PROPOSAL TO SUPPORT THE STRATEGIC PLAN TO IMPLEMENT THE CANADIAN NURSING ADVISORY COMMITTEE RECOMMENDATIONS

COLLABORATORS

ACADEMY OF CANADIAN EXECUTIVE NURSES
CANADIAN ASSOCIATION OF SCHOOLS OF NURSING
CANADIAN FEDERATION OF NURSES UNIONS
CANADIAN HEALTHCARE ASSOCIATION
CANADIAN NURSES ASSOCIATION
CANADIAN PRACTICAL NURSES ASSOCIATION
REGISTERED PSYCHIATRIC NURSES OF CANADA

LEADERSHIP OBJECTIVE C

COMPETENCIES REQUIRED OF NURSE MANAGERS

IDENTIFYING THE SKILLS, PERSONAL ATTRIBUTES AND KNOWLEDGE REQUIRED OF NURSE MANAGERS AND THE ENABLERS AND BARRIERS FOR NURSE MANAGERS TO ACQUIRE AND SUSTAIN THESE COMPETENCIES

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The recommendations contained in this report are those of the authors and do not necessarily reflect those of the collaborating organizations on the project Steering Committee.
EXECUTIVE SUMMARY

As part of a series of initiatives designed as follow up to the recommendations made in the Canadian Nursing Advisory Committee (CNAC) report (2002), this project addressed the required competencies of nurse managers, and the enablers and barriers affecting the acquisition and maintenance of these competencies. Competencies were defined as skills, knowledge and personal attributes. Nurse managers were defined as individuals in a first level management position who manage nurses (and others) providing direct care. Nurses included Registered Nurses (RNs), Licensed Practical Nurses (LPNs) and Registered Psychiatric Nurses (RPNs).

The research methods included a pan Canadian approach that was as inclusive as possible given the tight time lines. Several methods of data collection were implemented, including a review of relevant literature, key informant interviews, a web-based survey, an analysis of job postings and 10 focus group discussions. Altogether, 629 nurses participated in the project.

The results were overwhelmingly similar through all research methods and across the various groups sampled. The main findings are as follows:

- There were no discernable differences in responses between RNs, LPNs & RPNs.
- There was a high level of agreement among nurse executives, nurse managers, and nursing staff on the top five competencies judged important for nurse managers.
- The top five competencies included: accountability for professional practice; communication (verbal); team-building; leadership skills; and conflict resolution. Staff nurses included knowledge of ethical and legal issues in the top five competencies important for nurse managers.
- None of the 44 competency statements were rated as “not at all important.”
- The five most important enablers/barriers to the acquisition of competencies were similar for nurse executives, managers and staff.
- The five most important of the 16 enablers/barriers were:
  - supportive work environment;
  - clear and reasonable expectations;
  - balanced work/life;
  - reasonable workload; and
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- accessibility to management education programs. Staff nurses included accessibility to a mentor in their top five ratings.

- Focus group results highlighted very difficult and stressful working conditions for nurse managers.

- All groups sampled recommended more support for front-line nurse managers.

- The importance of the nurse manager role to the integrity of health care was emphasized.

Based on the findings of this study the following recommendations are offered with the ultimate aim of improving access to and quality of patient care by strengthening the competencies and roles of front-line nurse managers.

1. Health care employers should invest in front-line manager positions. They may see returns on this investment if they focus on patient care management. This study and the related literature suggest that a visible, knowledgeable front-line nurse manager can improve the quality and efficiency of patient care, the morale and motivation of staff and patient safety and satisfaction.

2. Employers should provide technical and clerical support to front-line managers to give them time to work with staff, patients and families.

3. Health care employers should provide support for managers and potential managers to access educational programs to increase and strengthen competencies. A supportive work environment was found to be the most important enabling factor for managers to acquire and maintain competencies.

4. National and regional mentorship programs should be supported to ensure adequate numbers of qualified front-line managers to sustain the health care delivery system. Several reports over the past few years have predicted a serious shortage of nurses in Canada in the near future. According to this project’s findings, in addition to fewer providers, there will be fewer staff interested in management positions. Staff nurses did not aspire to be managers who were overworked and not close to patient care.

5. Given that employers require more complex competency profiles for front-line managers, local educational programs should be available to support the development of these competencies. The analysis of job descriptions for nurse managers suggested a growing trend toward requiring more complex conceptual skills and knowledge. If these competencies are important, training should be readily available.

6. Health care employers and educators should consider interdisciplinary educational programs to teach core health care management/leadership competencies. The literature and the research
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reported here identify a number of important competencies for nurse managers that are more generic and not discipline-specific. These competencies include communication, team-building and resource management. Several positive outcomes may result from having different health care professionals learn together; working better together would be one of them. More intensive mentorship programs for nurse managers could provide discipline-specific competencies, such as managing nursing care.
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1 INTRODUCTION

1.1 Context

The purpose of this project was to identify the competencies (defined as personal attributes, skills and knowledge) required of nurse managers and to identify potential enablers and barriers for nurse managers to acquire and sustain these competencies. The project was conceived as a follow up to the report of the Canadian Nursing Advisory Committee (CNAC), which was constituted from March 2001, to March 2002. The report – Our Health, Our Future: Creating Quality Workplaces for Canadian Nurses – contained 51 recommendations to improve nursing human resources, work life, retention and recruitment, and, ultimately, the sustainability and quality of Canada’s health system. As noted in the report “….as nursing goes, so goes the rest of the system.”

CNAC was established as a result of several years of documentation of the growing degradation of Canada’s nursing workforce. Years of budget cuts in health care had a devastating impact on nursing and nurses, who make up more than 1/3 of the health workforce. Nurses lost full time positions, benefits and institutional support for professional practice, continuing education, decision-making and autonomy. Nurses were leaving the country to practise elsewhere, primarily in the U.S. and were also leaving the profession through retirement or choice. Furthermore, too few students were entering the profession to replace those leaving, which forecasted a serious shortage.

A significant part of the decline in nursing can be directly attributed to the loss of nurse managers in the system. Between the years 1994 and 2000, some 5,500 nurse manager positions were eliminated (CNAC, 2002). This fact had devastating effects on the nurses providing direct patient care. They no longer had a mentor, a leader or an advocate. The nurse managers remaining in the system were given larger more corporate portfolios. The distance widened between them and the providers for whom they were responsible. They became so removed from day-to-day practice that they were not aware of some of the overwhelming problems faced by direct care providers. Given the mounting evidence that the relationship with one’s immediate supervisor is an important predictor of job satisfaction and intent to stay in the job, the lack of a visible manager has serious implications for recruitment and retention (Blegen, 1993; Irvine & Evans, 1992; Thomson, Dunleavy & Bruce, 2002).

