Report of Senior Nurse Work Group

Recommendations for Middlesex-London Health Unit

December 2000

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Table of Contents

Preface

The Work Group presented their findings including 10 recommendations at the December 13, 2000 meeting of Directors' Committee, the Health Unit's senior management group. The report that follows was distributed to Directors as a confidential document on December 22, 2000. Directors' Committee reviewed the report and had extensive dialogue regarding the findings and recommendations proposed by the Work Group. The outcome of this dialogue is as follows:

Proposed Recommendation[1.]	Action Taken
Recommendation 1: *A Professional Practice Council-Nursing and a formal role of Professional Leader-Nursing be created.*	It was agreed to create the role of Professional Leader-Nursing. The job description (see Appendix I) for this position is to be revised as follows: • Reports to: It was agreed the position will report to the Medical Officer of Health • Time Allocation: This section is to be deleted. • Responsibilities: The following is to be added: Upholds a shared sense of responsibility for the whole organization. (see Appendix J) • Qualifications: Number of years of experience is to be specified. • An issue related to the establishment of the Professional Practice Council-Nursing was identified. That is, the Ontario Nurses Association Local 036 Collective Agreement has a clause calling for the establishment of a Nursing Liaison Committee to deal with nursing practice issues. This Committee has been meeting on a regular basis. Rather than have two Committees with similar mandates it was agreed that the Nursing Liaison Committee will be asked to incorporate as it sees fit, the proposed Terms of Reference for a Professional Practice Council-Nursing.
Recommendation 2: *The Professional Practice Council-Nursing be comprised of nursing staff representatives from each Service in which nurses work. This mechanism and the Professional Leader-Nursing should commence January 8, 2001 to coincide with the implementation of the program-based structure.*	There was agreement regarding the implementation of this recommendation subject to the provisions specified above under Recommendation 1.
Recommendation 3: *The Medical Officer of Health assign the role of Professional Leader-Nursing to a Service Director who is a nurse, for a two year term. The Professional Leader-Nursing will have dual accountability: to the Council and Directors' Committee. At the end of the two year assigned term, the Professional Practice Council-Nursing will assign the role to a candidate who has the qualifications and attributes established for the role.*	It was agreed that the Professional Leader-Nursing is to be appointed by the Medical Officer of Health (see Recommendation 1 above regarding that aspect of Recommendation 3 dealing with the Professional Practice Council-Nursing). It was agreed not to limit the appointment of the Professional Leader-Nursing to a two-year term. As per the decision in Recommendation 1 above, the Professional Leader-Nursing will be directly accountable to the Medical Officer of Health.

Recommendation 4: *Budget and support staff time be allocated to the Leader and Council to support implementation of their action plan.*	There was agreement in principle that a budget and support staff time are necessary for the Professional Leader-Nursing position to be successful. It was agreed to investigate mechanisms on how best to accomplish this.
Recommendation 5: *All staff at MLHU be oriented to the role of the Professional Leader-Nursing.*	There was unanimous agreement to support this Recommendation.
Recommendation 6: *A formal evaluation of the effectiveness of the roles of Professional Leader and Professional Practice Council-Nursing be completed in the final six months of the second year.*	There was unanimous agreement subject to the decision regarding the Professional Practice Council identified above in Recommendation 1.
Recommendation 7: *A Board Report be given annually, outlining the activities and outcomes of the Professional Practice Council-Nursing and the Professional Leader-Nursing.*	There was unanimous agreement.
Recommendation 8: *Concurrent with implementing the other recommendations, the Middlesex-London Health Unit explore the feasibility of negotiating with other health units in Southwestern Ontario to cost share a full-time Professional Leader-Nursing who would serve all of the cost-sharing health units.*	There was unanimous agreement not to pursue this Recommendation at this time.
Recommendation 9: *MLHU widely disseminate this report to all staff, the MLHU Board of Health, the MLHU Library, all Ontario Health Units, all professional nursing groups and all respondents who participated in the interviews for this report.*	There was unanimous agreement to support this Recommendation.
Recommendation 10: *The Medical Officer of Health disband the Work Group.*	There was unanimous agreement to support this Recommendation.

[1.] For full text of the Recommendations see p. 45

Ms. Diane Bewick, Director, Family Health Services was appointed by the Medical Officer of Health as the Professional Leader-Nursing on March 19, 2001.

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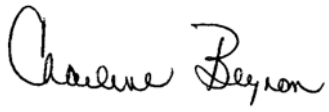
Acknowledgements

A report such as this requires the foresight, commitment and diligence of many people. Specifically, we wish to thank:

- Dr. Graham Pollett, Medical Officer of Health, and Directors for providing us with the opportunity to explore a question critical to how nursing is practiced at Middlesex-London Health Unit (MLHU)
- Nurses at MLHU who shared their perspectives and key informants who agreed to be interviewed
- Kathy Ellis who conducted and analyzed the key informant interviews and provided drafts of preliminary findings
- Heather McHale who collated and analyzed MLHU survey results and provided drafts of preliminary findings.

As the Chair, I wish to express my personal thanks to all members of the Work Group. Each member participated fully in the process, including writing sections of the report and critiquing the text. In addition, I wish to specifically recognize:

- Sharon Mytka, who, in addition to her role as a Work Group member, assisted us with the final edits and
- Nancy Forbes who provided invaluable administrative support throughout the entire project.



Charlene Beynon
Chair, Senior Nurse Work Group

Executive Summary

How should professional nursing practice issues be addressed within the new program-based structure being implemented at Middlesex-London Health Unit (MLHU)? This question was answered through a qualitative study done over a three and a half month period by a group of MLHU staff determined to review all options that fit within the given parameters. Ten recommendations have been made as a result of the completed study.

Background

Strategic planning in 1999 led to a new program-based structure designed to maximize multidisciplinary teams and flatten the existing structure, all within existing resources. The realignment of disciplines, teams, divisions and managers led to the realization that without a Director of Nursing position at Senior Management, nursing, as a discipline might not be represented. The Work Group was formed to conduct this study and make recommendations before the new structure was put in place.

Literature Review

Program-based restructuring has occurred in many areas of the health care industry, including many other health units, resulting in concerns that nurses have been distanced from the decision-making levels of their organizations. In recognition of this established concern, the Director of the Public Health Branch/Chief Medical Officer of Health and the Provincial Chief Nursing Officer recommended that a visible nursing leadership position be established in each health unit. The literature reveals no published data on the institution of such a position in Public Health and its outcomes to nurses.

Other sectors, such as acute care, have published their experience, sharing information on the skills, abilities and roles such positions can and should include and the pitfalls encountered. The literature regarding magnet hospitals also yielded good information on the dynamics of an organization that attracts and retains effective staff. Overall, the solution created must have the commitment of all levels in the organization and be carefully crafted to address even the deeper issues over time rather than just the obvious ones quickly. Trust, shared vision and strong nursing leadership and a supportive environment are the keys to success.

Methods

One outside consultant interviewed and analyzed the findings from the key informants, using a semi-structured interview format. Another analyzed the questionnaires completed and returned by MLHU nursing staff. In this way, Work Group members introduced no bias. The results were analyzed for common and recurrent themes and also for diversity of opinions so that a full range of options could be explored in making recommendations.

Findings

From the **Acute Care Sector**, strong support was given for a senior nurse position. This individual provides guidance on professional practice issues, resolves problems regarding nursing roles and liaises with professional nursing organizations. In the acute care sector these positions are held by Master's prepared clinical and leadership experts at senior levels. Role clarity and evaluation are important.

From the **Public Health Sector**, there was overall support for a senior nurse role. Responses varied due to the diversity of solutions implemented and their lack of formalization. Responsibilities were relatively consistent with those in the acute care sector regarding responsibilities, such as bringing nursing issues to senior management. Moreover, they strongly identified a need for flexibility in a constantly changing environment.

Key informants from the **Provincial and Professional Organizations** interviewed were able to share extensive information on the role, selection and recruitment and advantages of having a senior nurse position. Consistent with the acute care sector, they felt responsibilities should include issues related to standards of nursing practice and nursing educational opportunities, resource allocation and liaison with and advocacy for nursing.

MLHU Nurses support the need for a senior nurse position to ensure that the nursing voice is at the decision-making table and that the quality of nursing practice is protected and maintained. Role definition and collaboration were identified as both a challenge and a necessity. MLHU nurses see this position being at the senior level, held by an incumbent educated at the Master's level with a strong nursing background.

Discussion and Implications

Both external key informants and MLHU nursing staff indicated overwhelming support for a formalized senior nurse position that has decision-making authority at the senior management level. Leadership qualities, relevant experience, and graduate education are the requisites for this nurse leader position (Comack, Brady & Porter-O'Grady, 1997). Role clarity, with clear levels of authority, accountability, and working relationships, is important to ensure successful implementation of the nurse leader role. (Brittain & Langill, 1997)

Both the external and internal respondents recognized evaluation and organizational support at all levels were essential elements to sustain the senior nurse role. Organizational support was also identified as a major challenge. The Work Group recognized that whatever mechanism was put in place, the person(s) responsible would be accountable to the nurses working in the agency as well as to the agency.

Along with need for visible, cross-disciplinary support, they decided that a mechanism for ensured nursing representation at the senior management level was imperative. The Work Group also discussed the feasibility of one mechanism/role that would serve several health units or even the entire region.

Recommendations

The Work Group recommends that:

1. A Professional Practice Council-Nursing and a formal role of Professional Leader–Nursing be created.

2. The Professional Practice Council-Nursing be comprised of nursing staff representatives from each service in which nurses work. This mechanism and the Professional Leader - Nursing should commence January 8, 2001 to coincide with the implementation of the program-based structure.

3. The Medical Officer of Health assign the role of Professional Leader–Nursing to a Service Director who is a nurse, for a two year term. The Professional Leader-Nursing will have dual accountability: to the Council and Directors' Committee. At the end of the two-year assigned term, the Professional Practice Council–Nursing will assign the role to a candidate who has the qualifications and attributes established for the role.

4. Budget and support staff time be allocated to the Leader and Council to support implementation of their action plan.

5. All staff at MLHU be oriented to the role of the Professional Leader-Nursing

6. A formal evaluation of the effectiveness of the roles of Professional Leader and Professional Practice Council-Nursing be completed in the final six months of the second year.

7. A Board Report be given annually, outlining the activities and outcomes of the Professional Practice Council-Nursing and the Professional Leader–Nursing.

8. Concurrent with implementing the other recommendations, the Middlesex-London Health Unit explore the feasibility of negotiating with other health units in Southwestern Ontario to cost share a full-time Professional Leader–Nursing who would serve all of the cost-sharing health units.

9. MLHU widely disseminate this report to all staff, the MLHU Board of Health, the MLHU Library, all Ontario Health Units, all professional nursing groups and all respondents who participated in the interviews for this report.

10. The Medical Officer of Health disband the Work Group.

Introduction

"…challenge what is, incite what could be and help imagine a world that is not yet imagined," (Fine, 1994, p. 23).

This report seeks to address the question: How should professional nursing practice issues be addressed within the new program-based structure being implemented at Middlesex-London Health Unit (MLHU)? A Work Group was convened to address this question. It was understood from the outset that the proposed solutions must be found within the existing staff complement and that creating a new position was not a viable alternative at this time. Although Work Group members initially focused on the potential role for a senior nurse position, they were committed to examining a variety of options and to proposing recommendations that would best meet the needs of MLHU.

The report includes 10 recommendations developed by the Work Group. These recommendations are based on:

- A review of the literature
- Responses from an e-mail survey of nurse managers in other Ontario health units
- Interviews with key informants in acute care, public health, academia, and provincial nursing organizations
- An interview with the Provincial Chief Nursing Officer for the Province of Ontario
- Correspondence from the Nursing Action Team (MLHU) and
- Input from nurses at MLHU including program managers who are nurses.

A qualitative approach was selected as it is best suited to an in-depth analysis of complex and multi-faceted issues. A consensus approach was used to develop the recommendations. When consensus could not be achieved exceptions are noted. Project limitations are identified and the report concludes by identifying an action plan through its recommendations.

The timeline to complete the task was restrictive – August 30 until December 13, 2000. Nevertheless, the evidence collected and the resulting recommendations offer Middlesex-London Health Unit a solid foundation on which to take action. In addition, the action plan provides an opportunity to demonstrate leadership and innovation within Ontario's public health system.

Background

Precipitating Events

In 1999, the Board of Health of the Middlesex-London Health Unit (MLHU) initiated a strategic planning process to revisit the health unit's vision, mission, principles and values. The process was facilitated by an external consultant and involved front line staff, middle and senior managers, the Medical Officer of Health and board members. Three distinct areas of effort were identified that focused on:

- Developing a planning framework
- Enhancing communication strategies, and
- Reviewing the organizational structure.

The outcome of the third area of effort was the creation of a new organizational structure.

A New Organizational Structure

The following parameters for the new structure were identified at the outset by the Medical Officer of Health. The new model would:

- Be program-based, with a more even distribution of resources in contrast to the current discipline-based structure
- Where appropriate, maximize multi-disciplinary teams
- Be flat/horizontal, i.e., no more than two layers of management; and
- Be accomplished within existing resources.

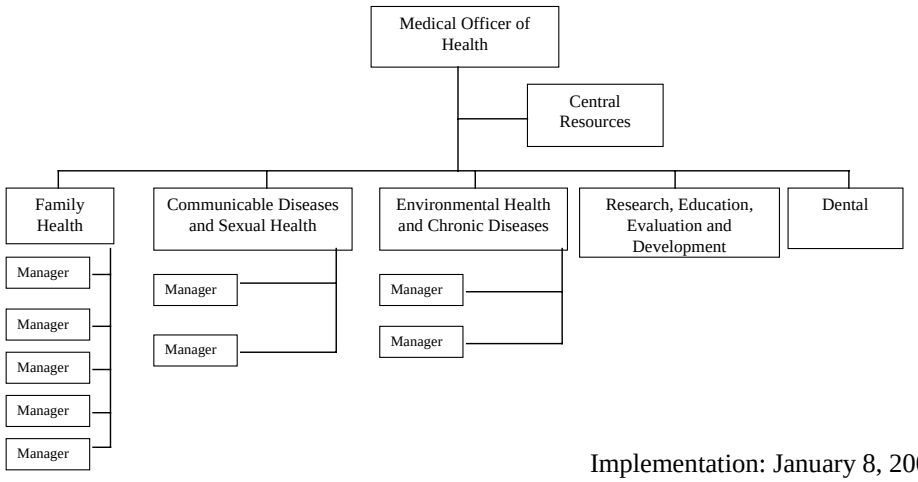
The external consultant, noted above, facilitated a brainstorming session with all managers to explore possible program groupings in a new organizational structure. Following this exercise, Directors reviewed organizational models from 17 health units, which had responded to a request from the MLHU Medical Officer of Health to share their organizational structure. Directors, then continued to examine, critique and customize possible structures to meet local needs. The end result was a structure consistent with the above parameters that was subsequently endorsed on June 15, 2000 by the Board of Health (see Figure 1).

An Emerging Issue

With the shift to a program-based structure, it was important to ensure that a nursing perspective and a strong nursing presence continue. A commitment was made at the outset by the Medical Officer of Health to have a "senior nurse position". However, without a designated Director of Nursing position, concern existed that there could be a potential lack of nursing leadership at the senior management level. In addition to discussion at the senior management level, this issue was further discussed with nursing managers and nursing staff as well as with the local

Figure 1

Middlesex-London Health Unit
Organizational Structure



Implementation: January 8, 2001

executive of the Ontario Nurses Association at specially convened meetings with the Medical Officer of Health (See Appendix A)

The Director, Education & Research (since renamed Research, Education, Evaluation & Development (REED) Services) and the Director, Public Health Nursing were directed by the Medical Officer of Health to explore this issue in collaboration with the Ontario Nurses Association local, with the understanding that the current nursing complement could not be increased. Because the Director, Public Health Nursing perceived the possibility of a potential conflict of interest, she withdrew from the process shortly thereafter, but remained available as a resource. In contrast, the Director, Education & Research agreed to continue. Although this latter position is held by a nurse, this Director did not identify a conflict. It was the incumbent's assessment that the current scope of the Education & Research position precluded her from assuming a "nursing" portfolio in the new structure.

Work Group

A Work Group was formed with representatives from ONA, and additional members were recruited from nursing staff and nurse managers. Administrative assistance was provided through the Education & Research Division. Work Group members selected the Director, Education & Research as their Chair (See Appendix B for Work Group members). The Work Group acknowledged that their outputs could serve the needs of other public health disciplines but due to the proposed implementation date of November 15, 2000 for the new structure and because the Work Group's issue focused on the need for nursing leadership, they decided against inviting other health unit disciplines to join the deliberations.

The Work Group identified the importance of reviewing the literature and learning from others' experiences. Members also articulated that MLHU nurses were experiencing a variety of feelings about the shift to an organizational model that no longer included a Public Health Nursing Division. Recognizing this context and the need for credible and sound recommendations, the Work Group determined that the group's mandate would be more fully realized if the data collection and preliminary analysis were done by an external third party with no vested interest in the outcome.

Terms Of Reference

Progress was delayed while a common understanding was reached between the Work Group's proposed action plan and the expectations of the Medical Officer of Health. Clarification focused on the potential scope of responsibilities and the organizational level for a position that would address nursing leadership issues.

As a result of ongoing dialogue and revisiting the issue at Directors' Committee, the Work Group was advised to proceed, and to include the Acting Manager of Human Resources & Labour Relations as a member. Early in the Work Group's development, one nursing representative asked to be replaced due to other competing demands and was replaced by another nurse who volunteered. Later, a permanent Manager of Human Resources & Labour Relations was hired and joined the group, replacing the Acting Manager.

Directors also requested that the Work Group develop explicit Terms of Reference consistent with the parameters they had been given and that they share these Terms of Reference with all nurses at MLHU (See Appendix C, Terms of Reference). The date of full implementation of the new structure was rescheduled to January 8, 2001; subsequently, the time line for the Work Group was extended to December 31, 2000. It was agreed that the recommendations would be developed from the literature and the experience of others and would be presented to Directors' Committee. The Work Group decided to present their report and recommendations to Directors' Committee at its December 13, 2000 meeting.

Literature Review

Overview

In recent years health care organizational structures have been undergoing rapid change. The trend is towards a flatter hierarchy with emphasis on flexibility, cost-effectiveness, efficiency, and partnership. Many health care facilities have moved from departmental organizational structures to program-based management models. Consequently, nursing divisions and many nursing management positions have been eliminated (Sorells-Jones, 1997).

These structural changes have raised issues within the nursing profession regarding the effect on nursing leadership (Registered Nurses Association of Ontario, 1999; Young, Ang & Findlay, 1997). The main concerns are the maintenance of nursing standards and practice, nursing representation at the senior management level, and the linkage to external communities (Ross, Macdonald, McDermott & Veldhorst, 1996). Examples of external communities are the academic community, other health care sectors and all levels of government.

A Nursing Task Force established in 1998 primarily focused on the nursing profession and its impact on the quality of health care in Ontario. The Task Force's final report, "Good Nursing, Good Health: An Investment for the 21st Century", presents eight recommendations to the Ministry of Health. The second recommendation states:

> *In order to improve patient outcomes and the level of nursing services provided to consumers, it is recommended that ongoing structured opportunities be provided for RNs and RPNs to participate in a meaningful way in decisions that affect patient care on both a corporate and an operational level. In addition, health care delivery organizations must ensure that there is specific responsibility and accountability, at a senior management level, for professional nursing resources. It is also recommended that this be achieved through amendments to relevant legislation. It is recommended that the Ministry of Health work with health care facilities and educational institutions to ensure nurses are prepared for their on-going leadership roles* (Ontario Ministry of Health and Long-Term Care, 1999 Appendix J).

In response to the Nursing Task Force's recommendation, Dr. Colin D'Cunha, the Ontario Chief Medical Officer of Health and Kathleen MacMillan, the Provincial Chief Nursing Officer proposed the creation of "a visible *(nursing)* leadership position with the Public Health Unit" (A memorandum to Medical Officers of Health re: Public Health Nurses, Ministry of Health and Long-Term Care, 2000) (see Appendix D).

