demographic structure including; size of the facility, type of hospital, age, gender, ethnicity, relationship with nursing directors/managers and CEO, years of experience, number of CNO positions held in the last 10 years, years of employment in current position, primary leadership style and educational level of the particular CNO. Participants of the study were asked to complete a demographic questionnaire to gain the previous information once they had consented to participate in the study (Appendix C).

In phenomenology research, sample size is determined by saturation (Creswell, 2007). For this study, the researcher anticipated a maximum of 25 participants or until saturation was reached.

Access and Recruitment of the Sample

In order to gain more complete access to CNO participants, the American Organization of Nurse Executives (AONE) and the American Hospital Association (AHA) were contacted. Targeted contact lists were purchased from these organizations and/or from third party providers. Initially, email invitations (Appendix B) were sent to the future participants to make them aware of the general scope of the ensuing study and determine if they would be interested in participating in the study. The CNOs were invited to participate in a private interview regarding their lived experiences as being the lead voice for the professional nurse. CNOs who indicated the desire to participate by email response were given explicit written and verbal instructions in accordance with the Informed Consent approved by Barry University's Institutional Review Board (IRB). In appreciation for their participation in the study, a $25 gift card was given to each CNO.

Inclusion Criteria

Participants in this study were CNOs within an acute care setting, a hospital which has facilities and all personnel including medical staff appropriate to diagnose, treat and care for acute conditions, including injuries, located within the Southeastern region of the United States. CNOs were identified as the highest ranking administrative registered nurse in the acute care organization, responsible for the practice of nursing throughout their healthcare system.

Exclusion Criteria

Anyone not meeting the inclusion criteria were excluded. Not included in this

study were department directors, division directors, unit or service managers, supervisors, charge nurses and other senior nurses who have non-nursing, executive positions in hospitals.

Ethical Considerations/Protection of Human Subjects

Human participants in this study were not subjected to physical testing, drugs, or medical devices. The rights of the participants were protected to the greatest degree by following the established guidelines for researching human participants, including; informed consent of voluntary participants, guaranteeing confidentiality, ensuring the highest ethical principles and demonstrating the irreproachable ethical standards of the nursing profession. The researcher obtained permission from Barry University's IRB prior to conducting this study. The study was explained to the participants prior to the interviews, in which all questions concerning the informed consent were answered. All the participants who meet the inclusion criteria and who agreed to participate in the study then signed the Informed Consent.

All interviews were tape recorded once permission was obtained. At any time, and without any penalty or consequence to them, participants could request to end the interview or request that the tape recorder be turned off throughout the interview. Participant names were omitted and de-identified by self-selected pseudonyms to maintain confidentiality. The researcher transcribed all data. A member check was conducted after the initial interview, to review the transcript for accuracy and to supplement any further information. Conducting member checks is a critical step in ensuring credibility of data analysis and interpretations (Creswell, 2007). All interviews were augmented by researcher field notes. Transcribed data and field notes are kept

locked in the researcher's home office, accessible only to the researcher. Consent forms containing the participants' names are kept in a separate locked file, unable to be traced to the audiotapes. There were no known risks in participating in the study.

Data Collection Procedures

Once approval was received from Barry University's IRB, data collection began (Appendix D). The interviews' dates and times were scheduled at the convenience of the participants and in settings that are private and comfortable for the participants. The length of each interview depended on the responses of each participant, expected to continue for approximately one hour. Confidentiality was ensured at the onset.

The process of data collection included the individual, taped, one-on-one interviews and the follow-up interviews for member check. All the audio taped interviews were transcribed, verbatim, by the researcher immediately upon completion of each interview, along with written field notes of the researcher's observations and interpretation of each respondent's interview. Collection of any pertinent documentation the researcher was able to obtain from the respondents was also included for analysis. This information was obtained not only through interviews, multiple interviews and member checks, but also through observations, journals and documents. The participants were asked over-arching, open-ended questions, followed, as needed, by further prompted questions under the direction of the participant. The researcher had guiding questions (Appendix E) for the interviews, allowing for in between questions for participants to talk freely or add to their responses. It was anticipated each initial interview would last approximately one hour. In addition, a member check to review the transcript for accuracy and to supplement any further information was conducted without

undue delay after the initial interview, at the convenience of the participants. The interviews proceeded until saturation was achieved (Creswell, 2007).

Analytic memos by the researcher made implicit thoughts explicit, in order to expand the data. Also, self-reflective journaling by the researcher documenting personal reactions to the participants' lived experiences was completed; in order to bracket the researcher's own biases and assumptions. The researcher valued the participant's own interpretations of reality, maintaining that knowledge emerges from achieving a deep understanding of the data and the context in which it is embedded. As noted, bracketing by the researcher ensued from the outset and continued throughout the entire data collection process and study. The researcher's own prejudgments were set aside as much as possible through epoche, in order to see the phenomenon for the first time and be open to its entirety.

Interview Questions

Intense curiosity of a particular issue or problem drives the researcher's excitement and desire to learn in phenomenological research (Moustakas, 1994). Following the two, expansive, over-arching research questions that guided this study, were the follow-up interview questions and prompts (Appendix E).

The participant needed to focus on the experience from different perspectives: emotional (mood and feelings); physiological (sounds, sensations and smells); and illustrating specific events without clichés or banalities. The researcher was responsible for generating an interview to achieve these objectives.

A semi-structured interview was utilized to prevent obtaining too little or unrelated data. Also, silence was performed in order to prompt the participant to

assemble their recollections and continue with their accounts of their experiences (Creswell, 2007).

The length of interviews was expected to last approximately one hour and the number of questions to ask varied in obtaining the essence of the participant's experience, which is the heart and truth of the individual's perceived experience. To obtain the holistic description, integration of the answers to the two overarching questions along with the interview questions (Appendix E) allowed the true experience of the participant to begin to surge and flow, imparting, again, both the "what" and "how" of the human experience.

Demographic Data

Once informed consent was acquired, demographic data was obtained. The demographic questionnaire included: age, gender, ethnicity, type of nursing degree, highest non-nursing degree if applicable, leadership title and reports, years employed in current position, primary leadership style, whether first CNO position, size of hospital, type of hospital, relationship with nursing directors and managers as well as with the CEO (Appendix C). This information gave a collective description of the sample. These categories have been included in other leadership studies referencing CNOs. Age, number of CNO positions and educational level may provide information regarding performance and achievement in relation to maturity, experience, quality and level of education achieved. Ethnicity and gender were selected to show the amount of diversity in the role of CNO. Their relationships with the nursing directors/managers and CEOs, as well as the years employed as a CNO, versus a novice CNO, may show significance regarding turnover and performance of the participants. Size and type of hospital gives

background for a possible correlation between the organization and effectiveness of the CNO as a voice for the professional nurse. The leadership title and number of reports were needed in order to exclude any senior nurse leaders who had non-nursing, executive positions in hospitals. The CNO's leadership style may yield an understanding of their contributions or other criteria for further studies.

Data Analysis

The researcher prepared field notes from each individual interview. These notes included; facial expressions, body language and other non-verbal behaviors of the participants, which the audio taped interviews did not capture. In addition, aspects of the interview, such as the environment, the room arrangement, seating arrangement, privacy of the location and position of the tape recorder, were also documented by the researcher.

The researcher continued to ensure proper bracketing was being done once data analysis occurred. Daily self-reflective journaling was done before and after each interview, to document the researcher's personal reactions. This self-reflective journal of the researcher's thoughts, reactions and opinions assured effective bracketing of her bias and assumptions regarding the phenomenon of the CNO being the lead voice for the professional nurse. This process allowed the researcher an open mind in hearing the lived experiences of the CNOs, so that the findings are genuinely the experiences of the participants and not the researcher.

The entire transcript, from each individual interview and journal entry, was read or listened to as many times as deemed necessary in order to gain understanding. Horizonalization was applied, in which each statement has equal value (Moustakas, 1994). Significant statements were then identified in order to develop a list of non-

repetitive, invariant statements (Moustakas, 1994). These statements were then grouped into larger segments of information, called themes or meaning units, transforming into cluster themes, which began to have a deeper meaning or analysis. A description of the textural, or "what" the participants experienced with the phenomenon, giving verbatim examples, were identified and prepared (textural description), followed by the identification of the structural experience, meaning "how" the textural experience happened, including thoughts and feelings about these experiences (structural description). This was the contextual framework of each participant's experience for the study. The researcher then provided a combination (composite) textural and structural description of each individual's experience.

When saturation of themes occurred, the researcher knew that enough participants have been interviewed for the study, due to repetition of themes being communicated, with no new ones emerging from the subsequent interviews. The researcher then interviewed six additional participants, to confirm saturation had been reached. Upon confirmation of saturation, the researcher made the decision to stop, due to the topic being completely exhausted as new information was no longer being communicated.

The individual composites were then integrated through abstract reasoning into an overall general, textural-structural description which synthesized the CNOs' lived experiences as the lead voice of the professional nurse at point of care in the acute care setting, discovering its essence, which is the underlying foundation/heart of the lived experience (Moustakas, 1994).

Research Rigor

Judging a qualitative study for accuracy involves the following components; credibility, transferability, dependability and confirmability (Lincoln & Guba, 1985). These four components are assessed as one and serve to establish the trustworthiness of the qualitative study.

Trustworthiness is equated to validity in quantitative research (Lincoln & Guba, 1985). In qualitative research, however, trustworthiness is not established but created and cultivated. The rigor or precision brings the richness and depth of the topic to qualitative research. This is accomplished through a methodical collection of data and the in-depth analysis of the data; yielding, thick, rich descriptions of the phenomenon of study that has been clearly saturated.

In order for the researcher to guarantee trustworthiness, several strategies were implemented. One-on-one interviews, along with member checks, were done. This safeguarded trustworthiness, providing the participants an opportunity to give feedback on the identified themes. The researcher continued to bracket effectively, not forcing her own feelings and thoughts on the experiences of the participants.

Credibility

Credibility means the results of the research are believable from the viewpoints of the participants of the qualitative study. Since the purpose of a qualitative study is to understand and describe phenomena of interest from the lens of the participant, the participants are the only ones who can determine the credibility of the results. In order to achieve credibility, it is important that the researcher is honest and learns from the inquiry, versus promoting his/her own preconceived theories. The continuous bracketing

to achieve epoche served as evidence of the researcher's honesty, along with the one-on-one interviews with member checks (Lincoln and Guba, 1985).

Transferability

Lincoln and Guba (1985) describe transferability as those results from the qualitative study which can be transferred to a different setting or population. Outlining the research process for future researchers promotes transferability. The objective of this study is that the findings may contribute to the success of the present and future CNOs as an effective advocate for the professional nurse and nursing profession. The researcher provided thick descriptions of the participants' experiences in order to augment the transferability of the findings from the study.

Dependability

Dependability is described as a study that is structurally sound and flows conceptually, in which the findings are consistent and could be repeated (Lincoln and Guba, 1985). This is assessed through the extent of research practices properly implemented in order to have a thorough understanding of the research methods and their effectiveness. This will be completed through an audit trail of data collection through data analysis and member checks. Each participant reviewed her or his verbatim transcript. Therefore, a clear and logical explanation was achieved between the methodology and findings of the study.

Confirmability

Confirmability refers to the degree to which the results can be confirmed or collaborated by others by providing evidence that the researcher's descriptions of the participants lived experience is that of the participant and not of the researcher. An

outline of the specifics of the study were completed in ensuring confirmability by showing details of the methodology used. This will allow an auditor to determine if the conclusions, interpretations and recommendations can be traced to their sources, as well as supported by the inquiry (Lincoln & Guba, 1985).

Chapter Summary

This chapter discussed the methodology that was utilized to conduct this study and articulate the answers to the research questions that lead to the discovery of the lived experience of the chief nursing officer as the lead voice for the professional nurse at point of care. Moustakas' Transcendental Phenomenology and the Naturalistic Inquiry Paradigm guided the research design, sample and setting, access and recruitment of the sample, inclusion and exclusion criteria, IRB related materials, ethical considerations, data collection, interview questions, demographic data, data analysis and research rigor.

CHAPTER FOUR

Findings of the Inquiry

The purpose of this study was to examine the lived experience of the CNO as the lead voice for the professional nurse at the point of care. Nurses in the acute care setting have had an unhealthy work environment for approximately 100 years; with decreased retention, increased turnover and loss of recent graduates as a recurring event. As a result, patient care and outcomes are declining. The Chief Nursing Officer is the professional nurse's leader and the absence of effective leadership and voice for nursing is significant.

Sample Description

Ten Chief Nursing Officers, defined as the highest ranking administrative registered nurse in the acute care organization responsible for the practice of nursing throughout their healthcare system, were interviewed in Florida, Kentucky and Tennessee. Confidential, one-on-one interviews were conducted at each CNO's workplace.

Characteristics of the Participants

The participants all choose pseudonyms to hide their true identities and maintain confidentiality. They will be described by their pseudonyms in this study. The one on one interviews were audio-taped and transcribed by the researcher. All interviews were conducted in the participants' work environment, as it was more convenient for them. A mutual respect, given the researcher's corporate healthcare background, was acquired throughout the interviews. The participants were generally veiled in a professional manner early in the interview, but were more forthcoming as the interview progressed

and they became more comfortable and trusting. Germane information was obtained from each interview.

Results of the Data Collection

All participants met the inclusion criteria and agreed via email to meet for a one on one interview, scheduled to last approximately one hour. All participants chose their work environment for the interview, as it was most convenient and conducive for them. At each interview's inception, the researcher again described the research project, including its purpose, risks and benefits and time commitment. The Informed Consent was then explained, questions were answered before the participants and researcher signed. Pseudonyms were chosen and the demographic questionnaires were completed by the participants prior to the actual one on one interview. At the conclusion of each interview, a $25 gift card was given to each participant in appreciation of their participation in the study. A subsequent member check confirmed the accuracy of the transcriptions of all participants' interviews.

All interviews were audio taped. The researcher transcribed verbatim and continually bracketed and reviewed the data. Invariant qualities and themes were identified, forming individual textural and structural descriptions. From these, overall composite textural and overall composite structural descriptions were developed after saturation was achieved and verified. A synthesis of the textural and structural composites intuitively reflected the essence of the lived experience of the CNO as the lead voice for the professional nurse. Those findings will be summarized as follows: demographic representation; characteristics of the participants; individual textural and

structural descriptions; themes; overall textural and structural composites and the overarching synthesis or essence of the lived experience.

Demographic Representation

The study included two male and eight female CNOs in Florida, Tennessee and Kentucky. The participants were in their mid-forties to late sixties. They were educated at least to a Master's degree level, primarily Caucasian, generally held several CNO positions in the last decade and had a good to excellent relationship with their current CEO. The types of hospitals represented included; corporate system, community, government, academic health center and rural facilities. The number of beds per hospital ranged from 25 to over 1,000. Direct reports to the CNOs number 10 or more. The CNOs rated their relationships with their directors/managers as very good to excellent; however, as noted later, most CNOs did not trust their direct subordinates' ability to fully communicate the CNOs vision and directives to the professional nurse at the point of care in the acute care setting. CNOs generally rated their leadership styles as transformational or participative, though autocratic decision making was also evidenced in the interviews. (Please refer to Table 1, Demographic Data.)

Table 1

Demographic Data

Demographic Data													
Age	Gender	Race	Highest Nursing Degree	Highest Non-Nursing Degree	Yrs. Employed in Current Pos'n	Is this your 1st CNO Posn	# CNO Pos'ns Held Last 10 yrs	# Licensed Beds in Hospital	# of Direct Reports	Type of Hospital	Relationship w Nursing Directors / Managers	Relationship w CEO	Self-Described Leadership Style Most Often Used
45	M	White	BSN	MBA	2 - 5	No	2	744	8	Academic	Very Good	Excellent	Transformational
49	F	White	MA		2 - 5	No	2	120	10	Community	Excellent	Excellent	Participative
50	F	Black	MSN		2 - 5	No	1	450	10	Government	Very Good	Excellent	Transformational
51	F	White	BSN	MBA	5 - 10	No	3	25	12	Rural	Excellent	Excellent	Transformational
54	M	White	MSN	BA	2 - 5	No	3	163	18	Community	Excellent	Excellent	Participative
54	F	White	MSN	MA Healthcare Admin	>10	Yes	1	1215	12	Community	Excellent	Excellent	Participative
56	F	White	MSN		2 - 5	No	2	333	26	Corporate System	Excellent	Very Good	Transformational
56	F	White	BSN	MA Healthcare Admin	5 - 10	No	2	481		Community	Excellent	Excellent	Transformational
63	F	White	MSN		>10	Yes	1	63	15	Rural, Corporate	Very Good	Very Good	Participative
66	F	White	MSN		>10	Yes	0	142	10	Community	Excellent	Excellent	Participative

Characteristics of the Participants

Miami Dolphin

Miami Dolphin is a 54-year-old Caucasian male VP, Chief Operating Officer (COO) and CNO of a 163-bed community hospital. This role is not his first CNO position. He has held three CNO positions in the past decade; and has been in his current position less than three years. His relationship with his current CEO is rated excellent; however, his past CEO relationships were less positive and his longevity was affected. He is one of the CNOs with formal business training, in addition to the usual MSN. His position has evolved in a very short time to also include the COO role. He views this additional responsibility as an honor and evidence of the confidence the CEO has in his

abilities. He did state that he has "almost the complete hospital" to answer and be accountable for. The interview did reveal that this CNO felt a "confidence booster" in his current position, since he has the ability to autonomously arrive at decisions versus his previous "almost oppressive" CNO environments, even though occasional mistakes will, or have, cost money at his current facility. This latitude was realized after he established his abilities by "proving himself" to the CEO. He explained that this was accomplished by being able to competently articulate not just "buzz words"; but the actual business impact of decisions to the bottom line and the nursing areas.

