



Nurses in Executive Practice: A Specialty For Today and Tomorrow

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About 35 year ago, I was asked to explain the role of a hospital nurse executive to a group of staff nurses at an in-service class, so they could better understand what nursing administrators did when not making rounds on the units. I brought my inbox — then a literal collection of papers — to a hospital auditorium to show the intricacies of the job. I described a role that included shaping and keeping tabs on patient care, staffing, budgets, productivity, safety and at least a dozen other claims on the time of a nursing executive. As the staff nurses left the room, I heard one of them mutter, “Well that sounds like a boring job!” I have never thought so.

The challenges of what was then called “nursing services” related to balancing the needs of patients, the community, the staff and the organization. Many of the challenges faced by nurse executives in the mid-1980s remain and have become more complex with new challenges brought by an ever-changing health care environment. What has not changed is that many people in the health care industry don’t have a clear understanding of the nurse executive role or its importance to health care and to nurses themselves. They also don’t realize that management is a nursing specialty.

Modern professional nursing practice has steadily developed since Florence Nightingale and Sr. Mary Clare Moore, RSM, led a group of Sisters of Mercy and other nurses to Scutari to care for British soldiers during the Crimean War. Since that time, nursing education and standards have continued to evolve. As the complexity of health care has increased, the generalist nurses of 150-175 years ago have become specialists. Medical-surgical nurses, pediatric nurses, critical care nurses, behavioral health nurses, perioperative

nurses, advanced practice nurses and other specialists and subspecialists practice with different training, skills and competencies. Nursing management, with a subspecialty of nursing executive practice, is itself a specialty that has become more sophisticated in recent years.

Several decades ago, it was not uncommon for nurses to be promoted into supervisory positions because of their excellent clinical skills. Those who progressed through the various levels of nursing management to eventually be named chief nurse executives learned the business of health care on the job. By the time they reached an administrative position, they had a thorough understanding of hospital operations from bedside to executive offices. Today, there is a greater understanding that leading the clinical enterprise requires a specific set of competencies in addition to clinical expertise and on-the-job learning. Both the American Organization of Nurse Leaders (AONL) and American Nurses Credentialing Center (ANCC) offer certifications in nursing management and executive practice. AONL published the first version of their Nurse Executive



Competencies in 2005 and has refined those over the past 15 years as roles have changed. The competencies include specific actions and abilities under the domains of communications and relationship management, professionalism, knowledge of the health care environment, business skills and principles, and leadership.¹

The recognition of nurse executive practice as a specialty has made selection of administrators more dependent on leadership abilities and education rather than on clinical expertise. Nurses pursuing these roles prepare for them through both education and certification. One nursing specialty group, the Association for Leadership Science (ALSN), focuses on nursing administration and leadership programs at undergraduate and graduate levels. Some of us have graduate degrees in management from schools of nursing; some have MBAs from business schools; some have MHAs. A growing number are educated beyond the master's level, with a Doctorate in Nursing Practice, from an AACN-accredited program (American Association of Colleges of Nursing, which includes the eight essential curricular elements listed in the sidebar below. Those elements correlate to the skills that will be needed if we are to transform our health care systems in

EIGHT ESSENTIAL CURRICULAR ELEMENTS FOR A DOCTOR OF NURSING PRACTICE

1. Scientific Underpinnings for Practice
2. Organizational and Systems Leadership for Quality Improvement and Systems Thinking
3. Clinical Scholarship and Analytical Methods for Evidence-Based Practice
4. Information Systems/Technology and Patient Care Technology for the Improvement and Transformation of Healthcare
5. Healthcare Policy for Advocacy in Healthcare
6. Interprofessional Collaboration for Improving Patient and Population Health Outcomes
7. Clinical Prevention and Population Health for Improving the Nation's Health
8. Advanced Nursing Practice

From *The Essentials of Doctoral Education for Advanced Nursing Practice*, American Association of Colleges of Nursing, October 2006.

order to provide higher quality, equitable care.