The Nurse Leader

A recent literature search found no published articles on the topic of nursing leadership in public health units that have restructured to program-based practice. Articles reviewed were from acute or long-term care facilities. The nursing leadership positions in these settings were diverse with varying titles, role expectations, responsibilities, and accountability. For example, the BC Rehab has created a practice leader who is involved in decision-making. Responsibilities of the practice leader include establishment of nursing standards of practice, student education, staff development, clinical service and research. This position reports to and is accountable to the Vice-President of Rehabilitation and Residential Program (Young et al., 1997). In contrast, The Academic Medical Centers in Virginia have implemented a 'professional nursing staff' position that is a staff role and has no administrative responsibilities. It focuses on discipline-specific practice issues and standards. This position is responsible to the patient care services administrator (Sorrells-Jones, 1997).

The suggested personal qualities and skill sets required by the nurse leader in the reviewed literature are similar despite the differing placement of the position in the hierarchy. They are vision, creativity, sensitivity, honesty, integrity, enthusiasm, and excellent problem-solving, collaborative, change agent and communication skills (Adamson, Shackleton, Wong, Prendergast & Payne, 1999; Comack, Brady & Porter-O'Grady, 1997). Ross, Macdonald, McDermott, & Veldhorst, (1996) suggest that the nurse leader have a Master's degree in nursing as a minimum qualification and also have advanced knowledge in nursing research and practice, and contact with nursing and community organizations.

Magnet Hospitals and Nursing Leadership

The concept of "magnet hospitals" was first described in the USA. Such hospitals create a culture and working conditions that serve to attract and retain nurses, even in times of nursing shortages. Over a period of two decades, studies of these hospitals have further shown that they have lower mortality rates, higher patient satisfaction and lower rates of nurse burnout than do hospitals without magnet status (Buchan, 1994, 1999; Mason, 2000). Nursing leadership was identified as one key factor contributing to the magnet status in these hospitals. These nursing leaders were consistently described with the following attributes:

- *Visionary and enthusiastic*
- *Supportive and knowledgeable*
- *Maintains high standards and high staff expectations*
- *Values staff education and professional development of all nurses within the organization*
- *Upholds position of power and status within the hospital organization*
- *Highly visible to staff nurses*
- *Responsive and maintains open lines of communication*
- *Actively involved in state and national professional organizations* (Scott, Sochalski and Aiken, 1999, p.10).

These qualities are congruent with the characteristics linked to transformational leadership (McDaniel and Wolf, 1992).

Major challenges in implementation

The creation of a Nurse Leader role can be an important part of the organization's plan for restructuring. The shift to program-based management creates both new structures and new working relationships within the organization. Successful implementation requires a well thought out strategic plan. Some strategies used to encourage communication and staff participation in the change process include forums, dialogue sessions, professional practice committees and nursing practice councils. Clear role descriptions and lines of accountability and authority minimize ambiguity and promote cross-functional teamwork (Brittan & Langill, 1997).

Adaptation to cultural change consumes energy (Rose & Reynolds, 1995). Comack et al. (1997), commented that "impatient for improvement, many people design superficial structural changes that leave deeper problems untouched" (p.39), and thus lead to confusion, fear and resentment. Trust, shared vision, strong leadership, a supportive environment, and the commitment to change at all levels are key elements to successful transformation when working in a new organizational structure (Bournes & DasGupta, 1997; Comack et al., 1997). The nurse leader position can help to establish these critical elements. Ongoing review and evaluation of the effectiveness of the nurse leadership role within the new organizational structure will ensure early identification and resolution of problems (Adamson et al., 1999).

The issue of compensation and rewards for such a position remain unresolved in the reviewed literature (Comack et al., 1997; Hoffart & Woods, 1996).

Methodology

As the Work Group set about planning how best to accomplish their task, they quickly realized that the short timeline for the study was a key determinant of the methods they would use. Recognizing the value of tapping into the wisdom of others who had experience with similar issues in other health care areas, the group decided to utilize key informant interviews as the main tool for data collection from external sources. The literature review had revealed that most of the documented experience with senior nurse positions rested in the acute sector of health care. A roster of possible key informants from this sector was drafted. Information was also needed from other Ontario public health units. A list of possible health units, their Medical Officers of Health and nursing contacts was also generated. The Work Group identified that provincial nursing organizations were likely to have a broad perspective on what worked when creating mechanisms for attending to professional nursing issues; a list of contacts in provincial/professional nursing organizations was drafted. Equally important was the need to know what the nurses at the Middlesex-London Health Unit (MLHU) believed would work for them in their setting. Therefore, the Work Group decided to distribute a self-administered survey to all nurses at MLHU. For a variety of reasons, but especially because of the need to eliminate bias and to complete the task in a timely fashion, the Work Group arranged for an external consultant to conduct the key informant interviews, analyze data from the survey tools and bring preliminary findings to them. Similarly an external consultant was hired to analyze MLHU survey responses and to identify findings.

The Work Group developed both the internal and external survey tools (Appendix E). All tools were pilot tested by members of the Work Group and revised to ensure that questions would be clear in meaning to respondents. The *external* survey was a semi-structured telephone interview, administered to key informants identified by the Work Group. There were two exceptions to the external survey. One respondent was interviewed in person and the second respondent returned comments by fax, as it was not feasible to schedule an appointment. All interviews were conducted between October 13 and November 2, 2000. The *internal* survey consisted of a semi-structured, self-administered written questionnaire given to all nurses at the Middlesex-London Health Unit.

External Survey

Semi-structured telephone interviews were conducted over a three-week period with key informants from three health care sectors (Appendix G).

This convenience sample included seven participants from public health, representing four health units; four participants from the acute care sector; and five participants including Ontario's Chief Nursing Officer from professional/provincial nursing organizations. All informants agreed to be interviewed. It should be noted that the interview respondents were selected on the basis of their knowledge and varied experiences with the topic. Interviews lasted approximately 30 minutes and were audiotape-recorded with permission. There was one exception and that interview was done in person and not taped. Introductory letters (Appendix F) were sent by fax in advance of the interviews. Shortly thereafter, an Administrative Assistant from Research, Education, Evaluation and Development Services made a follow-up telephone call. A time for the telephone interview was scheduled and the questionnaire was sent by fax. Responses to questions were transcribed and sent by email to the respondents to ensure perspectives were accurately represented.

There were two key informant questionnaires (Appendix E): one for the provincial representatives and one for all other participants. The provincial questionnaire was broad-based and asked questions related to: the pros/cons of a senior nurse position, organizational fit, reporting structure, responsibilities, supports, skill sets, and process for recruitment and selection. The second key informant questionnaire included specific questions related to whether a senior nurse position existed in their organization, particulars about the position, role expectations, supports, strengths/limitations of the role, evaluation, and how practice issues were handled. Both tools invited additional comments at the end of the interview. The Work Group advised the consultant to probe as needed to seek clarification of respondent comments.

Internal Survey

In October 2000, 117 nurses including nurses in management positions, at the Middlesex-London Health Unit, were sent a questionnaire with a covering letter explaining the survey and a return envelope. All questionnaires were placed in each nurse's health unit mailbox. In addition, a voice mail message about the survey was sent to each nurse to ensure that all nurses at MLHU, including casual staff, were aware of the survey. The questionnaire took approximately 20-30 minutes to complete. All responses were anonymous. Nurses were asked to complete the questionnaire within a one-week time frame. Two reminder phone messages were sent to all nurses in the organization and an extension of one week was given to ensure as many respondents as possible returned the questionnaire. When the questionnaire was completed, the nurse placed it in a labeled box in the Public Health Nursing Division mailroom.

The internal questionnaire included questions specific to the role of a senior nurse, the qualifications, skill sets, process for selection, and support systems required for the position (Appendix E).

Analyses

The focus of analysis was to gain a broad understanding of how nursing practice and professional issues were addressed in the health care sectors represented. The consultants treated all raw data collected from both the internal and external surveys as confidential. Responses to each question were reduced to individual units of text or phrases conveying individual concepts and were summarized within each health care sector. Themes were identified from the observations, comments and suggestions of the respondents as they pertained to topics such as: recruitment and selection of a position(s) responsible for addressing and resolving on an ongoing basis, issues related to the discipline and practice of nursing; roles and responsibilities; skills necessary to be successful in the role; organizational supports for the role; and strengths and limitations of the role. Common and unique themes were identified and compared both within each sector and across sectors. All summarized data were reviewed by the Work Group and recommendations were developed.

Results for the semi-structured interviews and questionnaires are presented in the following pages in four sections, on a question-by-question basis: Acute Care Sector, Public Health Sector, Provincial/ Professional Organizations and the Middlesex-London Health Unit nurses. As a means of adding support to the identified themes, individual quotes that best represent the theme are included.

During the course of the project, the Work Group received additional sources of information to contribute to their deliberations. This information is included in the section titled *Other Sources of Data Collection.* The results in the following sections represent the full range of responses.

Results

Acute Care Sector

Four individuals with nursing backgrounds, differing experiences and roles in large acute care centres were interviewed for this section. Two respondents are currently in positions related to nursing practice, and two who are not currently in senior nursing practice positions represent broader perspectives regarding acute care. All of the respondents have experience with a senior nurse position. Three acute care centres are represented by these interviews. All of the centres underwent restructuring from a discipline-base to a program-based structure more than three years prior to the interviews.

Three of the four respondents stated a preference for a program-based, interdisciplinary model for acute care, although their experiences and observations about nurses reporting to non-nurse managers are varied. Two of the respondents strongly advised against this potential outcome of a program-based system, their reason being that non-nurse managers simply do not understand the complexities of nursing practice.

> *We've done that here, and it doesn't work. In a clinical setting, it doesn't work.... At a clinical level, if you have people who are functioning as clinicians and the bulk of them as nurses, and you have non-nurse managers, they don't understand what the nurses do. [these individuals are] Master's [degree] prepared people and very good people, like people who are clinicians in their own practice, and excellent managers. And it doesn't work and they are no longer in these roles.... They don't understand the practice .. the practice is so complex.... The kinds of things you do as a nurse, the assessment, the nursing care plan.*

The other two respondents, acknowledged that dealing with issues related to this outcome (nurses reporting to non-nurses) is part of the senior nurse role and did not describe it as problematic.

> *It can be an issue, that's where I am often consulted. It would not be uncommon for a nurse in the area to call me, for example, if the manager is a social worker. And they call me, both the manager and the* [nurse]*. I am actually consulted more frequently in that area than other areas... And mostly because the manager is very encouraging to call... So they may call and say they have a question about standards, or they can't have that level of dialogue with the manager. So a lot of times, that's what these* [professional practice leader] *roles do, is support nurses.*

Senior Nursing Position and Nursing Practice Committees

All four of the respondents strongly supported the need for a senior nursing position. Two of the acute care settings have formalized, full-time positions devoted to nursing practice issues. One of the respondents, in one of these settings, is in a senior nursing position, with the role of providing leadership for nurses within the multidisciplinary hospital setting. A respondent from the third setting has formalized responsibility, on a part-time basis, for facilitation of practice committees for both nursing and non-nursing professions (e.g., physiotherapy, occupational therapy, nutrition, social work).

As three of the respondents described the roles and responsibilities associated with a senior nurse position in their respective centres, it became very clear that professional practice committees at each site also play an integral and ongoing part in ensuring that practice-related issues are addressed. Senior nurse positions function as either heads of these committees, and/or are members of cross-disciplinary committees. In one case, a nursing practice committee, composed of front-line nurses and nurses representing other nursing roles, predated the move to a program-based model. This committee was responsible for customizing a generic job description for a professional practice leader to address the nursing practice needs within a new, program-based structure. Further, professional practice committees associated with nursing and other professions were described as key to a smooth transition from a departmental approach to an interdisciplinary team approach. One respondent described the importance of the professional committees during the reorganization to a program-based structure:

> *When we started into the program structure, everybody was just .. you can imagine, we used to have department structures and people thought, "Oh my .. I am going to have my identity stolen away", and "I won't ever go to an educational conference again because my manager will never understand why I need to go to it." It was just huge. So a lot of*

> *what we did at the beginning of our work was work with managers to create principles of how teams could make decisions with reasonable and equitable principles,* [and] *still provide for those opportunities for within discipline.*

Responsibilities, Roles and Expectations

In response to the question, *What are the role expectations for this position?* a wide variety of roles, responsibilities and expectations were described. Utmost was the recognition of the need for professional support, at a senior level, for nurses. "Supporting nurses professionally with a strong voice" was the typical response. Roles, responsibilities and expectations of a senior nurse position were extensive, and often related to the size and complexity of these multi-site acute care centres. Respondents volunteered their perceptions of the differences between these large acute care environments and the much smaller health unit environment and highlighted some of the consequential issues with which practice leaders deal in acute care environments. These include the number of nursing staff, their varied educational backgrounds and the wide variety of nursing roles and responsibilities. One respondent observed that the wide variety of [educational] preparation led to issues of role clarity.

> *I have currently 1600 plus nurses that I am accountable to.*

> *I think preparation is an issue. In the health unit, if my interpretation is accurate, is that there is a higher level of preparation. So all of the nurses are baccalaureate prepared, whereas in the hospital systems we deal with more of a range of preparation. So role clarity and role blurring issue come up maybe more.*

All of the respondents mentioned that encouraging educational opportunities for nurses was part of the role supporting nursing practice. The position responsible for practice issues was described as needing to understand the variety of contexts in which nurses work. This requires talking to nurses in their various work environments, asking the right questions around issues, such as how standards are applied, or discussing the rights of sedated patients, or of resident/non-resident patients of the facility.

> *Another difference is the wider range of nursing roles in the acute care centres. It's really being able to think. I am not an emergency nurse and I am not a long-term care nurse from my clinical background days. And yet I need to be able to apply the practice, understand the environment, listen to the people, and understand context. Although I am not a content expert, I am a* [nursing] *context expert ...*

In general, the role of the senior nursing leader (or professional practice leader) involves providing leadership for nursing and promoting the discipline through interdisciplinary teamwork, within the context of the organization's mission and goals. These duties span broad areas of interdisciplinary teamwork, education, discipline-specific practice development, and regulatory functions. One job description outlines the roles of a senior practice leader in the acute care organizations to include:

- Collaborates with interdisciplinary teams to address systems issues related to the practice of nursing and patient care
- Represents nursing on the interdisciplinary [team]
- Assists teams to understand the contribution of nursing to specific patient outcomes
- Works collaboratively to develop a model of education which supports nursing development and agreed upon patient outcomes
- Ensures there is a system for integration of students into patient care teams for learning
- Maintains collaborative relationships with colleges, universities and other academic bodies
- Ensures there is a system to facilitate continuous inquiry and learning by nurses
- Provides leadership within the discipline at the community level
- Acts as a mentor and facilitator for [the nursing practice committee]
- Foresees implications of impending legislation, professional standards and trends in practice and facilitates appropriate action.

It should be noted that the responding acute care organizations have generic professional leader job descriptions that have been adapted to specific disciplines. The role of the nursing leader includes consulting on problematic issues and finding resolution through common agreement, interpreting standards of practice, ensuring that the standards are understood so that appropriate decisions can be made, participating in provincial and national professional organizations, sitting on College of Nurses committees, encouraging nurses to take advantage of educational opportunities and, in general, helping nurses understand their role.

Organizational Supports

The senior positions described by these respondents are all formalized, with written job descriptions (full-time at two sites, part-time at the third) and report to at least a vice-president level (patient care, nursing) or higher. Integral to feeling supported is a close relationship between these senior nurse positions and their supervisors, who clearly understand the senior nurse position's role:

> *I would say that having a close relationship… is very important. I have strong support from the person I report to in terms of understanding my role and having somebody I can knock around issues with. And being very clear about what I need to tell that person and what she needs to tell me.*

One respondent observed that having and meeting with senior positions in other disciplines allows these professions to work together better and serves as an organizational support.

Recruitment and Selection

All of the respondents stated that the successful candidate for the senior nurse position must be a nurse with a background in clinical nursing practice and with leadership experience. One generic job description for a professional practice leader includes discipline specific "Educational/Professional Certification/Registration", that the individual be licensed with their discipline's College and be a member in professional association(s).

Other required skills include:

- Effective interpersonal and group skills
- Demonstrated clinical expertise
- Effective teamwork
- Ability to apply research to practice
- Demonstrated leadership
- Shared decision-making ability
- Demonstrated consultative/collaborative skills
- Strong organizational skills.

Additional requirements for a nursing position include a Master's or doctorate degree, "demonstrated experience in integration of practice, education and research" and "demonstrated skills in facilitation, coaching and mentoring", "have a clear understanding and delineation" of the differences between operational and professional practice issues; have "wonderful professional presentation skills", and be "prepared to look out of the box and find new ways of addressing professional practice issues separate from operational issues."

Strengths and Limitations of Senior Nursing Positions

Because these positions are formal, with written job descriptions, responses to the question, *What do you see as the strengths and limitations of this role?* are less specific than those identified in interviews with other sectors of health care. One strength identified is being a member of interdisciplinary teams, which facilitates resolution of issues as well as understanding and communication across disciplines. Being in a senior position and one in which the supervisor (e.g., a vice-president) understands the role clearly is also identified as a strength. One respondent views being full time in her position as a strength: "I think we have more of a focus on nursing here because this is my full-time job to attend to nursing, and … how nursing fits within the context of a full interdisciplinary team."

These positions are described as challenging; role clarity of the position is an issue, at times, in these organizations that are large and multi-site. The most consistent limitation mentioned is having the time to address everything that needs to be addressed.

Evaluation of Senior Nurse Positions

There was a mixed response to the question, *Has the effectiveness of this role, i.e., not the person holding the position, been evaluated?* One respondent described evaluation in the form of developing goals for each year and discussing her accomplishments during an annual appraisal. Another respondent identified that a nursing practice committee established outcomes for the integration of nursing leadership across agency sites. These outcomes included a stronger voice for nursing as well as influence, continuity, and consistency across the sites. Role clarity is considered very important because, as one respondent stated: "You can't have accountability until you know what your role is". This respondent goes on to say:

> *Some of the dilemmas are issues of confusion. Because of the large organization and because the role is confusing, … I get asked the question* [What is your role as professional practice leader] *a lot. It's not like if I am a director, I could say to people "I am a director".… So* [evaluation includes] *Are you*

hearing what you need to be hearing, or being in the right places.

Anticipation of Changes to the Senior Nurse Positions

One respondent did not anticipate any changes to the part-time portion of the position addressing nursing practice issues. Another respondent indicated that her role is changing and adapting in response to continuing changes in the acute care sector (e.g., mergers, new roles).

> *... and we have to keep redefining ourselves based on what the need is and* [we] *can't keep doing the same thing. It's a matter of still coming together and being clear about what the need is and not holding on to the old. Making sure we have systems and people in positions to deal with that.*

Advice and Suggestions for MLHU

The respondents acknowledged that there are professional challenges when a health agency changes from the traditional discipline-based to a program-based structure. They strongly recommended that a position dedicated to addressing nursing practice issues be put into place. One respondent suggested that the health unit try a model for two or three years. Other observations included the need for organization-wide support for the position, and making sure that the "right" person is put into the position.

> *It has to be a position that is supported by the entire institution, including the physicians. Because of course, at our place they are the big drivers of the system. So it's one thing to have nursing think this is a good idea, but you have to have doctors on board.*

> *… its all in getting the right people in the right place. .. It is all in the person they put at the top, in the* [nursing] *leadership position, whether she will make it. And around her attitudes and needs, how people view this whole role. If people come into it negatively, it won't work. If people come in seeing an opportunity with this new model, outside of line control, they will make it work.*

> *It's hard when you've had a very traditional organizational structure. My recommendation would be that the health unit try a model for two or three years and see if there is a difference. I don't think they will be unhappy. .. I think they could make it work.*

Summary of Responses from the Acute Care Sector

All four of the respondents strongly supported the need for a senior nurse position whose role would be to support nursing practice issues. Such roles exist in the three multi-site acute care centres represented. Respondents described two full-time and one part-time formalized senior positions, supported by written job descriptions, and reporting to the vice-president level or higher. The roles and responsibilities are extensive and include providing leadership for nursing, and promoting the discipline of nursing through interdisciplinary teamwork with professional practice leaders of other professions. Respondents reported that a large nursing staff, with varied educational backgrounds, provides unique challenges to the senior nurse positions in their acute care settings that may not exist in health units. Nurses in these leadership positions provide guidance related to standards of nursing in a variety of contexts, help resolve problems with regards to nursing roles, liaise with the College of Nurses and other professional organizations, liaise with educational institutions, and suggest educational opportunities for nurses. Their ideal candidate would be a nurse with a Master's degree and a background in clinical nursing and strong leadership skills. Also seen as essential are strong interpersonal and group skills, experience in integrating and applying nursing practice, education and research, and being able to "think outside of the box and find new ways of addressing professional practice issues".