The CNAC report also noted that as the number of front-line managers decreased, those remaining were required to expand their responsibilities to include the management of portfolios other than nursing care. Finance, policy, other health professionals, physical plant, etc., are just some examples. The jobs expanded to consume more and more competencies and increased workload. It was reported that fewer and fewer nurses aspired to management positions as
these jobs are seen to be unrealistically demanding. Younger nurses observe the work lives of their managers and want nothing to do with such demands. The issue of succession planning was also identified as a serious challenge for the future.

In light of these observations, a number of CNAC’s recommendations attempt to improve the capacity and integrity of nursing. Some of these recommendations address the need to increase the number of front-line management positions, provide support to front-line managers to permit time for them to work with nurses, patients and families, and to provide resources to develop the required skills and knowledge to master the increasing complexity of managing the system.

While many of the CNAC recommendations were deemed urgent at the time, it is not clear in 2004 that there has been much significant progress. A collaborative working group, funded by Health Canada, was formed to address further implementation of the recommendations, particularly those on which there was little or no action to date. Seven national organizations are a part of this collaborative initiative with representation from the Canadian Nurses Association (CNA), Registered Psychiatric Nurses of Canada (RPNC), Canadian Practical Nurses Association (CPNA), Canadian Association of Schools of Nursing (CASN), Canadian Federation of Nurses Unions (CFNU), Canadian Healthcare Associations (CHA), and the Academy of Canadian Executive Nurses (ACEN).

A Workforce Management Project Steering Committee was formed to oversee a number of projects identified for further investigation. The current project may provide a timely glimpse into the situation of front-line nurse managers in the health care system. Identifying the perceived important competencies of managers across the system and the factors that support or deter from the development of such competences is one step toward our understanding. Furthermore, the perceived importance of various competencies, from the perspective of different stakeholders, may provide some evidence to guide the recommended restoration of the first-line management cohort.

1.2 Objectives

It is within the context described above that this research was undertaken. The objectives of the research were threefold:

1. Document the perceived competencies required of front-line nurse managers across the spectrum of health care, from public health to acute care.

2. Identify enablers and barriers for nurse managers to acquire and sustain these competencies.

3. Compare the competencies identified by executive level managers, front-line managers and direct care nurses, and determine similarities and/or differences between RN, LPN and RPN groups of nurses.
1.3 Definitions

Nurse Manager is an individual in a first level administrative position who manages staff providing direct care.

Competencies are knowledge, skills and personal attributes (CNA, 1995).

Health Care Providers: RNs, LPNs and RPNs.

Nursing includes three regulated occupational groups that work in a variety of roles and organizations across the continuum of health services. For the purpose of this report the following abbreviated definitions were used to clarify the three distinct nursing groups. These include: RNs, LPNs and RPNs.

RNs are licensed/registered nurses who may practice within a specific province or territory. They serve persons of all ages and at varying levels of illness or wellness and practice in a variety of settings including hospitals, long term care facilities, community, etc. (CNA, www.cna-nurses.ca). Registered nursing practice requires the application of an appropriate conceptual model, and utilizes the nursing process of assessment, diagnosis, planning, implementation and evaluation.

LPNs (known as registered practical nurses in Ontario) are licensed practical nurses who provide nursing services to assess and treat health conditions, promote health, prevent illness, and assist individuals, families and groups to achieve an optimal state of health. (CPNA, 2001, http://web2.gov.mb.ca/laws/statues)

RPNs are registered psychiatric nurses who are regulated as a distinct profession in Canada in the provinces of British Columbia, Alberta, Manitoba and Saskatchewan. RPNs use a holistic approach to provide psychiatric nursing services to individuals, groups, families and communities, whose primary care needs are related to mental and developmental health. (RPNC, www.crpnm.mb.ca/profile.pdf)

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1 In the province of Ontario, practical nurses are called registered practical nurses (RPNs). To avoid confusion, in this paper the term LPN is used for all practical nurses in Canada and RPN refers to Registered Psychiatric Nurses.
2 APPROACH AND METHODOLOGY

2.1 Approach

A pan-Canadian perspective was employed, incorporating the three occupational groups of nurses (i.e., RNs, LPNs and RPNs) in order to capture these groups' views on the competencies required of nurse managers in the Canadian health care system. Several approaches were used to collect relevant data. As a first step, a review of literature facilitated the identification of an initial list of required competencies. This list was then presented to a number of key information sources to verify the relevance of the competencies to the current demands of the Canadian health care context. The list of required competencies grew from 28 to 40 (see survey in Appendix A). None of the competencies derived from the literature were eliminated. An analysis of job postings for managerial positions in nursing comprised the final approach taken. The resulting list of 44 competencies formed the basis of a web-based survey and focus group discussions.

2.2 Methodology

2.2.1 Literature Search

Two approaches were taken to identify materials deemed relevant to the subject of competencies. The first consisted of an electronic search, via MedLine, of articles appearing within the last decade relating to the topic of competencies. The key words of competencies, management, leadership, general and nursing, were used to direct the search. This resulted in the identification of 176 potential references. Online resources accessed included Canadian Institute for Health Information (CIHI), Health Canada (HC), Canadian Nurses Association (CNA) and others.

The second approach involved a hand search, which led to a number of other sources considered pertinent to the subject.

2.2.2 Key Informant Interviews

Key informants were selected from organizations engaged in hiring and or preparing nurse managers, or from people who had extensive knowledge of management issues in health care. Interviews were held with five key informants, including leaders from employers, government, educators, and search firms specializing in health care. Interviewees were asked to identify five to 10 competencies that they believed were most important for nurse managers to
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work in today's health care system. They were also asked to identify enablers or barriers to the acquisition and maintenance of these competencies.

2.2.3 Analysis of Job Postings

Job postings for management positions in nursing were analysed to identify the most frequently cited competencies required.

2.2.4 Surveys

A final list of 44 competencies was used to form a survey questionnaire where each competency was to be rated on a Likert scale from 1, not at all important, to 4, very important. A copy of the survey is attached as Appendix A.