The nurse executives who lead in health care organizations have different titles and a variety of responsibilities. Depending on the structure of their organization's executive teams, they may be vice presidents, senior vice presidents, executive vice presidents, or senior executive vice presidents. Some have dual roles as chief operating officers. Many serve as the executive level leader for other clinical professionals in addition to nurses. Some work closely with chief medical officers as dyad leaders of the entire clinical enterprise. Critical access hospitals have nurse executives, as do other individual hospitals, home health agencies, long-term care facilities, outpatient clinics and other health care community services.

The growth of systems in the past decade has led to an additional type of executive, the system chief nurse. In 2015, AONL documented specific competencies related to this role.² How system CNE roles differ from single organization CNEs can be pointed out in the wording of the separate sets of competencies. For example, while an individual entity nurse executive is expected to adhere to professional associations' standards of nursing practice, the system CNO is required to hold the entity-based CNOs accountable for patient care standards. Currently, the individual entity nurse executive must ensure compliance with a specific state nurse practice act, while the system leader must maintain knowledge regarding state nurse practice acts in all states where the system has operations.

THE EVOLUTION OF THE CHIEF NURSE

The original "chief nurses" were called hospital superintendents, and they served as the top executives in the majority of acute care institutions until the late 1930s/early 1940s. (This was not true in early academic centers and a few for-profit hospitals, where MDs led (or, in the case of the for-profits, owned) the organizations. Most people are unaware of this history, but Margarete Arndt and Barbara Bigelow have extensively studied and published why and how hospital leadership was transformed in the first half of the 20th century. A few of their articles paint the picture of hospitals facing three major problems almost a hundred years ago: the need to fund new technology; the less-than-ideal relationships with medical staff; and pressure from business owners to address the increasing costs of health care.^{3,4,5}

It was less than 100 years ago that hospitals



transitioned from a nursing leadership model to a business model. Hospitals were beginning to be perceived as businesses in the first half of the 20th century, and the norms of the time dictated that businesses needed to be administered by business men. In 1929, Michael Davis published, *Hospital Administration: A Career — The Need for Trained Executives for a Billion Dollar Business, and How They May Be Trained*. Five years later, the University of Chicago established the first graduate program in Hospital Administration, with Davis as the program leader. In the 1940s, eight other universities offered this degree, with nine more in the 1950s, and 15 others in the 1960s. Arndt reports that when the MHA programs were established, they admitted virtually no female students. Nurse superintendents, from a female profession, were no longer hired by hospitals who wanted educated administrators. Nurse leaders retained the 24-hour-a-day, seven-days-a-week operations of the hospital, reporting to the MHAs who served as the chief executives.

The exception to this was in Catholic hospitals, where women religious, both sisters with clinical backgrounds and those with administrative experience, continued to hold the top leadership roles.

As late as 1968, nuns or priests served as CEOs of 770 of the 796 U.S. Catholic hospitals. However, in 2011, there were only eight of the 636 Catholic hospitals whose top executives were religious, as the leadership of these faith-based organizations was regularly being turned over to lay leaders.⁶ Today there are none, according to the Catholic Health Association.

The roles of health care leaders, including nurse executives, have continued to change in both Catholic and non-Catholic organizations. It wasn't that long ago that CNOs were mostly in acute care settings and heavily involved in the day-to-day operations of hospitals. Today, nurse leaders still have operational responsibilities, but they also have clinical practice accountability over care in a variety of settings where they do not have the operations responsibility. That distinction can be confusing, but it means that a leader outside the nursing profession may serve as the operations manager or supervisor of nurses in a clinic, post-acute facility, or even in a department inside the hospital. However, the chief nursing officer has responsibility and accountability for the practice of nursing — adherence to nurs-

ing care standards, evidence-based practice and nurse practice acts — wherever nursing is practiced in the organization. This is just one of the complexities of the modern health care system and has resulted in a plethora of dotted lines on what were once much simpler straight-lined organizational charts!