The senior nursing positions described by these respondents are all at senior levels within their organizations. Described as essential to their success, is a good relationship with their supervisor who has a clear understanding of the senior nurse role. Participation in committees with professional practice leaders from other disciplines is described as a strength. Occasional lack of role clarity and lack of time to address all of the relevant issues in the job are some limitations. The need for evaluation of the position is recognized as important, and is formalized in one case. One respondent suggests that her role will change and adapt as the whole organization goes through changes. Finally, the respondents acknowledge that there will be nursing practice challenges facing the MLHU in moving to a program-based structure.

Public Health Sector-Senior Nurses and Medical Officers of Health

Health Unit Structure

Four of the five health units[1] represented through these interviews had gone through a process of restructuring from a discipline-base to a program-base, usually involving the creation of multidisciplinary teams. Nurses are members of program teams, reporting to the managers of those teams, across the organizations. There is one exception in which the respondent is responding from a provincial perspective and also is in a senior nursing position at a health unit that has retained a discipline-based structure. It is apparent that, in three of the health units, the process of restructuring is ongoing and organizational change is constant.

1. one respondent provided a provincial perspective in addition to experiences in her health unit.

Senior Nursing Position?

Of the four restructured health units, none have identified formal positions responsible for addressing and resolving, on an ongoing basis, issues related to the discipline and practice of nursing. However, all have some informal mechanism in place, whether as part of one director's position, or a shared responsibility, or in combination with senior managers who are nurses and/or a nursing practice committee. At one agency, the nursing practice responsibilities are shared among two directors, two community nurse specialists, and a nursing task force committee. This health unit also has nurse managers who provide consultation to non-nurse managers. At another health unit, the senior managers who are nurses advise the non-nurse director on nursing practice-specific issues. This health unit also has a division director who is a nurse and brings nursing issues to the senior management team. Some of the diversity across health units appears to be related to the ongoing evolution of health unit structures, resulting in interim solutions. Even a simple response to the question, *Is there a position(s) in your organization responsible for addressing and resolving on ongoing basis, issues related to the discipline and practice of nursing?* is contradicted within health units. In one health unit, the Medical Officer answered 'Yes', while the nurse, a Program Director whose informal duties include dealing with nursing practice issues, responded, 'No, not at this time'. In another health unit the Medical Officer responded that there is not, while the nurse replied that such a position does exist. Perceptions differ as to whether the position/role of dealing with nurse practice issues is formalized in a job description, or informal, under 'other duties'. Those positions situated at the level of a division director report to their respective Medical Officers of Health and also are members of the senior management or executive committees of their health units. Middle managers who deal with nursing practice issues report to their division director. The community nurse specialists are described as being front line members of specific multidisciplinary teams.

> *I wouldn't say* [it's a position per se]*.... And it's changed over time. But currently it's a small part of my role and a small part of another director's, and a small part of two positions we have which are community nurse specialist positions. And that group has together a cross-divisional working group called a "Nursing Task Force Group". And they meet periodically. And in that forum we raise any nursing issues, any nursing policy issues, and deal with it there.*

> *No. We have identified people within senior management who take the lead in discipline – based problem solving.* [The] *Leader for nurses is a nurse and a* [division] *director.*

> *She* [Director of Health Promotion] *has reporting to her several managers who supervise nurses who deliver our programs. So she is working in conjunction with her managers* [and] *certainly provides expertise in the professional nursing area.*

Responsibilities/Role Expectations

All four of the restructured health units describe generic senior management positions: being a nurse is not a requirement. At the senior management meetings, these directors represent the interests of both the nurses and non-nurses who work within their divisions. All four health units have at least one nurse as part of their senior management structure; several have non-nurse directors who have nurse-managers reporting to them. At the discipline-based health unit, a senior nurse represents both nursing and nutrition practice issues at the senior management level. This respondent acknowledged that representing other disciplines is a challenge. With the exception of one discipline-based health unit, addressing and resolving issues related to nursing practice issues is a part-time role. In addition to bringing nursing practice issues to the

senior management committee, other role expectations include:

- Liaise with the College of Nurses around policies and standards for nursing
- Understand and ensure the Regulated Health Professions Act is followed
- Bring issues related to other disciplines from assigned program areas to the senior management committee
- Communicate with nurses across organization when need arises
- Other duties as needed; this may include being a member of a nursing practice committee.

The Role of Nursing Practice Committees

Several of the respondents made references to nursing committees; one restructured health unit described a formalized committee that includes managers who are nurses from each division and staff nurses from each division, who act as representatives for their sections. Activities of the committee include: bringing nursing practice issues for discussion and resolution, sharing information about new practices, considering new kinds of initiatives that are happening someplace else; looking after special activities such as "Nurses' Week", and responding to requests from external nursing organizations. This committee also addresses specific issues, such as the need for additional training, or gaps in nursing services (e.g., bilingual nurses). Committee recommendations and requests that require senior management input are brought to senior management by a division director who is also a nurse.

> *What I think works well is that people have a forum to get together and identify issues if there are any … so they feel that it is not pushed under the table, it is dealt with, things will happen if required. They feel that someone is at least looking after 'it' so to speak. And it's a forum where there is cross-fertilization across programs. … Because when you go to a program-based interdisciplinary structure, you get so scattered. And for them [the nurses] they can connect a little bit.*

Recruitment, Selection, and Necessary Skills for Position(s) to Address Nursing Practice Issues

The four program-based health units demonstrate variation in their processes for recruitment and selection of individuals to address nursing practice issues. In one health unit, the senior management committee made decisions about the need for a position and its requirements; while in another agency, nurses in management identified gaps and the need for a role related to nursing practice issues. In all four restructured health units, selection was from within an existing group of nurse managers, or by 'mutual agreement' between the two nurse directors to continue an existing role. The respondents identified the skills necessary for someone in the role(s) of addressing nursing practice issues. These include being a nurse who has worked in the public health environment and, therefore, can identify issues important to public health. Other necessary skills are: an understanding of the nursing profession in its broadest sense, the legal environment, the rules and laws under which nurses function, and the Regulated Health Professions Act.

> *..I think it fits under that category of "other"... It's where your job description gets particularized for you. Like you would never recruit for that if I left.*

Organizational Structures in Place to Support the Role

Given the informal nature of the roles addressing nursing practice issues in the four restructured health units, it is not surprising that the descriptions of organizational structures supporting such roles also vary. However, in response to the question, *Are there organizational structures in place to support this role?*, all of respondents mentioned the importance of having nursing represented at the senior management level, whether the role is informal or formalized. Having a voice, and nursing perspectives recognized at that level is identified as essential. At the time of the interview, one health unit's Medical Officer of Health and a nurse-director were developing a Board of Health report about the need for recognition of discipline-based issues (all disciplines covered by the Regulated Health Professions Act) and planned to include a request for a Board by-law. This by-law would make the role formal and ensure that there is a 'contact person' to bring practice-related issues to the senior management committee; it would not change job descriptions. One respondent viewed having a

nursing practice committee, whose role is recognized and acknowledged, as an important organizational support. Several respondents described how managers or assistant directors who are nurses provide discipline-related advice and assistance to non-nurse managers.

The Strengths of Present Arrangements for Addressing Nursing Practice Issues

The strength of the arrangements in the responding health units rests in having a strong voice at the senior management level. As mentioned above, all of the health units have at least one nurse who is a director. This level of recognition for nursing issues provides validity and recognition at all levels of the organizations. As one Medical Officer of Health stated:

> *At the most senior level, our executive committee* [is] *where there is a forum for discipline-based issues to be raised, given that we have representation from a nurse. So that's very important, and in my view, carries some weight as the director of the H.U.*

Other respondents indicated that despite initial fears related to restructuring, the arrangements have worked well, and that more program-based issues than discipline-based issues arise.

The Limitations of Present Arrangements for Addressing Nursing Practice Issues

The limitations of present arrangements for addressing nursing practice issues within the four restructured health units relate to the informal nature of the arrangements. Limitations include inadequate time and the somewhat "haphazard" nature of dealing with nursing practice issues when they are not a formal part of job descriptions. One respondent identified the need for non-nurse managers to *"know their limitations, what they know and what they don't know.. so they know when they need to consult."* This was acknowledged to be more of a "personality" issue, to be addressed at a job interview. Finally, there is the observation that, at one health unit, the front-line nursing staff *"perceive they are feeling less valued*" since moving to a program-based structure. The senior management committee is trying to address this situation by being responsive to professional practice issues.

Evaluation of the Effectiveness of the Present Arrangement

The health units observed that the mechanisms that they have chosen seem to be functioning but none have designed any formal evaluation. Reasons for this vary from not having the time or resources to do a formal evaluation to, *"I am not sure what else would be an indicator of success other than the quality of the work"*. One respondent described reasons for eliminating a full-time, designated senior nursing officer position in one of the health units.

> [Re: temporary position of Senior Nursing Officer: What were the indicators that lead your organization to know that it was no longer required?] *The more and more we saw what was required in the job, it just got less and less. And the more we thought about it, a lot of the work was "make-work" stuff. No longer.. well, you know, value for money. And I think the incumbent agreed with that at the time. The issues were diminishing, that's all I can say. And there wasn't really enough to occupy a full-time position. When that situation arises, it creates all sorts of problems because then people do need to create issues to deal with. And yet that's a really difficult position sometimes.*

Other Challenges and Anticipated Changes

A variety of challenges were mentioned, including the need to *"articulate what nursing practice issues are versus more general issues related to any discipline"*. This is seen as extremely important in an environment where nurses report to non-nurse managers. All of the health units described almost constant change and an evolution of roles related to nursing practice issues. Factors influencing these changes include both external factors such as municipal amalgamation and internal factors such as nurse dissatisfaction.

Advice and Additional Comments Related to the Public Health Sector

Respondents had additional comments and suggestions related to addressing nursing practice issues in the context of restructuring from discipline-based to program-based. Most are enthusiastic about the outcomes of the restructuring, suggesting that "form follows function" and that a program-based structure is a "much better fit with the mandatory programs in Ontario". Working in

multidisciplinary teams has provided opportunities for nurses to learn other perspectives and other ways of resolving issues; and generic senior management positions provide equal opportunities for all disciplines. Respondents acknowledged that restructuring can be very difficult initially, with nurses wondering: "How will they [non-nurse supervisors] know what I'm doing?" and "How can they [non-nurse supervisors] possibly supervise me when they are not in the same discipline?" and "We speak a different language." It needs to be recognized, from the outset of restructuring to a program-base, that there are practice-related issues that must be addressed, that nurses are licensed and have standards that determine how they practice. And it has been stressed that resources with discipline expertise (e.g., designated person, committee, director) need to be in place initially to address practice-related issues, and that these resources need to be well known and acknowledged throughout the organization. Several respondents echo the belief "..that you can have any discipline managing nursing and nurses managing any other disciplines as long as you have resources in place when you have discipline-related issues or discipline-specific expertise."

> *Nursing is unique in the sense, like physicians, they are licensed, there are practice standards, and the organization is liable for those practice standards being addressed. Because there is a College, because they are licensed, because there are standards, it puts the organization in a different liability position. So you have to address it more.*

Summary of Public Health Sector Interviews

Respondents from four restructured health units described and recommended the need to address nursing practice issues within a program-based environment where nurses are members of multidisciplinary teams. Solutions were varied, including combinations of division directors who are nurses, program managers who advise non-nurse managers, and nursing practice committees. All of these health units had at least one division director who was a nurse and was a member of senior management. This representation at the senior management level was viewed as one of the major strengths of the arrangements that these health units had instituted. None of the restructured health units had a formalized arrangement, in which the role of addressing and resolving nursing practice issues was part of a job description. In all cases, it was considered "other duties as necessary" and done on a part-time basis. One health unit was initiating a board by-law in recognition of the need for the role. Despite the lack of formal job descriptions, respondents identified role characteristics and the necessary skills for dealing with nursing practice issues. Role expectations included: bringing nursing practice issues to the senior management level, liaising with the College of Nurses around policies and standards for nursing, interpreting the Regulated Health Professions Act; communicating with nurses across the organization, participating in a nursing practice committee. A nurse with public health experience who had an understanding of nursing practice, the legal environment related to nursing, and the Regulated Health Professions Act would be considered the best candidate for the role. Limitations of the existing arrangements for addressing nursing practice issues in the restructured health units included not enough time to adequately address the role. None of the health units had formally evaluated their mechanisms for addressing nursing practice issues. The respondents described environments with almost constant change, indicating the need for some flexibility in arrangements dealing with nursing practice issues. And one of the challenges included the need to articulate nursing practice issues in contrast with more general issues related to all disciplines within a health unit.

Provincial/Professional Organizations

Individuals from four professional nursing organizations and the Chief Nursing Officer for Ontario were interviewed regarding a nursing position responsible for addressing and resolving issues related to the discipline and practice of nursing within program-based public health units. The organizations represented were: the Ontario Nurses Association (ONA); the Registered Nurses Association of Ontario (RNAO); the Community Health Nurses Initiatives Group (CHNIG); and the Association of Nursing Directors and Supervisors of Ontario Official Health Agencies (ANDSOOHA) – Public Health Nursing Management. Their observations and opinions were based on broader perspectives than those of a single public health unit, and they were combined for this analysis. Not all questions were answered. In some cases, respondents viewed the questions as being outside of their experience. As one respondent said, "It's really hard for me to relate because of not working in that [restructured public health unit] situation."

The Strengths and Limitations of Having a Position Responsible for Nursing Practice Issues

All of the respondents expressed strong opinions and observations about the need for a position to address nursing practice issues, and about the implications for nursing when restructuring from discipline-based to program-based health units. Depending on how they were framed, most of the respondents' observations and opinions formed either the strengths of having such a position, or the reasons such a position was necessary, or the limitations of eliminating such a position during restructuring. Some respondents acknowledged problems with restructuring but expressed their concerns as strengths associated with the need for a position and did not identify limitations.

> *I only see positives, and in fact the necessity to have such a position. Nurses consistently convey … the frustration they experience when they report to an individual who does not have a solid understanding of nursing issues and nursing practice. Indeed, organizations that have opted for a flat, programmatic approach with no clear nursing leadership are suffering today from poor morale levels and low productivity. In turn, clients are experiencing the results of disillusioned nurses.*

All of the respondents identified the need for a dedicated nursing voice at the senior management level to ensure:

- Decisions such as budget, patient care, and planning, were made with recognition of the principles and standards of nursing practice
- Patient care is not negatively impacted

> *I don't think that a non-nurse understands the practice issues or the patient care issues of nursing.*

- Issues of nursing are not minimized at the senior management level:

> *… in a program-based model it's expect*[ed] *that nurses will take off the nursing identity, … and will therefore be at the table without their professional identity.*

> *If you don't have a strong nursing advocate at the decision-making table, you don't make decisions that support patients from a nursing perspective.*

- Prevention of frustration, low morale, low productivity, and disillusioned nurses resulting from lack of nursing leadership and having to report to non-nurses who do not understand nursing practices or patient care issues.

> *Program-based structures mean a non-nurse rather than a nurse in charge of nursing. It is really critical that there's an opportunity for nurses who are reporting to non-nurse managers be able to speak with a nurse manager regarding nursing practice issues.*

- Health units act in accordance with the Ontario's Nursing Task Force Report (1999, see Appendix J) that recommends health care service agencies ensure "that there is specific responsibility and accountability, at a senior management level, for professional nursing resources."

Organizational Location, Supports, and Reporting Arrangement

All respondents agreed that the position must be at the senior level of management, and be a member of the senior management committee, with the authority to ensure that decisions made at the executive level reflect nursing priorities. The position should report to the Medical Officer of Health or the senior administrator. The respondents also believed that the position should be formalized and recognized as the nursing leader within the organization. It was also suggested that the nurse leader be provided with human resources support, an assigned budget line, and that the leader's workload be such that this individual has "adequate time to address the issues".

> *They should be reporting to the Medical Officer of Health and they should be at the executive table. The reason I say that is because they* [nurses] *represent the largest group of providers in the organization. And if the issues they are encountering as a group, as it* [sic] *relates to nursing practice is not championed at that level, it may not happen.* …[organizational supports] *not to support the program management but to support the nurse, at the senior management table, and patient outcomes from a nursing perspective, where she* [senior nurse] *has a full voice and vote.*

Responsibilities

Since all of the respondents believed that there should be a position dedicated to addressing nursing practice issues within a program-based structure, they also suggested an extensive list of responsibilities. These included:

- Budget decisions which support nursing perspectives
- Patient care decisions which support nursing perspectives
- Nursing human resources allocation
- Advocacy for nursing
- Authority over non-nurse managers related to safe nursing practice
- Ensuring that the standards of practice for nursing are met
- Ensuring that there is ongoing professional development and nursing career planning
- Liaising with nursing faculties to help predict and plan education changes for the future.

Recruitment and Selection

The respondents were very clear about the recruitment and necessary skills of the person responsible for addressing and resolving nursing practice issues in a public health unit. Their ideal candidate would:

- Be a nurse with public health experience and expertise
- Have a graduate degree
- Understand the organizational structure
- Understand the relevant legislation governing nursing
- See the big picture
- Be able to see "outside of the box"
- Have good interpersonal and negotiation skills
- Be a good communicator (written and verbal)
- Know how to read and critique research
- Be well connected in the profession
- Be eligible for a cross-appointment with an academic health science center (requiring a review process)
- Be aware of union issues.

One respondent indicated that the selection process depends on the structure as well as the goals of the organization. For example, if the organization is flat, with all program managers reporting to the Medical Officer of Health, someone could be recruited from outside of the organization. One respondent suggested three sources for recruiting external candidates: RNAO's *RN Journal*; the Globe and Mail Newspaper; and an executive search firm. If the health unit has existing directors who are nurses, selection from within would be more likely. It was suggested that there should be quite a bit of "up front work" to design a position that will work and not have an untenable situation. A hiring committee needs to be clear on what qualities and skill sets are desired in the nurse leader, keeping the "big picture" of nursing issues in mind.

Several respondents had suggestions for the hiring committee, which included:

- A credible nurse leader from outside the agency
- The MOH
- Several nurse managers
- Maybe several public health nurses
- Representatives from other disciplines
- Representation from the community. (e.g. District Health Council)

Staff input into criteria selection, interview process and decision regarding the best candidate. I would recommend having the participation of an external nurse leader in the interview process.

In establishing a hiring committee, respondents noted that there needs to be acknowledgment and recognition of the various professions in the agency; consideration should be given to including a representative(s) from other professions on the hiring committee. This might foster broader agency support for the role and the selected individual. In suggesting this, one respondent acknowledged that the hiring committee was potentially too large, and might need to be "pared down", but emphasized that the need for credibility and acceptance of the position made this inclusiveness important.

Challenges to Operationalizing the Role

There were varied responses to the question, *"What do you see as the major challenges to operationalizing this role?"*. One respondent replied*:* "There should be no challenges in operationalizing this role since it is essential to ensure excellence in nursing practice and client outcomes." Another respondent identified workload as a potential problem, and that "one of the major challenges would be the balance of having non-nursing administrative staff to deal with". One respondent stated that a challenge to operationalizing a role responsible for nursing practice issues was the "legislated" structure of public health units, which allows for unilateral decisions to be made. Several respondents suggested that there may be concerns from other disciplines within public health (e.g., inspectors, nutritionists) - that they may "feel left out of the power structure", and that "maybe the other professional groups need to also be given the opportunity to identify there is a need for them". As one respondent commented:

There can be a big backlash – "Oh, there's the nurses asking again, they just want to be special" … We are only raising our concerns, we can't speak for other professional groups.