A second part of the survey asked respondents to rank, on the same Likert scale, the importance of 16 enablers or barriers to the development and maintenance of these competencies. The variables comprising the scale were again derived from the literature and from key informant interviews. Finally, the survey included a section on demographic information.

Intended respondents included staff nurses, nurse managers and nurse executives from the three regulated nursing groups (RNs, LPNs and RPNs) from across the country and from a wide variety of health care services. Given this broad range of potential respondents, the survey questions were designed to be as inclusive and clear as possible. The survey was reviewed by the Steering Committee, translated and posted to a dedicated website. Slightly different processes were used to solicit respondents from the target groups of nurses.

Nurse Executives

E-mail invitations to participate in the competency survey were sent to 65 members of the Academy of Canadian Executive Nurses (ACEN), 185 senior nurse executives in homecare, 55 people identified by the Ontario Community Health Association and 44 from the B.C. Community Health Association one week prior to the launch of the web survey. An e-mail reminder was sent on the day of the launch.

Letters were sent to 1067 members of the Canadian Healthcare Association (CHA) including 5 areas of facility-based health care (teaching hospitals, community hospitals, mental health institutions, rehabilitation and long term care). There were several hundred more letters sent to long-term care facilities, as this was the most complete list in the database. A further 330 letters were sent to community-based health care services, including home care, public health, community health centres and mental health services. Finally, some 133 letters were sent to other groups, such as Canadian Forces Health Services.

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There were several avenues available to recruit nurse managers’ participation. Direct mail letters of invitation were sent to members of CHA who identified nurse managers in their organizations. A total of 388 letters were sent. A reminder letter was sent one week later on the occasion of the launch of the survey website. Several other organizations were sent e-mail letters of invitation and were asked to distribute these to their members who were nurse managers. A copy of the letter of invitation is attached in Appendix A. The following organizations participated in this sampling strategy:

Canadian Nurses Association and its associate and affiliate members including ACEN, Canadian Public Health Association, Ontario and British Columbia community health centre associations, Department of National Defence chief nurse, Canadian Home Care Association, CPNA and RPNC.

All of these activities encouraged people to go to a dedicated website arranged by the CNA. The electronic survey was completed on a voluntary basis and the provision of personal identification was optional. This resulted in a convenience sample of nurse managers. The response rate (n=249) was higher than anticipated, suggesting that the approaches used were reasonably successful.

Staff Nurses

The participating members of the CNAC Steering Committee were asked to post a website promotion and link to their national and provincial websites to be functional by the day of the survey launch. The member associations of the collaborative initiative were also asked to promote and link to the survey website. This resulted in a convenience sample of staff nurses.

2.2.5 Focus Groups

Several focus group discussions were conducted both in person and by teleconference. The purpose of these focus groups was to ensure the inclusion of the perspective of the three regulated nursing groups, that may not have responded to the web-based survey and to explore in more depth the meaning and importance of those competencies deemed important and those deemed less important. A total of 10 focus groups were held with the following distribution:
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<table>
<thead>
<tr>
<th></th>
<th>No. of participants</th>
<th>Provinces/Territories</th>
</tr>
</thead>
<tbody>
<tr>
<td>RPN managers</td>
<td>6</td>
<td>Sask., Alberta, B.C.</td>
</tr>
<tr>
<td>RPN practitioners</td>
<td>12</td>
<td>Saskatchewan</td>
</tr>
<tr>
<td>RN executive nurses</td>
<td>7</td>
<td>B.C., Alberta</td>
</tr>
<tr>
<td>RN managers</td>
<td>6</td>
<td>Nova Scotia, Ontario, Quebec, Manitoba, Alberta</td>
</tr>
<tr>
<td>RN practitioners</td>
<td>4</td>
<td>Ontario, Quebec, Alberta</td>
</tr>
<tr>
<td>LPN managers</td>
<td>7</td>
<td>Manitoba</td>
</tr>
<tr>
<td>LPN practitioners</td>
<td>18</td>
<td>Alberta, Ontario, Nova Scotia</td>
</tr>
</tbody>
</table>

2.2.6 Demographics

All respondents to the survey and all participants in the focus groups were asked to complete a demographic questionnaire. Questions related to area of employment, title, education, professional designation, age, etc., were included. A copy of the demographic questionnaire is included in Appendix A. The questions, which were meant to support sample description and to inform the data analysis, included those variables considered to be relevant to the primary question. The demographic questionnaire was anonymous but people could provide contact information if they wished in the event of any follow-up to the research.

2.3 Constraints or Limitations

A number of limitations can be identified in this project. Sampling for the surveys required respondents to have access to Internet services and the respondents were voluntary. This resulted in a convenience sample which, when compared to Canadian norms, was more highly educated than the majority of nurses. However, given the congruence of responses across the three regulated nursing groups and across three levels of positions, it is unlikely that education had a significant impact on the results.

The sample was weak on Francophone respondents particularly from Quebec. For RNs at least, this is related to the Quebec regulatory body’s reluctance to participate in national projects. Some Quebec nurses did participate in focus groups, recruited directly by their employers.

The survey sample size itself was not large enough to allow for detailed comparisons at all levels of analysis. That is, it was not possible to make
meaningful comparisons between the three regulated nursing groups. On the other hand, given the time constraints, the response rate was reasonable and, taken together with the literature and focus group results, there was a high level of agreement among the responses of all nursing groups.

There was disproportionate variability in location by province and type of workplace. These factors dictate caution in generalizing the results to the larger population of nurses.
3 SUMMARY OF FINDINGS

3.1 Literature Review

The materials reviewed fell within three major categories: those dealing with the issue of competency of leaders/managers within the corporate/business arena; those which focused on the health care field; and those which addressed the topic of competencies at the managerial/leadership level within the nursing profession. Further categorization of these articles in terms of their primary focus revealed three main topics: a description and discussion of competencies as they related to the field under study; the development and sustainability of these competencies; and a focus on the assessment of competencies.

These categories provide the organizing framework for the review of the literature. Salient issues relevant to each of these areas of discussion were highlighted with some general observations on the “competency movement” offered as background. The review concludes with an analysis of those factors identified in the literature that facilitate or impede the development of competencies.