There is now widespread understanding that CNEs must have a good grasp of both the macro- and micro-economics of health care, manage large budgets and share responsibility with their executive peers for the financial health of the organization. In the past few years, nurse executives have become more involved in partnering with our finance colleagues. This is highlighted in the AONL System CNE competencies under business

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skills, where one of the five financial competencies is to “participate in system activities related to system bond ratings, investing, and attainment of operating margins.”

The list of single entity accountabilities for CNEs differs from organization to organization, but at a minimum it includes either sole or shared executive accountability for the management of the nursing enterprise staff; management of quality, safety and patient experience; staffing the nursing care areas 24 hours a day, seven days a week; reduction of adverse events; adoption of evidence-based standards; development of processes and care models; compliance with regulations and applicable laws; cost reduction; clinical adoption of new technology, including electronic health records; and productivity. Some of the tasks taken on by nurse leaders in the past few years have been dictated by changes in regulations, payment systems and technology. Others are simply the right thing to do in support of our missions and for the various stakeholders we serve. These stakeholders are not silos, and the health and well-being of one group affects the health and well-being of the others. One obvious stakeholder

is the nursing care team — nurses and those who work with them to provide care. The COVID pandemic of 2020 has underscored the need to ensure their well-being, not only for them as individuals but for the good of the community's — and the world's — health.

THE YEAR OF THE NURSE

Early in 2019, the World Health Organization announced that 2020 would be the International Year of the Nurse and Midwife. It was planned around Florence Nightingale's 200th birthday and the final year of the Nursing Now global campaign to raise the profile and voice of nurses. On the last day of 2019, a cluster of pneumonia cases in Wuhan, China, was reported to WHO. Seven days later, Chinese health officials shared that the affected people were victims of a novel coronavirus that would come to be known as COVID-19. We were not aware that this newly discovered threat to human health would become, almost overnight, a worldwide crisis. As a result, it was less about the Year of the Nurse, and more about the Year of COVID, that placed nurses in the media spotlight.

Frontline nurses have been caring for the pandemic victims, while nurse executives have been supporting them in health care systems that scrambled to get ready and then face the treatment challenges that come with victims of this still mysterious virus. Nurse leaders sat (and still sit) on hospital and community crisis command centers. Many of us have been working with other community organizations to coordinate local care. We have been advocating for frontline staff, working with teams to secure essential protective supplies, approving novel ideas for using equipment and technology, moving staff and resources to the sites where they were (and are) most needed, and reporting to hospital or system boards and to others on the heroic, hard and exhausting work being done on the frontlines. We have been cheerleaders for our clinical specialty colleagues, not only where staff can hear this, but in the executive suites as well.

Nurse leaders have a uniquely synchronized view of all issues during a crisis. As clinical executives who have experienced leadership of hospital operations around the clock, we have been required to maintain updated knowledge in the operational side of the organization, the business side of health care and current clinical best practice. As nurses, we are part of a culture that understands work arounds that are done in the best

interest of patients, as well as the realities of moral distress, burnout and compassion fatigue. Part of the nurse executive role in this year of COVID has been to seek resources and plan interventions to support the mental and physical health of the staff.

We also know the difference between nurse specialties. A number of nurse executives have commented that they were surprised at how their non-nurse colleagues reacted to shortages of critical care and ECMO (extracorporeal membrane oxygenation) nurses at a time when other nurses, including clinic nurses, were without work. They thought that the logical solution was to send nurses with different specialties to work in critical care. However, this solution is not as optimal as it may seem. Nurses who are educated, trained and experienced in various specialties are not interchangeable, and a pandemic is not the time to substitute a novice for an expert in any specialty. Knowing this, nurse leaders reacted quickly to develop care models where the specialists needed could be augmented with other nurses who could perform the general nursing duties that all inpatients need, while critical care nurses led teams and gave care that required their expertise. In some cases, this expertise has been leveraged through technology in the form of virtual nursing.