Miami Dolphin noted the importance of a work-life balance and a sense of humor. He works at least 10 hour days, which include an average of 300 daily emails. Miami Dolphin describes himself as a participative leader who is "savvy with a sense of humor".

Grace

Grace is a 56-year-old Caucasian, female CNO of a 333-bed corporate system hospital. This is not her first CNO position. She has held two CNO positions in the past decade and has been in the current position four years. She also served as interim COO, along with her present position. Prior to her tenure, there were five CNOs in a five year period. Her relationship with her current CEO is rated very good. She has over 25 direct reports, which is high. She "always wanted to be a CNO," which is unique, since most of the other CNOs were encouraged to fill a temporary void or apply for that position, because of their clinical and educational competence. This was not previously part of their professional growth plan.

Grace relies on her spirituality and views herself as "motherly" in this role, occasionally implementing "tough love" to achieve accountability from her reports.

Grace also notes the long, 10 hour plus days and "physically draining, emotional draining" nature of the CNO position. She vacations, though is unable to escape business correspondence. Grace views herself as a transformational leader.

Grace describes herself as "intelligent," and "loving, caring…always wanted to do right by people and never hurt anyone." Of course, shrewd negotiation, trade-off and relationship building are integral components of her daily professional life.

Hourglass

Hourglass is a 45-year-old, Caucasian male CNO of a 640-bed Academic Health Center. He has a BSN and an MBA. This is not his first CNO position. He has held two CNO positions in the last decade and has been in his current position two years. He has previously held a joint COO/CNO position as well as a CEO position in smaller facilities. He has eight direct reports. His relationship with his CEO is described as excellent and his relationship with his Nursing Directors/Managers is characterized as very good. He sees himself as a transformational leader.

Hourglass utilizes his infectious sense of humor despite the 10-to-12 hour workdays. He jokingly says he receives a "1,000 emails a day." His office days do not allow time for strategy and planning, this is done at home, in the shower and on the ride to work. He describes himself as being pragmatic, realistic, fun loving, attempting to be a visionary and "trying to always keep my eye on where the ball is going, not the flavor of the day."

Jane Smith

Jane Smith is a 66-year-old Caucasian, female, VP, CNO of a 142-bed community, non-profit hospital with an MSN degree. This is her first CNO position,

which she has held for 20 years. Her relationship with her current CEO is rated excellent, as is her relationship with the nursing directors/managers. She has 10 direct reports. The hospital is in a challenged economic area and consistently loses over $10 million per annum. It is part of and supported by a large, non-profit hospital organization.

The hospital facility is new, modern and well maintained and will soon implement the hospital organization's computerized documentation pilot, including an acuity component. Jane Smith is a loyal employee and spokesperson for her hospital organization. She plans to retire after this position.

Her responses to interview questions were often not on point. For example; when asked about the facility's inter-nurse relationships, her reply did not pertain to nurse-to-nurse behaviors but instead discussed a prior ill-mannered physician incident, which "could not happen now." When asked whether, in her opinion, CNOs in general had adequate financial acumen for their Corporate Suite (C-Suite) dealings, her response was an in-depth review of their capital and operating budget procedures.

Jane Smith's self-described leadership style is participative. She also notes the importance of a work-life balance, though she only feels comfortable taking vacations of one week or less at a time, due to the demands of the role. She describes herself as "passionate, about nursing. And I would hope that people would think that I was very fair. Honest."

Bunny

Bunny is a 50-year-old black female CNO of a government health organization with an academic affiliation responsible for approximately 400 beds and 10 direct reports. She has prior history in a government health system. Her highest nursing degree

is an MSN. The program she attended could have granted her a joint MBA if she continued one more year there. However, for personal reasons she relocated. This role is her first CNO position, which she has held for approximately three-and-a-half years. Her mother and sister are nurses and her husband has extensive experience in the business side of healthcare.

She rates her relationship with her CEO as excellent and her relationship with her nursing directors/managers as very good. Her self-described leadership style is transformational. She believes that she understands the fiscal piece of healthcare, which she feels "it is very difficult for nurses to grasp." Her easy ability to understand math and her fascination with business is her reasoning for understanding the bottom line.

She describes herself as "caring, passionate, balanced, fun and I love to laugh. If there is a way, I will find the way or I will make a way. I will bloom in a box. I love a challenge."

Pink Panther

Pink Panther is a 56-year-old white female CNO, VP of 2 community hospitals consisting of 480 beds. This is not her first CNO position and she has been in her current role approximately 6 years. She has had 2 CNO positions in the last 10 years with a total of 4 CNO roles in her career. Her degrees are a BSN and a Master's Degree in Health Administration. She reports an excellent relationship with her managers and directors as they supervise approximately 1,000 nurses. She reports an excellent relationship with her CEO. Her leadership has evolved to a blend of participative, transactional and transformational styles.

She works five, 10-hour days at the facilities, strategizes and catches up at home on job-related issues for another 1 to 2 hours, in addition to making rounds for at least 4 hours on Sundays. Her work life balance consists of Saturdays with her husband of many years. Throughout her career she has been promoted and placed in positions in which she had no prior experience or knowledge. She loves to learn and succeed, which she has done.

She describes herself as passionate about being a CNO, first and foremost. She wants to make a difference, doing for others before herself, "servitude." "A listener, change agent; thriving for knowledge, more challenge."

Florence

Florence is a 63-year-old white female CNO of a 105-bed rural, corporate system hospital. This is her first CNO position, lasting over 10 years. She has been a nurse for over 4 decades, continuously rising through the ranks. Her highest degree is an MSN. She has 15 direct reports and rates her relationships with both her nursing directors/managers and her CEO (depending on her CEO) as very good. Her primary leadership style is participative.

She works a solid 10 hour day beginning at 8 am. She has been married for many years and reserves Saturday to be with her husband. Florence describes herself as hard to insult, analytical, caring, sometimes aloof, bottom line goal oriented, more permissive than she should be and transparent.

Cindy

Cindy is a 51-year-old white female CNO of a 25-bed rural community hospital. This is her third CNO position in the last 10 years. She is in her current CNO role for

over five years. She also unofficially functions as the COO and takes clinical responsibility for the non-nursing departments. Her degrees are a BSN and an MBA. She is currently completing her DNP. She has 12 direct reports and her relationships with both her director/managers and her CEO are seen as excellent. Cindy strives to be a transformational leader, but her natural leadership style is autocratic, which occasionally causes her conflict.

Both Cindy's mother and daughter are nurses. Her father is an exacting engineer. Work life balance is her sports on the weekends.   She and her husband have been married for approximately 30 years. Cindy drives for 1 hour and 10 minutes each way and has learned to limit her time in the office to an 8 hour day.

Her self-description is wife, mother, and nurse. She is clear headed and logical with high expectations, wants people to do well and is controlling but is aware that this is not where she wants to be professionally or personally.

Princess

Princess is a 49-year-old female Caucasian CNO of a 120-bed community hospital. Her degrees are a BSN and MA. She has 10 direct reports and rates her relationship with both her nursing directors/managers and CEO as excellent. She has developed her directors/managers team with strategic replacement and also upgraded their education to the Master's level. Her most often used leadership style is participative. This is her second CNO position and she has been in it for less than 4 years.

Princess has been married for many years and has children. She describes herself as very sensitive and takes things personally and is presently working to be less sensitive.

She notes she is brutally honest yet strives for peace and harmony, though she constantly finds herself battling for patient safety.

Her work life balance is Saturdays off and spent as personal time; such as; shopping, hairdressing, or gardening. She and her husband enjoy Sunday church and mealtime in addition to her Saturday freedom. She works at least 10 hours a day in the office with 1 to 2 hours of homework time during the week. Strategizing is primarily done at night in bed. Numerous emails are part of the job.

Cindy 2

Cindy 2 is a 54-year-old female Caucasian CNO of 1,200-bed community hospitals. Her academic credentials are a nursing diploma, BA and MA in Health Care Administration and an MSN. This is her first CNO position and she has been in this role for 15 years. She has 12 direct reports and rates her relationship with both her nursing managers/directors and CEO as excellent. Her self-described leadership style is participative.

She is devoted to her family and both her children are nurses. She enjoys socializing and Saturdays away from the office. Her typical work week is 55 hours in the office and work at home on Sunday morning. She describes herself as grateful, blessed and fortunate enough to have had some good opportunities.

Individual Textural and Structural Descriptions

Miami Dolphin - Textural Description

Miami Dolphin noted a lack of support from the executive A-Team, “Your peers are the problem” “I learned to navigate in shark infested waters and survive.”, “Battle weary, maybe”, “it is brutal.”

He realized that a CNO’s tenure is just a few years; “The CNO job is probably the toughest job in the C-Suite…that is why there is such a high turnover in CNO’s roles.”

In his view, there is a perception that other executive suite members perceive CNOs as not quite as smart in financial/business matters versus clinical matters: “… you just know nursing; just know patient care and don’t understand business. And I think there is some validity to that…. (however) I think CNOs are much smarter and have a lot more savvy than they’re given credit.”

Exclusion from key decisions has taught this CNO that consensus building and behind-the-scenes deal-making are the means to manage, though excluding your boss does not increase longevity:

> You learn how to actually get things done; but, I almost hate to say it, I hate to say a back door way, but sort of a back door way, that you know, was less confrontational but you could still get things accomplished. I think if you build relationships with other people who can be your allies, sometimes that is enough to get you by…to get along, have consensus with the group.

He notes the CNO must remain objective, see the complete picture, stick to the facts and choose battles while leaving “the personal stuff out of it.” These are the components necessary to be heard by the CEO:

> Have your facts in order and be able to articulate. You know what the issues and concerns are, you know on a professional and respectful manner. You have to have very thick skin and have to try to stay objective and stick to the facts.

Building and maintaining relationships with nurses, as well as in the C-suite, is essential for the CNO, even though the challenges are there regarding the actions of nurses:

> I think part of it is we are a caring profession that leads us to be non-confrontational and so I think it breeds passive aggressive behavior because we got to get it out. I am upset or angry, but, we don't do it directly, we don't have those crucial conversations.

Miami Dolphin - Structural Description

In the C-suite, there is an unwritten hierarchy and the CNO is at the bottom, not on the same level as the CEO, CFO and COO, which comprise the core team of the C-suite. "It is not written but there is an unwritten hierarchy."

Being the sole clinical member of the core team of the C-suite and the sole voice for the patient, as well, can be well received or not. The members of the board of directors of hospitals are patient care advocates and not the CNO's adversary. Other members of the executive team are "the problem" in patient care and clinical matters.

His past experiences as a CNO included "a very non-nursing supported leadership team" which he describes as:

> very secretive, very dictatorial. So, you know, decisions would get made that was without discussion, that was detrimental, without my discussion. I would have to go back to them and then they would have to change their decision and they would get mad and, of course, they didn't look good when they would have to reverse their decisions.

Nurses comprise the majority of the hospital workforce. They are also the bulk of the employee budget. Non-clinical executives are threatened by that potential power the CNO might have:

> non-clinical VP type people, often think, oh, since nurses are the largest workforce, we are the largest component of the dollar. With these two components, right there that gives you a lot of power…people don't like to see nursing with that type of power.

His present VP, CNO position and responsibilities have been added to with the additional title of COO and all of its accompanying responsibilities. However, his level on the organizational chart is below over a half dozen other hospital executives, for example, the VP of Marketing and the Director of Compliance, though he realizes he is accountable for much of the running of the hospital "Yeah, I run most of it, yeah."

He has autonomy and a certain amount of freedom to make an occasional error due to the current system of Medicare reimbursement changes now "linked to our quality outcomes…and our patient satisfaction." The care is delivered by the nurses, the "biggest bucket in the hospital", which gives the CNO some power and authority not experienced before

Grace - Textural Description

Coming to work is entering a battle. "…you come to work and you have to be the very skilled warrior, where skills are honed and refined and you're sharp and you are spot on." "You have to pick your battles."

She has been advised to present arguments in a non-emotional manner, even though she describes herself as "very sensitive".

The CNO position carries certain, but limited, authority:

> Many times it is an autonomous decision; go ahead and do it and then say, oh, by the way I did it. Asking for forgiveness, you know that is something else. ...the role comes with certain authority…that is part of it…and I should be able to do it without worrying and so, if I build the relationship there, she or he will know that I'm cognizant of the financials.

To accomplish nursing goals and initiatives, the CNO must also rely on backdoor deal making: "you got to, you know, get in through the back door.", "Yes that is certainly part of it."

Relationships are of primary importance:

> I think that sometimes CNOs fail because they do not nurture that C-suite, or A team, relationship. So you are managing your relationship with your CEO, your COO, your CFO. …Every time you have a new person enter into the C-suite or the A team, you know you have to build that. …building the relationships is crucial to your success. You have to nurture the relationship with your direct reports. I enjoy my relationship with the HR director.

The CEO relationship is most crucial to the CNO. "Politically, have to get the support of your CEO", "I want you to be successful as CEO … and I am here to help you." "And I am very appreciative and thankful that I voice my opinion."

If the CEO's requirements are not met and the bottom line is not adhered to, the CNO is vulnerable:

> The CEO goal is to save money, meet budget, make money and often times that conflicts with the goals of quality nursing care; but you have to be able to frame

> it. Frame your request… non-dramatically, Here we go. Here is why I am here. I am only here because I am meeting all of the elements that I am required to meet. He is the captain of the ship.

This CNO must rely upon her direct reports to accurately report to her and to convey her message and vision to the staff nurses; however, the communication of the directors to their staff may not accurately reflect the CNO's voice:

> Because, times they will present you the way they want to present you and not the way you truly intend it to be, …if I truly do not care for my directors, they cannot truly trickle down; and I say that to them and I say that to the staff and I do care about my directors, I really do. With the directors, I find that as I get more tenured, that I need to speak to intelligent people. I don't mean that to cast aspersions on anyone or not. But, I need to be able say something and that person understands it, you know. …your directors are very influential in your relationships with the physicians and the staff.

Grace - Structural Description

The CNOs job is weighty; you are alone with no one to trust, even other CNOs:

> You always have to watch your back. …I think it's part of managing the politics. It is also not possible to fraternize with your old co-workers; nor can you befriend them, as your role requires possibly disciplining, or even terminating them. So it is such a big, big job. It is truly a weighty position, I do recognize the weightiness of the position and sometimes I do feel like atlas holding up that ball. I do, but you cannot become this martyr person. You continue to do it, because you are

> shouldering this responsibility right now and you're saying to yourself, if not you, who else is going to do this? You are alone. It is something that, if you come up through acute care, you understand. That it is a very rare person will be your friend or become friends with, because eventually you may have to reprimand them, discipline or fire them. You have to keep that distance no matter what.

Financial criteria determine your success to such a large extent, though your background is clinical. CNOs do not stay long in their position:

> I look at the literature and see the turnover of CNOs and I do believe it has much to do with the CEO, COO, CFO relationship and the conflict. I do believe we are dependent to them, because we work at their pleasure and if we don't hit our metrics, they will look for somebody else. …in this region, where there are a number of hospitals they have let 2 CNOs go in the last 3 weeks... we were surprised. I am sure you have come across to the bureaucratic caring, where Dr. xx says non administrators care in a different way. They care giving you a good budget. And you care ethically, morally and socially.

Grace does not have the financial skills to frame requests, e.g., for special MRI equipment or to justify the expense for 30 additional traveling nurses when needed. As a result, the CEO denied her request for the MRI equipment and directed her to speak directly with the CFO in order to persuade him of the business case for the additional nurses:

> my CEO, he has verbalized that I have the hardest job in the hospital, so he acknowledges. However, when I say to him I will need 30 contract travel

nurses… to handle the high volume… he understands that, but he will say to me, you got to talk to the CFO and make him wrap his head around those 30 contracts.

Reimbursements in health care are in the midst of change. The CNO benefits from this, as the professional nurse is the primary deliverer of patient care "they (CNO) know they have to hit budget… It is changing a little now, since we are changing from the volume base reimbursement to the value base reimbursement. It's changing."

When asked whether the CNO, is an equal partner in the C-suite, Grace responded, "Oh, absolutely not. Oh absolutely not."

Hourglass - Textural Description

Hourglass notes the long, pressure-filled days:

You're only as good as your last month. There's a lot of pressure, their emergency becomes your emergency sometimes… your time here you get sucked into other things… you get beat up enough. Understanding that everything is not urgent or a fire. If you hop up every time someone thinks something is an emergency in a hospital, you'll never get anything done. You just have to have tough skin.