There were a few final comments from provincial informants and some added advice, including establishing a nursing practice committee, and "be[ing] open to dialogue, hear the nurses". Reiterating the need for the position, one participant said, "We are such a large group of health care providers that it's really critical that we are performing at our optimal" and another said, "What's done should be to strengthen and unify nursing."

Summary of Provincial/Professional Organizations

All respondents strongly supported the need for a position to address nursing practice issues and recommended the need for a dedicated nursing voice at the senior management level. Having the position formalized and seen as the nursing leader within the organization were viewed as critical elements. An extensive list of responsibilities focusing on internal and external activities was generated. Workload and the response of other disciplines to such a position were identified as potential challenges.

Middlesex-London Health Unit Nurses

Of the 117 surveys sent to all full-time, part-time and casual nurses, and managers who are nurses, 49 surveys were returned, resulting in a 42% response rate. Ninety-four percent of the respondents indicated that they were employed full-time or part-time and 6% were casual. The response rate is thought to be lower than expected in part due to the short time period respondents had to return the questionnaire. Only three casual nurses out of a possible 33 responded. Although casual nurses did receive a voice mail informing them of the survey, they may not have been scheduled to work during that period of time. If casual nurses are not included in the response rate, the response rate increases to 55%. The 55% response rate is consistent with a recent survey of nursing division staff education needs conducted at MLHU. When taking into account only full-time nurses, part-time nurses, and nurses managers, the staff education survey's response rate was 57%.

Results are presented below on a question-by-question basis.

Senior Nursing Position?

In response to the question, *Do you think MLHU should have a Senior Nurse Position?* 90% of respondents replied yes, while 10% were not certain. No one stated that this position was not necessary. Three main themes evolved from the nurses' comments as to why this position was needed. They identified that the position was needed to:

1. **Ensure and maintain the quality of nursing and nursing practice**

   Maintain current quality of care & excellence in nursing. Maintain partnership in London & entire nursing community that we have worked so hard to establish. Maintain nursing standards - professional, legal, ethical. Provide mentorship in the development of new nursing leaders. Ultimate responsibility for decisions that affect nursing care provided to clients.

   To ensure that nursing standards are maintained by all nurses. To honour the nursing profession.

2. **Allow nurse's access to an administrative/ management professional who is of the same profession to:**
   - Ensure professional needs and accountability issues are addressed
   - Act as a resource
   - Promote communication
   - Provide a broader view of nursing that is beyond the program level.

This response stems from approximately one third of respondents who made comments expressing their perception that nurses would not necessarily be reporting directly to nurses.

> *Many nurses who have had a nursing leader will no longer have a Director or a manager who is a nurse. A "Senior Nursing Position" would ensure that all nurses' professional needs, accountability issues are addressed.*

> *This is needed because the Director of Public Health Nursing position is disappearing and this position has traditionally ensured that these matters are addressed. There is no guarantee that there will be public health nurses in senior positions in the future.*

3. **Represent nurses at the senior level of management**

   To ensure adequate representation of nurses ("nursing") at the senior level of management. To ensure that nursing practice standard are maintained. To be a resource to both staff and management about nursing practice issues. To have someone who can interpret nursing practice standards to non-nursing management & staff when nursing staff work with/report to non-nursing staff.

Individuals who indicated that they were either uncertain or did not feel there was a need for a Senior Nurse Position were also asked: *How do you see issues related to the discipline and practice of nursing being identified and resolved on an ongoing basis?* and *Are there any organizational structures in place to support this arrangement?* Although only 10% of respondents indicated that they were uncertain as to the need for a Senior Nurse Position, 16% of overall respondents answered these questions. Several of these individuals felt that a process could be put in place to bring issues forward to managers as the need arose. If nurses were reporting to a non-nurse manager or non-nurse director, the manager or director could be oriented to nursing standards in

order to assist nurses, if issues arose. A further suggestion was that the Liaison Committee[1] could expand its current function.

1. The Liaison Committee is mandated by the collective agreement with the Ontario Nurses Association. It has both union and management members and deals with non-contractual, professional issues.

Major areas of responsibility for the role

In response to the question, *What do you see as the major areas of responsibility for such a role?* (i.e., what types of issues/situation would this role deal with?)", a number of themes emerged. Overall it appears that respondents want to see a role that is multi-faceted. The areas of responsibility include:

1. Practice Guidelines:

a) Ensure that practice guidelines are adhered to by nurses and by the organization.

Scope of practice/promoting excellence in practice. Documentation of nursing practice. Monitoring outcomes of nursing practice e.g., Quality Assurance [QA]. *Reflective Practice/ CNO* [College of Nurses of Ontario*] Portfolio as part of QA. Ensuring that CNO Standards are addressed in performance appraisals. Consulting/coaching non-nurse managers.*

This person should be at a level in the organization that would allow the autonomy to ensure the appropriate action occurs, e.g., a staff nurse may have a concern that a manager may not agree with - yet the staff nurse is right. The "Senior Nurse" should be in a position to side with whomever is correct.

b) Promote/educate about nursing practice guidelines to others within the Middlesex-London Health Unit, in particular non-nurse managers.

Assist management/staff (both nursing and non-nursing) with practice issues that would arise as part of the job i.e., What are the nursing standards relationship to an issue, who should do what (is this a nursing function? A function that non-nurses can also do?)

2. Advocate/Mentor/Consultant

Guide progress and development of nursing practices & the profession. Encourage, coach & support other nurses in the development of expertise, self-confidence and professionalism…

Role model & mentor to encourage, coach & support. Expertise in all professional issues. Advocate for nursing in multi-disciplinary situations - interpret professional issues to others. Partnerships with other community resources - in London but outside as well. Networking with nursing leaders at the provincial/federal level - allows for inservice opportunities such as Kathleen MacMillan [Provincial Chief Nursing Officer], *Doris Grinspun* [Executive Director of the Registered Nursing Association of Ontario], *etc., etc.*

3. Provide input into the decision-making at the organizational level rather than to individual issues that can be handled at the manager/director level.

Spokesperson/advocate for the practice of nursing across the agency to the highest possible standard. "Trouble-shooter" around … concerns - e.g., Documentation; inservice; education opportunities (not doing but ensuring availability for all). Communication (between all nurses in all services; with management).

In addition, a few respondents felt that the Senior Nurse Position should be involved in operational issues such as hiring staff and nurses grieving job situations where the non-nursing director is unaware of standards of nursing practice.

Do supports need to be in place for this position to work?

Forty-three of the 49 nurses answered this question, of whom 91% responded that supports needed to be in place in order for this position to work. One person indicated that supports were not necessary, and three people were uncertain. Respondents who advocated for supports were consistent in their comments on why they believed that supports were needed. As evidenced by the following comment, they indicated that the organization as a whole needed to commit to this position and the role it would serve: "It is essential that the position be supported by all individuals - especially the MOH*!* [Medical Officer of Health]". In addition, they identified that the person in this position would need to work collaboratively with all levels of employees and therefore, the

position would need a clear description of responsibilities, decision-making authority, and a budget allocation.

> *Upper management must respect & trust this person and listen to their advice & recommendations.*

> [Do supports need to be in place?] *Absolutely! This position needs to have the authority/ power to deal directly with Health Unit staff of all levels to communicate, deal with nursing issues.*

> *Needs to sit a senior management table & have responsibility & authority legitimized for dealing with issues related to the discipline & practice of nursing. Role expectations need to be clear & common understanding across agency at all levels - senior & middle management & front line. Needs to have budget responsibility for addressing training related to nursing practice that crosses all services (other training should be responsibility of each service). Annual report to the Board of Health. Position requires a job description.*

> *The position needs to be respected and supported by senior management. There needs to be adequate funding for the position.*

Comments also gave the impression that a Public Health Nurse could not hold the Senior Nurse position because of the level of decision-making authority: "I can't imagine how a staff level nurse [in such a position] would ever be taken seriously by upper management." This observation is strengthened by responses to the later question asking where the position should be placed within the MLHU organizational chart.

One person commented that the position should not be an "add-on" position.

Major Challenges Implementing this Role

In response to the question, *What do you see as the major challenges to implementing this role?* respondents identified challenges that centred around two areas: the organization and the position itself. More specifically, within the organization, a challenge would be to make the role understood, accepted, respected, valued and embraced by all.

Responses to this question are consistent with the need for organizational support, previously described:

> *Lack of understanding & appreciation of why position needed. Need to build a case that to be successful & maximize the potential benefits of this position it requires autonomy, authority & accountability. Current environment & feeling surrounding restructuring & new organizational chart. Lack of trust, anger, etc.*

Some concern was expressed as to whether other disciplines might perceive that the position is not needed or see nurses as an elitist group: "Why shouldn't PHI [Public Health Inspectors] have a Senior Inspector Position?

The second major challenge focused on the position itself. There is potential for the position to have a vast scope of responsibility. Thus, the position needs to have a clear and concise role description that includes what the role involves, decision-making authority, and reporting structure.

> *It will be difficult to find one person skilled & knowledgeable in so many different areas.*

> *Allowing the nurse in this position to have power & decision-making abilities.*

A few respondents suggested that other challenges may arise in implementing the role or even as part of the role. These challenges include funding for the position, if it is newly created within the current organizational structure. Or, if the position is added to an existing assignment, there may be issues of time management and of managing conflicts of interest, if the "Senior Nurse" role conflicts with responsibilities of the existing assignment.

> *Finding position in present organization chart as MOH* [Medical Officer of Health] *does not want structure to change. Can't be a staff position as they need to have some power re: decisions & implementing change.*

> *Building this role into someone's assignment - deciding if it warrants 1/2 day or full day etc. - how does this person accommodate people should demands increase.*

The challenges tend to reinforce the responses about necessary supports being put in place for the position

to work. Essentially, it seems that if the supports are in place for this position then the challenges will be reduced or minimized. However, if the supports are not in place, then the challenges will definitely become issues.

Placement of the Position

Respondents were asked to *indicate where this position should be placed on the MLHU organizational chart and to whom should this position be reporting.* Responses varied. In terms of the reporting structure, some respondents saw this position at the Director level, reporting directly to the Medical Officer of Health; others indicated that the reporting also should be to the Board of Health. A few felt the position would be suited for a manager but raised the issues of who, then, the person would report to and in what department this position would be located.

Within the organizational chart many respondents stated that this position should not be directly part of one department, in order to allow accountability and availability to all nurses within the organization. Others thought that this position should be part of a dual role for either the Director of Family Health or for the Director, Research, Education, Evaluation, and Development, as long as these positions are held by a nurse.

> *Should liaise with all service areas that involve nursing (except Dental) - Report to the 4 directors involved - & if need be Central Resources & MOH* [Medical Officer of Health] *if further issues can't be resolved. Liaise with managers in each area, report to Directors where there are nurses.*

> *The responsibility should be at the Manager or Director level and be part of that person's assignment. I do not see this as a separate position on the organizational chart, but it (the portfolio) does require that the person have some power and decision-making ability in the organization.*

> *The Senior Nurse position should be directly below the MOH* [Medical Officer of Health] *because nurses are in all but one division and this position would need to address nursing issues across the whole agency.* [on the MLHU organizational chart this respondent placed the position on same line level as Central Resources]

Skill Sets Required

What skill sets and qualifications are needed to be successful at this position? The majority of respondents indicated that the Senior Nurse Position would require someone who holds a Master's degree, with a strong nursing background, and who is knowledgeable about current nursing practice. As captured in the following responses, skills that were deemed important for the person in the position include leadership experience, excellent communication and interpersonal skills, conflict resolution/negotiation skills, management skills, and collaborative skills. Additional requirements that were mentioned include: systems thinker, public health experience, and involvement in professional organizations.

> *Management skills/ leadership role experience. Extensive public health nursing experience, experience in managing change/ development of staff. Needs to know how to assess staff needs and evaluate interventions. Master's level education.*

> *Nurse, prepared at Master's level as a minimum. Ability to think & plan critically, to see "the big picture". Effective negotiator, politically skilled - able to advocate strategically. Multi-tasked – well organized. Seen as credible & respected internally & externally. Excellent written & communication skills, strong presentation skills.*

Processes for Recruitment and Selection

What process(es) should be used for recruitment and selection? Recruitment for this position was suggested by many to be an internal posting, followed by an external advertising in the avenues of newspapers, universities, and journals. A few respondents felt that an internal candidate(s) already existed within the organization and that this person should be approached before an external process took place. As a few individuals felt this position should not be newly-created but part of an existing assignment, their process would then focus on who is qualified to undertake this position and who is interested in having it added to their role. It was not clear from the responses whether this suggestion was made because the individuals truly believed this was the best alternative or because they understood this to be the only option within the new organizational structure. Some respondents were aware of the Medical Officer's directive to the Work Group that any senior nurse position would be a function added to

the assignment of someone within the existing staff complement.

Respondents indicated that selection for this position should be conducted through an interview committee that could consist of the Medical Officer of Health, a Director (nursing background), a staff nursing representative, and a manager (non-nursing/ nursing). Some suggestions included: having external representation on the interview committees such as an ONA [Ontario Nurses Association] executive, while a few others suggested "voting" for a nominated person if this was an internal person. Examples of responses include:

> *Look within MLHU. Advertise provincially & federally. Selection committee made up almost exclusively of nurses from all levels departments/teams of staff. Also, representation from UWO* [University of Western Ontario] *& another CNO* [Chief Nursing Officer] *from different location. This committee* [Senior Nurse Position Work Group] *would do.*

> *Depends on where on the organizational chart the position ends up. If this is part of another job maybe this person should be chosen by the nursing staff from those functioning in the eligible positions.*

> *Team interview process - nursing staff representation. Given that new structure combines many disciplines, representation from those disciplines could be a part of interview process.*

> *Eligible nurses should volunteer for position. If required, have all nurses vote for their preference for nurse leader.*

Summary of the Middlesex-London Health Unit Respondents

Middlesex-London Health Unit nurses support and express that there is a need for a Senior Nurse Position to ensure and maintain quality of nursing and nursing practice within MLHU, to ensure that nurses have a "voice" at the management level, and to enable nurses to access an administrative/ management person who is a nurse. There appears to be a perception by approximately one third of respondents that, in the new organizational structure, nurses will potentially be reporting to a non-nurse manager.

Almost all respondents identified that organizational supports need to be in place for a Senior Nurse Position to work effectively. Organizational support, working collaboratively with managers and directors, and role definition are seen as supports that need to be in place for this position to be successful. Interestingly, these areas are also seen as major challenges to implementing this role within MLHU.

The Senior Nurse Position is seen as a role that must have decision-making authority; therefore, it needs to be at the Director level in MLHU's structure. The position is not necessarily linked directly with one Service but seen as a self-standing and working collaboratively with the Services which have nurses. A few respondents believe that this position could be part of an existing assignment of a Director as long as a nurse (e.g., Family Health or Research, Education, Evaluation, and Development) holds this position. However, it is not clear whether this view is expressed because the respondents' believe that the position will only be accepted as a dual role or whether they believe this is the most appropriate positioning. Whoever holds this position is expected to have a Master's degree, with a strong nursing background. A person with previous management experience is seen as ideal because such a candidate is more likely to have leadership experience and conflict resolution/negotiation skills.

Summary of Survey and Interview Results Across Sectors

A summary of the results of the interviews and questionnaires from the four health care sectors surveyed (acute care, public health, provincial/professional organizations and nurses at MLHU) are in included in this section.

Senior Nursing Position

All of the respondents across the four health care sectors included in this consultation support establishing a position(s) whose responsibilities include addressing and resolving, on an ongoing basis, issues related to the discipline and practice of nursing (see Table 1). Respondents from both the public health and acute care centers described experiences that included broader representation for nursing practice issues through nursing practice committees.

All agreed that nursing representation needs to be at a senior level within the organization. Respondents from the MLHU, the public health care sector and those from provincial/professional organizations also recommended that the position be part of the senior management, and report to the Medical Officer of Health or higher. Respondents from the acute care sector, which involved large, multisite organizations, described positions that were either part of the senior management committee or at the level of manager, and reporting to either a vice president or higher. There was a suggestion from the nurses at MLHU that the position be independent of any particular department. Only the acute care sector had full or part-time senior nurse positions formalized with a written job description. The respondents from the public health sector described part-time positions with no formalized job descriptions for the senior nursing function.

TABLE 1 Need for a Position

Health Care Sector	Summary of responses
Acute Care Sector	• Supports the need for a position • Have formalized full or part-time positions dedicated to nursing practice issues, with written job descriptions • Positions are senior level, report to vice president or higher.
Public Health Sector	• Supports the need for a position • No formal positions, but informal mechanisms • Variety of solutions – shared responsibilities, including nursing practice committee • All described as part-time roles by respondents • At senior level as heads of divisions, part of senior management team; reports to Medical Officer of Health.
Provincial/ Professional Organizations	• Strongly supports need for a position • Strong concerns about the need to move to program-based structure and the implications for nursing in public health especially related to lack of nursing leadership and nurses reporting to non-nurse managers • Position should be at senior level and member of senior management team, report to Medical Officer of Health.
MLHU	• Majority support the need for a position • Position should be at senior level, to represent nurses; report directly to Medical Officer of Health (or higher) • Position should not be part of one department to allow accountability and availability across organization.

Responsibilities of Senior Nursing Position

Respondents from the four health care sectors described the responsibilities of a senior nursing position (see Table 2) as encompassing interactions at three levels: with nurses and other disciplines within the organization, at the senior management level of the organization; and beyond the organization. Respondents from public health and the acute care sector described nursing practice committees as important in addressing nursing practice issues on an ongoing basis and during times of changes such as restructuring. Across the organization, responsibilities of the senior nurse should include communication and collaboration with nurses and members of other professions to ensure adherence to standards of nursing practice, quality assurance, providing advice, mentoring nurses, encouraging their educational development, overseeing nursing documentation standards and practice, and providing overall nursing leadership. Respondents from public health, acute care, and provincial/professional organizations recommended nursing representation at the senior management level to support nursing issues and to ensure that decisions are consistent with nursing practice standards and regulations. Other management level activities for the senior nurse include the possibility of administering a budget and having authority to allocate human resources for professional practice issues. Beyond the organization, the senior nurse should maintain a connection with the College of Nurses and other provincial associations, as well as stay informed about impending legislation and other initiatives that might impact on nursing within the health unit. Finally, the senior nurse should be linked with educational facilities to facilitate continuity and development of educational opportunities.

Table 2. Roles and Responsibilities

Health Care Sector	Summary of responses by organizational level
Acute Care Sector	***Organization-wide*** • Liaise with nurses in a variety of working environments to ensure nursing standards for quality patient care are appropriately applied • Ensure role clarity • Provide leadership for nursing • Ensure there is a system to facilitate continuous inquiry and learning by nurses • Encourage educational development for nurses and consistency in educational preparedness of nurses within organization • Ensure there is a system for integration of nursing students into patient care teams • Promote nursing through interdisciplinary teamwork, and/or represent nursing on interdisciplinary professional practice committees • Act as mentor and facilitator for nursing practice committee and other professional practice committee. *Nursing practice committee* Ensures nursing practice issues are addressed; plays an integral role in ensuring position is in place during transition to program-based structure and other organizational changes. ***Management*** • Represent nursing at senior management level. ***Beyond the organization*** • Maintain collaborative relationship with educational institutions • Provide leadership within nursing at the community level • Anticipate and interpret impending legislation, professional standards and trends in practice and facilitate appropriate action.