Note should be made at the outset on the use of the terms manager and leader/leadership as they appear in the materials reviewed. A number of authors (Hudson, 2003; King, 2000; Longenecker, 1998; Upenieks, 2003) make a clear distinction in their writings between the two terms/roles. Hudson (2003) writes: “Creating and enunciating an innovative vision and the ability to inspire people to move to areas to which they don’t want to go, are key elements of leadership. Management is characterized by putting into action operationalizing the strategies that are created by the leader to support the innovative vision. The search is on for those special individuals who have both leadership and management competencies” (p.4). In the majority of articles reviewed, however, the authors appear to use the two terms (manager and leader) interchangeably or do not distinguish between these two concepts in their discourse. The literature review that follows, therefore, does not make this distinction unless specifically noted otherwise by the author.

3.1.1 Background

The search for answers to the question, what characterizes the successful leader, has occupied thinkers over the years. As a prelude to a discussion of leadership qualities and leadership development in the field of health care, Leatt and Porter (2003) offer a brief historical picture, highlighting how these concepts have changed in recent years, both in business and in health care settings. As they note, the 1940s and ’50s witnessed a focus on identifying the traits associated with the successful leader. They further observe that the 1990s saw the
emergence of large-scale research projects such as that by Hay/McBer, which led to new insights as to why some individuals appear more successful than others. It was from this latter study that the concept of “emotional intelligence” (Goleman, 2004) arose, a concept that, as will be noted later, has captured considerable attention in recent years. Other writers, such as Calhoun et al. (2002), also provide some of the historical background to the issue of competencies, with an emphasis on works from the fields of education and psychology.

3.1.2 Leadership in the Corporate Field

Quoting Fitz-eng, Leatt and Porter (2003) state, “Arguably the most compelling challenge facing organizations entering the new millennium is not the general shortage of talent. It is the deart of executive leadership” (p. 19). According to the Conference Board of the United States, the rising interest and concern regarding leadership requirements for the future has been fuelled by a number of forces: globalization, technology, hyper-competition, expectations of Boards and financial markets, an emphasis on customer relationships, changing organizational structures, employee expectations and workforce demographics (Barrett & Beeson, 2002).

The shortage of individuals, across all industries, with the capabilities to meet such demands, is of particular concern (Leatt & Porter, 2003). Barrett and Beeson (2002) contend that the new reality surrounding leadership development will take place within an “environment of extreme cognitive complexity.” This will, in tum, require competencies such as extraordinary strategic thinking skills and the ability to make high quality decisions quickly. Leadership skills as opposed to technical skills, personal and organizational skills, communication skills, and analytic abilities will characterize leadership success in 2010.

3.1.3 Leadership in the Health Care Field

The message across all the materials reviewed concerning leadership in the health care field was consistent – the increasing complexity of the health care system (Robbins et al., 2001), shifts in the organization of health services (Longest & Brooks, 1998), the uncertainty and unpredictability of the current context (Calhoun et al., 2002) all call for a re-examination of the concept of leadership and those competencies required of persons in such roles.

Hudson (2003) speaks of the “cacophony of health care noise concerning poor performance” which he suggests is a further indicator of the necessity of evaluating the qualities required of leaders in the field. Health care, according to Leatt and Porter (2003), is at a stage of unprecedented change and as such requires different skills, knowledge, attitudes and competencies of its leaders than are required in times of predictable and stable circumstances.
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The majority of those writings reviewed dealt with the types of preparation needed for present and future leaders in the health care field, beginning with the competencies required. As Leatt and Porter (2003) point out, leadership development must be competency-based and the ability to identify, quantify, develop, measure and evaluate competencies for health care leaders is of utmost importance. Baker (2003) stresses that, “the articulation of health care leadership and management competencies provides a framework and a language for identifying the leadership knowledge and skills required for high-quality care in the twenty-first century” (p.49). Baker cautions, however, that the task of identifying essential competencies for the health care field will be a slow and deliberate process. Unlike those fields which are more technical and where there is high consensus on the work and tasks required, health care is a complex field with challenges that are not easily reducible to simple problems. Indeed, Baker questions whether or not identifying the core competencies of health care leadership could be considered antithetical to a system such as health care, which is complex and adaptive. He wams of the danger of “reducing these (competency) frameworks to ‘to do’ lists rather than using them as tools for learning and growth” (p.57).

In exploring the issue of preparation for leadership, those competencies deemed essential in leadership/managerial roles were first addressed. Surveys and reviews of the literature were the approaches most frequently taken to answer this question. Although there was some variation in terminology, there was general consensus across the articles reviewed that interpersonal, analytical and conceptual, technical/clinical skills and knowledge were the key competencies required of leaders/managers in the health care field (Allen, 1998; Guo, 2003; Longest & Brooks, 1998; Robbins et al., 2001). In their discussion of integrated health delivery systems, Longest and Brooks (1998) add the categories of political, commercial and governance to their categories of competencies. They stress the importance of these particularly for those in senior management positions.

A study conducted in the early 1990s of the most important domains in health care administration found that while a business orientation was important for organizational survival, equally important areas were person-oriented skills, knowledge and abilities (Hudak et al., 1997). Consistent with such thinking is the work by Goleman (2004) on “emotional intelligence.” Goleman describes the chief components of this concept as: self-awareness, self-regulation, motivation, empathy and social skill. Goleman’s research, which has included studies of a number of large, global companies, demonstrated that emotional intelligence may be the key attribute distinguishing outstanding performers from those who are merely adequate.

Summaries of work conducted on competencies are found in the articles of Baker (2003) and Calhoun et al. (2002). Baker gives a detailed description of the findings of the National Centre for Health Care Leadership.
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In its study, the Centre found six overarching competencies associated with leaders in the health care field. They label these as: 1) leadership (i.e., creates and communicates a shared vision); 2) collaboration and communication (i.e., develops cooperative relationships and effective information exchanges); 3) management practice (i.e., identifies, evaluates and implements strategies and processes); 4) learning and performance improvement through continuous assessment; 5) professionalism and 6) personal and community health systems through the integration of the needs of individuals with those of the community. Calhoun et al.’s (2002) article offers detailed descriptions of selected competency models in management. These authors also looked at a number of studies and compared them in terms of the rankings they gave to selected competencies. In terms of importance, findings revealed that communication skills and interpersonal skills were ranked in the top two positions.

In addition to the more general articles in the health care field dealing with leadership and its associated competencies, a number of writings focused on the work of particular health professional groups as they examine the issue of competencies in their leaders. These studies dealt with physicians (Aluise, Vaughan, & Yaughna, 1994; Estes, 1997), physical therapists (Bryan, Geroy & Isemhagen, 1993), physician executives (Gustafson & Schlosser, 1997; Vavala, 1994), nurse leaders in public health programs (Misener et al., 1997), clinical laboratory personnel (Beck, 1994; Christian et al., 1997), ambulatory health care administrators (Hudak et al., 1997), social workers (Meneffe & Thompson, 1994) and sterile processing technicians (Doyle & Mamott, 1994).