The CNO position does have frequent turnover, with its often conflicting goals of patient care, the bottom line and employee satisfaction:

So keeping the relationship with the staff nurses is one reason there's heavy turnover, because it's not easy. So, you got to keep the nurses happy, but, there's also this extreme pressure to get the largest workforce in the hospital to perform well for everyone else. They don't want to hear it. No one wants the nurses upset. So that's how powerful nursing is. No one wants the nurses trying to bring

> in a union. No one wants the nurses picketing in front of the hospital. I'm as good as my last quality report and employee satisfaction report.

It is noteworthy that this 45-year-old CNO plans to leave the profession after this position and move into a non-operational healthcare role.

Hourglass advised that the importance of relationships to the CNO cannot be overstated:

> relationships within nursing is important, but unless you learn to build peer and lateral and upward and downward relationships, don't become a CNO. Cause that's what it's about every day, that's what it's about every day. You can be the smartest person, it's easy to be the smartest person in the C-suite, quite frankly, because you're the CNO and now CNOs have more education than all their peers and they know what the product is, but that's not good enough. It's about influencing…

Hourglass continued, explaining that; compromise, negotiation and skilled deal making, all within the constraints of fiscal reality, are essential in getting what you need as a CNO:

> it's salesmanship. What does it mean to the organization, what does it mean to their organizational goals, what does it mean to the patient and, ultimately, because everyone's human, what's in it for them. … talk about bottom line, the bottom line is unfortunately the bottom line, staffing needs is probably the biggest battle since it's expensive and I had all kinds of data about the correlation of nurse to patient ratio, to mortality, to harm events, to patient satisfaction and I had graphs of my own hospital. As patient loads went up, patient satisfaction went

> down and, at the end of the day, it was, well, we'll give a little but all that, we can't do that, because we believe that's a soft financial argument. I thought, well, at least I walked away with something, there's still organizational behavior, so now you can have all your ducks in a row and your facts together, but they still don't want to do it, they are not going to do it.

Developing your directors, even those with advanced degrees, to function at the expected level takes time and patience:

> All my directors have a graduate degree. I spend a lot of time with the directors making sure that we're on the same page. …they've all been on pips at one point, but I think we've now gotten mutual respect.

Hourglass - Structural Description

The workforce of professional nurses cannot be meaningfully reprimanded, modified or terminated for substandard, unprofessional or incompetent behaviors. Patient satisfaction measures are below benchmark expectations. For example, Hourglass explained:

> we've had instances where we've had nurses chart breath sounds and they don't even have a stethoscope. So, it's an ethical issue. I think the excuse that no one's looking at it; I think that's the excuse, that's the victim. I think the issue is that those minorities of nurses really don't understand their role, or they don't care about their role, one of the two.

The CNO's level of frustration includes the fact that he must continuously answer to the CEO regarding the Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) patient satisfaction scores:

> So, on value based purchasing we got our process measures, you know, core measures; we got our outcome measures with mortality and things like that, so we didn't have to pay a penalty so that's good, but HCAHPS is the challenge. …this is what I tell my boss all the time. You know, HCAHPS is not about 1 or 2 things ... So, the performance of a nurse is one aspect. That's the thing everyone wants to go to.

Hourglass was advised by other C-suite members not to be emotional and he also admitted that his feelings were hurt in certain executive dealings:

> A couple times I can remember someone saying you're too emotional. I think I get my feelings hurt when you can just sort of tell there's a different agenda and they're just picking an idea apart for the sake of picking it apart and it's not based in science. It's easier to get your feelings hurt when you're like, this is what the data says, what do you mean we're not going to do anything about it, not prioritize it?

Having political know-how positively affects your day-to-day experiences:

> I think you can sense when someone's got a wall up. That's an advantage, to use your sense of humor, recognize there's a little bit of a social aspect to work, you know, take them out to lunch or out to a cocktail afterward. And I think in nursing, you're good at making a personal connection, anyway. And the reason I feel comfortable with that is, if I've already taken all this time to sit down with the system's CFO and explain all this and now he's going to a different person, there's probably a different agenda, because he didn't come back to me. I think I've taught that it won't be productive to have the meeting without me, right? So

> they're not going to fill me in, I'm not going to go in; I'm not going to answer their questions.

Developing transformational care to reduce hospital readmissions is also changing the healthcare environment. This, in turn, can assist in achieving better patient care outcomes delivered by the professional nurse. A turning point may occur for nursing and inevitably the CNO's role and power may be enhanced:

> I think, an exciting time for nursing because we are the discipline, not that physicians don't participate, I think it's a great time for physicians and nurses to partner and say, there are those different transformational care models out there that really have a focus towards population health. And the truth is the incentives have never really been aligned to population health unless it was for some completely altruistic reason, like a faith based organization. So I think it's an exciting time. What's interesting is, everybody believes in some way that when they read, the switch has been flipped. But I still have to have one foot in one world and one in the other. I still need to drive volume and procedures. I need to have the volume. When you're in a safety net hospital like this one, 2% penalty isn't a lot when you're 15% Medicare. As that increases, we have to get our foot more and more in the other world.

Jane Smith - Textural

Jane Smith described the CNO role numerous times as "Very challenging", "I find it very challenging", "challenges", "…it continues to be challenging." Though in the first few minutes of the interview this was described as positive and exciting, as she

became more comfortable in the discussion, she noted that she was often worn down and required the time away from the environment:

> There are days I sit here and I think, and it's too many stressors at once. And it's like, what am I doing here? What am I doing here? And before I had a little vacation last month I felt like that and we had a retirement class and I went to it. Tell me that didn't get all around the hospital. …and when I walk out of there I have a headache every time.

Jane Smith has an excellent relationship with her present CEO but did not always have that in her past CEO relationships:

> We were just far apart on our thinking. I've had not as good relationship with past ones as I have with this one. There was one, I could never anticipate what this guy, you know…he was a control person; he didn't like me going off on my own and do things and tell him about it. He wanted me to go to him first and I didn't like that…

Realization of negotiation and deal making is necessary for survival in the C-Suite. This was called the meeting before the meeting:

> He'd say to me, have you had the meeting before the meeting? ... it was something that I wanted them to approve. He'd say… when you walk in that room, you have to know that you've got the votes. And you meet with the people that you think will not support you ahead of time and ask them for your support… I had to have my ducks in a row… you were not going to get what you wanted if you were not prepared.

Her overall current relationships within the C-Suite, including, the CEO, COO and CFO, are very good. “But this group here, we don’t have any problems…let’s just put it that way.”, “I’m on my third CEO and I like this one best; it’s like a marriage.”

Financial constraints are part of the hospital setting with a small amount of input from the CNO to remain within the restriction of monies available for nursing. An initial budget based on history is prepared by the CFO, directors request, finance reviews and a final dollar amount is given to nursing to allocate. The CNO is then involved for a review of the revised budget with the other executives in the C-Suite:

> They do a budget, the CFO and his people, based on history. And then it goes to each manager… And then it goes back to finance and, you know, they talk to us about this, that, or the other… There’s a certain place they need to be. So they run the numbers and there are times they say, no, we’re losing too much. So we have to adjust here and there… And sometimes they’ll just take 2% off, or whatever. And it’s fair.

Count on the directors for information at point of care and to communicate to the directors on expectations:

> I have a one-on-one every month with each of my direct reports and I have a list of things that we go over…I get everything. In the old hospital, when we were smaller, I knew every nurse’s name and something about them. But I can’t do that now, I can’t do it. … you can’t make friends with the people you’re supervising. I learned that a long time ago.

Jane Smith is aware of the professional nurses' issues only through the monthly meeting with her direct reports and from two computerized surveys of the professional nurse each year:

> we keep a finger on it through various surveys. There's at least two surveys that we do every year. …we have education on bullying. That's number 1. …has tons of behavior policies, so the mangers don't put up with it basically. …thing that's called the high, middle, low… The manager sits with each employee once or twice a year

Her facility's patient satisfaction is excellent. "This is the first year we're getting an award for having patient satisfaction above the 95th percentile for an entire year."

Jane Smith - Structural

The current CEO was a subordinate of hers earlier in his career and he gives her a certain amount of latitude now:

> The CEO here, he used to be the lab manager… and he came to see me before he took the (CEO) job and said, I'm going to need your help, because I've never done this before and frankly I'm a little uncomfortable with it. So we have a very good relationship. The COO and CFO were previously middle management, while she was already the CNO. The other two; one used to be a respiratory therapist, head of daycare, HR… And the third one was a planning person, helped us plan the new hospital…

Patient satisfaction results are based upon standardized procedures throughout this system's hospitals and implements Studor Group's philosophy and recommendations.

"That was 7, 8 years ago. xx was our coach for a while. We implemented all the strategies. The culture began changing."

Jane Smith is required to use the standardized procedures and policies set by corporate within meetings that she may or may not be part of. One of those meeting is the bi weekly CNO meeting that consists of all the hospital system's CNOs. This is facilitated by the corporate CNO. The corporate CNO is not invited to lunch by the hospital CNOs. Jane Smith finds these morning meetings very stressful and exhausting. She does not return to the hospital on those days in order to recover. "…And it's like, please, so and so, just shut up… and when I walk out of there I have a headache every time….I go home…I do emails from home that day."

Bunny - Textural Description

Bunny began:

> From day to day it varies. It can be rewarding, at times very frustrating, for a number of reasons. …it allows me to be the voice for a body of people I'm so passionate about, nurses. ...it sucks you…powerless is draining. So you have to be empowered and then you get energized.

Despite, in the initial minute of the interview, professing representation of nurses as the primary motivator for her leadership; as the interview progressed and she became more comfortable and transparent, it was noted that patient representation was this CNO's primary goal:

> I advocate for…Because I have to think what's best for the patient, not best for the nurses. What's best for the patients right now might be what's best for the nurses today. But it might not be that. Do you understand?

Bunny notes elsewhere that she would never do anything that harmed a patient.

She is not fearful of losing her job. She feels that as long as she does what is right, she will overall come out better. “And because I do the right things, I usually win. If I am wrong, I will put the brakes on immediately... Because I will always do the right thing; even at the cost of…” “ I’m not afraid of being fired.”

At times, Bunny finds her nursing staff to be extremely manipulative and passive aggressive:

> I was meeting with them the other day and I jokingly said to them, if I was the type of person to carry grudge, based on what I’ve heard people say, I wouldn’t speak to half of you here. I also know when I have to tell my directors of nursing, I’m not buying that, because I know what it is.

She acknowledges that bullying exists in her facility. “Nursing can be so bullying… Very much so... And I still have a lot of work to change…”

Overall, Bunny felt that the bedside nurse is not competent in leadership and critical thinking:

> As far as competence for nurses from a leadership perspective, I think it is sorely lacking. I think much more of our programs need to be Boardroom focused. And then there’s critical thinking skill and I think that piece is missing.

Even though this CNO felt confident in the C-suite, she felt there is a hierarchy in the board room. “There is an unwritten hierarchy.”, “…historically the Nurse Executive reported through the Chief of Staff, as recently as 12 to 15 years ago.”

Bunny feels that a CNO needs to be competent in finance as well as in leadership in order to develop trust to be legitimate. “Well, first of all you have to have

competence…" "Competence isn't just in finance, but leadership…" Bunny explains that a nurse executive noting that her staff is too small to, for example, give patient's baths on a given day is sure to fail in her request for additional professional nurses. However, a CNO who is able to speak in financial, business terms can be heard and understood by her fellow executive suite members. She has learned to phrase requests in terms that include; standards, savings, pro forma, feasibility and breakeven:

> So, I'll give you an example. I need more nurses, I'm short staff. I can't even bathe patients. What does that say? That doesn't say anything. It just says you're a whiner. But, if you say, for example, our hospital acquired pressure ulcer rate is running higher than the national average, say 4. If you choose, based on the information from ARC that the average cost of a patient who has hospital acquired pressure ulcer is x; if you anticipate by the rate it will cost us so much in dollars, what I am asking for is lower level, unlicensed, what we call assistive, personnel. If I were to hire this number on this floor, times this number salary and so forth; look at what I could save the organization. Uh, huh, now they're listening. I said the same thing; I cannot bathe patients, I cannot turn patients. But how did I say it?

Bunny - Structural Description

Bunny is not fearful of losing her job because she feels her faith will render her at least whole "Because I will always do the right thing. And my faith tells me, when you do the right thing you always land on the feet, regardless of the outcome."

The hierarchy in the C-suite is more than implicit in the actions of the CEO and other executive suite members. The clues are not subtle:

> When I got here, chairs were aligned a certain way, the parking was aligned a certain way. The CEO was at the head of the table. To the right of the CEO was the COO. The left of the CEO was the Chief of Staff. And then at the right of the COO was the Nurse Executive… Historically, the Nurse Execs reported through the Chief of Staff, as recently, I think, as 12, 15 years ago.

Bunny was an excellent student. She always found math and science easy. When she was in graduate school, her program included a work study component of several, 40 hour weeks at major healthcare organizations, both public and private. She was mentored by CEOs and CFOs and was required to solve an existing problem and present a business plan, including financial documentation, to solve it. In addition, her husband's credentials include CPA, MBA and several decades as a healthcare CFO. She not only knows how to voice in financial terms, but also has a more than rudimentary understanding of whether a decision makes sense from a financial perspective. Accordingly, she can choose her battles and has a reasonable success rate. "In fighting, you have to know when to hold and when to fold. And the art…" She does not take things personally. In these regards she is somewhat atypical of a female nurse executive. "… even if they try to cut my knees off, I just look at that as part of the dance. That's just part of their dance I went to":

> I'll be honest with you, my God, sometimes it's sad. When I met with the CNOs from the sister facilities, I said, you know what guys? We have to be able to speak the language. I do not have that problem at my facility. I did. I said you guys often times ask for more than you need and then you lose legitimacy. Or you don't know how or why you arrived at what you're asking for. When you're

> asking for that, you have no legitimate power. You have no influence. Because I say to them, guys, if I come here, you know I've done my homework and they say, we know you have. And I could sell it to anybody. Just whining…

The unhealthy work environment existed well before Bunny's tenure and in this unionized, governmental facility personnel change is a difficult endeavor. "… it will go all the way up (to this seat of government)" and "…to change an agency, an organization that is so entrenched." In addition, Bunny knows that a CNO only has a short time in a given position "It's about three years."

Pink Panther - Textural

Pink Panther arrives at work each day changing, adapting and morphing to the needs of her customers and constituents. She notes that "adaptability is essential" to meet the CNOs challenges ranging from:

> quality from the patient aspect to accountability to the finance department and to insurers. Then there's the financial component of understanding and watching dashboards for how we are managing resources on a daily, weekly, monthly, year to date comparative. There's the quality, there's the finance, there's the people aspect; where it's the human interest. The connectivity of being with, serving your staff every day.

She believes that communication is a prime component of relationship building. "You can't over-communicate enough." and "The trio is the people, the quality and the finance. The relationships are paramount…"

In the C-suite, she has to communicate in a financial, non-emotional manner:

> So they see me not as dramatic; they see me much more as factual, very businesslike. Very factual, I have to have my ducks in a row. I do my preparation, I get my financial and I get my pro forma. I have my case statement in place, if you will, and then we go from there.

Deal making and political savvy are essential to the CNO. For example, the CNO is responsible for the nursing staffing productivity, yet the COO oversees the productivity numbers. In order for her to manage this challenging situation and exert some degree of control, she opted to invite the COO to her twice daily staffing meetings to resolve this situation:

> I invited the COO into my morning and afternoon productivity reviews. That way I could stay on top of it. I did it twice a day. He stood back and watched. Then when I was inclusionary with him, I changed my style. And then you get change and you get better relationships.

Similar inclusionary strategies resulted in the HR Director and CFO feeling they owned the nursing education programs.

Despite the financial acumen and constant communication, this CNO has experienced C-suite decisions involving clinical matters made without her knowledge, input or discussion:

> There were times. From every experience there are, there's no panacea out there; there are always downsides to things. But I chose to look at it as the glass is always half full. So there's more there for me to learn, even if it's a negative experience…So if that's the way I needed to figure that out, I needed to stay further ahead. I needed to work it. I needed to be more savvy. I really made it

> about me, not them. How am I going to morph my style? I morphed my style again.

The available nursing workforce, especially recent graduates, is not proficient in Pink Panther's view. Communication with deans of nursing schools did not result in positive, noticeable change:

> I'm not sure it translates down to the adjunct professors. I'm not sure how much communication gets down to our professors or to teaching our students, or the curriculum, or the shortness of the curriculum…the right profile student. Now, it's all numbers. However, the score is what you get. It doesn't mean; there's not the interview anymore. So we don't see the passion, we don't see the drive; if they are a nurse that has that passion, or whether they are in it because they couldn't get a job anywhere else. When I talk to physicians, when I talk to the nurses on the floor, the charge nurse, they say, these little new ones, so, you know. Some of them don't even know what nursing is…

Bullying among nurses is not tolerated by this CNO. Neither is it sought out. "Horizontal violence, we don't tolerate that… And we have a great HR department. They can go down to HR if they don't want to come to me."

This CNO has experienced medical care, including nursing, as a patient's spouse (cancer related) on numerous occasions over 25 years. She has related their experiences of medical errors, surly nurses, demeaning physicians and other less than professional behaviors. "Patient advocate. It's been continuous. So he's a warrior. I understand patients and families."