Public Health Sector	***Organization-wide*** • Communicate with nurses across organization when need arises • Advise non-nurse managers as needed • Understand and ensure the Regulated Health Professions Act is followed. *Nursing practice committee (described for one health unit)* Acts as a forum for bringing up nursing practice issues for discussion and resolution, addressing special training needs or gaps in nursing functions; sharing information about new practices, initiatives, special nursing activities; requests from external nursing organizations; has organization wide nursing representation. ***Management*** • Bring nursing practice issues to the senior management committee • Bring issues related to other disciplines within assigned program areas to the senior management committee • Other duties as needed, may include membership in nursing practice committee; take committee issues to management as needed. ***Beyond the organization*** • Liaise with the College of Nurses around policies and standards for nursing.
Provincial/ Professional Organizations	***Organization-wide*** • Ensure that patient care is not negatively impacted [within program-based structure] and patient care decisions are made which support nursing perspectives • Be a strong nurse advocate • Work toward prevention of frustration, low morale, low productivity, and disillusionment of nurses • Ensure professional development and nursing career planning • Have authority over non-nurse managers related to unsafe nursing practice issues. ***Management*** Represent nursing at the senior management level. Ensure decisions such as budget, patient care, planning are consistent with standards of nursing practice Have authority for nursing human resources allocation Ensure health units act in accordance with the 1998 Nursing Task Force Recommendations. ***Beyond the organization*** Liaise with nursing faculties to help predict and plan education changes for future.
MLHU	***Organization-wide*** • Work collaboratively with all levels of employees within MLHU • Ensure that practice guidelines are adhered to by nurses and the organization – including promoting practice excellence, documentation, quality assurance, consult, coach and promote/educate non-nurse managers about practice guidelines, ongoing nursing education. • Advocate, mentor and consult; this includes supporting nurses in development expertise, etc. • Role model, mentor, encourage expertise, and interpret professional issues. ***Management*** • Influence and provide input about nursing practice into broader decision-making at the organizational level. ***Beyond the organization*** • Network at the provincial level.

Organizational Supports for Senior Nursing

Position

Table 3 clearly indicates that the senior nursing position needs to be supported by the organization to maximize the success and minimize the challenges. Placing the responsibility at a senior management level was seen as important in ensuring that decisions are made to support nursing's professional standards and practice, and that the senior nurse has authority to deal with staff at all levels.

Placement at this level gives the position visible organizational recognition and commitment. Respondents identified that reporting to someone who clearly understood the senior nurse role was viewed as supportive. While only respondents from the acute care sector described positions that were formalized with written job descriptions, respondents from the other three health care sectors mentioned the need for a clear and concise job description to encourage organization-wide recognition for the role. Allotment of adequate time to address all of the necessary responsibilities was also mentioned as an organizational support.

Table 3 Organizational Supports

Health Care Sector	Summary of responses
Acute Care Sector	• A formalized written job description • The senior level of the position is a support. • Supervisor who understands senior nurse roles • Meeting with senior positions for other disciplines to address common issues.
Public Health Sector	• At senior level as heads of divisions, part of senior management team • Formalize position, e.g., board by-law • Position is recognized across organization • Having a nursing practice committee whose role is recognized within organization • Role includes advisory function for nurses within organization and for non-nurse managers about nursing practice.
Provincial/ Professional Organizations	• The senior level of the position – authority to ensure decisions related to nursing are made • Membership on senior management committee • Position should be formalized and recognized across organization • Position should have resources, including budget line and human resources authority • Position should have adequate time to address necessary activities.
MLHU	• Organizational supports needed to ensure success of position and reduce challenges • Position at a senior management level • Position needs a clear and concise job description and common understanding of responsibilities and decision-making authority, and budget allocation • Requires common understanding and commitment by entire organization for position • Position requires the authority to deal directly with staff at all levels regarding issues related to the discipline and practice of nursing.

Necessary Skills for Senior Nursing Position, Recruitment and Selection

The most consistent response from all of the health care sectors represented in this consultation stated that the successful candidate must be a nurse with experience in public health nursing. Respondents from MLHU, the acute care sector and provincial/professional organizations also believe a graduate degree is necessary. The senior nurse should be knowledgeable about current nursing practice, with an understanding of the standards and relevant legislation governing nurses within the organization. This person should be a member of professional nursing organizations, and possibly hold, or be eligible to hold, a cross-appointment at an academic institution. Respondents also identified demonstrated expertise in management, leadership, negotiation and conflict resolution as well as a shared decision-making style and teamwork and collaborative skills. The senior nurse should have strong organizational, communication, and interpersonal skills, and be able to 'think outside of the box'. Finally respondents from both acute care and provincial/professional organizations mentioned that the individual in this role must understand the organizational structure. While the positions described by respondents from public health were recruited from within the organizations, at least one acute care center had external recruitment, and respondents from both the MLHU and provincial/ professional organizations suggested selection by a committee with broad agency-wide representation (see Table 4).

Table 4 Skills, Recruitment and Selection

Health Care Sector	Summary of responses
Acute Care Sector	***Skills*** • A nurse licensed by the College of Nurses, with a background in clinical nursing practice and demonstrated clinical expertise, and a Master's or doctorate degree • A member of professional nursing organizations • Demonstrated leadership • Demonstrated effective teamwork, shared decision-making ability, consultative/collaborative skills, and has effective organizational, interpersonal and group skills • Demonstrated experience in integration of practice, education, and research • Understands differences between operational and professional practice issues and is prepared to think 'out of the box' and find new ways of addressing professional practice issues • Is interested in the position. ***Recruitment/Selection*** • Recruitment and selection practices varied, e.g. one position was recruited from elsewhere, another from within.
Public Health Sector	***Skills*** • A nurse with public health experience • Understands the nursing profession in the broadest sense • Understands the legal environment for nursing, the rules and laws under which nurses function and understands the Regulated Health Professions Act. ***Recruitment*** • Because positions were informally part of existing positions, there was no formal recruitment among the health units interviewed. ***Selection*** • Selection was made by a variety of mechanisms, including mutual agreement between two directors, and selection from within by the senior management committee.

Provincial/ Professional Organizations	***Skills*** • A nurse with public health experience and expertise, and a graduate degree • Understands the relevant legislation governing nursing • Understands the organizational structure, and is aware of union issues • Is well connected in the profession • Has good interpersonal and negotiation skills, is a good communicator (written and verbal) • Knows how to read and critique research, and is eligible for a cross appointment with an academic health science center • Sees the big picture. **Recruitment** • Recruitment from within if organization has directors who are nurses, or, if necessary (e.g., flat organizational structure) external recruitment through sources such as RNAO's RN *Journal*, the Globe and Mail, or an executive search firm. ***Selection*** • Selection committee with representation from across organization to ensure credibility and acceptance, e.g. include nurse leader from outside organization, the Medical Officer of Health, nurse managers, staff nurses, representatives from other disciplines, someone from the community (e.g. District Health Council).
MLHU	***Skills*** • A nurse with a Master's degree and a strong nursing background and public health experience • Knowledgeable about current nursing practice and is involved in nursing professional organizations • Leadership experience and management, conflict resolution and negotiation skills • Collaborative; communication and interpersonal skills • Is a systems thinker • Interested in taking on this position as part of job. ***Recruitment*** • Is recruited through internal posting first then external, may possibly be part of existing position. ***Selection*** • Selection by a representative committee including the Medical Officer of Health, a Director with nursing background, a staff nurse representative, and a manager, with possible inclusion of an ONA executive.

Evaluation of Senior Nurse Position

One respondent from the acute care sector described a formal evaluation with annual identification of goals and accomplishments; another described outcomes of work done by a nursing practice committee (see Table 5).

Otherwise, evaluations of the senior nursing positions, as described by respondents in the public health and acute care sectors, were informal, if done at all. One public health respondent cited inadequate time and resources for evaluation. A few respondents from both sectors mentioned that changing/evolving roles and environments made evaluation difficult.

Strengths and limitations associated with senior nurse position

Respondents from the two health care sectors (public health and acute care) that had a senior nurse position offered differing observations regarding its associated strengths (see Table 6). The part-time positions within public health included representation at the senior management level, which afforded validity and recognition for the position across the organization. In a comment about the program-based structure, one health unit respondent pointed out that most of the issues that needed to be dealt with were program-based, and not related to discipline-specific issues. Strengths described by respondents in acute care reflected the large size and complexity of the organizations, and included the observations that the full-time senior nurse position allowed for a greater focus on nursing issues, and that the senior nurse participation on interdisciplinary teams facilitated communication and understanding across disciplines.

In terms of limitations associated with senior nurse positions, respondents from all four sectors mentioned lack of time or heavy workload as problematic. Respondents from acute care and the MLHU raised the issue of lack of understanding about the role across the organization. Respondents from public health mentioned a need for clarity about nursing practice issues versus other discipline-related issues, particularly with non-nurse managers. Non-nurse managers must be able to recognize their own limitations in dealing with nursing practice issues and seek help from appropriate sources. Respondents from MLHU and provincial/professional organizations expressed concern that by establishing a senior nurse position, nurses could be viewed as 'elitist' or trying to be special.

Table 5 Evaluation of Position

Health Care Sector	Summary of responses
Acute Care Sector	• Formal in one location, with annual identification of goals and accomplishments • Nursing practice committee helped identify evaluation outcomes for integration of nursing across sites • One respondent suggested that the senior nursing role needs to continue to evolve and adapt to ongoing changes in acute care sector.
Public Health Sector	• No formal evaluation of position among respondents • Informally, "the system seems to be functioning" • Limited time and resources for evaluation • Senior nursing role changing in response to changes in public health environment.

Table 6 Strengths and Limitations Related to Senior Nursing Position	
Health Care Sector	**Summary of responses**
Acute Care Sector	***Strengths:*** • Participation on interdisciplinary teams facilitates issue resolution, communication and understanding across disciplines • When formalized, easier for supervisor to understand role • Full-time in position allows more of a focus on nursing. ***Limitations:*** • Position is challenging • Role clarity can be an issue in large, multisite organization • Having enough time to address all that needs to be addressed.
Public Health Sector	***Strengths:*** • Having nursing representation at the senior management level • Senior level recognition of nursing issues provides validity and recognition for position across organization • Management can focus on program issues if nursing discipline issues are dealt with proactively. **Limitations:** • Need for clarity about what are nursing practice issues versus issues common across disciplines, especially if nurses report to non-nurse managers • Inadequate time contributes to 'haphazard' nature of dealing with nursing issues • Non-nursing managers need to recognize their own limitations regarding nursing practice and know when to consult • Position may need to change as health unit environment changes.
Provincial/ Professional Organizations	***Strengths:*** • Position will address nursing practice issues • Ensures management decisions are consistent with nursing standards • Creating position supports the recommendation of Ontario Nursing Task Force • Ensures nursing issues receive appropriate attention at the senior management level. ***Limitations:*** • Workload may be a problem • Concerns that other disciplines may "feel left out of power structure" • May need to examine such a position for other disciplines • May be a backlash – perception by others that nurses are elitist.
MLHU	***Strengths:*** • Ensure and maintain the quality of nursing and nursing practice • Allow nurses access to an administrator/manager who is a nurse • Represent nursing at the senior management level ***Limitations:*** • Position may not be understood, accepted, respected, valued or embraced across organization • Nurses may be seen as elitist by other disciplines • Responsibility beyond scope of position • Funding for position may be a problem • Time management and conflicting responsibilities may be problem if part of existing assignment.

Observations, Advice and Suggestions Related to Senior Nursing Position

A number of the observations offered by respondents from public health, acute care, and provincial/professional organizations related to restructuring from discipline-based to a program-based structure (see Table 7). While acknowledging difficulties such as concerns about nurses reporting to non-nurse managers, all of the respondents from public health and acute care preferred a program-based structure. The respondents from all three sectors did offer some suggestions to the MLHU, including the need to acknowledge the concerns and to ensure that some mechanism is in place (position, committee etc.) initially to address nursing practice-related issues. The position or other mechanism needs to be recognized and supported across the organization, and the solution needs to serve nursing in a positive sense, "what is done strengthens and unifies nursing."

Table 7 Observations, Advice and Suggestions Related to Senior Nursing Positions

Health Care Sector	Summary of Responses
Acute Care Sector	• It is difficult going from traditional discipline-based to program-based structure; practice issues do arise and need to be addressed • Try the structure with a senior nursing position for two or three years • Secure organization-wide support for the position • Make sure the right person is put into the position.
Public Health Sector	• Restructuring can be initially difficult, leading to concerns about nurses working under non-nurse managers; having a senior nurse can lessen the challenges • Needs to recognize 'up front' that because nursing has practice standards and liability issues, nursing practice issues need to be addressed • Resources with nursing discipline expertise (e.g. designated person, committee) and recognition across the organization need to be in place initially to address nursing practice related issues.
Provincial/ Professional Organizations	• Have a nurse practice committee • "Be open to dialogue, hear the nurses" • Ensure that what is done [related to senior nursing position] strengthens and unifies nursing.

Other Sources of Data Collection

Email Survey of Ontario Health Units

When the issue of a senior nursing leader was first emerging at Middlesex-London Health Unit (MLHU), an informal email was sent to a distribution list of 28 nursing contacts at 17 health units in Ontario. This email asked how their health units were addressing the issue of a Chief Nursing Officer or Nursing Practice Leader. In addition, they were invited to identify any related issues that had emerged or that they were anticipating in the near future.

Representatives from nine health units responded. In addition, a response representing the Community Health Nurses Initiatives Group was received. Some of the email responses duplicate information received through the more formal key informant survey of public health units that was conducted later on by an external consultant.

One respondent indicated that management at her health unit was preparing recommendations for adoption by the Board of Health. They were planning to recommend bylaws to entrench the role of a senior practice leader in the agency structure. When passed, the bylaws will establish this role for each of the professions regulated by the Regulated Health Professions Act or required in health units under the Health Promotion and Protection Act, provided that there is more than one person employed in that category by the health unit. This health unit is also considering recommending that these roles be assigned to senior managers who have direct input into key agency decisions, including budgetary issues. Management at this health unit identifies two unresolved issues: they anticipate a possibility that, in a program-based structure, not all the professions will be represented at the senior management level and they also perceive that there may be job evaluation implications if some senior staff have these additional responsibilities while others, in the same position and at the same pay level, do not.

Two health units, both in a program-based structure, are exploring how best to address the issue of chief nursing officer. One is examining the possibility of a nurse practice leader and discipline-based committee. The other has identified the creation of discipline specific committees in its strategic plan and is pondering an implementation plan. The respondent from the latter health unit also expressed the belief that, from a liability perspective, the nursing practice leader should be in a senior manager position.

The remaining six health units have no formalized process or position for addressing practice issues or for the creation of a Chief Nursing Officer. All of the responding health units report that a nurse at a managerial or director level has assumed the role. Some respondents listed the responsibilities of this individual. These range from maintaining a binder of College of Nurses requirements, to responding to requests for assistance from non-nurse managers of nurses, to responding to issues identified by nurses. One described a more extensive role that includes distribution of College of Nurses information to nursing staff and ensuring that related policies are in place. Examples of these policies include credentialling requirements, licensing requirements, provision of quality care, risk management guidelines, safety of clients, safety of staff, professional development needs assessment and appropriate nursing staff education. One respondent described her broad role as follows:

> *By having this responsibility within a management portfolio we can easily track what activities are occurring and ensure that the information is built into our policies and procedures. Many of these items I delegate to others, such as staff development, however as manager I ensure that professional development committees exist, that an annual educational needs assessment is conducted and that there is an adequate budget for nursing education.*

As the following comments indicate, respondents identified that discipline-specific issues are often neglected when no formal designated practice leader or committee is in place.

> *There is not a great deal of proactive work around Nursing since we shifted away from a discipline-based structure in the early 90's.*

> *In practical terms, there is little time nor support for a disciplinary focus of any kind since the highest value is placed on inter-disciplinary work…*

> *Over the years we have invited speakers from College of Nurses etc. to discuss professional issues and invited all of the nurses in the agency to attend. However this has fallen off over the years as we have become more program specific.*

The Community Health Nurses Initiatives Group (CHNIG) provided anecdotal information from nurses working in the Healthy Babies, Healthy Children Program in health units that do not have a formally designated Chief Nursing Officer. CHNIG described how some of these nurses report to non-nurse managers "with minimal understanding of the nursing process. Consequently, they receive minimal support for their professional practice." These nurses report that some of these managers place such strict parameters on home visiting that nurses have minimal time for nursing assessments, interventions, client advocacy, breastfeeding home visiting or clinics. They noted that in some of these communities, there is no other breastfeeding support service. The following comments reflect the experiences of those who responded:

> *Nurses have consulted with the College of Nurses of Ont*[ario] *about these and similar practice issues. They were advised that PHNs* [public health nurses] *would not be meeting professional standards of practice if they did not offer support when the client has been assessed by the nurse as needing nursing intervention. Consequently, a few PHNs in some areas have decided to do the needed home visiting on their own time.*

> *Nurses are experiencing declining job satisfaction, decreased respect for their professional abilities and increasing frustration over limitations placed on their practice. They are looking for some strategies that will support them in their role as registered nurses. In listening to their stories and experiences I believe that formally designating a Chief Nursing Officer in each Health Unit who is a strong advocate for professional nursing practice standards will offer some needed support to these front-line nurses.*

Summary

Nine of seventeen health units (52%) responded to this informal request for information about their current activities related to a Chief Nursing Officer. One reported a plan in progress and two were exploring the issue. All had informal arrangements whereby a nurse who is a manager or director assumed varying scopes of responsibility for professional practice issues. Several themes emerged. These included:

- Decreasing attention paid to professional issues with the move to a program-based structure
- Competing demands of program-based responsibilities for those who had informal roles for professional practice issues
- Overall support by nursing respondents for the assignment of discipline-leader roles at a managerial or director level to ensure direct input into decision-making, policy and procedure or to address potential liability issues.

One health unit stated a concern that a compensation issue might arise from formal job evaluation, if some individuals at the same organizational level and salary grid carried additional responsibilities for professional practice.

A Nurse's Story[1.]

During the course of developing this report, Work Group members had occasions when they met with colleagues from other health units for program purposes. On at least one of these occasions a member mentioned in passing the planned restructure of the Middlesex-London Health Unit and the Work Group's assignment. A nurse from another health unit, who reported to a non-nurse manager passed the following note to the committee member:

> *Reorganization of our Health Unit 5 years ago left us without a Nursing Leader. Since then I have been asked to make baby visits when I was sick. The purchase of scales to weigh babies was cancelled. Computers were ordered instead -- our work is not recognized as important.*

> *Managers are continually arguing with the College of Nurses, and new PHN's are left with little or no orientation (certainly no mentoring).*

> *Our manager continually is unable to understand the difference between acute care and health promotion. Programs are put before the consideration of patient care.*

1. Used with permission.

Discussion and Implications

Both external key informants and MLHU nursing staff indicated an overwhelming support for a formalized senior nurse position that has decision-making authority at the senior management level. These findings are consistent with the literature.

Competent professional practice is viewed as the foundation for proficient client-centered service (Young et al., 1997). Nursing leadership at the senior management level is essential to ensure the delivery of quality care (Brittan & Langill, 1997). Adamson et al. (1999) found that it was impractical and confusing to the staff to have a 'Professional Leader" in a staff role at the London Health Sciences Centre which was reorganized to program-based structure in 1995. Magnet hospitals in the USA are recognized for their ability to recruit and retain nurses leading to better patient outcomes. Nursing leadership that is highly visible, exacts high standards of nursing practice and upholds a position of power and status within the hospital organization, is one key to magnet hospital success (Scott, et al., 1999).

The responsibilities, skill sets and personal attributes of the senior nurse identified in the findings are consistent with those cited in the literature. Leadership qualities, relevant experience, and graduate education are the requisites for this nurse leader position (Comack et al., 1997). In the findings, the suggested role expectations of the 'senior nurse' appeared to be all-encompassing as expressed by one respondent: "It will be difficult to find one person skilled and knowledgeable in so many different areas." Therefore, role clarity, with clear levels of authority, accountability, and working relationships, is important to ensure successful implementation of the nurse leader role (Brittain & Langill, 1997).

The perception that the practice of nursing is not being valued, associated with the feelings of anxiety and fear due to organizational change, are serious concerns expressed by the respondents. "Fear is a powerful deterrent to successful change" (Sorells-Jones, 1997). Structure and process that would empower staff are necessary for a smooth transition to the new culture (Comack et al., 1997). Both the external and internal respondents recognized the importance of organizational support at all levels as an essential element to sustain the senior nurse role. Organizational support was also identified as a major challenge for implementation of the senior nurse position.

None of the health units where the key informants worked had a formal evaluation process in place for a nurse leader role. Evaluation of the nurse leader role over time is important to gauge its impact on the nursing practice in restructured organizations. Some methods for evaluation may include staff satisfaction and empowerment surveys, client and staff focus groups, annual performance reviews, research projects and publications (Bournes & DasGupta, 1997; Ross et al., 1996).