Authors who wrote about leadership and competency identification in the health care field had some cautions. The authors noted that:

1. although some competencies may be relevant to several health care settings, others are specific to particular sectors of the health care industry (Robbins et al., 2001);
2. competencies may differ according to the stage of an individual’s career development (Robbins et al., 2001);
3. competencies are not static, they are dynamic and may have to be changed over time in response to changes in the health care environment (Calhoun et al., 2002; Fine, 2002; Longest & Brooks, 1998);
4. there continue to be methodological issues which need to be resolved when determining and assessing competencies (Calhoun et al., 2002);
5. the most effective approaches to leadership development have yet to be determined (Reagan, 2003); and
6. a relationship has yet to be shown between leadership qualities and organizational effectiveness (Reagan, 2003).
3.1.4 Competencies for Managers/Leaders in Nursing

Nursing, like other professional groups in the field of health care, faces turbulent times. What constitutes good management and leadership within such an environment, in particular what competencies are needed to assume such roles of responsibility, are questions that challenge the profession of nursing. According to some, these questions are of particular importance as the influence of nursing and its leadership extends beyond the profession itself to the future development of the health care system as a whole and of the political system (Ferguson-Pare et al., 2002; Mahoney, 2001). King (2000), quoting Grohar-Murray & DiCroce, states that given the growing diversity and complexity of nursing work and the myriad social and professional factors, the nurse manager role “is and will be the most challenging of any industry.”

As in the materials described above relating to the corporate world and the health care field, the call for a re-examination and identification of the competencies required for the new millennium was at the forefront of writings relating to nursing leadership. Note must again be made of the fact that some writers differentiated between a nurse leader (executive) and nurse manager in discussing the issue of competencies. In other instances, the terms were used interchangeably. Reporting in this section uses the terms and wording of the authors.

Although there was some variation in terminology, the dominant categories or domains of competencies (i.e., those seen as most important for leaders in nursing), in the articles reviewed, related to: interpersonal (including communication) skills; expertise in collaboration (team-building); analytical thinking; seeing the big picture; resource management; information technology; awareness of the political arena; and clinical knowledge and skills.

Of the competencies identified above, interpersonal (including communication skills, negotiation and conflict management) skills were seen as highly relevant and important for those in leadership/managerial positions (Allen, 1998; Chase, 1994; Coming, 2002; Laschinger et al., 2003; Mathena, 2002: Parsons & Stonestreet, 2003; Russel, 2003; Squires, 2001). Indeed, when ranked against other competencies, interpersonal skills were rated as being the most important to the success of a manager (Coming, 2002; Mathena, 2002). Coming’s (2002) work, which involved a study of 20 nurse executives from across the United States, found that “people skills” constituted all of the top five most important leadership competencies, and 60 per cent of the top 10 for nurses assuming senior level positions. Coming’s results are consistent with those of others, who claim that people skills are nearly twice as important as technical skills in this era. For example, Goleman (2004) noted that people who score highest on “emotional intelligence” rise to the top of corporate hierarchies. Mathena’s (2002) findings from a study of 55 nurse managers likewise showed that interpersonal skills were amongst the top three categories of skills important to the success of nurse managers. In particular, communication ranked number one.
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Closely allied with interpersonal competencies were the abilities to collaborate and build alliances (Laschinger et al., 2003; Mathena, 2002; Scoble & Russel, 2003; Squires, 2001).

The ability to “think globally” and “see the bigger picture” were competencies that also received considerable attention in the materials reviewed (Coughlin, 2002; Fosbinder et al., 2000; Mahoney, 2001; Mathena, 2002; Upenieks, 2003; Urden & Rogers, 2000). On the basis of 870 survey results, which included nurses (n=805) and physicians (n=65), Urden and Rogers (2000) found that the ability to think globally was one of the hallmarks of a front-line manager. A competency that was seen as essential to “seeing the bigger picture” was the need for political acuity. This quality was noted by authors, including Duffield (1991), Mathena (2002) and Sanders et al. (1996).

Other competencies that were the focus of discussion in many of the writings on leadership/managerial qualities had to do with: analytic skills/critical thinking (Allen, 1998; Coughlin, 2002; Mathena, 2002; Scoble & Russel, 2003); resource management, including staffing and scheduling (Coughlin, 2002; Gould et al., 2001; Kleinman, 2003; Mathena, 2002; Sanders et al., 1996; Scoble & Russel, 2003; Squires, 2001) and information technology (Coughlin, 2002; Gould et al., 2001; Squires, 2001).

With reference to the competency related to human resource planning, staffing and scheduling, Kleinman’s (2003) subjects (i.e., 35 nurse managers and 93 nurse executives) both considered these to be among the most important competencies required of managers.

In general, although the ratings of competencies in order of importance varied somewhat, there was general consensus within the writings reviewed for this report that the competencies noted above were necessary and important in today’s world and in the future.

Of interest and some concern, however, was the limited reference in the materials reviewed to competencies associated with patient care. Sanders et al. (1996) note that in terms of the clinical component of the nurse manager role, “there is much disagreement.” Some attention to the matter of clinical competency, however, was found in the materials reviewed. In one study identifying nurse managers’ perceptions of important aspects of their role and the leadership qualities (i.e., competencies) associated with the role, respondents reported a high degree of consensus on the importance associated with the competency related to the care (generally indirect) of the patient and family (Sanders et al., 1996). Similarly, Urden and Rogers (2000), in a study of the essential qualities of front-line nursing managers, found that advocacy for quality patient care and outcomes ranked second only to the competency of collaboration within and across departments in order of importance. In Urden and Rogers’ study, a total of 805 surveys were returned with both registered nurses and physicians (n=65) completing the survey.
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Upenieks (2003) refers to those works that link the attributes of visibility and accessibility to the leader as essential to success in the leadership position. Upenieks' (2003) own results support this: “The visibility of the nurse leader and his or her responsiveness to clinical nurse interests and concerns were considered qualities that are particularly crucial....” (p.147). In a reflection on her own transition to a front-line nurse leadership position, Stevenson-Dykstra (2003) observed in her own work environment that, “all nurses expected their leaders to be visible and to be supportive” (p.63).