Pink Panther - Structural Description

The reason she continuously changes is to best serve her patients:

> I love what I do. If my nurses are well taken care of, my patients will be well taken care of. It starts with me. I realized if I'm going to help my nursing staff, going to help the patients, help the organization regardless of the structure, which I can't change I'm going to have to change my style.

Pink Panther meets challenges by viewing the glass as half full, not half empty. She is "grateful" for all aspects of her professional life, even the negative experiences. She knows that a CNO's tenure is often three years. In fact, she has held four CNO positions including one lasting just one year. In addition, her husband is a 25 year cancer warrior:

> the average life of a CNO or CEO is three years. I'm a nurse and we have a sense of humility and we went into our profession to serve. Not everybody in the C-suite's going to serve. It's an advantage and it's an opportunity for them to see it can be different for them, too. You have to have a sense of humility. On any given day, I make mistakes, we make mistakes, and it's not perfect. We don't all have what we need. We know we are going to have to do more with less. Yet, we know we need to be grateful for what we have.

The current nursing workforce is not meeting the needs of the facilities the CNO is in charge of. Instead of 2 training programs per year to try to mold other nurses to their requirements, the CNO has started a nursing school to serve them:

> Um, hum. We have the (name of school). It's an associate's degree college of health sciences. We had a radiology program; it's now an associate's program

> and now a nursing program, to grow our own. The dean of nursing was our director of education. She's been here 25 years, so she knows the hospital's culture. They'll work weekends, they'll work 12 hour shifts; they know our nurses and our nurses will embrace them.

Pink Panther was taught the necessity and means of communicating in financial terms by a female CFO, who did not make her feel stupid:

> I had a great relationship with the CFO. She was female. The way I grew up in (the other for-profit), they were financially driven, too but totally inclusionary of CNOs. I learned my whole base of finance and efficiencies from them. Non-judgmental, working with me, coaching me all the time. It was a positive experience.

Florence - Textural

Florence views the CNO role as a figure head who at all times is to appear and act in a professional manner:

> when I walk in I look professional; I act professional because I am an example to the others, all the others and not just nursing, but all of the healthcare providers. But my primary role, I think, is to be professional. To demonstrate to staff what I believe professional is and means and expect the same from them.

She experienced utmost pressure from her CEO regarding staffing and productivity:

> Oh, lord. It's the law of the land; it's what we've been dealt. Therefore, understand, if you don't do what the expectation are, there are consequences to that. The CEO, CFO and I had monthly productivity calls with operations people

> from corporate. When things were going well, the sky was blue and you ate banana nut bread. When you were doing poorly, it did not go well.

Florence's primary concern was for the patient, not the nurse, though much of her day was spent managing and coordinating nursing issues. For example, her primary focus included whether a patient might fall, even though the nurses' did not have the resources to adequately prevent these falls. She gave encouragement though, but no real solutions or ideas. "I said to the nurses, you do the very best you can, that's all I'm asking. I know there are times you can make a difference."

The necessary financial component was learned on the job:

> It's all about money whether it's a for profit or not for profit. It's all about money. We were a not for profit and now we're for profit. These are the cards we were dealt. My CFO, fabulous teacher and didn't make you feel stupid. Fabulous woman.

The HCAHPS scores are a challenge for Florence even though the nursing staff lives in the community:

> ER is horrible. They'd be up and they'd be down. We have major drug issues in (this geographic area). As a result, a fair amount of the ER patients were drug seeking. We made a policy and publicized it in the newspaper; chronic pain needs to be managed by your primary care physician. Some folks would still come in and be upset. When that stuff happened, we got the poor HCAHPS. They gave me grief; it affects the bottom line. Prior to Medicare coming down, I couldn't get them to listen to me on quality.

Florence did not believe that bullying is as big of a problem as the nursing literature indicates. She does not believe it is more prevalent in nursing than in another type of job. She does acknowledge that bullying among nursing has more of an impact than in some other jobs:

> I don't think it's as widespread, as much as the literature says. It's there, it's there. If you work at Wal-Mart, I think, you will have colleagues that are half-empty, they'll roll their eyes, they will do that. I do not think the nursing profession is any more or any less. I do think though, that dynamic affects the dynamic of the nurse doing the work. I do not think it has as much of an effect at Wal-Mart, the work they do. That is my opinion.

Florence evaluated the competency of today's new graduate nurses to be less than 10 years ago. "10 years ago you had the diploma schools, they were clinically competent. The nurses getting out of school now are not as clinically competent as that. They are not confident fresh out of school, they aren't leaders then."

Florence - Structural

Florence believes a CNOs primary role is to be professional because she is an older, genteel Southern woman. Florence's gracious, Southern manner and charm was not only evident, but explained by Florence as a tool to convey a message, even a strong message, with utmost politeness and professionalism. "You're never disrespectful. Sometimes you can be firm but you are never disrespectful…We would have little fireside chats."

The CEO's message and directives regarding staffing and productivity were not conveyed by Florence to her nursing managers/directors and thus were not conveyed to

the staff nurses. Florence had been told to relay this message to her direct subordinates and did state to her boss, the CEO, that this was done. However, it was not:

> One of the other things she would do is say to me, why aren't you telling your managers the things I am telling you, which is they will lose their jobs if they don't come up to snuff, to these standards? I, in good conscience, couldn't do that. I didn't tell her that. I said the managers are doing everything they can.

Florence had a difficult time obtaining the engagement of the nursing staff. She, however, was not engaged herself and let that be known to her directors/managers and nurses. The expectations seemed to be lowered, since she didn't believe herself that the nurses could consistently make a difference. She did not ask for their input on ideas nor did she have many ideas to share:

> I would tell the staff in the women's center; in this thing we were the sacrificial lamb. I was like, how can we, you've tied our hands. So, you sing those kinds of songs as to why you weren't meeting it. After a while those are perceived as excuses.

Eventually, Florence tried to ask for ideas from her leadership team and nursing staff, but by this time they did not believe any new initiative except an increased productivity standard would work.

Learning the essential financial piece was difficult for Florence. Her prior expertise was solely clinical. But the CNO's success is in relation to their knowledge and ability to speak in financial terms, in order to communicate in the C-suite. "When I first started, they were speaking in tongues…Well, now I'm the CNO. I do feel I've learned it, though I could have learned more." Florence's communications with her CEO and

CFO were not stated in financial, accounting terms; instead she spoke in non-quantitative terms, "If we don't have the one-to-one, there's going to be a broken hip and a lawsuit. It's going to cost a whole lot more money. So, you sing those kinds of songs as to why you weren't meeting it."

Economically challenged areas throughout the Southeastern United States have a drug problem. The drug varies, with methamphetamines reported more prevalent in financially depressed areas. Florence's Emergency Department experienced a high percentage of drug seeking patients which contributed to her low HCAHPS scores. "We have major drug issues in (this geographic area)."

Florence does not tolerate bullying behavior if discovered. However, Florence does not seek out bullying, which she does not believe to be as widespread as the nursing literature indicates. When it does occur, it involves mostly "new folks" and is the result of the "personalities of the nurses."

Florence stated she was lonely professionally. She did not have colleagues or mentors at her clinical leadership level:

> Yes. Not because my other (C-suite) colleagues weren't lovely at the time. It's because you had no peer group to bounce things off. You had no peer group… If you're not working for the same company, an inadvertent remark could hurt you.

Cindy - Textural

It is difficult to be a nurse leader, caught between clinical and organizational leadership:

> You know, I think one of the most difficult things being the nursing leader is being that middle piece between clinical (and clearly understanding the needs of

> the patient and the needs of the staff) and translating that to the organizational leadership…

Cindy is well aware of the hierarchy of the C-suite:

> By virtue of the organizational chart, the CEO is the daddy. He owns the home. I report directly to the CEO, as does the CFO. However, I would tell you there is a leveling there as CFO is a higher position, as he holds all the goodies. When I went to a conference they decided I didn't need an administrative assistant and they reassigned her without discussing it with me. I was ticked and I will say three years later, still ticked.

This CNO knows that asking for a piece of equipment or additional nurses in the C-suite is not effective. "The answer's no." So requests and arguments need to be framed in financial, business terminology always keeping in mind that the CNO's role is to protect and heal the patient:

> I worked in a Catholic organization for many years and, straight from Sister Elizabeth's mouth; no money, no margin, no mission. You know, you have to be able to fund and fuel the efforts that you want to take. But, understanding that there are things that are appropriate in how you do that. You can't just make a pure financial decision. You're holding people's lives in your hands.

Cindy does acknowledge bullying within her facility. However, she does not seek it out and is aware only when a staff nurse has the courage to bring it to her attention. "We do see bullying here; more prevalently in the specialty areas, which I don't think is uncommon. ER nurses, OR nurses and ICU nurses are mean and mean people suck. There's no reason." "…when you see it happening…"

The HCAHPS scores are a challenge and bafflement for Cindy. She cannot put her finger on why OR has excellent HCAHPS scores while Med-Surg is mediocre. Her ER HCAHPs scores are very bad, even more than drug seeking patients would explain. "It's very difficult. Our HCAHPS scores in our OR are very good. Our HCAHPS scores in our ER are very bad. Med–surg tends to be somewhere in the middle. We're obviously missing something."

Cindy feels the competence level of the new nurse graduates is basically the same as it was 10 years ago. However, she does not feel they are clinically competent to perform as nurses when they graduate from school. She would like to see a nurse residency in place as part of their education program, though she does not know how to implement or fund it:

> I would say it's very similar. The difference is in the generational expectations. The kids who are getting out now are more I work because I have to, but there are other things I'm interested in. Work is a 9 to 5, or whatever their hours are. I'd love to see nursing include a residency. I'm not sure how we operationalize and afford that.

There were tears in Cindy's eyes when she noted that a CNO is alone.

> Yes. If I knew back then what I know now... I'd like people to tell… I don't need you to fix it, I'd just like to tell you. I want you to feel sorry for me for 5 minutes and then I'll go on.

Cindy - Structural

The nursing leader is the middle piece, the facilitator and communicator, between

the patient centric, clinical staff and the financial and business concerns of the non-clinical CEO and CFO, who both happen to be accountants in her C-suite:

> CEO and CFO, who tend to be non-clinical people, financial people. And learning to speak that language, so you can help them understand the clinical pieces and then turn around and translate the financial and the business concerns in a way the clinical people can understand.

The hierarchy in the C-suite is the result of more than the fact that the hospital is a business and the CEO and CFO are business focused while the CNO is a nurse who has been promoted through the ranks and is devoted to the patient first and foremost. In addition, both the CEO and CFO are employees of the same management firm contracted to run the hospital while the CNO is the top employee of the hospital. They are not naturally aligned:

> In our structure here, we have a management contract with x. They are both x employees. I am the highest level employee of the facility. But because they are both employees of the same employer, the conversation is between the 2.

Cindy feels her MBA allows her to be effective in understanding the financial component of healthcare. She also knows how to communicate to her accountant CEO and CFO regarding clinical matters. This financial acumen allows her not to be misled or excluded from the business decisions of the facility. Her clinical expertise does, however, cause conflict regarding quality of patient care, as her nursing values drive her patient centric focus:

> Emotional is probably not something they would ever tag with me. Having the MBA really makes a difference in terms of: I can read the revenue and expense

> report; I understand cost accounting; I understand budgets; I can write them in my sleep. So you can't tell me something that's not true. And sometimes they're leaving out information with nurses who don't understand and the nurse is just like, ok, ok. No. Not just no. We're not going to do that. So being able to do those communication pieces, while I would say both our CEO and CFO are accountants by background… And we do a really good job here keeping it about the patient.

Bullying is expected by Cindy, especially entrenched among the ER, OR and ICU nurses. She believes that terminating one nurse as an example will speak volumes to the rest of the staff and quell bullying. When it does not, she will facilitate a meeting between nurses but she is "not there to fix it." She believes healthy confrontation and yelling will lead to resolution:

> They need to be polite, professional and not make it personal if it's not. They need to take care of things. I do a facilitated meeting if I've got two that are not getting along. I'm not the third peg; I'm not there to fix it… Eventually you'll yell yourself out, we'll get through it.

HCAHPS scores in the ER are low in part because drug-seeking patients will not be satisfied. However, ordinary patients leave her ER after 15 minutes to wait several hours in a much larger facility, feeling they are receiving better care. In addition, initiatives in the Med-Surg Unit such as a whiteboard notation on what each patient is looking for have not improved results. Her OR HCAHPS scores are very good. The facility's leadership is unable to ascertain why. They don't understand what they should

be doing. “Didn’t impact scores at all, though it was a great idea. We really haven’t come up with what is the issue? ”

Cindy believed that new graduate nurses are not able to perform as professional nurses because they lack proper clinical training and expertise:

> I think the clinical experience in school is number 1 very limited, number 2 what the student makes out of it. So you get a wide variety; some are, some aren’t. And it’s so protected. You’re going to take care of one patient. Broadening that to a group is a big change.

The CNO is alone as the nurse leader. CNOs have ascended to the position because of their clinical competency, learning leadership through trial and error. There are no CNO mentors or senior clinical people to guide them. Everything is learned piece by piece the hard way:

> I’ve never really had a mentor…There wasn’t a senior person to kind of guide and say, you could do that but think about this. I would have really appreciated that. Learn by the school of hard knocks. Continuously. In this organization, or in any organization. My husband is the one who has to tell his day from the minute he gets up. No, I just listen and nod my head.

Princess – Textural

Princess feels she is always fighting and it is usually about financial matters, nurse standards, staffing and patient safety. These battles take up a significant amount of her time. “It seems like all I do is fight. I have to fight; it’s a constant battle and usually it’s financial, about costs.”

Princess does not feel she has adequate financial skills for the CNO job. This skill set is needed in order to adequately communicate and battle the cost issues she is faced with every day:

> He's probably the best CFO I've ever worked with. I say, for instance, my standard needs to be changed. Based on these guidelines, this is what it needs to be. Get me there. He does the legwork and gives me that financial stuff and then presents it... It's my weakest.

There is bullying among the nurses in Princess' facilities. Her subordinates are reluctant to bring the bullying to her attention:

> The bullying comes not only from within nursing, but also the physician group very ethnically charged. I have a lot of x. So anytime the news comes on about x, you can be sure that it's going to be a rough day.

As a CNO, Princess feels she is very sensitive both for others and for herself. "Very sensitive; sensitive to other's feelings and sensitive myself I can take things very personally. If something happens to a patient, I may not have been the one at the bedside, but it's my fault."

Princess – Structural

Nursing is a cost center. It does not generate revenue. Princess is always fighting costs because nursing is not only a cost center, but it is the most significant employee budget in the hospital: "it is the first thing attacked."

Princess regrets the fact that she does not have MBA as her Master's degree because she feels financially inadequate. Much of her day is spent fighting: costs, battles she must differentiae in order "to get the biggest bang." She was not mentored and was

just told to get a Masters and she choose the MA thinking she would receive more organizational behavior education. She regrets this decision:

> You learn: Am I going to get the biggest bang for the buck on that one? You learn to discern where to put that energy. I would have been better served with an MBA, but I didn't have any guidance there. It was, get a Master's; you're on the CNO track.

The bullying in Princess' hospitals is entrenched and her subordinates do not trust her with regard to reporting bullying. Princess does not seek out bullying, though if it is discovered it is dealt with swiftly and decisively:

> There's been behavior in this organization that's been enabled for years. It's not unique to this organization, I know. Just change the names and it's the same as (previous CNO location). It's the same; you have the kingpin. We do annual bullying education. It's required by the corporation. But it's miniscule, part of everything else they have to get and it gets lost. I found out my night supervisor was verbally abusive in a sexually connotative way to my nursing staff. Big guy, deep voice, excellent nurse, but he was a bully. Very intimidating. And it went on for two years before anybody came forward. What was shared was they were afraid if he got reprimanded it would get worse… They didn't trust me.

Cindy 2 – Textural

Cindy 2 describes her philosophy about relationships and the battles at work:

> Here's what I tell all the directors and they tell me they remember it; one hand washes the other, it's all about relationships. Swallow your pride, just roll with it, always take the high road. What goes around comes around, I've been around

long enough to; you don't have to fight every battle, but don't be walked on. Try to mend the relationship even if you don't think you were wrong. And get to know your people, because your people will be your greatest asset.

There have been times that Cindy 2 has noted a clinical decision had been made in the C-suite without her input or knowledge:

> I can tell something's already been discussed in the past. I can sometimes think something's already been decided. And then I try to weigh out if it's decided because there is no other choice, or if it's because of their own biases. If I decide it's that, I say; you can go that route but here are the consequences. Here is the fallout from that. And I've had decisions changed… It was clinical.

Cindy 2 feels she has respect in the C-suite due to her financial knowledge and therefore her colleagues do not challenge her on these issues:

> My financial background, when I started here 25 years ago, I had a nurse manager who took me under her wing and we created budgets for nursing departments using an adding machine with paper. And she taught me hours of care operation reports, revenue; I mean she was really awesome. And that's another thing that's really helped me a lot with COOs I can speak the financial language. I know pretty quickly if you reduce FTEs, how that's going to affect hours of care, what it would save them, what it would cost them.