After carefully reviewing the findings and the literature, the Work Group, set about the task of how best to address the process for managing professional nursing practice issues within the program-based structure being implemented at Middlesex-London Health Unit. During their deliberations, members were clear that management of professional nursing issues included anticipatory and proactive measures (such as updating nurses on changes in legislated/ regulated requirements and standards) as well as dealing with professional practice issues that arise in the course of day to day public health nursing. The Work Group differentiated between professional practice issues and clinical practice issues. They particularly liked the concept of a "context expert" rather than a "content expert" and recognized that whatever mechanism was put in place to deal with practice issues, the person(s) responsible would be accountable to the nurses working in the agency as well as to the agency.

The members acknowledged that in one health unit, a senior nurse role was discontinued because of a lack of practice issues and that one acute care respondent had hinted that there might not be issues at a health unit due to a smaller nursing staff and the homogeneity of their education. Still, the Work Group concluded that it would be more strategic for the health unit to create a formal mechanism than not to do so. Lastly, the Work Group recognized that professional practice issues are enmeshed with agency accountability and liability and that public health nurses constitute the largest discipline working for the Middlesex-London Health Unit; especially for these reasons, along with need for visible, cross-disciplinary support, they decided that a mechanism for ensuring nursing representation at the senior management level was imperative.

There were other areas of discussion as well. Members of the Work Group were intrigued by the concept of "magnet" hospitals and briefly discussed the possibility of actively building "magnet" health units. In contemplating the fact that the practice

issues were likely to be similar from one program-based health unit to the next, and realizing that health units in the Southwest regions might not have the human resources to attend to professional issues, the Work Group also discussed the feasibility of one mechanism/role that would serve several health units or even the entire region. The recommendation concerning this was made with caution because some members of the Work Group anticipate that the nursing representation at the senior management level of the relevant health units could be compromised. This concern was counterbalanced by the possibility of a consistent, dedicated, reliable and credible mechanism for public health nursing in the Southwest.

Limitations

1) Process

The timeline for conducting this study restricted the amount that could be reasonably done, especially when it was concurrent with a restructuring process, accreditation preparation and other full-time job responsibilities.

Given a longer time line or more resources the committee would have:

- Sought representation from other disciplines within the health unit
- Sought external representation
- Consulted more widely within all the sectors in the report
- Used additional strategies for consultation, such as focus groups.

Dealing with professional practice issues in a program-based structure is relatively new to public health. Mechanisms are not well established or evaluated.

2) Recommendations

Parameters were set on the recommendations in that it was clear from the beginning that any allocation of human resources would have to come from within the existing complement and that no new positions could be created. Further it was clarified that increasing the number of people who are part of Directors' Committee would not be an acceptable option.

Given these restrictions the committee:

- Did not take into consideration the possibility of recruiting from outside of the health unit
- Recognized that the duties for the Professional Leader and Professional Practice Council would likely be in addition to current duties and thus restricted the time allocation
- Determined that the importance of the Professional Leader being a Director outweighed the limitation that there is a minimal number of qualified nursing candidates to choose from
- Acknowledged that the Director/Professional Leader may need to respond to organizational issues in which professional and program priorities conflict; this situation is no different in discipline-based structures where a Director of a discipline may experience the same conflict.

The Work Group recognized the importance of implementing the recommendations concurrent with the timeline for restructuring. This timeline restricted the viable options for the selection process.

Recommendations

The Work Group recommends that:

1. The Middlesex-London Health Unit will best address professional nursing practice issues by creating a formal mechanism within its new program-based structure. This formal mechanism should take the form of a Professional Practice Council-Nursing and a formally created role of Professional Leader-Nursing.

2. Management at Middlesex-London Health Unit facilitate the establishment of a Professional Practice Council–Nursing by ensuring that there is nursing staff representation from each Service in which nurses work, in addition to the Professional Leader–Nursing (see Appendix H for draft terms of reference). Further, that management initiates these mechanisms to coincide with the implementation of the program-based structure for the Health Unit, i.e., January 8, 2001.

3. The Medical Officer of Health assign the role of Professional Leader–Nursing to a Service Director who is a nurse, for a two year term and allot adequate time for the Professional Leader to meet the related responsibilities and to be accessible, in this role, to Health Unit staff. The Professional Leader will take the lead in establishing the Professional Practice Council-Nursing. Thereafter, the Professional Practice Council–Nursing will assign the role to a candidate who has the qualifications and attributes they have established for the role (see Appendix I for draft role description). The Professional Leader-Nursing will have dual accountability – to the Council and to Directors' Committee.

4. A budget and support staff time is allocated to the Leader and Council to support implementation of an action plan.

5. Management ensure that all staff at MLHU are oriented to the role of the Professional Leader-Nursing.

6. A formal evaluation of the effectiveness of the Professional Leader role and the Professional Council role is initiated in the first year and completed in the second year. The Council provides the leadership in setting up a process for evaluation. Strong consideration should be given to involving an evaluator external to the Council.

7. A Board report be prepared annually outlining the activities and outcomes of the Council and the Professional Leader-Nursing.

8. Concurrent with implementing the other recommendations, the Middlesex-London Health Unit explore the feasibility of negotiating with other health units in Southwest Ontario to cost share a full-time Professional Leader–Nursing who would serve all of the cost-sharing health units.

9. Management ensure that this report be widely disseminated to all MLHU staff, MLHU Board of Health through a Board Report, MLHU library, Ontario Health Units, ANDSOOHA, the Provincial Chief Nursing Officer, the Chief Medical Officer of Health, RNAO, CHNIG, UWO Faculty of Health Sciences, and all respondents who participated in the interviews for this report.

10. The Work Group be disbanded.

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Annotated Bibliography

1. Adamson, B., Shackleton, T. L., Wong, C., Prendergast, M., & Payne , E. (1999) The criteria of a professional leader role in an academic health sciences centre. Health Care Management Forum, Summer, 12 (2), 42-47.

Setting: Victoria Campus, London Health Sciences Centre, London, Ontario
Title Used: Profession Leader

A Nursing Profession Leader (PL) was one of 14 positions designated for each of the clinical professions identified in the 1995 organizational restructuring. The mandate of the new role was to 1) facilitate the advancement of professional practice; 2) promote discussion of professional issues within the organization; 3) represent the profession in internal and external forums; 4) develop and foster links with the university to promote education and research; 5) optimize opportunities to enhance the level of interdisciplinary processes across the organization; and 6) manage core functions of the discipline as assigned. The role was seen as similar to former departmental, supervisor or manager roles in the previous organizational structure.

Four key components were common to all PL roles: professional leadership for practice; professional education and research activities; quality improvement; and profession resource planning. Specific activities for each component are included on page 43. Time commitment for the PL role varied by the size of the discipline and was negotiated with individual PLs. The authors acknowledge that the time required to prepare, educate and provide ongoing support to professional staff involved in the organizational change was underestimated.

Core competencies used to select internal candidates were: transformational leadership skills, commitment to interdisciplinary practice and patient-centred care, excellent verbal and written skills, political and health systems awareness, consumer and community responsiveness, professional issue expertise, change agent skills, collaboration and team building skills, commitment to academic pursuits, flexible, innovative, excellent conceptual and problem solving skills and systems thinking.

A matrix reporting structure was used whereby PLs reported to the Vice-President of Patient-Centred Care and to the Manager of Patient Care Support Services (for further detail see pg. 43). Determining appropriate compensation was an unresolved implementation challenge.

An important aspect of operationalizing the PL role in this setting was the creation of PL Council. An overview of this group including accountability and core functions are outlined (see pg. 44).

The authors conclude that strong leadership and specific purposeful administrative strategies are required for the introduction and administration of any new role in a dynamic changing environment. Profession leadership was seen as an essential component of organizational renewal and especially critical to empowering staff in developing new competencies, developing greater appreciation of the interdependencies among professions and enhancing ability to function more autonomously in the transition to a program management organizational structure.

2. Aiken, L.H. & Patrician, P.A. (2000). Measuring organizational traits of hospitals: The revised nurse work index. Nursing Research, 49 (3), 146-153.

Setting: USA
Title Used: N/A

The organizational context in which nurses practice is important in explaining variation in patient outcomes, but research had been hampered by the absence of instruments to measure organizational attributes empirically. The revised Nursing Work Index (NWI-R) was used in a national AIDS care study and was found to capture organizational attributes that characterize professional nursing practice environments. The NWI and NWI-R were developed directly from the findings associated with the early research on magnet hospitals.

A professional nurse practice environment empowers nurses to exercise control over the delivery of nursing care and provides them with increased opportunities for autonomy, accountability, and control over the environment in which they deliver care.

Characteristics of these practice environments were first identified in the 1980's with research into the 'magnet' hospitals that were able to recruit and retain nursing staff. These hospitals were 'characterized by their staff nurses as having adequate staffing levels; flexible scheduling; strong, supportive and visible nurse leadership; recognition for excellence in practice; participative management with open communication; good relationships with physicians; salaried rather than hourly compensation for nurses; professional development; and career advancement opportunities. These institutions were also found to have a somewhat richer nursing skill mix, reflecting the high priority they placed on quality patient care" (p. 147).

Later studies showed that magnet hospital nurses reported greater job satisfaction and adequate to excellent staffing levels. These hospitals were successful in attracting and retaining nurses over at least a decade despite cyclical national and regional nursing shortages. They also demonstrated lower mortality rates than matched controls.

3. Brittan, B., & Langill, G. (1997). Structuring the design and implementation of leadership and teamwork for program management. Health Care Management Forum, 10 (2), 50-52.

Setting: Royal Ottawa Health Care Group
Title Used: Discipline Leader

As part of a program management model, discipline leader roles were created to monitor and ensure the quality of care provided by various clinical disciplines. The authors highlight in their conclusions the importance of clear accountability, clear working relationships and accountability between discipline leaders and program managers and clear role relationships.

4. Bournes, D. A. & DasGupta, T. L. (1997). Professional practice leader: A transformational role that addresses human diversity. Nursing Administration Quarterly, 21 (4), 61-68.

Setting: Sunnybrook Health Science Centre, Toronto, Ontario
Title Used: Professional Practice Leader

This article used Parse's Theory of Human Becoming and describes the Professional Practice Leader's role as providing leadership that facilitates a shift from nursing that focuses on assessing, diagnosing and categorizing clients into pre-established problem-oriented categories to one where the nurse works in true partnership with clients. The role description offered for the PPL is closer to that of a Clinical Nurse Specialist as described in other literature. A definition of shared governance (sharing responsibility & accountability for practice) is included (pg. 63). The authors do emphasize that one of the key roles of a PPL is to create an environment where it is safe for nurses to create visions and challenge current reality. They comment: "There is nothing more important than a supportive environment when persons are in the process of disengaging themselves from old expectations, old assumptions and old identities. The neutral zone must be crossed before one feels comfortable with a new identity based on new conditions" (pg. 65).

5. Buchan, J. (1994). Lessons from America? US magnet hospitals and their implications for UK nursing. Journal of Advanced Nursing, 19, 373-384.

Setting: N/A
Title Used: N/A

This paper critically reviews the appropriateness of the concept of the USA magnet hospitals for the UK nursing market. It reviews key characteristics of 'magnet hospitals' that typically demonstrate lower nurse turnover and higher levels of reported job satisfaction than other hospitals. Detailed case studies of employment practice in 10 USA hospitals and 10 Scottish hospitals are reported with attention to remuneration, methods of organizing nursing care, establishment-setting and flexible hours. The paper concludes that there are features of magnet hospitals that are relevant and applicable to the UK but cautions against a piecemeal approach. "Successful employment and deployment of nurses is not automatic result of adopting any particular form of managerial practice or organizational structure. …The commitment of management, and the availability of appropriate resources and expertise is also required" (p.384).

6. Buchan, J. (1999). Still attractive after all these years? Magnet hospitals in a changing health care environment. Journal of Advanced Nursing, 30 (1), 100-108.

Setting: Hospitals in the USA
Title Used: N/A

'Magnet hospitals' is a term used to highlight hospitals that have a good reputation for recruitment and retention of registered nurses. This study examines the research base for magnet hospitals and assesses the relevance of the concept to hospitals in the United Kingdom. Key characteristics of magnet hospitals are grouped into three main categories: administration, professional practice and professional development.

Characteristics of administration include a participatory and supportive management style, well-prepared and qualified nurse executives, a decentralized organizational structure, adequate nurse staffing, deployment of clinical specialists, flexible work schedules, and clinical career opportunities (clinical ladders).

Professional practice characteristics that contribute to a magnet hospital include professional practice models of delivery of care, professional autonomy and responsibility, availability of specialist advice and emphasis on teaching responsibilities of staff.

In the area of professional development, magnet hospitals usually have a planned orientation for staff, with emphasis on service/continuing education, competency based clinical ladders and management development.

With respect to administration, there is emphasis on open, participatory management with an emphasis on two-way communication with staff and led by well-qualified nurse executives in a decentralized structure.

These characteristics are not in themselves new or novel but magnet hospitals plan for and integrate these characteristics within a strategic framework.

Recent research has linked organizational characteristics of hospitals with outcomes of care (i.e., mortality rates), reflecting new priorities in the management of nursing resources in the USA.

Staff shortages are not currently a main policy issue in the USA but quality of care and organizational efficiency in health care are now key factors. Magnet hospitals appear by one measure to provide better care.

The American Nurses Credentialling Center (ANCC) has established a magnet-oriented credentialling system for hospitals in the USA. Their approach monitors and revisits participant organizations. The authors support both monitoring and a process of re-accreditation to maintain a 'live' register of magnet hospitals.

The US Congress established an Institute of Medicine Commission to examine the adequacy of the nursing workforce in the USA to meet health care demands. The Commission, in its report expressed concern about the increased use of ancillary nursing personnel as employers come under increasing cost-containment pressure and resort to 'cheaper' mixes of staff. Cost containment has driven changes in the nursing labour market and organization of US hospitals; the result has been that some of the first-identified magnet hospitals have lost core characteristics of 'magnetism' while other have retained these characteristics despite organizational change..

7. Comack, M., Brady, J., & Porter-O'Grady, T. (1997). Professional practice: A framework for transition to a new culture. Journal of Nursing Administration, 27 (12), 32-41.

Setting: Toronto East General, Toronto, Ontario
Title Used: Profession Leader

Ensuring that professional practice standards continued as the hospital moved to population-based services was identified as an important issue. The personal attributes of the experienced, knowledgeable individual traditionally providing professional leadership in the role of manager or director were identified as a potential missing link in the new system. The authors describe an Essential Elements Model (see pg. 34) which articulates independent and

interdependent functions of the Profession Leader within four domains – practice, leadership, research/CQI and education with activities identified for each domain (e.g. regulations, standards, professional development, profession leadership, research, vision, creativity). The role of the PL was held by unionized staff. This position was seen as an interim step to ensure the integrity of each profession during the transition to a new culture and combined direct care responsibilities with what traditionally is considered management responsibilities. The newly defined PL accountabilities were similar if not the same as the supervisor's role in the previous structure. Salary remuneration was identified as an unresolved issue. The authors provide a thorough description of two groups – Professional Practice Committee and Nursing Practice Council. Both were identified as temporary with specific terms of reference and work plans.

8. Hoffart, N., & Woods, C. Q., (1996). Elements of a nursing professional practice model, Journal of Professional Nursing, 12 (6), 354-364.

Setting: N/A
Title Used: N/A

This article is included for two key points: accountability without power leads to frustration and failure (p. 361); it takes at least one year for an innovation to "settle in", hence repeated follow-up surveys after that period are recommended (p. 362). An interesting article that describes a professional practice model designed to support nurse control over the delivery of nursing care and the environment in which care is delivered.

9. Kramer, M. and Schmalenberg, C. (1988). Magnet hospitals: Part I. Institutions of excellence. Journal of Nursing Administration, 18 (1), 13-24.

Setting: USA magnet hospitals
Title Used: N/A

Using the eight characteristics identified by Peters and Waterman in their book *In Search of Excellence* this study analyzes 16 magnet hospitals to determine if they possess characteristics similar to the best run companies in the corporate community. Analysis indicates a strong correspondence and that these conditions have enabled the studied hospitals to deal effectively with the nursing shortage. The article then examines how these hospitals have integrated the first three principles of excellence: bias for action (fluidity and informality that allows for quick and easy communication at all levels), staying close to the customer to ensure a quality product and service reliability, and fostering an environment of autonomy and entrepreneurship that supports experimentation from both a value and a physical resource perspective.

10. Kramer, M. and Schmalenberg, C. (1988). Magnet hospitals: Part II. Institutions of excellence. Journal of Nursing Administration, 18 (2), 11-19.

Setting: USA magnet hospitals
Title Used: N/A

The authors continue their examination of magnet hospitals with respect to the identified characteristics of best-run companies in the corporate community. These characteristics include productivity through people (treating people with dignity and high performance expectations), and a hands-on, value driven culture leadership (leaders create, instill and clarify the value system of the company).

Leadership is an interactive flow of pathfinding, decision-making and implementation. One individual is not enough; it is the team at the top that is crucial. Top nursing executives in magnet hospitals were seen as visionary, enthusiastic leaders in nursing who "stir emotion" and were supported by a strong, cohesive and well-educated nursing management team.

Unlike excellent corporations that remain with the business they know best, magnet hospitals were diversifying.

Magnet hospitals demonstrated a strong belief in decentralization, and especially valued the quick decisions and quality actions that the flexibility and control of practice at the unit level permitted, although some were moving toward more centralized standards for documentation, records and some policies and procedures. Magnet hospitals also demonstrated loose-tight properties wherein there is lots of individual autonomy, flexible

organizational structure, extensive experimentation, copious feedback and informality coupled with a tight, culturally driven and controlled seer of rigidly shared values.

The authors conclude that health care organizations need to look to the characteristics of both the excellent companies and the magnet hospitals as models. They assert that more attention is needed in selection of management teams who can instill, clarify and protect the agency's core values and that there must be congruence between nursing's core values and the remainder of the hospital. In magnet hospitals, patient care is the product and nursing is the main department in this product line. "The central theme of all excellent companies is that everything, all other departments, must support the product line"(p. 17).

Magnet hospitals have created conditions that minimize the internal nursing shortage; nurses prefer to work in these hospitals.

11. Kramer, M. (1990). The magnet hospitals. Excellence revisited. Journal of Nursing Administration, 20 (9), 35-44.

Setting: USA hospitals
Title Used: N/A

One third of the magnet hospitals that were identified in the original study by the American Nurses' Association were revisited in 1986 and again in 1989. Generally these were acute care, urban and medium to large-sized community or medical center hospitals. Although some of these hospitals have increased the number of beds and others decreased, overall they have maintained their market share. All of these hospitals reported selectivity in filling staff vacancies while about half noted that qualified applicants for leadership and managerial positions were much scarcer than for experienced staff positions.

Most dramatic in the changes observed was the debureaucratization of the nursing department through flattening of the structure and increased professionalization, as evidenced by a larger percentage of registered nurses in the department work force. Flattening resulted in a marked increase in the nurse managerial span of control and flattened departmental structure. Layers of clinical decision-making above the level of the head nurse were markedly reduced or eliminated. Assistant directors of nursing were specialists in budget, financial, strategic or operational planning, education and research, personnel issues, etc. Staffing, scheduling and staff replacements were decentralized to the unit or service level. Concurrently, the number of patient care units for which head nurses were responsible were increased.

About half of the magnet hospitals in the study had moved to a salaried status for nurses. Most of the hospitals had a system of autonomous, self-managed, self-governed operation at the unit level and systematic, participative, representative involvement by unit staff nurses in nursing department-wide governance issues, especially related to clinical decision-making and nurse-physician collaboration.

Nursing care delivery systems seemed to be in an experimental phase with two trends emerging: an all RN staff with some nursing and non-nursing assistants assigned to the nurse and/or differentiated practice at the RN level based on educational preparation.

Findings around core values of these hospitals are in line with research around the core values of best run companies. There is a culture of excellence, of respect for all, of competence and scholarship, of quality care through autonomy at the front-line, competence and pride in self and work, and cost-effectiveness.

Quality nursing leadership is essential to a culture of excellence.

12. Mason, D. (2000). Nursing's best-kept secret. Magnet hospitals can save health care. American Journal of Nursing, 100 (3), 7.