Despite the above claims, Duffield (1991) makes the observation that a “definite trend has emerged, over the years, towards describing the role of first-line nurse managers as managerial rather than clinical, thereby altering the skills and functions of those in this role” (p. 1251). Rudan’s (2002) study, the aim of which was to identify why the number of graduate students considering administration positions was shrinking, found that lack of support and encouragement from their managers in terms of patient care issues was influential in their decision not to pursue such roles. Simpson et al. (2002) point out that “staff nurses today value nursing leaders who understand the challenges of their work, provide direction, support, information and resources” (p.3). In describing the conceptual framework used in the D.M. Wylie Nursing Leadership Institute these authors note that the framework recognizes that today’s nurse leaders must have competence in nursing practice along with competencies related to professional and business issues.

Although in the literature reviewed there were indirect references to differing perceptions of leadership competencies amongst the various levels of nursing staff, few systematic studies could be found to support this contention. One exception was a study by Kleinman (2003). Using a survey questionnaire, Kleinman looked at the perceptions of nurse managers (n=35) and nurse executives (n=93) regarding competencies required for nursing management roles. Both nursing management groups agreed that staffing and scheduling, management and human resources were the three most important competencies for nurse managers. However, perceptions differed between the two groups regarding significant competencies required for the nurse executive role. Nurse managers rated finance and management as the two most important competencies for nurse executives, whereas the nurse executive respondents perceived strategic planning, finance and human resources as the most important for their role.

Upenieks’s (2003) qualitative study of nurse managers and nurse executives from two academic magnet hospitals and two non-magnet community hospitals (total n=16), reported similarities and differences between the two groups in terms of what characterizes a successful nurse leader. The issue of visibility of the nurse executive was one factor perceived by the nurse manager level as differing between magnet and non-magnet hospitals.
3.1.5 Enablers and Barriers to the Acquisition and Sustainability of Competencies

There was overwhelming consensus in the materials reviewed regarding those factors considered essential to the acquisition and ongoing development of leadership competencies. Two of the most frequently discussed factors in terms of their importance were mentorship (Allen, 1998; CNAC, 2003; Corning, 2002; Grindel, 2003; Mathena, 2002; Sanders et al., 1996; Seaver, 1997; Stevenson-Dykstra, 2003) and the availability/provision of a supportive environment (Allen, 1998; Barrett & Beeson, 2002; Corning, 2002; Gould et al, 2001; Laschinger et al., 2003; Mathena, 2002; Sanders et al., 1996; Stevenson-Dykstra, 2003; Upenieks, 2003).

Mentoring is one of the most effective means of developing managers and closing skill gaps according to Sanders et al. (1996). Grindel (2003), in her article on mentoring managers, cites a number of studies that demonstrate that, in addition to enhancing role socialization, mentoring has been associated with increased job satisfaction and enhanced preparation for assuming leadership roles. Use of mentor relationships should be a career-long activity according to Grindel, but might take the form of more than one mentor and possibly long distance mentoring.

The importance of a supportive environment to developing and sustaining leadership and managerial competencies was stressed throughout the materials reviewed. Findings from Upenieks' (2003) study suggest that organizational efforts focusing on access to information, resources, support and opportunity have the potential to enhance leadership. According to the respondents in Mathena’s (2002) study, organizational support (i.e., an environment that is supportive and conducive to the commitment of a reasonable amount of time for professional development) is essential.

There were countless references to the importance of education in developing leaders and leadership skills. Indeed, the majority of writings contained some reference to this facilitator. This could take the form of continuing education directed towards leadership development or advanced academic preparation (Calhoun et al., 2002; Gould et al., 2001; Longenecker, 1998; Kleinman, 2003; Mathena, 2002; Stevenson-Dykstra, 2003; Sullivan et al., 2003; Squires, 2001).

Kleinman’s (2003) study focused on the perceptions of nurse managers and nurse executives regarding the competencies required for nursing management roles and the educational preparation required to attain them. Interestingly, the results produced conflicting perceptions about the importance of graduate education; nurse executives valued the acquisition of a master’s degree as essential for nurse managers’ performance while fewer nurse managers agreed with this.

Longenecker (1998) and others speak to the importance of continued and ongoing educational support for those in managerial/leadership positions.
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Conversely, nurse managers identified the lack of time and resources for such activities in Mathena’s (2002) study as major barriers to their professional development. Authors such as Calhoun et al. (2002) stress the advantages of academicians and practitioners working in concert to identify and prioritize major educational outcomes for health care management.

Other factors identified as contributing to the ongoing development of nurse managers/leaders included a balanced work and personal life (Allen, 1998; Parsons & Stonestreet, 2003), and reinforcing self-confidence and self-esteem (Allen, 1998; Longenecker, 1998).

3.2 Position Advertisement Analysis

The authors searched a selection of job boards and websites of several members of the Canadian Healthcare Association (CHA). The job boards included: MedHunters, Canada Health Jobs; Canadian RN, Health Match BC and Workopolis.com. The search, conducted for January 2004, used key words of nurse, nurse manager, head nurse and nurse management job categories.

The search identified 25 appropriate nurse manager job descriptions. An analysis of these descriptions identified 271 competencies employers required of the positions. These fell into 50 discrete categories, including the most frequently required noted below:

- teamwork and collaboration;
- communication;
- human resource management and financial management;
- planning, implementing and evaluating care or programs of care;
- problem-solving;
- knowledge of relevant policies, procedures, including legislation; and
- knowledge of corporate vision, mission and goals.

Leadership qualities were mentioned frequently followed by knowledge of the clinical area/clinical expertise and teaching, mentoring and staff coaching.

Most of the job descriptions required or preferred graduate education and two to three years of experience in a management-level position. Most advertisements required the incumbent to be a nurse.

Overall, there was some interesting variety in the style and intensity of the advertisements. A few reflected a previous era when supervision and discipline were the prevailing characteristics of front-line managers. At the other extreme, new competencies began to emerge that potentially reflect the future role of nurse managers. Such skills as strategic-planning, change management, innovation, work ethics, knowledge of research methods and statistics,
information management and evidence-based decision-making began to appear, often together, in the competencies required.

Taken together with the competencies identified in the literature, and the results of key informant interviews, the list of discrete competencies was reduced to 44 and used as the basis of the Likert scale of the web-based survey.