Cindy 2 conformed to the norms expected in the C-suite:

> I try not to whine. I try to come prepared; to speak like they speak. Instead of saying it in three paragraphs, I say it in three sentences. Try to tell them what I

> need, try not to ask too often. It didn't always go how I wanted; but I didn't ever feel I wasn't valued or taken seriously in that room. My opinion mattered.

Bullying is not tolerated, nor is it sought out. If it is suspected, the person being bullied may be moved to another department. If the bullying is confirmed, the bully is terminated swiftly:

> I'm absolutely sure that is happening to some degree maybe I'm not aware of. Having knowledge of it, it's not tolerated. We draw very firm lines in that…Well even if I couldn't confirm it, our antennas would go up. We'd be watching very closely. If it was so subtle you couldn't prove it, I might try to change out the person I thought might be the victim to a better environment. But if I absolutely knew it and could prove it, the person would be terminated. That's in an instant; if you can prove it.

Initially, Cindy 2 described the nursing work environment as collaborative. She criticized another hospital in their system for being harsh:

> We believe in having nurses involved in decision making. We have a very strong nursing council structure. I try not to ask a nurse to do something I absolutely wouldn't do. I try to think, how would I feel if this was being done to me? If I can't change it, I think everybody deserves to know why we're doing something. That's not the culture in the other hospitals; here's what needs to be done, suck it up, do it. You didn't like it that way? Oh, too bad.

As the interview progressed and Cindy 2 became more comfortable with the interviewer, she described her management style with her direct reports:

I'm a lot more thick skinned. I used to be very empathetic and think through how's this going to affect people. But the world of healthcare is moving pretty fast. I sometimes go to my direct reports and I say we have to do this, we can talk about it all day long, but this is the way it is. What we can talk about is the way we roll it out. And so I let them know up front this is the way it is, get over it, everybody over it, ok. And they're perfectly fine with it.

Cindy 2 – Structural

The other departments in the hospital are under intense pressure to cut costs. They tried to do so by transferring their responsibilities to nursing, the largest and most visible workforce in the hospital:

So being the voice for nursing, as dollars get tighter other departments are tightening their belts…because, we'll eliminate this person at night. It won't be much for the nurse to do. Well, not so much. And, so, I don't want to be; I've really tried to change the view of nursing in our organization so we're not viewed as spoiled and queen bees …And I really try to build strong relationships with those directors, vice presidents; because I want to be viewed that nursing is flexible, but we can't be walked on.

Cindy 2 loves the financial aspect and enjoys teaching her directors and managers. She notes they have no financial expertise even with an MSN degree, so she begins teaching them from day one. Cindy 2 is able to communicate basic financial and healthcare concepts. However her knowledge is simple revenue, expenses and hours of care per patient day arithmetic. She was trained by a wonderful mentor; however, this

person was a nurse manager and not a sophisticated financial business teacher. That is the level of financial knowledge that Cindy 2 teaches her direct reports and managers:

> I think, this is a sad thing, I think organization's CFOs and COOs go in thinking the nurse leader's not going to know too much financially. They don't have high expectations. So just because I love it and I had a wonderful mentor, that's one of my strengths. So because of that, financially they leave me alone sometimes, too...for our aspiring leaders, that's one of the things I teach in the classes, what does that mean? We have charge nurses doing staffing; we say if you have this many patients you can have this many nurses. I try to give them the background; what does all that mean? If I add a nurse day after day after day at the end of the month what does that cost, at the end of the year what does that cost? So I explain, at home we live on a budget, here we live on a budget. So the refrigerator's going to break at home; some days we're going to work with an extra nurse, maybe we can work another day a little leaner another day without compromising care? So I try to give our charge nurses, our nurse managers, the background financially.

Overall, Cindy 2 feels her relationships in the C-suite are very good. She hired one of her now C-suite colleagues, so there is a former, positive relationship:

> I'm very fortunate. I have three COOs; they are awesome. I actually hired one of them years ago, he is a nurse by background. I have one who is retiring soon. I have one who's always been in the hospital leadership. Our president is now over all the hospitals in x, that's a transition. He's very supportive of nursing.

Even though Cindy 2 feels her relationships are solid in the C-suite, she did describe a battle with the corporate CFO that did not end as planned. In addition, she did state that she could "not totally" trust the other CNOs in her organization:

> Our corporate CFO, he really upset me one time. If payroll fell on a holiday or if Monday was the day we're supposed to do payroll, everybody's check was delayed a day. I thought that was crazy. I'm like; this is a 24x7 hospital. I went down that road, why do we have to do it that way? And I really challenged. I said, if people are going to be here on Christmas, I think your people can do payroll, hello. Well, he said, you have shots across the bow. It's not all about you and your nurses. He really lit me up. And it didn't change.

Cindy 2 does not encourage disrespect or ill will. But she is under great pressure due to the HCAHPS and the cost-cutting initiatives. She is affected to a great degree:

> I've been in leadership a gazillion years and I've never had anything harder than these patient satisfaction HCAHPS. That is sucking the life out of me. I feel pretty stretched; I don't mind being stretched, if I see results. And these HCAHPS things, they've stretched me about as far as I can stretch. I feel frustrated because I couldn't help the team. I wouldn't want to do anything else. I would love to think I'd be here 'till I retire.

Cindy 2 however, didn't sound confident that she will be able to stay until retirement. "I mean, there are three of us. Do we really need three for all of (company)?"

Cindy 2 was getting more emotional as she talked:

> But, me, I'm not as happy as I used to be, because I feel I, I feel frustrated that the pace we're going we don't have time to put the cherry on top, of nursing. We're

surviving, we're not thriving. I don't have time to see my people. I feel pretty stretched; I don't mind being stretched, if I see results.

Results

Themes

Ten, confidential, one-on-one, audio-taped interviews were completed by the researcher. Saturation was obtained after four interviews and confirmed by six more. Verbatim transcriptions following each interview were member checked for accuracy. In accordance with Moustakas' Transcendental Phenomenology, there were multiple reviews of each transcription, listening for voice cadence and emotion, along with field notes describing demeanor, mood, and non-verbal reactions. These reviews led to the researcher's identification through horizonalization and delimited meanings of the invariant qualities, in which patterns and themes emerged from each interview. Bracketing and epoche were continuously done throughout the study. From these patterns and themes, an individual, integrated textural description was completed for each participant. Imaginative variation was utilized; looking at the perspectives of the phenomenon from different vantage points, constructing a list of the structural qualities of the participant's experience. Through patterns and themes, an individual integrated structural description was also completed for each participant.

After careful and studied consideration and analysis of the phenomenon being studied, Chief Nursing Officers as the lead voice for the professional nurse at point of care, one primary theme and three essential themes emerged. The primary theme that surfaced was challenging. The three essential themes were battling, morphing and relating.

This primary theme of challenging and the three essential themes of battling, morphing and relating, exemplify and link the human day-to-day experiences and world of these CNOs as the lead voice for the professional nurse at point of care. Their existence is time and context bound, incorporating multiple holistic realities, from the individual perspective of each CNO.

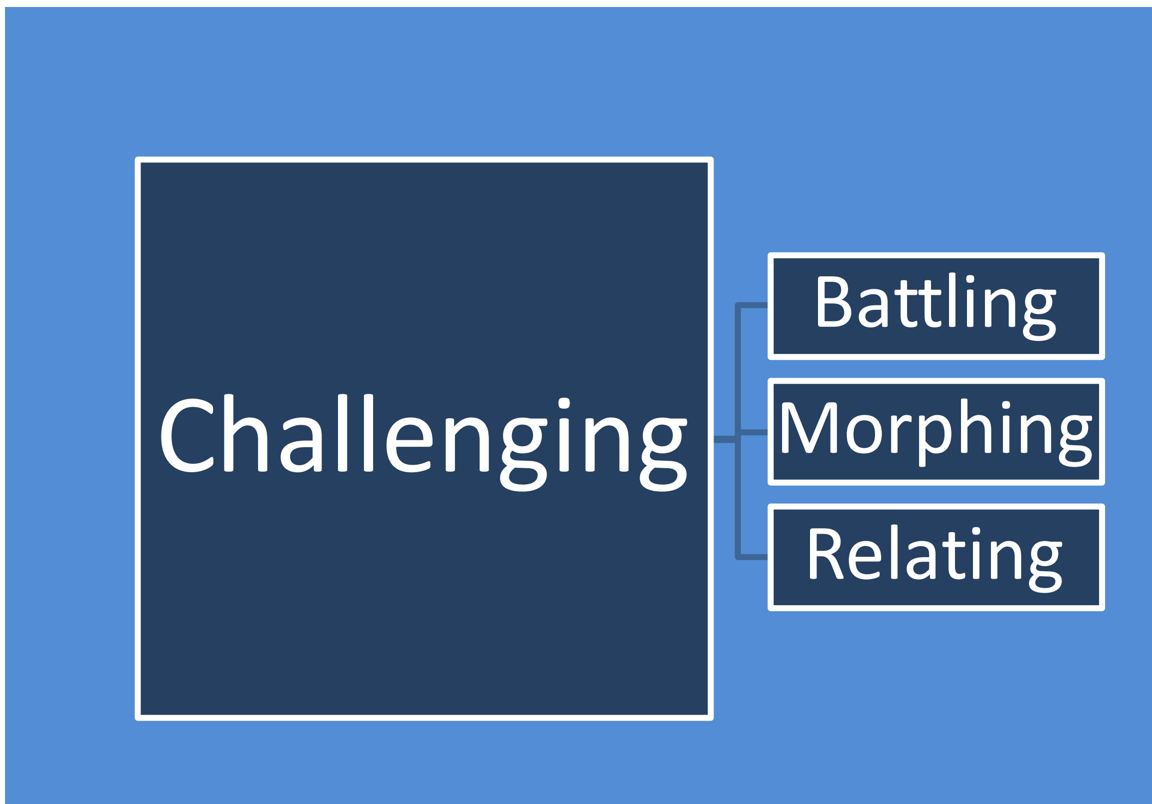

Figure 3. Ingwell's (2013) conceptual representation of the themes of the lived experience of CNOs as the lead voice for the professional nurse.

Primary Theme – Challenging

The primary theme of challenging was mentioned by each participant numerous times, often in the first sentences of the interview. It is the principal theme of the

phenomenon being studied. Challenging is defined as to subject to a challenge; a call to engage in a fight, contest, or competition (Free Online Dictionary, 2013).

The Chief Nursing Officer is the conduit between the clinical and business functions in the acute care facility. By definition, these roles of patient care and bottom line finance are not aligned. Yet, the CNO must operate with more than one foot in each world. Advertisements, commercials and bill boards all convey that the primary goal of the healthcare organization is quality patient care. However, a hospital is a business and every business, over time, must have at least as much revenue as expenses to perpetuate. For-profit facilities are in business to increase shareholder wealth, meaning they strive to increase revenue even more. That is the purpose of every for-profit corporation; something taught the first day of business school (Stout, 2012). For example, Cindy noted this at the beginning of her interview:

> You know, I think one of the most difficult things being the nursing leader is being that middle piece between clinical (and clearly understanding the needs of the patient and the needs of the staff) and translating that to the organizational leadership, being CEO and CFO, who tend to be nonclinical people, financial people. And learning to speak that language, so you can help them understand the clinical pieces and then turn around and translate the financial and the business concerns in a way the clinical people can understand.

All CNOs interviewed began as clinical nurses and were promoted and worked their way up through the ranks based on their clinical expertise and innate abilities. Nurses are caring, compassionate, feeling individuals that want to make a difference in people's lives, by giving the best possible patient care. Nurses are taught continuously

throughout nursing school that patient care is primary (Perry & Potter, 2013). As Miami Dolphin states:

> I think my background really is critical care and emergency nursing. All of my life, you know, gravitating for some reason because I have a big mouth and wanted my opinions heard. I knew better, you know, ended being charge nurses, never wanted a leadership role.

Bunny started as a nurse's aide:

> I started as a nurse's aide so there's no little you and big guys. Every role has its importance. And I was an LPN, so I love to say I crawled up the ladder, if there's a ladder, so to speak. And I've worked in varied areas. I was a supervisor, I worked pediatrics, outpatient, ICU, medical-surgical, ED; all the ICUs.

Pink Panther also noted: "I always get promoted to positions I know nothing about."

Grace sums up the caring of the nurse: "we focus on what is of value and patient centeredness. Then it will come. I think that sustaining is caring for people."

The Chief Nursing Officer, by virtue of the title, might be assumed to chiefly represent nursing. However, all CNOs, who are after all nurses, noted their primary goal and responsibility was the patient. According to the CNOs, this may or may not coincide with the best interest and objectives of the nurses. For example, Hourglass stated: "People know that I have the patients' best interests at heart." Additionally, Bunny noted: "Because I have to think what's best for the patient, not best for the nurses. What's best for the patients right now might be what's best for the nurses today. But it might not be that. Do you understand?" Princess conveyed the same message:

> That's why I round on patients, because that reminds me why I do what I do every day. If I didn't see the patients, because I'm a nurse first; so if I don't know that what I do every day, no matter how ridiculous it may sound, I'm doing it for that patient in the bed, I would go crazy, it wouldn't be fulfilling… If something happens to a patient, I may not have been the one at the bedside, but it's my fault… because my priority is the patient safety. I am high on the courage category. I'm not going to back down. There are some things I need to learn to back down on sooner: I won't let that one go.

In addition, the CNO is responsible for managing the largest workforce and expense in the acute care setting, the nursing workforce. She or he is under "extreme pressure" to make the nursing workforce perform for everyone else in the hospital, including patients and other disciplines. Nurses, overall, deliver the product the healthcare industry is selling.

According to Miami Dolphin:

> non-clinical VP type people, to think, oh since nurses are the largest workforce, we are the largest component of the dollar. With those two components, right there that gives you a lot of power. Which is not often, people don't like to see nursing with that type of power.

Hourglass also stated:

> No one wants the nurses trying to bring in a union. No one wants the nurses picketing in front of the hospital. So, you got to keep the nurses happy; but, there's also this extreme pressure to get the largest workforce in the hospital to perform well for everyone else.

Nurses are taught clinical subjects. Members of the executive C-suite, including CNOs, must utilize non-clinical skills and rely on; leadership skills, relationship building, political savvy, financial acumen and depersonalization, skills that are not regularly taught in sufficient depth in the graduate nursing curriculum for the success of the CNO. As Florence noted, she was totally unprepared for the CNO leadership position, "When I first started. They were speaking in tongues. Hey, wait a minute, what's…...Well, now I'm the CNO. I could have learned more."

Cindy stated that she acquired her CNO skills on the job: "Learn by the school of hard knocks. Continuously."

Bunny stated:

> And I could link it to the hard stuff and the soft stuff. I could link it to patient satisfaction, which I call the service quality piece of it. And then I can link it to the clinical quality piece of it. You have to be able to do that. If you can't do that, then you're not really speaking the language and you won't be heard. You're just whining… I'm not seeing that in even in some of the programs that are, what are they calling it, nursing administration specific in the master's program. I think that's missing.

In order to be an effective leader, the individuals you lead must have a work environment conducive to success, feel valued, have opportunities to advance professionally and have a voice (Aguayo, 1991). Only one of the CNOs interviewed, Pink Panther, identified this connection; that if the nurses are allowed to self-actualize, the patient will be the ultimate beneficiary. She stated: "If my nurses are well taken care of, my patients will be well taken care of. It starts with me."

In the C-suite, CNOs must converse with their executive peers in financial and business terms in order to be heard. A CNO asking for “more nurses” to, for example, provide better patient care will not be adequately communicating and the result will be a “no” from the CEO and other members of the executive team. However, if that simple request was stated as, for example, two additional nurses at a rate of $250 each are required to meet industry standards so that patients are turned and bathed in wing x, which will alleviate pressure ulcers likely to occur in 2 to 3 of those patients, at a cost to the hospital of (more than $250) each. That request will be heard and therefore evaluated and most likely be approved. These requests, according to the CNOs interviewed, cannot be made in emotional terms. As Hourglass stated: “A couple times I can remember someone saying you’re too emotional. I’m basically factual about the piece of equipment, or whatever.” Grace concurred: “you have to be very methodical, rational, can’t be emotional, have to think things through, take the time and really think why.” Miami Dolphin also stated:

> you have to take the emotion out of it and I think you have to make your case for what you need, or what is going on, or stand up for what is right. Have your facts in order and be able to articulate. You know what the issues and concerns are, you know on a professional and respectful manner... have to determine are the issues more global towards nursing, you know, or is it more personal? You have to take the personal stuff out and have to look at what the real issues are behind it, why you have to get the needs accomplished, or getting what needs to be done, or things like that. It can be very difficult. You have to have very thick skin and have to try to stay objective and stick to the facts.

Bunny also believed: “You have to be able to do that. If you can’t do that, then you’re not really speaking the language and you won’t be heard. You’re just whining.”

Grace stated: “she or he will know that I’m cognizant of the financials… I understand the budget, I understand the financial constraints, I get meaningful use dollars and I understand that and I will not make a decision that is not without that understanding, at least.”