Setting: USA hospitals
Title Used: N/A

External consultants to hospitals have advised hospitals to meet financial goals by reducing professional nursing staff. There is an alternative. 'Magnet hospitals' are cost-efficient, have shorter lengths of stay, higher patient satisfaction rates, lower mortality rates and lower rates of nurse burnout and needlesticks to nurses. The American Nurses Credentialling Center (ANCC) accredits magnet hospitals and has demonstrated that nurses at ANCC magnet hospital "have fewer patients in their workloads, better support services, greater participation in policy decisions, and more powerful chief nurse executives" (p. 7).

13. McDaniel, C. and Wolf, G. (1992). Transformational leadership in nursing service. A test of theory. Journal of Nursing Administration, 22 (20), 60-65.

Setting: Nursing department of one Pennsylvania, USA health facility
Title Used: Nurse executive

In this study the authors test the theory of transformational leadership in one nursing department with an executive, mid level administrators and staff nurses. Transformational leaders pay attention to employees and demonstrate an understanding of the specific employee situation. Followers exhibit a desire to emulate the qualities of the their leader and are stimulated by their leader to be intellectually curious, try out new behavior and seek new solutions to old problems. Transformational leadership is shown to be highly congruent with the characteristics of magnet hospital leadership and is related to work satisfaction and higher productivity among employees. Dimensions of transformational leadership can be learned in leadership programs. Nurse executives can model these behaviors and create structures to reinforce these qualities. Such structures may take the form of innovation teams, problem-solving groups, quality circles, journal clubs, committee structures or inservice programs.

14. Rose, M. D., & Reynolds, B. M., (1995). How to make professional practice models work. Critical Care Nursing Quarterly, 18 (3), 1-6

This article addresses issues related to designing and implementing a professional practice model, principles for successful organizational change and changes in the nurse manager's role necessitated by a changing work environment. It is included in this annotated bibliography for its reference to the following: 1) the reasons for implementing a model must be unique to the particular setting; 2) mapping the boundaries of authority, and control fosters trust between management and staff; and 3) if clear role expectations are not defined, confusion and distrust will occur.

15. Ross, E., Macdonald, C., McDermott, K. and Veldhorst, G. (1996). The chief of nursing practice: A model for nursing leadership. Canadian Journal of Nursing Administration, 9, (1), 7-22.

Setting: Women's College Hospital, Toronto, Ontario
Title Used: Chief of Nursing Practice

With reorganization in 1991 to a program management structure, issues identified by nursing staff included: 1) loss of a voice for nursing at the senior management level; 2) maintenance of professional standards of nursing practice; 3) representation to the external nursing communities; and 4) links with the academic community. A task force, with internal and external nursing representatives recommended that a new senior nurse position – Chief of Nursing Practice, reporting directly to the Board and CEO be established. The authors clearly acknowledge that the importance of this position reporting to the Board and CEO cannot be overstated.

Role expectations included: 1) articulating a vision for nursing; 2) enhancing the value and image of nursing within and externally; 3) maintaining and strengthening contact with external nursing communities; 4) being a resource for nursing practice issues; 5) developing and directing decision-making committees for professional practice; 6) being a nursing voice on senior level committees; and 7) advancing nursing research and nursing practice. Personal prerequisites identified for the position were: honesty, integrity, humour, enthusiasm, energy and exemplary communication and listening skills. Role requirements identified by the task force included educational

qualification of Master's in Nursing, with PhD preferred, demonstrated evidence of supporting nurses with political activity and demonstrated active involvement in nursing organizations at the provincial and/or national level.

The authors emphasize that when traditional management roles are eliminated, new models of nursing leadership are needed if nurses are to continue to provide quality patient care. The position of the chief of nursing practice is a role model for nursing leadership and one viewed as pivotal for the professional identity of nursing and for the provision of high quality patient care. Evaluation within 3-5 years is suggested.

16. Scott, J.G., Sochalski, J. and Aiken, L. (1999). Review of magnet hospital research. Findings and implications for professional nursing practice. Journal of Nursing Administration, 29(1), 9-19.

Setting: USA hospitals
Title Used: Nurse administrators, Chief Nurse, Nurse Executive

This article synthesizes the magnet hospital research that describes and evaluates the professional practice of nurses within these institutions and it identifies areas for future research to advance professional nursing models within current hospital organizations.

Research subsequent to the identification of characteristics on magnet hospitals illuminated the professional nursing practice of nurse administrators and staff members. Visibility and staff support were reported as important and effective traits of magnet hospital nurse leaders.

Leadership attributes of the nurse administrators were identified and included:

- Is visionary and enthusiastic
- *Is supportive and knowledgeable*
- *Maintains high standards and high staff expectations*
- *Values education and professional development of all nurses within the organization*
- *Upholds position of power and status within the hospital organization*
- *Is highly visible to staff nurses*
- *Is responsive and maintains open lines of communication*
- *Is actively involved in state and national professional organizations (p.10).*

Chief nurses at magnet hospitals were able to create an organizational culture that enhanced staff satisfaction and fostered professional growth through autonomy, collaborative relationships, and status. Although the administrators' active involvement in staff issues existed, it did not result in authoritarian control over clinical issues. . The nurse executives' presence and communication skills supported staff involvement in decisions and their control over patient care issues.

Nursing staff in magnet hospitals also exhibited characteristics in common. These included their ability to establish a patient-nurse relationship, autonomy and control and the presence of collaborative nurse-physician relationships at the level of the patients.

When compared with matched control hospitals, magnet hospitals showed lower mortality rates and higher patient satisfaction.

The authors assert that the leadership attributes of nurse executives remain relevant in contemporary health care settings and that there is increased demand for nursing leaders to use these skills in communities. The nurse executive is a team builder who supports the professional development of staff that fosters both accountability and sounder clinical decision-making. The nurse leader must understand both the clinical discipline of nursing and the major financial and other challenges that an institution faces. " If the nurse executive is perceived as such a leader, the nursing organization may be integrated into the larger institution without losing its identity. Also, the greater

visibility of the nurse executive to the staff nurses fosters recognition of their work and gives them greater opportunity to express their concerns and suggestions" (p. 10). Communication between the nurse executive and the staff must be open and effective. Communicating about nursing to those outside the institution in dealing with funding issues, patient advocacy, and shaping public opinion on health care issues, is becoming increasingly important.

17. Sorrells-Jones, J. (1997). The challenge of making it real: Interdisciplinary practice in a "seamless" organization. Nursing Administration Quarterly, 21 (2), 20-30.

Setting: University of Virginia Medical Centre, Charlottesville, Virginia
Title Used: Lead Role

This article describes restructuring in an academic medical centre which saw the Division of Nursing eliminated along with 35% of previously existing management positions. The title of nurse manager was also eliminated and the position of patient care services administrator introduced. A chief nurse executive with a dual role as chief patient services officer was included in the new model. One of the biggest concerns with restructuring centered on a professional identity. The author acknowledges that many legitimate functions are served by an unidisciplinary department in addition to administrative functions such as: 1) co-ordinating education activities for discipline members and students; 2) easy access to expert professional consultation; 3) oversight of the discipline's standards of care and practice; 4) socialization of new practitioners into the discipline; 5) high level peer review activities that require knowledge of the professional practice of the discipline.

The need for a professional spokesperson or "point person" was identified for all major professional disciplines. The term "lead role" was adopted. The lead role is a staff role, not a line one, and included no administrative responsibilities. The role focused on professional issues and on being the professional leader of the discipline. The individual selected for this role is given time up to 50% for these professional duties. Activities include: convening regular meetings of the discipline staff, ensuring that all of the professionals of a particular discipline have an opportunity to meet regularly, to maintain their own professional identity and relationships and to deal with discipline-specific practice issues and standards.

The author differentiates between multi-disciplinary and interdisciplinary practice (see pg. 26) and concluded that most professionals simply do not know how to work together in teams, especially teams of "equals". Several contributing factors were identified including: an astonishing lack of understanding between disciplines about practices of each other; problematic lack of a common vocabulary; limited ability or apparent willingness to confront and handle conflict. These factors are not unlike the experiences of others in other settings, but this facility was surprised by the depth and intensity of all of the contributing factors. At the time of writing, "leads" were continuing in place for each of the major professional disciplines. Limited discussion of specific implementation issues related to restructuring is evident.

18. Young, J. M., Ang, R., & Findlay, T. (1997). Interdisciplinary professional practice leadership within a program model: BC Rehab's experience, Health Care Management Forum, 19 (4), 48-50.

Setting: BC Rehab, tertiary care rehabilitation facility
Title Used: Practice Leader

Issues identified as this facility shifted from a departmental organizational structure to a program management model included: maintenance of professional standards, education of students, loss of professional identity and continuing education. Accountable to the Vice President, Professional Practice Leaders (PL) were designated for each of 10 disciplines. PL responsibilities crossed all services and programs and included: 1) provision of effective and efficient clinical service; 2) establishment of standards of practice; 3) coordination of student education; 4) promotion and facilitation of continuing education and research; 5) monitoring issues and trends in professional practice; 6) development of practice goals and objectives; 7) establishing and evaluating discipline specific quality management practices. Practice Leaders are included in decisions concerning human resources, quality management, research, professional development and student education. Additional responsibilities included: development of committees and delivery systems to support professional practice, assessment of discipline education needs, management of budgets for professional development within the specified discipline and implementation of educational programs.

Effective working relationships with academic institutions, professional licensing associations and other external agencies as well as having an academic appointment were identified as important for several reasons, i.e. to keep informed of developments within the discipline, to employ external resources to further professional practice within the agency and to positively influence professional practice and teaching within the external community. The PL's work closely with Program and Service Directors, e.g. Human Resources to define professional qualifications and competencies, to determine staff requirements, orientation, hiring, performance appraisals and disciplinary activities.

The amount of time allocated to the role varied primarily on the number of staff within the discipline (e.g. Nursing, OT, PT and Social Work were full time positions).

Lack of clarity around the roles of Program Directors and PLs was a major concern. Although PLs in this model have no final authority over budgets, and Program Directors made the final decisions in all administrative matters, they were compelled to work with PLs and Clinical Program Directors in coming to decisions. Biweekly meetings of PLs, Vice President of Rehabilitation and Residential Services and Program and Service Directors served as a forum for discussion, information sharing, problem solving, operational decision making and consensus building around common issues.

The authors acknowledge there is a danger that "leadership and authority within a professional discipline may be viewed as holdovers or remnants of the departmental model and therefore incongruent with program management". They conclude that it "must be remembered however that competent professional practice is the foundation of clinical services". Practice leaders were viewed in this organization as being in a unique position to promote interdisciplinary client-focused services and to foster collaborative approaches where otherwise adversarial or competitive relationships may exist.

Appendix A – Correspondence from Nursing Action Team - including notes from September 19, 2000

Dr. Graham Pollett
Medical Officer of Health
Middlesex-London Health Unit
50 King St.
London, Ontario
N6A 5L7

Tuesday, September 26, 2000

Dear Dr. Pollett,

Thank you for agreeing to meet with the Nursing Action Team of public health nurses this past week. We view your attendance at this meeting as a positive response to the collective concerns of Middlesex-London Health Unit nurses. It was important to these nurses that this forum be initiated so that our perspectives could be shared and so that we could receive information that had been previously unavailable to us. As discussed, please find enclosed the summary of our presentation in its unedited form.

We recognize that there is significant diversity of thought with respect to nursing leadership at Middlesex-London Health Unit.

We believe that, for the most part, our current questions have been answered, our perspectives have been heard and respected.

The Middlesex-London Health Unit has been a leader among Ontario health units in providing service to the public. This is due in part to the visionary thinking of nursing leaders who have worked collaboratively with colleagues in all circles – within the Nursing Division, the agency, within the broader community and across the province. For example, the Middlesex-London Health Unit Nursing Division retained home visiting as a priority vehicle for the delivery of health care to the most challenged sectors of our community. This set us in good stead for the implementation of the Healthy Babies, Healthy Children initiative.

We believe that to maintain this excellence, we must have an experienced nurse leader, with the power to make decisions at the senior management level (minimum director position). This person must be in a position to:

- ensure quality of nursing care,
- ensure quality of system effectiveness,
- allocate staff, financial and other resources,
- support new nursing leaders,
- contribute to the outcomes and successes of the current restructuring process, and

- be accountable directly to the Board of Directors.

We understand from our discussion with you:

- that you are committed to supporting a senior nursing leader role, as a necessary part of restructuring
- that the visioning and development of this role will fall within the responsibilities of the Senior Nurse Position Project Team chaired by Charlene Beynon, Director of Education and Research.
- that the Senior Nurse Position Project Team is currently in the process of developing terms of reference and a work plan.
- that staff input through the Nursing Action Team will be incorporated in the terms of reference formulation process.
- that these terms of reference will be made available to all staff.
- are confident that a CNO could be a likely outcome of the process described and that at this time, and
- that presenting to the Board of Directors would be "out of process" and premature, until the Senior Nurse Position Project Team makes its recommendations.

As you consider the issues that we have raised, and as you consider the value that a Chief Nursing Officer might have in the immediate transition toward restructuring, we would be pleased to work with both you and the assigned Senior Nurse Position Project Team to initiate this role at the earliest possible time. We believe that there is sufficient evidence to support the value and "fit" of this role at Middlesex-London Health Unit.

The Nursing Action Team has brought closure to our group's activities *with the understanding that future professional nursing issues will be managed* through the usual channels as needed. We look forward to your comments and reply.

Yours sincerely,

The Nursing Action Team

Contacts:
Pam Dietrich
Karleen Mepham
Maureen Mouritzen
Linda Olsen
Barb Sussex

cc Diane Bewick and Nurse Managers
Charlene Beynon

Meeting of the Nursing Action Team with Dr. Graham Pollett MOH
Middlesex-London Health Unit
Tuesday, September 19, 2000
Middlesex County Rooms 9 and 10
1200-1300 hrs

Agenda

1. Welcome and Background Information – Barb Sussex
   ONA Executive
   Moderator of today's discussion

2. Presentation of Rational for Chief Nursing Officer at MLHU

   Pam Dietrich, RN
   Public Health Nurse
   RNAO and ONA Member

   Karleen Mepham, RN
   Public Health Nurse and Coordinator of Family Home Visitors
   RNAO and ONA Member

   Maureen Mouritzen, RN
   Public Health Nurse
   RNAO and ONA Member

3. Dialogue among MLHU nursing staff and Dr. Pollett

4. Future planning

KEY POINTS FOR RECOMMENDING A CHIEF NURSING OFFICER OF HEALTH
Meeting between Nursing Action Team and Graham Pollett
September 19, 2000

QUALITY OF CARE

RNAO Definition

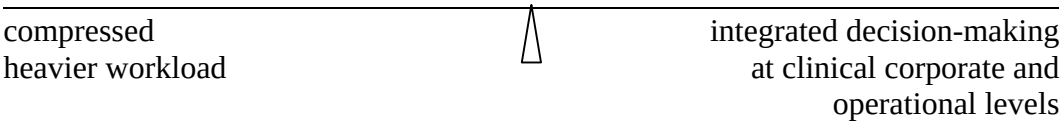
- Nursing contributes a holistic and comprehensive approach to health care that allows for integrated care to Ontario's communities

Discussion

- Quality of Care is a legislated requirement of all nurses in Ontario
- Quality of Care is impacted by a wide variety of variables such as leadership, professional development, performance appraisals
- Quality of Care is attained through accountability, leadership, advocacy and communication at every level of service
- The things that help this are a nursing analysis at all levels of service whether in 1:1, groups, populations, program or policy development
- This then helps nursing service to be bounded and non-diluted (in its practice/service delivery)
- Quality of Care is delivered in partnerships with the community. Public Health Nurses are uniquely educated at the baccalaureate level to be able to do this. Nurses have had a key role in establishing partnerships in the community and the public expects to see this. Partnerships are established and maintained by the skills that Public Health Nurses easily use. These partnerships act as vehicle to harvest the greatest potential in terms outcomes for clients and community
- "can't expect plumbing (Medical or other non-nursing leadership) to conduct electricity" (Nursing)

SYSTEM EFFECTIVENESS

- RNAO Definition the schemata below briefly demonstrates the current health care system



Nurses are able to:
assess
evaluate and
provide evidenced based practice
within this besieged situation

Discussion

- The assignment of Kathleen Macmillan to the provincial CNO position
  - "indicates how serious the Ministry is about strengthening the Nursing profession in Ontario"
  - Furthermore, "the Ministry is committed to following through all of the recommendations of the Nursing Task Force". This task force recommended nursing leadership that has the authority, accountability and autonomy to operationalize nursing care delivery (Supporting the Profession to Protect the Public).
- In the recent RNAO Policy Statement – Value of Leadership in Nursing Administration, it was identified that:
  - There is a "concern that Ontario residents are experiencing decreased access to professional nursing care" and that
  - Nursing leadership is particularly indispensable in times of tumultuous change"
- Quality of care, the health care system and the nursing profession are all interlinked components of the bigger system i.e., when one is adversely affected the others are impacted. When the nursing professionals involved in a system are not supported by qualified, discipline-specific leadership, many side effects are inevitable:
  - e.g. low retention of staff who want to be lead by nurses;
  - low staff morale and energy;
  - the inappropriate loss of nursing attention, focus and output related to continually having to orientate non-nursing leadership to nursing care
  - a lack of advocacy on the Nursing profession's behalf
- In February 2000 Memorandum to all MOHs in the province, Colin D'Cunha and Kathleen MacMillan jointly recommended that the contributions of Public Health Nurses be supported through the creation of visible leadership positions as recommended by the Minister's Task Force (i.e. leadership requires "authority and accountability for professional nursing practice, resource utilization and for decisions that affect the health care consumer")
- There is a risk of losing status as a Teaching Health Unit when nursing is one of the main professionals that would use the MLHU for student development

  e.g. student placements are in flux and in jeopardy because we can't make a commitment at this point

IMPLICATIONS FOR THE PROFESSION

RNAO Definition

- Leadership/mentoring
- Translation of bigger picture/evolving nursing knowledge theory
- Visionary
- Authority accountability and autonomy to operationalize nursing care delivery

Discussion

- Nursing like any professional discipline is best lead by its own discipline
- While the influence of other disciplines is beneficial, these other disciplines can hardly be expected to adequately provide the leadership that would understand promote strengthen or challenge the unique contribution that nursing provides to the community

- When clinical placements are being sought for nursing students, clearly present nursing leadership is a selection criteria. If this is absent in Public Health settings, then this is counterproductive to future the health of our community
- Less than half of the nurse registered are either not working of are ½ time and

RATIONALE FOR CNO

Discussion

- The Middlesex-London Health Unit has exhibited wisdom in the past, to do the "different thing", to be visionary and on the "cutting edge". This has proven to be most strategic and prudent. For example, keeping home visiting as a priority vehicle for the delivery of health care to the most challenged sectors of our community, set us in good stead for the implementation of the Healthy Babies, Healthy Children initiative.
- A CNO would be able to augment the big picture, multi sector perspective in which to position and predict future health care decisions.
- Why does a nursing leader need to be a nurse? Who else could support the following characteristics of Public Health Nurses?
    1. Public Health Nurses work outside the "medical model" of interpreting and delivering service to clients.
    2. Public Health Nurses also have a long history of comprehensive, integrated service-development, implementation and evaluation in the community.
    3. Public Health Nurses are familiar with the impact of the social determinants of health on the lives and health of the individuals, communities and whole systems. *This is one of our unique contributions and is unprecedented in any other profession.*
    4. Nurses have a social and political analysis that translates through service in such manners as advocacy and impacting on health care legislation for women, children and communities living in poverty.
    5. Public Health Nurses have a wide breadth of skills in communication, teaching, home visiting, assessment, service coordination, coalition building and much more. They also possess the ability to transfer these skills and knowledge from one situation to another. They are often the glue that holds together the fabric of communities and systems during change.

    Any leader, other than a nurse would not have the qualifications, analysis, interpretation or skills necessary to assist Public Health Nurses with the ongoing provision of this breadth of service to the community
- From recent survey, nurses are "the most trusted professional" in the public's eye
- Public Health Nurses are ambassadors and "communicators" for the health unit. Clear leadership that is congruent with nursing perspectives will support and enhance their ongoing "dialogue with community".