3.3 Surveys

The web-based survey was directed to three levels of staff and three regulated nursing groups. The response rates for executives (n=228) and managers (n=249) were respectable. The response rate of staff nurses was disappointing, while the number of LPN and RPN respondents was too low to make meaningful comparisons. Therefore, the staff nurse results (n=87) are reported as one group.

Part of the reason for the low response rate was an unfortunate error in the survey’s introduction, which made the targeted respondent ambiguous. It appeared the staff survey was directed at managers rather than “about” managers. While several staff nurses apparently visited the website, only a fraction completed the survey. To correct for staff nurse involvement in the research, focus groups were conducted with all three regulated groups.

3.3.1 Demographics

Provincial/ Territorial Location

As depicted in Table 1, survey respondents were located in almost all provinces and territories in Canada. Prince Edward Island and the territories had the fewest participants. Across the three levels of staff, Ontario had the highest participation rate but this was in part due to the disproportionate number (41%) of executive level nurses who responded. The response rate in Quebec was lower than one would expect given the population, as noted in the limitations section of this report. Overall, the distribution of respondents clearly provided perspectives representing eastern, central and western Canada.
Leadership
Objective C: Competencies Required of Nurse Managers

Table 1: Location of respondent

<table>
<thead>
<tr>
<th>Province</th>
<th>VP (Number, %)</th>
<th>Manager (Number, %)</th>
<th>Staff (Number, %)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alberta</td>
<td>14 (3%)</td>
<td>70 (28%)</td>
<td>21 (24%)</td>
</tr>
<tr>
<td>British Columbia</td>
<td>21 (9%)</td>
<td>32 (13%)</td>
<td>14 (16%)</td>
</tr>
<tr>
<td>Manitoba</td>
<td>16 (7%)</td>
<td>25 (10%)</td>
<td>2 (2%)</td>
</tr>
<tr>
<td>New Brunswick</td>
<td>23 (10%)</td>
<td>21 (8%)</td>
<td>5 (6%)</td>
</tr>
<tr>
<td>Newfoundland</td>
<td>6 (3%)</td>
<td>7 (3%)</td>
<td>3 (3%)</td>
</tr>
<tr>
<td>Nova Scotia</td>
<td>16 (7%)</td>
<td>18 (7%)</td>
<td>4 (5%)</td>
</tr>
<tr>
<td>Ontario</td>
<td>94 (41%)</td>
<td>56 (23%)</td>
<td>19 (22%)</td>
</tr>
<tr>
<td>P.E.I.</td>
<td>-</td>
<td>3 (1%)</td>
<td>1 (1%)</td>
</tr>
<tr>
<td>Quebec</td>
<td>21 (9%)</td>
<td>1 (.04%)</td>
<td>15 (17%)</td>
</tr>
<tr>
<td>Saskatchewan</td>
<td>14 (6%)</td>
<td>9 (4%)</td>
<td>3 (3%)</td>
</tr>
<tr>
<td>Yukon</td>
<td>-</td>
<td>1 (.04%)</td>
<td>-</td>
</tr>
<tr>
<td>N.W.T.</td>
<td>1 (.04%)</td>
<td>5 (2%)</td>
<td>-</td>
</tr>
<tr>
<td>Nunavut</td>
<td>1 (.04%)</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>TOTAL</td>
<td>227</td>
<td>248</td>
<td>87</td>
</tr>
</tbody>
</table>

Age

Executives: A total of 226 executive level nurses responded to the survey. Their ages ranged from 26 to 60+ with about half (n=100) over the age of 51. Another 86 respondents (38%) were between the ages of 41 and 50 while the remainder were under the age of 40. Eight respondents were under the age of 35. Nine respondents did not answer the question.

Managers: The age distribution of the 249 managers was similar to the executive group. The range was 26 to 60+ years with slightly less than half (n=103) over the age of 51. One hundred respondents were between the ages of 41 and 50, and the remaining 39 under the age of 40. Only 15 respondents were under the age of 35. Data were missing for two respondents.

Staff: The respondents in the staff nurse category were slightly younger with 53 of the 87 respondents (approximately 62%) under the age of 45. Thirty-six per cent (n=31) were older than 45. Only 18 (21%) were under the age of 35. These demographic data are fairly consistent with national data that report an aging nursing workforce with the following mean age: RNs, 44.2; RPNs, 45.7; and LPNs, 44.2. (CIHI, 2003).
**Table 2: Age of Respondent**

<table>
<thead>
<tr>
<th>Age in years</th>
<th>VP</th>
<th>Manager</th>
<th>Staff</th>
</tr>
</thead>
<tbody>
<tr>
<td>&lt;25</td>
<td>0</td>
<td>0</td>
<td>4</td>
</tr>
<tr>
<td>26-30</td>
<td>3</td>
<td>6</td>
<td>5</td>
</tr>
<tr>
<td>31-35</td>
<td>5</td>
<td>9</td>
<td>8</td>
</tr>
<tr>
<td>36-40</td>
<td>22</td>
<td>24</td>
<td>14</td>
</tr>
<tr>
<td>41-45</td>
<td>40</td>
<td>38</td>
<td>22</td>
</tr>
<tr>
<td>46-50</td>
<td>46</td>
<td>62</td>
<td>19</td>
</tr>
<tr>
<td>51-55</td>
<td>62</td>
<td>73</td>
<td>9</td>
</tr>
<tr>
<td>56-60</td>
<td>31</td>
<td>24</td>
<td>3</td>
</tr>
<tr>
<td>60+</td>
<td>7</td>
<td>6</td>
<td>0</td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
<td>216</td>
<td>242</td>
<td>84</td>
</tr>
</tbody>
</table>

**Note:** missing data account for discrepancies in numbers

**Education**

Executives: The educational preparation of the respondents identified as vice-presidents, and/or directors of nursing and/or patient services, ranged from diploma-preparation to graduate degree with the following distribution: 54 per cent (n=76) had a diploma; two per cent (n=5) held certificates; 30 per cent (n=66) had baccalaureate degrees; and 33 per cent (n=75) had graduate Masters degrees.

Managers: The educational preparation of managers reflected a higher level than that of executives. Of the 244 respondents, 16 per cent (n=39) had a diploma; two per cent (n=7) held certificates; 51 per cent (n=124) had baccalaureate degrees; and 30 per cent (n=74) had graduate degrees.