Battling

Battling means an encounter between opposing forces; armed fighting; combat (Free Online Dictionary, 2013). The CNOs noted that their day is a battle, a war. The battles could be about money, staffing, patient satisfaction surveys (HCAHPS), or politically relevant items such as parking space, office window area, or seat placement in the C-suite. As Grace stated: “you come to work and you have to be the very skilled warrior, where skills are honed and refined and you’re sharp and you are spot on.” Princess continued:

> It seems like all I do is fight. I have to fight, it’s a constant battle and usually it’s financial, about costs. Nursing is a cost center. We don’t generate revenue so therefore, it is the first thing attacked… For instance, I’m battling a standard change.

Miami Dolphin also stated: “ absolutely miserable and extremely frustrated, cause I was anyway and, um, because I thought it was a battle every day, just to do the right thing… you have to pick your battles” Hourglass notes the ongoing nature of the battles:

> probably around staffing needs is probably the biggest battle since it's expensive… I was challenged to prove that little bit of an adjustment made a difference. And I was able to do that and then the next year you get a little bit more.

Florence, a Southern genteel woman, did not use the terms battle or war; however, she stated that she is constantly under siege: "I would be chastised because you, CNO, know what the productivity standards are.", "She (CEO) was a bully. I think she was a bully." "in this thing we were the sacrificial lamb." "I was like, how can we, and you've tied our hands."

One of the CNOs' most significant battles is the competency of nurses. The CNOs were in agreement that graduate nurses are unable to function as professional nurses.

Princess noted that in her facilities:

> We love new grads. But I get worried about the skills I have on the units, I have no skilled nurses here. I mean, my directors worked some nightshifts not because they were concerned with the number of people – but who they had working, because of the skill set.

Cindy also stated:

> I think the clinical experience in school is number 1 very limited, number 2 what the student makes out of it. So you get a wide variety; some are, some aren't. And it's so protected. You're going to take care of 1 patient. Broadening that to a group is a big change. I'd love to see nursing include a residency. I'm not sure how we operationalize and afford that.

Hourglass describes his view of the new nurses:

> I think nursing schools are focused on the NCLEX pass rates, so they teach to the test. It's a multiple choice test and when you are a nurse you don't walk into a room and A, B, C, D and E don't drop out of the ceiling. So we have something here called Performance Based Development System by Dr. Del Bueno that is an assessment that they watch a clinical vignette and they actually have to write the problem and they have to write their interventions and what they anticipate and what we find nationally is a new graduate has a 65% not-successful rate and it helps guide the orientation and we're no different than national. So we spend a lot of time in that first 10, 12, 14, 16 weeks getting them up to speed with, ok, your patient's having an MI; what do you do. Take them to the Sim Lab. More and more schools are using the Sim Lab, which is good; I think they just have to get using it towards the right things.

Pink Panther was also not satisfied with the lack of skill and leadership competencies of new nurses:

> When I talk to my colleagues, they all agree. When I talk to physicians, when I talk to the nurses on the floor, the charge nurse, they say, these little new ones, so, you know. Some of them don't even know what nursing is.

As a result, a nursing school was started by Pink Panther in order to grow her own:

> The accountability, the learning, the experience themselves for that they'll learn it through repetition or enough role modeling. So we created a college of nursing. We have the (name of school). It's an associate's degree college of health

> sciences. We had a radiology program; it's now an associate's program and now a nursing program, to grow our own. It's like a 3 year program, because they come with their 1 full year of prerequisites. And then they do 2 years, so it's like a 3 year program. The dean of nursing was our director of education. She's been here 25 years, so she knows the hospital's culture. They'll work weekends, they'll work 12 hour shifts; they know our nurses and our nurses will embrace them. We pretty much moved away from; because we need the clinical slots and time for them, we moved away from the LPN programs. We have just this year; (it's one of things; it takes time, persistence and patience). I was able to get in this fiscal year budget, all LPN positions eliminated.

Morphing

Morphing is defined as to gradually change into a different image (Merriam Webster Online, 2013). The CNOs, by virtue of their training and experience as nurses, must now continuously transform themselves into whatever is needed at the time; they are not always comfortable in their environment. It is more than just learning to analyze and communicate in business and financial terms. Hourglass noted that at the beginning of the process: "You're wearing the hat of the leader and got to be sure you're always sending the right message…But you can't gossip, I can't participate in some of those things I used to participate." Florence, at the beginning, described the growth required: "I was looking at it from a department manager position, which I had been. The revenues have absolutely nothing to do with me; it's beyond my control." Jane Smith noted: "my job, because it changes frequently." Cindy also stated: "I had to learn to step out of it and

leave him alone (CEO)...You can always find a way to work with people…." Miami Dolphin said: "when they first changed my role, how am I going to do that?" "I learned how to navigate and get things accomplished in a very difficult environment… with a very non-nursing supported leadership team." Pink Panther explained it best:

> So if that's the way I needed to figure that out, I needed to stay further ahead. I needed to work it. I needed to be more savvy. I really made it about me, not them. How am I going to morph my style? I morphed my style again. And then when I came here to the non-profit, the culture was different. Every culture is different. If you go in as this is your CNO style, you might be successful if it happens to match. But then again, you might not. I really had to morph to the style here because there is a lot of longevity in the CEO position in this organization.

In other words the CNOs are required and expected to change on a dime, to conform to the CEO and CFO and, sometimes, the COO, though the CNO often functions as, or has the title of, COO. This might be argued as analogous to a new pet being trained by its owner, in which the owner has ultimate control regarding performance and behavior. It is not about respecting and learning each other's style, it is more about conforming to only one style. One consequence is the turnover of CNOs, on average, every three to five years (Kippenbrook, 1995).

Relating

Relating is defined as to show or establish logical or causal connection between (Merriam Webster, 2013). It is somewhat of a paradox that CNOs are alone, yet must form and rely on relationships in their peer group, with their superior CEO and with their

subordinates beginning with their directors/mangers to their staff nurses. The peer group relationships are most important for the survival of the CNO. Many negotiations and deals with that peer group are made outside the C-suite, to the exclusion of the CEO, or in a meeting before the meeting at C-suite level, where a transaction has already taken place for the CNO. This can put the relationship between the CNO and CEO at jeopardy, but is found to be effective in getting things accomplished for the CNO, patient and nursing. However, there are also occasions in which the CNO is excluded from C-suite level decisions, even those of a clinical nature. This is especially distressing, as the CNO is usually the only clinical expert in the C-suite. When he or she becomes aware of those decisions, the decision is often modified or reversed, causing embarrassment and antagonism toward the CNO by the non-clinical leaders. As Miami Dolphin explained:

> You learn how to actually get things done; but, I almost hate to say it, I hate to say a back door way, but sort of a back door way, that you know, was less confrontational but you could still get things accomplished. I think if you build relationships with other people who can be your allies, sometimes that is enough to get you by and, then again, that you have enough support you'll get it does not mean you will be popular with your boss; but, you sort of have to get along, have consensus with the group… I learned how to navigate through really shark-infested waters and survive.

Grace also agreed: "but you got to, you know, get in through the back door."

Jane Smith described the meeting before the meeting:

> when you walk in that room you have to know that you've got the votes. And you meet with the people that you think will not support you ahead of time and ask

them for your support. That's the meeting before the meeting and, so, he (CEO) taught me that.

However, Hourglass spoke of being excluded from meetings where he should have been involved in the decision:

> I think I've taught that it won't be productive to have the meeting without me, right? So they're not going to fill me in, I'm not going to go in; I'm not going to answer their questions.

Miami Dolphin concurred:

> it was very secretive, very dictatorial. So you know decisions would get made that was without discussion that was detrimental, without my discussion. I would have to go back to them and then they would have to change their decision and they would get mad and, of course, they didn't look good when they would have to reverse their decision.

Princess had been told by the CEO that a requested staffing standard was approved, but the CFO has yet to implement it. This has been going on for three-and-a-half years, in which she obtained final approval for the standard change six months ago, but the CFO has not implemented the change. She presently must write a monthly action plan explaining her variance from the current standard. This is her feeling on the matter: "Lip service? I did not at first but now I do since it's taking so long." She had also been excluded from decision making by her prior CEO. The relationship is described as: "I couldn't trust her as far as I could throw her."

Cindy also described being excluded from decisions in the C- suite that concerned her:

When I went to a conference they decided I didn't need an administrative assistant and they reassigned her without discussing it with me. I was ticked and I will say three years later, still ticked.

On the organizational chart, the CFO, CNO and COO are all equal in status below the CEO. However, in most instances, a hierarchy does exist in the C-suite.

As noted by Cindy:

By virtue of the organizational chart, the CEO is the daddy. He owns the home. I report directly to the CEO, as does the CFO. However, I would tell you there is a leveling there as CFO is a higher position, as he holds all the goodies.

Miami Dolphin also noted:

Really I would say that in most organizations you don't say that. It is not written, but there is an unwritten hierarchy… I think that there is a non-clinical C-suite. People often, I think, don't think nurses are smart enough for them. I'll be perfectly honest with ya. "You don't have a business; don't understand business, you just know nursing; you just know patient care you don't understand business." And I think there is some validity to that... So you kind of came across that you couldn't speak the language and you didn't understand the finances and, so, if you can't do that, you're sunk, you're sunk.

Grace's actual position is below the CFO:

It is a little more complicated than feeling like an equal partner right now. The relationship I have with my CEO; he has verbalized that I have the hardest job in the hospital, so he acknowledges. However, when I say to him I will need 30 contract travel nurses this winter to handle the high volume in the winter season,

> he understands that, but he will say to me, you got to talk to the CFO and make him wrap his head around those 30 contracts.

Even though there is a hierarchy in the C-suite, peer relationships are the most important for the CNOs, as explained by Hourglass:

> This is my advice to fellow CNOs, it's a trap you can fall into; education and certifications are important, relationships within nursing is important, but unless you learn to build peer and lateral and upward and downward relationships, don't become a CNO. Cause that's what it's about every day, that's what it's about every day…It's about influencing and being calming.

Miami Dolphin also explained the importance of peer relationships:

> You have to learn the politics of the institution, the relationships and you can see pretty quickly who gets with who, where the cliques are, you figure all that out fairly quickly. Then you learn how you have to have good relationships with people in order to be successful. In these jobs, you have to build relationships, not just for nursing folks.

Grace concurred: "building the relationships is crucial to your success. So you are building your relationships as CNO, building your relationships as with the C-suite, building your relationships with the physicians…"

Pink Panther is the natural leader of the group. She most effectively conveyed her strategies and vision:

> The relationships are paramount today as it relates to, first of all, the administrative team. As a leadership team, it first starts with the board and us first being on the same plane and field, equally amongst each other as colleagues,

> as well as our vision and where we want to go which is continually morphing and changing with accountable care… Relationships as it relates then to my directors; so where those initiatives or that strategy or that vision comes from, that I effectively understand it and that I effectively communicate it timely, clearly, giving the resources necessary. And then assisting, mentoring, or coaching my directors and mangers, assistant nurse managers, so they have a direction to disseminate that to the bedside. Because that's the key.

Despite these relationships, the clinical expert of the executive team, the CNO, is alone. When interviewed, they stated they felt "alone," as if they had the weight of the world on their shoulders. They all felt they needed to become thick skinned, yet some CNOs felt they were sensitive and take things personally. As Grace stated: "I do feel like atlas holding up that ball. I do, but you cannot become this martyr person…I'm the least thick skinned person in the whole world."

Cindy stated that she feels alone being a CNO; she then explained:

> I've never really had a mentor…There wasn't a senior person to kind of guide and say, you could do that but think about this. I would have really appreciated that… I'd like people to tell just like they do to me. I don't need you to fix it; I'd just like to tell you. I want you to feel sorry for me for 5 minutes and then I'll go on.

In addition, Cindy has no support system at home: "My husband is the one who has to tell his day from the minute he gets up. I just listen and nod my head."

Florence explains that other CNOs in the system may, on occasion, be a support system for certain job related issues:

> It's because you had no peer group to bounce things off. You had no peer group. Several of the CNOs from the corporation met within the state for lunch. It was very trusting; you didn't talk out of school. The one thing you didn't talk about, you didn't throw your facility under the bus. I didn't have regional CNO meetings. If you're not working for the same company, an inadvertent remark could hurt you.

Princess also stated she was alone and, like Florence, certain CNOs in the same corporation might be trusted; however, they had to be a nurse and not a "company person":

> You can't have friends at this level. So I don't have that network I had (prior job). We had a group of CNOs (there), but we're much more spread out here. We have conference calls monthly and I know I can call the one at x and say, just listen. I trust them some, but not all. I got good at that.

(both laugh.)

> You can pretty much tell who's a company person and who's a nurse. I do the right thing first and then I get promoted. I didn't look to get promoted. That's all they do, I'm doing this to get promoted. They do get promoted. Some make a difference regardless, but their motive was different. I never did that.

Grace disagreed with this. Regarding other CNOs of her healthcare system, she noted:

> You always have to watch your back. I don't know. I think it's part of managing the politics. You share some of the frustration, but you don't share all of it. You are alone. It is something that, if you come up through acute care, you

> understand. That it is very rare person will be your friend or become friends with, because eventually you may have to reprimand them, discipline or fire them. You have to keep that distance no matter what. So um, I look for relationships with other women who understand and try to understand and will listen. I have a significant other male, significant other who tries. He is very supportive to a point. They don't totally get it. So you talk to them and it is good to verbally let it out. And they want to fix things and they can't fix everything. You know it is very isolated.

Composite Textural Description

The participants are clinically competent, hardworking nurses facing a 10-to-12-hour work day fraught with challenges. The participants' world is one of battling and fighting; much of it related to financial issues stemming from productivity and staffing of the nurses, the largest workforce and expense in the acute care setting. Clinical competence is the core training and expertise; yet they are called upon to be politically savvy, financially competent, astute in business and financial parlance, skilled in relation building, great communicators and figureheads. They were all aware of the frequent turnover of CNOs: a three to four year timeline was mentioned by them.

The participants did not seek the position. They were great nurses, often promoted into roles they were not quite competent for, or trained for, then. They all succeeded and rose further. They did not receive formal leadership training commensurate with the role. Financial basics were sometimes acquired by way of a CFO who did not make the CNO feel "stupid." Only those participants with an MBA degree, 20% of the co-researchers, were able to not only communicate in business and financial

terms; they were also able to comprehend complex financial statements enough to challenge their executive peers in the C-suite. Most of the participants were not able to do that, as they were learning on the job from a reactionary viewpoint.

All of the participants' primary purpose was about patient care. Several mentioned they would lose their job before they would jeopardize patient safety. However, the workplace environment for nurses at point of care was only an ancillary concern for the chief nursing officer. Only one of the participants seemed to understand that providing a healthy professional nurse work environment would result in improved patient care. The vast majority of the participants did not implement this principle of leadership, whether they comprehended it or not.

The participants face their workplace challenges without adequate, formal financial and leadership education or training, as they have not even been mentored. The participants described trial and error and the lack of experienced guidance regarding strategic and tactical decision making. In fact, the participants felt alone, there was no one else for them to turn to and they were mostly accountable and responsible for the operations of the hospital. In this regard, they were constantly explaining, defending and protecting themselves against the CEO and the other C-suite executives. The participants were an easy target as they represented the majority of the hospital's workforce. These CNOs lacked extensive leadership experience, which was necessary to fully engage their direct reports to be an extension of them in conveying their vision to their staff nurses. Not only were the participants working a full 10-hour day in the office: they would also work at home and only had time for strategizing after that in bed, in the shower or during the ride to the office. The participants did not have time to adequately mentor their direct

reports consistently. All of the participants indicated on the pre-interview, demographic form that they had a very good or excellent relationship with their nurse managers/directors. During the interviews, however, their direct reports were seen as unable to understand their directives, requiring multiple instructions and meetings for clarification and follow-up. All of the participants required their direct reports to acquire a higher nursing degree; they all indicated this made a difference.

The participants' day consists of corporate emails, clinical fires, peer meetings at lunch time, closed-door deal making, the meeting before the meeting to have transactions completed before the official discussion in the C-suite, planned meetings and events, rounding to be seen, and, arguably most importantly, reporting to the CEO regarding staffing and HCAHPS - patient satisfaction and the future of healthcare with the new initiatives coming down the pike.

These challenges and constant battles weigh on the participants. Some of them even cried or teared-up during the interviews. Several of them rely on their faith, some have a support system in terms of family and others do not. Forty percent of this study's respondents volunteered they are seriously considering leaving the CNO position.

Composite Structural Description

The participants face two paradoxes: a nursing uniform stuffed into a business suit and a patient advocate in charge of the patient's caregiver. Nurses are natured differently: they want to please; they are service oriented and need to make a difference. They are sensitive, not only for themselves but for others, they see people in pain before most do. This is their identity; this is how they perceive themselves. If this is taken away, their complete person is gone.

The expertise nurses bring to the table in the healthcare industry is priceless, since the product that is being sold is patient care delivered primarily by the nurse. The profession of nursing has been doing this for over a hundred years, working the kinks out, which could be close to flawless if allowed to be done right. However, it is not being done right. The CNO is being asked to morph daily into something not even near what they can possibly be, or be very good at. It would be similar to asking a CFO to go out and deal with parents of a terminally ill child and expect them to function at a high, or even adequate, level…..this probably would not happen. Diversity of skills make the work environment the very best and to expect the leadership team to be all the same in their thinking is asking for mediocrity or less. The nurse's world is life, death, sickness and human crisis. To not be able to talk in the C-suite using those terms is like asking the CFO to never add or subtract in their head. Granted, the CNO needs more leadership, finesse and financial education to be effective, but to ask them to continually morph to such a level is equivalent to asking a left-handed person to write with his right hand.