INTO THE FUTURE

Even though we don't know when, we do know that this pandemic will come to an end some day. We still need to get through it, and nurse executives are setting up programs to educate specialists projected to be in greatest demand if surges of infection continue. We are also planning programs for caregivers who may face post-traumatic stress issues and documenting plans (based on recent learnings) for possible future national or international health crises. Of course, nurse executives are not alone in any of this work. Nor will we be alone in transforming our systems "post-COVID." We will continue to partner with colleagues, communities and patients themselves as we leverage what we have learned to improve our care models for the future. This pandemic has made it even more obvious that no single profession, individual or specialty can accomplish what needs to be done to improve care in our systems. Nurses are educated and experienced in teamwork, which will be important as we set up new multidisciplinary models in the future.

It is true that the year of COVID has overshadowed the Year of the Nurse and Midwife. It has,



however, demonstrated again how important the intellect, hands and hearts of this profession are to the health of the world, which was what WHO wanted to highlight in 2020. The organization's conviction is that there will never be universal coverage until we have more nurses, who will be universally recognized for their contributions to holistic care and wellness. Those nurses will need to practice at the top of their licenses and specialties. The specialty known as executive practice will continue to do our part as the voice of nursing at the executive table: as balancers of stakeholder needs; as educators of health care colleagues and communities about this profession; and as supporters of advanced practice, multidisciplinary team care and all nursing specialties.

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NOTES

1. AONL Nurse Executive Competencies: www.aonl.org/resources/nurse-leader-competencies.
2. System Chief Nurse Executive Competencies: www.aonl.org/system-chief-nurse-executive-competencies.
3. Barbara Bigelow and Margarete Arndt, "The More Things Change, The More They Stay the Same," *Health Care Management Review* 25, no. 1 (January 2000): 1999: 65-72.
4. Margarete Arndt and Barbara Bigelow, "Hospital Administration in the Early 1900s: Visions for the Future and the Reality of Daily Practice," *Journal of Healthcare Management* 52, no. 1, (Jan-Feb 2007): 34-45.
5. Margarete Arndt "Education and the Masculinization of Hospital Administration," *Journal of Management History* 16, no. 1 (Jan 12, 2010): 75-89.
6. Kevin Sack, "Nuns, a 'Dying Breed,' Fade From Leadership Roles at Catholic Hospitals," *The New York Times* Aug. 20, 2011, <https://www.nytimes.com/2011/08/21/us/21nuns>.

QUESTIONS FOR DISCUSSION

Kathy Sanford has been a nurse executive for several decades with Catholic Health Initiatives, now CommonSpirit. Her perspective on the executive nurse role has a unique vantage point in that she has seen the role of executive move from nursing sister to lay businessmen and women in little more than a generation. Her article is concerned with the balance of clinical excellence, executive acumen, administrative skills and a strong commitment to mission.

1. How is the role of executive nurse understood in your ministry? Does it oversee only nursing or other clinical specialties too? In addition to being a voice for clinical excellence, what other practices and decisions within the health system does the nurse executive speak to?
2. How did you feel about the section on pgs. 28-29 in which Sanford describes the transition from a nursing model to a business model? Talk about what you think may have been lost and what may have been gained in that transition. What is the impact on your own ministry?
3. During this time of the pandemic, when all things are being reimagined, what opportunities do you see in reexamining how our ministries are led? What are the implications as we continue to strive for excellence and quality?
4. Sanford notes the confusion caused when hospitals or health systems made deep cuts to some nurses while other nurses were working long and grueling shifts. What do you think of Sanford's explanation of nurse specialties? Do you think more emphasis on specialties should be given in nursing schools? What suggestions do you have for preparing nurses for the next epidemic or pandemic?
5. Sanford's reflection on the Year of the Nurse and the Year of COVID is both poignant and ironic: it took a pandemic for the World Health Organization's goals of recognition and appreciation for nurses to be fully valued. What is your ministry doing to recognize the important contribution of nurses as essential workers and to honor their unique skills and expertise? What is your system doing to help nurses who may be experiencing burnout, compassion fatigue or post-traumatic stress disorder caused by the pandemic? Do you have suggestions for what else it could do?

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