EXAMPLES OF OUTCOMES WHEN THERE IS A LACK OF *EMPOWERED* NURSE LEADERSHIP

Discussion

- different charting practices (?within College regulations or not)
- duplication of externally driven processes between 4 different divisions (e.g. performance appraisals)
- outflux of senior Nursing Managers (rationale)
- for nurses who are considering leadership, wondering who is going to be their leader
- workload of managers when they are having to mentor other non-nursing managers therefore less available to staff

Our mission statement declares:

1. *"we believe that staff are essential to the delivery of effective programs and services and therefore are our most valued resource"*
2. *"the organizational culture that fosters ongoing learning is essential to ensure excellence in public health programs"* and
3. *"the effective and efficient use of public health resources and in being accountable to our stake holders for the development and delivery of quality public health programs and services"*
4. *"community partnerships are essential to achievement of our common goals"*

For Middlesex-London Health Unit nurses, having access to mentorship, communication and learning opportunities *through a nursing leader* would be the best and most expedient way to ensure that these values are operationalized.

The RNAO task force recommendations are also in harmony with these values through the provision of a strong Nursing Leadership presence in Ontario health units.

What is the rationale for not having a CNO?

Appendix B – Work Group Members

Senior Nurse Position Work Group

Work Group Members

Charlene Beynon, Director REED Services, Chair
Yolanda Camiletti, Community Health Nursing Specialist
Nancy Forbes, Administrative Assistant
Amy Mak, Public Health Nurse (Replaced Linda Olson)
Linda Olson, Public Health Nurse, ONA Local 036, Bargaining Unit Representative (Replaced by Amy Mak)
Sharon Mytka, Manager, Public Health Nursing, Prevention Team
Barb Sussex, Public Health Nurse, ONA Local 036, Bargaining Unit President
Bob Totten, Acting Manager Human Resources & Labour Relations (Replaced by Louise Tyler)
Louise Tyler, Manager Human Resources & Labour Relations (Replaced Bob Totten)
Bonnie Lynn Wright, Nurse Researcher/Educator

Appendix C – Terms of Reference

Middlesex-London Health Unit
"Senior Nurse Position" Work Group
Terms of Reference

Purpose

The Work Group will develop recommendations for a role within the existing complement that ensures that on a continuing basis, issues related to the discipline and practice of nursing are identified and resolved.

Reporting Relationship

Accountable to the Directors Committee through the Chair.

Deliverables

The final product will be a report identifying recommendations re:

- scope of responsibilities i.e. role description[1]
- qualifications/skill sets required
- process for selection
- position title
- infrastructure required to support the implementation and sustainability of the role e.g. accountability, reporting structure
- process for evaluation, including who will be responsible for the evaluation

[1] Although the role may be filled by a member of the management staff, no staff will report directly to the role.

Timeline

Recommendations are to be presented to the Directors Committee at the December 13, 2000 meeting to allow implementation by January 8, 2001. The committee will disband following the presentation to Directors Committee.

Membership

Acting Director, Human Resources & Labour Relations Manager, 3 nursing staff, 1 Nurse Manager, Nurse Researcher/Educator, PHRED Program, Director, REED Services. Additional expertise to be sought as needed. Chair to be identified by the members.

Minutes

Approved minutes will be e-mailed to all nurses at MLHU. Minutes will be available from the Chair.

2000/09/21

Appendix D - Correspondence from Ministry of Health & Long Term Care, February 2000

Ministry of Health
and Long-Term Care

Ministere de la Santé
et des Soins de longue duree

Ontario

Public Health Branch
5th Floor, 5700 Yonge Street
Toronto ON M2M 4K5

Direction de la santé publique
5700, rue Yonge, 5e étage
Toronto ON M2M 4K5

Telephone/Téléphone: (416) 327-7392
Facsimile/Télécopieur: (416) 327-7438

February 18, 2000

MEMORANDUM TO: **Medical Officers of Health**
RE: **Public Health Nurses**

Dear Colleague:

Our organizations have undergone marked change to reflect our goal of increasing public sector partnerships to design and deliver public health programs that can achieve our goals for the health of Ontario's citizens. At this time in our evolution, we need to ensure that we are also taking full advantage of the rich mix of health professionals who comprise the public health team. Many of you have already done so.

Public Health Nurses have a long history of contribution to public health services and the recent expansion of the Healthy Babies, Healthy Children program is one indication of their important role. In order to ensure that this rich contribution can be felt and supported, we would like to propose some options for Public Health Units who have not already done so, to create a visible leadership position with the Public Health Unit. This action would also serve to meet one of the important recommendations of the Minister's Task Force on Nursing which delivered its report in January, 1999.[1]

Options that many organizations have used include:

- designate a senior nurse to be responsible for nursing quality assurance,
- designate a senior nurse to be "Nursing Practice Leader", or
- designate a "Chief Nursing Officer" for the Public Health Unit.

One of these options may be appropriate to your individual organization. If you would like clarification, please contact the Chief Medical Officer or the Provincial Chief Nursing Officer at the Ministry of Health. We would be pleased to provide assistance or advice.

Sincerely,

Colin D'Cunha, MBBS, MHSc, FRCPC
Director, Public Health Branch and
Chief Medical Officer of Health

Kathleen MacMillan, RN, MA, MSc
Provincial Chief Nursing Officer
Nursing Secretariat

1. "...require that health care delivery organizations in every sector of the system designate a nursing professional(s) with authority and accountability for professional nursing practice, resource utilization and for decisions that affect the health care consumer." (Nursing Task Force, January, 1999, pg. 11)

Appendix E – Data Collection Tools

- "Senior Nurse Position" Work Group – Key Informants Interviews
- "Senior Nurse Position" Work Group – Key Informants Interviews – Provincial
- Middlesex-London Health Unit "Senior Nurse Position" Staff Questionnaire

"Senior Nurse Position" Work Group
Key Informant Interviews

Informant Profile:
Name: _____ **Agency:** _____

Position/Title: _____ **Phone:** _____ **Ext. #** _____

E-Mail Address: _____

1. Is there a position(s) in your organization responsible for addressing and resolving on ongoing basis, issues related to the discipline and practice of nursing?
   _____ **YES** _____ **NO**

   If no, proceed to question # 9

   If yes:
   - position title(s) used?_____
   - how long has such a position been in place?
     _____
     _____
   - process used to recruit?
     _____
     _____
   - process used to select
     _____
     _____
     _____
   - where is the position located on the organizational chart?
     _____
     _____
     _____

- what position does this position report to?_____

  _____

- time dedicated to this role?
  _____ full-time
  _____ part-time (please specify)

  _____

  _____

  _____ other (please specify)

  _____

  _____

- does this position carry other assignments, _____ YES _____ NO. If yes, please describe

  _____

  _____

  _____

2 What are the role expectations for this position? Request a job description
❁If interviewing more than one informant from the same institution, request once) ❁

Interviewer Probe: what types of issues/ situations would this role deal with?

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

3 What skills are needed in order to be successful in this role?

_____

_____

_____

_____

_____

4. Are there organizational structures in place to support this role? Yes_____ No_____

If yes, please describe:

5. What do you see as the strengths and limitations of this role i.e. what is working and what isn't?

Strengths:

Limitations

Any other challenges:

6. Has the effectiveness of this role i.e. not the person holding the position been evaluated?

Yes_____ No_____ Do Not Know _____

If yes, please describe the process used to evaluate the role:

7. Are you anticipating any changes to this position? Yes_____ No_____

If yes, please describe:

8. Do you have any additional comments or advice:

Thank You!

Interviewer Notes:

If no position in place:

9. How are issues related to the discipline and practice of nursing identified and resolved on an ongoing basis in your organization?

10. Are there organizational structures in place to support this arrangement? Yes____ No_____

If yes, please describe:

11. What do you see as the strengths and limitations of this arrangement i.e. what is working and what isn't?

Strengths:

Limitations:

Any other challenges:

12. Has the effectiveness of this arrangement i.e. not the individual(s) been evaluated?

Yes_____ No_____ Do Not Know_____

If yes, please describe:

13. Are you anticipating any changes to this arrangement? Yes_____ No_____

If yes, please describe:

14. Do you have any additional comments or advice:

Thank You!

Interviewer Notes:

"Senior Nurse Position" Work Group
Key Informant Interviews – Provincial

Informant Profile:
Name: _____ **Agency/Association:** _____

Position/Title: _____ **Phone:** _____ **Ext. #**

E-Mail Address: _____

1. In a program-based organizational structure what do you see as the pros and cons of having a position responsible for addressing and resolving on an ongoing basis, issues related to the discipline and practice of nursing?
   Pros:

   Cons:

2. Where should this position be located in the organizational chart? Why?

3. What position should this position report to? Why?

4. Should there be organizational structures in place to support this role?
   If yes, please describe:

   If no, why not?

5. What do you see as the major areas of responsibility for such a role? (i.e. what types of issues/situations would this role deal with?)

6. What do you see as the major challenges to operationalizing this role?

7. What skill sets and qualifications are needed to be successful in this role?

8. What process(es) should be used for recruitment?

9. What process(es) should be used for selection?

10. Any additional opinions, reflections, advice . . .

Thank you!

Interviewer Notes:

Middlesex-London Health Unit

"Senior Nurse Position" Staff Questionnaire

Please return by Friday October 20th to the box marked "Senior Nurse Position" Questionnaires in the mailroom, Public Health Nursing Division.

Please check:

_____ Full Time/Part Time _____ Casual

1. Do you think MLHU should have a "Senior Nursing Position"?
   _____ Yes _____ No _____ Uncertain
   Why:

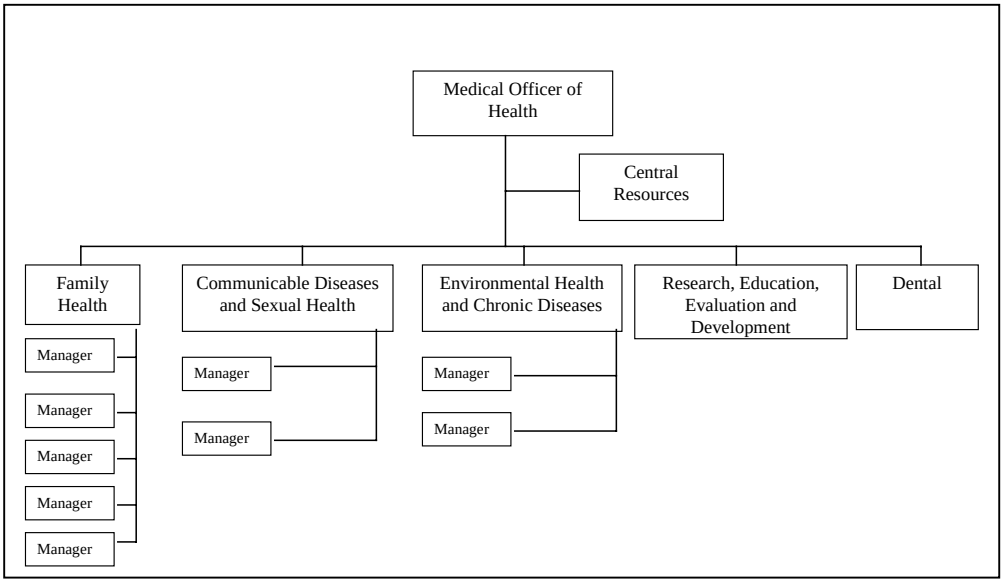
If yes – go to # 2

If no – go to #10

2. What do you see as the major areas of responsibility for such a role? (i.e. what types of issues/situations would this role deal with?)

3. Do supports need to be in place for this position to work?
   _____ YES _____ NO _____ Uncertain
   Comment:

4. Please indicate where this position should be placed on the MLHU Organizational Chart? Who should this position be reporting to?



5. What do you see as the major challenges to implementing this role?

6. What skill sets and qualifications are needed to be successful in this role?

7. What process(es) should be used for recruitment?

8. What process(es) should be used for selection?

9. Any additional comments?

Thank you for participating!

If no or uncertain:

10. How do you see issues related to the discipline and practice of nursing being identified and resolved on an ongoing basis?

11. Are there organizational structures in place to support this arrangement?
    ____ YES _____ NO _____ Uncertain
    If yes, please describe:

12. Additional Comments:

Thank you for participating!

Appendix F – Sample of Correspondence Sent to Key Informants

October 2, 2000

{*name*} Fax:
{*address*}

Dear _____:

I am writing to ask for your assistance. Middlesex-London Health Unit is currently undergoing organizational restructuring to reflect a program-based model. The "divisions" in this structure now being referred to as Services are:

- Family Health
- Communicable Disease and Sexual Health
- Environmental Health and Chronic Diseases
- Research, Education, Evaluation and Development
- Dental

In the new model there is the potential for Public Health Nurses to report to non-nursing managers. Consequently, at the request of senior management, a Work Group is developing recommendations for a position that identifies and addresses, on an ongoing basis, nursing practice and professional issues. Other responsibilities might include being vigilant of emerging trends, advocating for nursing and ensuring that the delivery of public health nursing services within Middlesex and London is not adversely affected. This will not be a new position but rather will become part of a current portfolio. Would you be willing to be interviewed to assist us with our deliberations? If you are not the appropriate person to respond to this request, please advise who we should be contacting.

Kathy Ellis, an independent program evaluation consultant, on contract with Middlesex-London Health Unit, will be conducting telephone interviews with key informants and opinion leaders such as yourself. A copy of the questions will be sent to you prior to the interview. It is anticipated that this will require 20-30 minutes of your time. We would like to have the interviews completed by October 27, 2000.

With your permission, to facilitate accurate data collection, we would like to tape the interviews. If you would prefer that we not tape your comments, we still would like to interview you. Only members of our project team, including Administrative Assistants, would have access to the tape. The tape would be destroyed following the analysis and individuals and specific agencies will not be identified by name in any presentations, final report or publication. We will be looking for common themes in order to identify recommendations pertinent to our health unit. We would be pleased to share a copy of our findings.

Nancy Forbes, Administrative Assistant will be contacting you in the next few days. We do hope that you will be willing to be interviewed. Your perspective and experiences would be most helpful to the Work Group as we develop recommendations for this position at Middlesex-London Health Unit.

If you have any questions, please contact me or Nancy Forbes, Administrative Assistant, 519-663-5317 ext. 2462 or by e-mail at nancy.forbes@mlhu.on.

Yours truly,

Charlene Beynon
Director
Research, Education, Evaluation & Development (REED) Services
519-663-5317 ext. 2484
cbeynon@julian.uwo.ca

CB/nlf

Appendix G – Key Informants

The Senior Nurse Position Work Group wish to thank the following for their input by participating in this consultation:

Bonnie Adamson, Seaforth General Hospital

Evelyn Butler, ANDSOOHA, Public Health Nursing Management

Dr. Adeline Falk-Rafael, Community Health Nurses Initiatives Group

Joyce Fox, Simcoe County District Health Unit

Jane Gianfrancisco, Regional Municipality of Waterloo Community Health Department

Doris Grinspun, RNAO

Dr. Hanif Kassam, Regional Municipality of Waterloo Community Health Department

Rosemary Kohr, London Health Science Centre

Sandra Laclé, Sudbury & District Health Unit

Kathleen MacMillan, Chief Nursing Officer, Province of Ontario

Maureen Murphy, Region of Ottawa-Carleton Health Department

Dr. George Pasut, Simcoe County District Health Unit

Karen Perkin, St. Joseph Health Care Centre

Eleanor Ross, International Council of Nurses, Geneva

Dr. Penny Sutcliffe, Sudbury & District Health Unit

Barb Wahl, Ontario Nurses Association

Appendix H - Appendix H - Professional Practice Council-Nursing – Draft Terms of Reference

Draft

Professional Practice Council–Nursing
Terms of Reference

Purpose:

To contribute to quality assurance in nursing practice, a quality work environment and excellence in practice by identifying and responding to professional nursing issues.

Membership:

- Professional Practice Leader–Nursing
- At least one staff nurse representative selected by peers from each service in which nurses work. Consider:
  - Representation by population
  - Representation by a non-nurse to whom nurses report.

Duties of Members/Committee:

- Members will represent their nursing colleagues through contributions to the agenda and active participation in addressing issues arising.
- Staff representatives will bring meeting reports back to their colleagues in their respective Service.
- Representation to senior management via the Professional Leader–Nursing; the Professional Leader will update Directors' Committee, quarterly or as needed.
- Communicate and assist with the application of College of Nurses of Ontario professional standards, expectations and programs and other legislative and regulatory requirements for nurses.
- Examine the implications of impending legislation, professional standards and trends in practice and facilitate appropriate action.
- Support research and education in quality assurance. Foster evidence-based practice and excellence in nursing care.
- Assist coworkers to understand the contribution of nursing to specific client outcomes.

Decision-Making:

Consensus will be the preferred method of decision-making. When consensus is not reached, a vote will be taken.

Chair:

- The first meeting to be chaired by the Professional Leader–Nursing; the agenda of the first meeting will include the selection of a Chair from the membership.

Agency Support

- An allocated budget and dedicated administrative support for Council activities
- Allocated time for members to participate in meetings and conduct related business between meetings.

Meetings:

At least monthly for the first six months , then bimonthly or at the call of the Chair.

Minutes:

Minutes of all meetings to be recorded by Administrative Assistant. Approved minutes are made available to all Health Unit staff.

Term of Office:

Two years, staggered replacement for members including a two year term of office for the Chair.

Appendix I – Draft Role Description: Professional Leader-Nursing

Draft
Role Description

Title: Professional Leader–Nursing

Salary Range: N/A Status: Non-Union

Reports to: Professional Practice Council-Nursing and to MLHU Directors' Committee

Time Allocation: Seven hours/week, flexible time

Original Date Approved: _____ Revision date: _____

Signature: _____
Graham Pollett, Medical Officer of Health

_____
Louise Tyler, Manager of Human Resources and Labour Relations

Summary: Professional Leader–Nursing contributes to quality assurance of nursing practice by interpreting and assisting with the application of the College of Nurses of Ontario Professional Standards, expectations and programs, and other legislative and regulatory requirements impacting on the practice of nurses working at Middlesex-London Health Unit. Role models, mentors and helps guide the progress and development of public health nursing practice and the nursing profession. Promotes professionalism and leads to excellence.

Staff: No direct supervision; administrative support as required

Responsibilities:

- Assumes the leadership role for professional nursing practice at Middlesex-London Health Unit.
- Works with the Professional Practice Council–Nursing, health unit management and staff to communicate, interpret and assist with the application of College of Nurses of Ontario professional standards, expectations and programs and other legislative and regulatory requirements for nurses. Acts as a mentor and facilitator for the Professional Practice Council–Nursing.
- Maintains membership and active participation in professional nursing organizations.
- Foresees implications of impending legislation, professional standards and trends in practice and facilitates appropriate action.
- Manages an allocated budget for the Professional Practice Council.
- Represents nursing practice issues at the Directors' Committee.

- Advocates for appropriate nursing and other human resources that lead to excellent client care.

- Works collaboratively to support research and education in quality assurance and excellence in nursing care. Assists management and staff to acculturate evidence-based practice. Ensures there is a system to facilitate continuous inquiry and learning by nurses. Participates in orientation of nursing staff.

- Collaborates with interdisciplinary teams to address systems issues related to the practice of nursing and client care.

- Assists teams to understand the contribution of nursing to specific client outcomes.

- Maintains collaborative relationships with colleges, universities and other academic bodies.

- Contributes to the job and professional satisfaction of MLHU employees by advocating for management and professional practices that contribute to a quality workplace.

- Provides leadership within the discipline at the community level.

- Is easily accessible.

Qualifications:

- A Director within the Middlesex-London Health Unit who is a nurse

- Baccalaureate Degree in Nursing which includes Public Health Nursing preparation

- Master's prepared in Nursing or relevant equivalent

- Current registration with the Ontario College of Nurses

- Excellent communication and interpersonal skill, both oral and written

- Computer literate

- Current CPR certificate

- Current Ontario driver's license and use of a car

Appendix J – Relevant Documents

- Report of the Nursing Task Force – Good Nursing, Good Health: An investment for the 21st Century (Taken from web-site – www.gov.on.ca/MOH/english/pub/ministry/nurserep99/issues.html) Also excerpt from Report – Summary & Recommendations.

- RNAO Policy Statement – Value of Leadership in Nursing Administration

- Sample Position Descriptions