The CNO is not respected for what she or he brings to the table as an expert nurse. CNOs are considered just a nurse and not a business person. This perception brings about an unwritten hierarchy in the C-suite that does not favor the CNO.

Profit margins in a hospital are very low, often 1% or less of revenue. Every dollar saved equates to $100 or more of revenue that must be generated, to have the same effect on the bottom line. Nursing, as the largest expense in the acute care setting, is a very visible and easy mark. The fact that all CNOs face staffing and productivity pressures is therefore not surprising.

Traditionally, nursing is only a cost center they do not generate revenue. Value-based care now means the nurse will affect top-line revenue. With this new found power for the CNO, the challenges and pressures also mount. HCAHPS are a new and significant challenge for the nursing leader. The quality of nursing graduates was perceived as lower than 10 years ago. At a minimum, clinical training was severely criticized and each hospital was forced to develop expensive programs to train RNs to do the job they were hired to do. This hospital paid training could last, in some cases, as long as one year before the new RN was independently responsible for the patient. At the extreme, one of this study's CNOs started a brand new nursing school, so that the nursing graduates would be deemed competent for the job they were hired for.

Having strong relationships in the C-suite is a priority for the CNO. The CEO is the de facto boss. The CFO can be a powerful ally and often imparts some financial knowledge to the CNO. However, just as many CFO relationships are detrimental to the CNOs success since the CFO is the CEO's compass and all the decisions are financial based.

Communication occurs continuously and at every level, from the CEO to the other executive suite members to the nursing manager/directors, across all disciplines in the hospital, with administration and with the staff nurses and their support and, ultimately, with the patients and their families. That communication is tailored to the client, customer, or adversary with whom you are dealing. It is ever changing, which is also a challenge.

Restatement of Research Questions

There were two research questions in this study: What is the lived experience as a CNO as the lead voice for the professional nurse at the point of care? Why are CNOs typically identified as the lead voice? They were followed by interview questions led by the participant.

After careful analysis of the data using Moustakas' Transcendental Phenomenology through the formulation of textural and structural composites from the identified themes, the true essence of the lived experience of the CNO as the lead voice for the professional nurse is obtained from the synthesis of these composites.

Synthesis

The lived experience of the CNO as the lead voice for the professional nurse is challenging; a series of never ending battles, continuously morphing and always relating. Alone as the senior nurse leader; grateful for this opportunity.

A skilled warrior, always choosing your battles - you cannot fight every fight. The patient is your ultimate windmill, but what about the nurse? You manage the nurse, you care about the nurse; but you are under pressure, too. Cut the cost, provide excellent patient care. Yet, it is all about volume; moving them out and getting them in. Keeping them happy; the patients, family, nurses, CEO and the shareholders. What about the nurse? Don't let them picket, don't let them unionize; make them work as much as they can.

You learn by trial and error. No mentor or clinical peer to guide you. Forever an achiever. Does not fail. Always watch your back, do not trust anyone. You cannot befriend your subordinates, you may have to reprimand them or even let them go

someday. No more office gossip, be restrained, wear the mask of the leader. Beware of trade associations; an inadvertent slip could cost you your job.

Those C-suite meetings. Always explaining. Did they make the clinical decisions without me? I have to speak their language in three sentences or less. Don't ask too often. To get things done, back door deals. I am at risk; but surviving. It's not about you and your nurses. I am getting thicker skinned. Those C-suite meetings…I am morphing to fit.

10 hours in the office. Hundreds of emails. No time to think or strategize; that is left for home in bed, the shower, or the commute. Feel important, very important. Never planned for this, what an honor. Family is proud. Quite a journey for a great clinical nurse. What about the nurse? My primary concern is the patient. We have all been there; it can be done. But is it right?

Financial? Is this that important? Yes, it is very important! I have an MSN, I need an MBA. I have the MBA, but I don't have the leadership experience. I am a great clinician. What about the nurse? I am a patient advocate and will lose my job before I will harm a patient. I try not to ask the nurse to do the impossible. We just need to work a little leaner. What is right for the patient might not be what is best for the nurse today. Do you understand?

New nurses are not able to do the job they are hired for. I do not think the message we give to the deans makes it to the faculty. Only interested in NCLEX pass rates. We have to train them ourselves. They are not getting enough clinical. Only can afford to hire once or twice a year. These new ones, we do have to support them, they are our future. But are they any good? Let's start our own nursing school and grow our own.

I am a patient advocate first and foremost. Yet, the HCAHPS scores are low. I do not know why. I have tried everything. Maybe the questions are not written right. I just do not know. I am stretched as much as I can be. I need to get those scores higher. I am under the gun.

Bullying among the nurses? Yes, if I am aware and can prove it, swift termination will be done. But I don't look for bullying. Nurses are afraid to report, may have repercussions. Nurses do not trust me. I think the rate of bullying among nurses is no different than any other workplace. It is definitely there. If you terminate one, the rest will stop.

I am grateful and blessed. I may not last; I am doing all I can do or know to do. It just doesn't seem to be enough. I know the average life of a CNO is 3 to 4 years. Saturdays with family. Sunday preparing for the week, making rounds at hospital.

What about the nurse, though? If my nurses are well taken care of, my patients will be well taken care of. It starts with me…Finally, the answer.

Critical Social Theory

The participants in this study were transparent and talkative concerning their lived experiences as a CNO being the lead voice for the professional nurse. Their candor was not only appreciated; the extent and ease of their openness was a surprise to the researcher. It almost seemed as if a consensus was reached, even though this was not the case, to finally speak about their unique world.

The participants described their challenges in many ways, including: all the battles and small victories; their unending efforts to morph themselves into a C-suite executive, trying to emulate the business demeanor of the other C-suite executives;

relating to the CEO, their executive peers, nurse directors, staff nurses, support personnel, other disciplines and patients and their families; all the while doing everything in their power to further patient care. It seemed that most of the CNOs interviewed felt the accountability and responsibility of the total operations of their hospitals. They were consistently defending their leadership and in many cases were the scapegoat for ineffective results and patient outcomes.

A type of behavior was noted in the participants' descriptions within the C-suite, similar to a browbeating type conduct. The literature notes that bullying in the executive, C-suite does occur (Labinjo, 2012; Kets de Vries, 2012). Its cost to the organization is significant, in terms of lost human talents, productivity and blocked progress (Hanson, 2011). This bullying's effect on the receiving executive is "taking away people's belief in themselves and their abilities, and their trust in others, leaving some of them cynical, bitter, and almost unable to function" (Kets de Vries, 2012, p. 5). The respondents in this phenomenological inquiry consistently revealed these effects of executive peer bullying (Cindy 2: "But, me, I'm not as happy as I used to be, because I feel I, I feel frustrated… they've stretched me about as far as I can stretch. I feel frustrated because I couldn't help the team." Florence: "we were the sacrificial lamb…you've tied our hands…She was a bully (CEO). I think she was a bully." Grace: "sometimes I do feel like atlas holding up that ball. I do, but you cannot become this martyr person." And, Pink Panther, after losing her job after just one year: "I really made it about me..."

The hospital's C-suite is generally comprised of the CEO, CFO, CNO and COO. They are the leadership team, the key executives. However, the CNO has significantly less business and leadership experience and this is a business environment. Bullying in

the C-suite is unique to this rarified environment and its social interactions; it will take a longer time to repair (Labinjo, 2012).

In being so candid, these participants were implementing Critical Social Theory (CST), in which it is realized that their social reality is produced and replicated by people with various forms of political and cultural domination. People can consciously choose to change social behaviors; however, these dominations and mores slow or halt meaningful change. The main dependent construct of this theory is emancipation and social equity. The independent construct of CST is conflict and opposition (Horkheimer & Habermas, 1972). "CST…does not ask…to wait until answers to difficult social problems are available before they critique them, as if a person cannot point out a fire because she cannot extinguish it (Leonardo, 2004, p.13). The CNOs had no solutions to their identified issues; they were, however, voicing their world with its sadness, frustration and disappointment.

Chapter Summary

This chapter summarized the findings of "A Study of Chief Nursing Officers as the Lead Voice for the Professional Nurse: A Phenomenological Inquiry", in order to understand the world of the professional nurses' leader, the CNO. Utilizing Moustakas' Transcendental Phenomenology; this chapter provided a sample description of each participant and results of the data collection, including themes, individual textural and structural descriptions; as well as composite textural and structural descriptions. The research questions were restated and the findings were synthesized from the composites, to convey the true meaning and essence of the phenomenon being studied: the lived experience of the CNO as the lead voice for the professional nurse. The essence of the study was connected to the formulation of the Critical Social Theory.

CHAPTER FIVE

Discussion and Conclusion of the Inquiry

The purpose of this study was to explore the lived experience of the CNO as the lead voice for the professional nurse. A discussion of the findings of this phenomenological inquiry is presented in this chapter. This researcher examined and analyzed the patterns and themes that emerged from each participant's social realities and truths, which through intense analysis were synthesized finding the essence or meaning of the study. These multiple realities were context bound. The researcher's descriptive words explaining the participants' experiences are open to other interpretations (Sandelowski & Barrosa, 2007). Further interpretive analysis of the themes, textural, structural and synthesized descriptions that emerged from this study will be defined and correlated to the literature. The implications and significance of the study for nursing knowledge in education, practice, research and health/public policy and its limitations will be presented.

Exploration and Meaning of the Study

This study was a phenomenological inquiry to discover the lived experience of the CNO as the lead voice for the professional nurse at the point of care utilizing Moustakas' Transcendental Phenomenology. This quest began with an intense interest to explore and uncover something of significance about this particular population's experiences with this phenomenon. Further justification for this study was the absence of phenomenological research on this subject. A void existed.

As the personal descriptions were compiled and Moustakas' methodology was implemented, the researcher's efforts yielded the essence of the CNOs' lived experience,

identifying the primary theme of challenging and the essential themes of battling, morphing and relating. These themes emerged even more with the individual detailed textural and structural descriptions and their composites, which were synthesized into the true essence of the phenomenon. These activities were fully detailed in the previous chapter.

The researcher reviewed her notes and transcripts, reliving each interview in its entirety, making certain each description were accurately portrayed. Trustworthiness was maintained throughout the study.

Interpretive Analysis of the Findings

To interpret the findings of this study, it is best to first restate the problem identified in its opening pages. An unhealthy work environment among professional nurses at the point of care has not changed significantly in approximately a century. Patient care and outcomes are suffering as a result. Approximately half of all new graduate nurses are leaving the profession within one to three years of graduation. The absence of effective leadership or voice for nursing in the acute care setting is noteworthy.

As noted in great detail in this study; the unhealthy work environment among professional nurses is known to the CNO. However, this research has uncovered a lack of meaningful effort by these nursing leaders to discover horizontal violence/bullying, even though they know it exists. This is especially disturbing, as the literature notes that strong nursing leadership is required for a healthy work environment (Sherman & Pross, 2010). When bullying is discovered and provable, the culpable employee is swiftly terminated in accordance with corporate policy. That is what the nursing and

management literatures expect (Hanson, 2011). In addition, rationalizations were expressed that bullying occurs in all disciplines at the same rate as for nursing. Others in the study felt that one termination of an employee for bullying will set the example and end it in their facility. Therefore, lack of ferretting out this behavior was noted, which can cause even more entrenchment of this type of conduct.

The low HCAHPS scores were a topic of discussion from all the CNOs interviewed. They were all baffled as to why these low scores are occurring. Many participants were frustrated and discouraged by what can be done. It almost seemed that they did not believe their own scores, or even more so, those hospitals that are getting the better scores. These patient satisfaction scores measure the performance of care in their facilities and they struggled to believe their low scores were accurate. Only one CNO had success with her HCAHPS scores. This success had taken some time, but her corporation purchased and adopted the Studer plan in order to raise and maintain its scores to a high level. Many of these initiatives seemed to make common sense; as the literature notes that treating the patient with respect and courtesy enhances the patient's hospital experience (National Association of Public Health Systems, 2008).

The graduate nurse's competence was also discussed by all CNOs. They noted it was an expense and hardship to their facilities to get these nurses well trained in order to provide good, competent patient care, both from a clinical and leadership perspective. Different types of residency programs were established and conducted, but due to the expense of these programs, their facilities only hired and provided these programs once or twice a year. One CNO had actually developed an associate nursing program in her facilities in order to grow their own nurses. This tactic was a creative and financially

savvy way to enhance the facilities' staffing and training issues and provided a more nurturing environment from her staff nurses to the new graduate nurses. This school is just in its early stages. Nurse bullying, nurse retention and decreased nurse turnover need to be investigated in this facility.

The literature notes that nursing leaders with leadership education are more innovative (Clement-O'Brien et al., 2011). The literature fails to note that the CNO primarily represents the patient, not the nurses. However, these beliefs and attitudes are already evident in nursing leadership. For example the American Association of Colleges of Nursing (AACN, 2007) work environments guidelines to achieve magnet status emphasize managing the nurse; while improving the quality of patient care. The concept of managing the nurse, versus actually leading and enhancing the nurses to be leaders is not addressed. This may help explain why the study's participants overwhelmingly voiced their allegiance to the patient first and foremost, even at the expense of the nurse. One should never be at the expense of another. This, in turn, causes low self-esteem, lack of value, no autonomy and no voice for the professional nurse. When the professional nurse does not have a supportive work environment that allows her or him to be successful, patient care suffers (Wong et al., 2010). By definition, HCAHPS scores are then diminished. The literature notes the void of executive leadership programs for CNOs (Morgan-Smith, 2012). This lack of leadership knowledge was prevalent in all the CNOs interviewed except one; this sole CNO made the correlation between the nurse being set up for success and the nurse who can give good care. Ultimately, the facility will be successful (Aguayo, 1991). It is the proverbial win-win.

From the results of this study, it is evident that the lack of leadership in the acute care setting for the professional nurse is noteworthy. Most of the CNOs interviewed were disheartened and frustrated due to their inability to affect meaningful long-term patient care improvements. To obtain positive patient care outcomes, the CNO needs to address the means of achieving those outcomes, which is through their nurses. It is analogous to driving your car for one year without maintaining the car and expecting it to do a cross country trip without car trouble. This is not a reasonable expectation. Neither is it reasonable to expect nurses to function at a high level when there does not seem to be anyone absolutely concerned or caring enough about them to enable their success.

If nurses are successful, they will be giving the best patient care they can. When they cannot give the best care: apathy; anger; lack of autonomy, confidence and self-esteem all emerge (Han & Jekel, 2010; Feltner, Mitchell, Norris, & Wolfe, 2008). Everyone wants to do a good job. Nurses, who are service oriented and care givers, need to identify themselves doing a good job. If they do not succeed, it contributes to behaviors such as horizontal violence, passive-aggressive behavior and, ultimately, leaving the facility and possibly the profession (Dong & Temple, 2011; Roberts, Demarco, & Griffin, 2009). This failure from top to bottom is neither what the CNO nor the staff nurse desire and neither has received appropriate leadership and guidance.

Implications of the Study for Nursing Education

This study is significant for nursing education, particularly graduate nursing education in the nurse executive/leadership track, as it sheds light on the lived experience of the CNO as the lead voice for the professional nurse. This area was not previously explored in the literature.

CNOs are the highest nurse executive in the acute care setting. The findings of this study show that leadership education for the CNO is an area that requires more formalized curriculum specific to their role in today's nursing profession.

The CNO's responsibilities and expectations have changed and are continually changing to encompass more of the total operations of the acute care settings. As the CNOs indicated in this study, they require enhanced financial education similar to the level of an accountant in order to understand complex statements and cash flow projections at the hospital leadership level. This knowledge, in turn, will allow them to be able to communicate, defend and strategize for the benefit of nursing care in the C-suite in order to sustain positive patient care outcomes.

This study also showed that relationship building and communication were essential to the CNOs' success. These skills involve all disciplines in the hospital, at all levels. The better the relationships and communication, the more effective the CNO will be according to the study's participants. Education in these areas needs to be improved and structured for the CNOs' achievements.

Implications of the Study for Nursing Practice

This study identified two significant issues for nursing practice; ill-prepared new graduate nurses and unhealthy nurse behavior at bedside. According to this study's participants, nursing school graduates are educated to pass the NCLEX and not sufficiently focused on providing bedside clinical care at a competent, safe level. Passing an NCLEX exam does not fully correlate with the skills, critical thinking and bedside behavior that the CNOs in this study stated they require. Nurse residencies and in-depth

orientations are a significant financial cost to the hiring hospitals, even though these would assist the new nurse in their professional success.

The CNO and their nurse leadership team must actively seek out actual, confirmable bullying, horizontal violence and other unhealthy nursing behaviors. Merely waiting for a report from a staff nurse who is being bullied and making a case of the bully has not produced results, though several study participants ineffectively used this mode of action. The unhealthy work environment has been noted in the literature for much longer than the lifetime of anyone reading this paper (Helmstadter & Godden, 2011; Keddy, Jones, Jacobs, Burton, & Rogers, 1986; Selanders, 2012; University of Virginia School of Nursing Center for Historical Inquiry, 1930).

Staff nurses should embrace the new graduates, the future of the profession according to the study's participants. There was clear support for young graduates among CNOs and a realization that they were not welcomed into the profession; however, the majority of the participants did not deal with this issue, they only spoke of it. This issue again relates to being overwhelmed and somewhat fearful and having a lack of knowledge on how to deal with these situations.

The primary focus of the study participants was not setting up their nursing workforce for success at point of care. It was about providing positive patient outcomes, even at the expense of the nurse.

A professional nurse who is not given a healthy work environment will not present the most professional demeanor or communicate consistently or positively with the patient. Nor will they provide their utmost care to the patient (O'Brien-Pallas et al., 2010 & Wong et al., 2010). HCAHPS satisfaction scores are negatively affected in

several ways, as the patient's total experience in the hospital is determined by the care givers' approach to the patient. Nursing practice needs to address these issues as found in this study.

Implications of the Study for Nursing Research

This study of the lived experience of the CNO as the lead voice for the professional nurse has begun to fill the void of phenomenological research of CNOs. The only other recent phenomenological study of CNOs focused on their leadership education as it relates to acquiring magnet level status (Morgan-Smith, 2012). At the inception of this study, there were no phenomenological CNO studies. Voids therefore exist.

As the CNO evolves into an even more effective leader through the possible solutions identified in this study, further effective outcomes are anticipated in both nursing and patient care, which could stimulate even more research, locally as well as globally.

Implications of the Study for Nursing Health/Public Policy

The study has shown the CNO's concern of the negative effects of the new healthcare initiatives tying payments to patient satisfaction and readmission rate penalties. The nurse is the primary deliverer of care in the acute care setting. CNOs are ultimately responsible for the actions of those nurses as they relate to patient satisfaction and reducing the readmissions. But just as important, for those reasons, the CNOs need to implement new strategies to reduce the readmission rates, by enhancing more inter-professional and community caregiver collaborations.

However, even though these new healthcare policies are causing concern in the healthcare industry, many of the CNOs in this study felt this was a window for CNOs to

implement positive changes. This opportunity is due to the value-driven initiatives, versus the old way of being totally volume driven. Therefore, nursing now affects revenue; it is not just a cost. According to the participants this opportunity may not last, so they must act quickly.

Strengths and Limitations of the Study

The strengths of the study include its fairly wide geographic area, the Southeastern United States and that all the participants within that broad geographic region faced the same challenges and spoke passionately about the same issues. Their perspectives were their own; however, the similarities were uncanny and surprising to the researcher. The researcher's extensive healthcare leadership background afforded her the opportunities and entries into their world that another researcher might not have had. The great variety in the healthcare systems and the size of their facilities is strength of the study, as it is more representative of the healthcare industry. The participants of the study were transparent and forthcoming. There were no requests to limit the transcription or turn off the tape recorder.

Limitations of the study included the time constraints of the busy nurse executives interviewed. The one-hour interview might have missed a point that a substantially longer interview could have covered. In addition, even though saturation was reached very early in the study, there might be some regional differences had the study progressed outside of the Southeastern United States. Setting appointments for the interviews did require extensive ground work. The responses to the email invitations were far less than 100%, as the potential respondents were not only busy executives but might have also been concerned about sharing information. Many of the CNOs were willing to fill out a

survey but not participate in a one-to-one interview. Qualitative research is not intended to be generalized. The study is an exploratory one.

Recommendations for Future Study

As noted throughout this paper, phenomenological research on CNOs is sparse. The themes that percolated to the surface in this study and the challenges faced by the CNOs should be further investigated in studies that are quantitative, qualitative and/or mixed method. Larger sample sizes in quantitative and mixed methods studies are suggested. Studies in other geographic regions should also be done. After further studies confirm the findings and themes of this one, subsequent studies should also begin to offer solutions. For example, areas of interest that might be studied include standardization of CNO education and what this would entail.

Conclusions

The 10 participants in this study were gracious and informative. The knowledge gleaned was invaluable, especially as there were previously no one-to-one, face-to-face interviews on this phenomenon. Moustakas' Transcendental Phenomenology was utilized and four themes emerged; primary among them was challenging, with battling, morphing and relating as the essential themes. The individual textural and structural descriptions were completed after each interview. After the interviews ended, a composite textural and structural description was formed. This was then combined into a synthesis that yielded the essence of the lived experience of the CNO as the lead voice for the professional nurse.

These CNOs face the challenges of their constantly changing world, coming to work each day to face the battles, only some of which they can choose. Their families

and faith, along with their strong clinical skills, allow them to be grounded when their world becomes extremely difficult.

These 10 Chief Nursing Officers were very candid, forthright and open to their interviews. I was astonished by the willingness of each and every one of these leaders to speak without hesitation and convey the lived experience of the CNO as the lead voice for the professional nurse at point of care. Their graciousness and transparency consistently illuminated their own experiences in this exclusive world. Without their openness and honesty, this study would not have been possible. I am grateful for their participation. Understanding their world allows the nursing profession to move even further forward. We respect and honor them.

Chapter Summary

Chapter Five explored the meaning of the study; the lived experience of the CNO as the lead voice for the professional nurse. It interpreted and analyzed the findings and discussed the implications and significance of the study in the areas of nursing education, nursing practice, nursing research and health/public policy. The strengths and limitations of the study were discussed. Recommendations for future study were also considered.

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Approved by Barry University IRB:
Date: SEP -3 2013
Signature:

Appendix A

Barry University
IRB
Informed Consent Form

Your voluntary participation in a research project is requested. The title of the study is "Chief Nursing Officers as The Lead Voice for the Professional Nurse: A Phenomenological Inquiry". The research is being conducted by Charlene Ingwell, MSN, RN a doctoral student at Barry University College of Health Science, Division of Nursing. You will be asked to contribute to the further success of current and future Chief Nursing Officers (CNO), helping to address the challenges of the healthcare industry. The purpose of this study is to understand the lived experience of the CNO as the lead voice for the professional nurse at point of care in the acute care setting. The maximum number of participants will be 25. To volunteer for this study, you must be the highest ranking administrative registered nurse in the acute care organization, responsible for the practice of nursing throughout your healthcare system.

If you decide to participate in this research:

1. Complete a short 15 item questionnaire for the purpose of obtaining demographic data before the interview.
2. You will be asked questions about the lived experience of a CNO being the lead voice for the professional nurse at point of care in the acute care setting. This initial, confidential, one to one interview will be audio taped and will last approximately one hour, scheduled at your convenience and in a private and comfortable setting.
3. A follow-up interview for the purpose of making sure the interview transcript is correct and to answer any questions you may have, also scheduled at your convenience in a private and comfortable setting. This second meeting will not be audio-taped and will not last more than 1 hour.

Your consent to be a study participant is strictly voluntary and should you decline to participate, or should you choose to discontinue at any time during the study, there will be no negative effects or consequences. As a participant, you:

- May choose to stop the interview and withdraw from the study at any time. If you choose to withdraw, your information will not be used for the study.
- May refuse to answer any specific question or questions.
- May ask that the tape recorder be turned off at any time. The researcher will continue to use the information you share unless you decide to completely withdraw from the study. If you choose to withdraw, your information will not be used in the study.

There are no known risks in this study. In appreciation for your voluntary participation in the study, you will receive a $25 gift card.

As a research participant, the information you provide will remain confidential to the extent permitted by law. The following procedures will be followed to ensure your confidentiality:

1. You will be asked to choose a different name (pseudonym) that will be used in place of your actual name for this study.
2. No real names will be used in any published results of this study. Quotes or group themes only will be published.

3. All paper transcripts, documents and field notes from this study will be kept in a locked cabinet in the researcher's home office. Informed Consent Forms signed by the participants will be stored for at least five years in a locked file in the researcher's home office apart from other study documents. Audio taped codes and participant pseudonyms will be kept separate from their code keys in a locked file in the researcher's home office.
4. The audio tape will be destroyed subsequent to researcher verification that the interview transcripts are correct and all questions of the researched have been clarified during the second meeting. If the follow-up, second meeting does not take place, the audio tape will be kept in a locked file in the researcher's home office and destroyed 90 days after the initial interview.
5. Security of electronic documents will be maintained with the use of an exclusive, password protected, personal computer at the researcher's home office. Electronic transcripts will be deleted from the researcher's personal computer five years after completion of the study.

If you have any questions regarding the study or your participation in the study, you may contact me, Charlene M. Ingwell MSN, RN 954-226-4174, or my advisor, Dr. Claudette Spalding, PhD, ARNP, CNAA 305- 301-7627 or the Barry University Institutional Review Board point of contact, Barbara Cook, at 305-899-3020. If you are satisfied with the information provided and are willing to participate in this research, please signify your consent by signing this consent form.

Voluntary Consent

I acknowledge that I have been informed of the nature and purposes of this study by Charlene Ingwell, MSN, RN and that I have read and understand the information presented above, and that I have received a copy of this form for my records. I give my voluntary consent to participate in this research.

______________________	__________	______________________	__________
Signature of Participant	Date	Researcher	Date

Appendix B
Email Invitation

I am inviting your confidential participation in a research study to determine the lived experience of the Chief Nursing Officer (CNO) as the lead voice for the professional nurse.

If you would be kind enough to be interviewed for approximately one hour in this confidential study, it is anticipated that current and future CNOs may benefit.

I will follow up with you in approximately one week to answer any questions you may have and discuss details of the prospective interview. I, of course, hope you will agree to participate in this qualitative, university based study, which I anticipate will benefit the highest levels of nursing leadership.

In appreciation for your voluntary participation in the study, you will receive a $25 gift card.

The purpose of this study is to gain a better understanding of how CNOs demonstrate being a lead voice for the professional nurse and to validate these experiences as a nurse leader. This study information will also help determine how today's CNOs, as well as future CNOs, may be even more successful as an effective advocate for the professional nurse and, inevitably, for the overall nursing profession.

If you decide to participate, please email me at Charlene.ingwell@mymail.barry.edu so we can arrange the particulars of the interview.

Thank you in advance for your considered participation.

Sincerely,

Charlene Ingwell MSN, RN

Appendix C

Demographic Questionnaire

1. Age in years (Please enter) ___________

2. Gender (Please circle) Male Female

3. Race (Please circle)

    White or Caucasian African-American or Black Hispanic or Latin

    Asian/Pacific American Native American Other

4. Highest Nursing Degree/Diploma (Please circle)

    Diploma Associate Degree BSN MSN DNP PhD

5. Highest Non-Nursing Degree Achieved, if applicable

6. Years Employed in Current Position (Please circle)

    < 2 years 2 to 5 years 5 to 10 years >10 years

7. First CNO Position? (Please circle) Yes No

8. Number of CNO Positions Held in the Last Ten Years? (Please enter):________

9. Size of Hospital (Please enter # of licensed beds):_____________

10. Actual Leadership Title (Please enter):______________________________

11. Number of Direct Reports (Please enter):_______________________

12. Type of Hospital (Please circle:

    Community Rural Academic Health Center Corporate System Other

13. Relationship with Nursing Directors/Managers (Please circle)

    Poor Fair Good Very Good Excellent

14. Relationship with CEO (Please circle)

    Poor Fair Good Very Good Excellent

15. Leadership Style Most Often Used (Please circle)

    Laissez-Faire Autocratic Participative

    Transactional Transformational

Appendix D

Interview Protocol

Date / Time:

Researcher: Charlene Ingwell, MSN, RN

Pseudo Name: ___________________________________

1. Describe research project.
   - ❖ Purpose of the study
   - ❖ Risks and benefits of the study
   - ❖ Time commitment
2. Obtain consent.
3. Assure confidentiality and obtain pseudonym.
4. Provide a list of local community social services programs.
5. Ice breaker.
6. Obtain demographic information using demographic questionnaire.
7. Assure participant that she:
   - ❖ May choose to stop the interview and withdraw from the study at any time.
   - ❖ May refuse to answer any specific question or questions.
   - ❖ May ask that the tape recorder be turned off at any time.
   - ❖ May request to take a break at any time.
8. Request permission to begin interview and audiotape recording. Conduct interview.
9. Ask if there is anything else participant might want to discuss.
10. Closing.
    - ❖ Thank interviewee and give $25 gift card.
    - ❖ Reconfirm assurances of confidentiality.
    - ❖ Request for a follow-up meeting and confirm a method of contact for scheduling.
    - ❖ Offer availability by phone or email if questions arise.
    - ❖ Ensure that communication with the researcher will be through a secure, confidential, and password-protected e-mail account and phone number to be used exclusively for this study.
11. Post Interview:
    - ❖ Label audiotape with participant pseudonym.
    - ❖ Complete researcher notes and introspection.
    - ❖ Begin transcription of taped interviews immediately.

Appendix E
Interview Questions

* How do situations which are addressed by CNOs affect their experience of being the lead voice?
* What are your challenges?
* What is your vision for the CNO?
* What is your vision for the professional nurse?
* What are some of your experiences in achieving the vision?
* How would you describe your leadership style?

Appendix F

Barry University IRB Approval Letter

11300 NE Second Avenue
Miami Shores, FL 33161-6695
phone 305-899-3020
800-756-6000, ext. 3020
fax 305-899-3026
www.barry.edu

OFFICE OF THE PROVOST
INSTITUTIONAL REVIEW BOARD

Research with Human Subjects
Protocol Review

Date:	September 3, 2013
Protocol Number:	130812
Title:	A Study of Chief Nursing Officers as the Lead Voice for the Professional Nurse: A Phenomenological Inquiry
Meeting Date:	August 21, 2013
Researcher Name:	Ms. Charlene Ingwell
Address:	4132 Carambola Circle South #401 Coconut Creek, FLA 33066
Faculty Sponsor:	Dr. Claudette Spalding Nursing

Dear Ms. Ingwell:

On behalf of the Barry University Institutional Review Board (IRB), I have verified that the specific changes requested by the convened IRB on August 21, 2013 have been made.

It is the IRB's judgment that the rights and welfare of the individuals who may be asked to participate in this study will be respected; that the proposed research, including the process of obtaining informed consent, will be conducted in a manner consistent with requirements and that the potential benefits to participants and to others warrant the risks participants may choose to incur. You may, therefore, proceed with data collection.

As principal investigator of this protocol, it is your responsibility to make sure that this study is conducted as approved by the IRB. Any modifications to the protocol or consent form, initiated by you or by the sponsor, will require prior approval, which you may request by completing a protocol modification form.

It is a condition of this approval that you report promptly to the IRB any serious, unanticipated adverse events experienced by participants in the course of this research, whether or not they are directly related to the study protocol. These adverse events include, but may not be limited to, any experience that is fatal or immediately life-threatening, is permanently disabling, requires (or prolongs) inpatient hospitalization, or is a congenital anomaly cancer or overdose.

The approval granted expires on August 31, 2014. Should you wish to maintain this protocol in an active status beyond that date, you will need to provide the IRB with and IRB Application for Continuing Review (Progress Report) summarizing study results to date. The IRB will request a progress report from you approximately three months before the anniversary date of your current approval.

If you have questions about these procedures, or need any additional assistance from the IRB, please call the IRB point of contact, Mrs. Barbara Cook at (305)899-3020 or send an e-mail to LBacheller@mail.barry.edu. Finally, please review your professional liability insurance to make sure your coverage includes the activities in this study.

Sincerely,

Linda Bacheller, Psy.D., J.D.
Chair, Institutional Review Board
Barry University
Box Psychology
11300 NE 2nd Avenue
Miami Shores, FL 33161

Cc: Dr. Claudette Spalding

Appendix G

VITA

Charlene Ingwell, MSN, RN

September, 1953	Born – Darlington, Wisc.
1974	RN, Madison General Hospital School of Nursing Madison, Wisc.
1974 – 1976	Staff Nurse, Wausau Hospital N Wausau, Wisc.
1976 – 1985	Staff Nurse, Holy Cross Hospital Ft. Lauderdale, Fl.
1985 – 1994	Staff Nurse, Kennestone Hospital Marietta, Ga.
1995 – 2001	Director of Clinical Education St. Mary's Hospital Rogers, Ark.
2001 - 2003	Staff Development Educator Nurse Manager Neuroscience Unit JFK Medical Center Atlantis, Fl.
2003 – 2004	Director Medical Services Boca Raton Community Hospital Boca Raton, Fl.
2004	BSN, Summa Cum Laude Florida Atlantic University Boca Raton, Fl.

2004 – 2005	Manager Critical Care Services/Dialysis JFK Medical Center Atlantis, Fl.
2006	MSN with Honors Florida Atlantic University Boca Raton, Fl.
2006 – 2012	Director of Workforce & Organizational Development HCA East Florida Division Ft. Lauderdale, Fl.
2010 – Present	PhD Nursing Student Barry University Miami Shores, Fl.
2012 – Present	Assistant Clinical Professor Undergraduate Nursing Florida International University Miami, Fl.

PUBLICATIONS

VRE Instructional Training Manual	Copyrighted 1997

PRESENTATIONS

Poster Presentation "Voice: An Evolutionary Concept Analysis in Nursing leadership"	30th Anniversary of Nursing Florida International University Oct. 12, 2012