Staff Nurses: The educational profile of staff nurse respondents was also higher than might be expected. Of the 85 respondents, 33 per cent (n=28) had a diploma; six per cent (n=5) held certificates; 45 per cent (n=38) had baccalaureate degrees; and 16 per cent (n=14) held graduate degrees.
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Objective C: Competencies Required of Nurse Managers

Table 3: Education of respondents

<table>
<thead>
<tr>
<th>Type of education</th>
<th>VP</th>
<th>Manager</th>
<th>Staff %</th>
</tr>
</thead>
<tbody>
<tr>
<td>Diploma</td>
<td>76</td>
<td>39</td>
<td>28 (26%)</td>
</tr>
<tr>
<td>Certificate</td>
<td>5</td>
<td>7</td>
<td>5 (3%)</td>
</tr>
<tr>
<td>Baccalaureate</td>
<td>66</td>
<td>124</td>
<td>38 (41%)</td>
</tr>
<tr>
<td>Masters</td>
<td>75</td>
<td>74</td>
<td>14 (30%)</td>
</tr>
<tr>
<td>PhD</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
</tbody>
</table>

**TOTAL** 222 244 85 (100%)

**Note:** Respondents were asked to identify the highest level of preparation obtained; missing data account for discrepancies in numbers.

Taken together, the overall sample reflected a much higher level of education than the national data reported by CIHI (2003). Table 3 presents the national educational preparation of RNs, RPNs and LPNs. In the present study, less than 30 per cent of respondents had diploma or certificate level of education compared to 72.7 per cent of all nurses in Canada.

Seventy-one per cent of this study’s sample held baccalaureate and graduate degrees compared to 27.3 per cent of all nurses in Canada. It should be noted that the numbers reported in this study for diploma include LPN and RPN respondents as well as RN’s. The figures quoted from CIHI are for RNs only. This finding suggests the overall sample has an overrepresentation of highly educated nurses. This might be expected since the overall sample was made up primarily of executives and managers who were more likely to be RNs. Moreover, the preponderance of RN managers and executives would be required to have undergraduate and graduate degrees. More education may also heighten the likelihood of participating in a research project. Nonetheless, this sample cannot be considered normative from an education perspective.

Again, to attempt to balance the input of all nurses, focus groups included staff level RNs, RPNs and LPNs, whose education was more reflective of national education profiles.

**Area of employment**

At the level of executives, there were significantly more respondents from the long-term care sector (see Table 4). Public health was the least well represented and the response rate from teaching hospitals was lower than would be expected. This may have occurred because there many more long-term care facilities listed in the sampling databases used for the project.
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For the nurse manager group, the largest number of respondents was from the teaching hospital sector and the lowest number was from the community health sector. Long-term care was not as well-represented as one would expect.

Staff responses were low across all sectors, with almost 50 percent of the respondents representing teaching hospitals.

Taken together across all the three groups, most health care sectors had some representation among respondents, with the public health sector the least represented.

Table 4: Area of employment of respondents

<table>
<thead>
<tr>
<th>Area of employment</th>
<th>VP</th>
<th>Manager</th>
<th>Staff</th>
<th>Total</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Teaching hospital</td>
<td>15</td>
<td>101</td>
<td>37</td>
<td>153</td>
<td>28%</td>
</tr>
<tr>
<td>Community hospital</td>
<td>37</td>
<td>52</td>
<td>13</td>
<td>102</td>
<td>19%</td>
</tr>
<tr>
<td>Regional health auth.</td>
<td>12</td>
<td>25</td>
<td>6</td>
<td>43</td>
<td>8%</td>
</tr>
<tr>
<td>Long term care</td>
<td>109</td>
<td>16</td>
<td>8</td>
<td>133</td>
<td>24%</td>
</tr>
<tr>
<td>Home care</td>
<td>12</td>
<td>13</td>
<td>4</td>
<td>29</td>
<td>5%</td>
</tr>
<tr>
<td>Public health</td>
<td>3</td>
<td>14</td>
<td>2</td>
<td>19</td>
<td>3%</td>
</tr>
<tr>
<td>Comm. health centre</td>
<td>15</td>
<td>5</td>
<td>4</td>
<td>24</td>
<td>4%</td>
</tr>
<tr>
<td>Other</td>
<td>24</td>
<td>17</td>
<td>5</td>
<td>46</td>
<td>8%</td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
<td>227</td>
<td>243</td>
<td>79</td>
<td>549</td>
<td>100%</td>
</tr>
</tbody>
</table>

Years in position

Executives: Respondents indicated the number of years they had held their current position. Of the 225 executive respondents to this question, 57 percent (n=128) had been in their position for more than four years. Of these, 53 had four to six years of experience and 75 had more than six years. Thirty-one percent (n=70) of respondents had been in their position from one to three years and 12 percent (n=27) for less than one year.

Managers: Of the 243 manager respondents to this question, 63 percent (n=153) had been in their current position for more than four years; 25 percent (n=61), for four to six years; 37 percent (n=92) for more than six years. Twenty-four percent (n=59) had been in their position from one to three years and 13 percent (n=31) had been in the managerial role for less than one year.

Staff Nurses: There were significant problems in reporting the data on this question for staff nurses. The analysis of this question was not possible due to missing and confusing data.
3.3.2 Competencies

Nurses from the three regulated groups, including nurse executives, managers and staff, were asked to complete a survey to rate the importance of required competencies for nurse managers. A total of 563 respondents completed the web-based survey, comprised of 228 nurse executives, 248 nurse managers and 87 staff nurses.

Most of the 44 competency statements were ranked more or less important. Very few were considered not at all important. Therefore, the results were examined by comparing the five most important competencies and the five least important.

**Most important competencies**

The top five (most frequently selected as very important) competencies were identified for each group. Interestingly, there were few differences noted. Nurse executives and nurse managers chose the same most important competencies: accountability for professional practice, communication (verbal), team building, leadership skills and conflict resolution.

Staff nurses mostly agreed with executives and managers, but they did not select conflict resolution in the top five. Instead, they included competencies related to legal and ethical issues. The focus groups explored the actual meaning of this choice in more depth, which will be discussed later in this report.

**Least important competencies**

There was somewhat more variability between the three groups in their choice of the least important competencies. The choices are noted below for each group:

- **Executive level**: marketing, management of information systems, succession planning, computer literacy and strategic planning.
- **Nurse managers**: marketing, management of information systems, teaching skills, preceptorship and clinical expertise.
- **Staff nurses**: management of information systems, computer literacy, project management, presentation skills and succession planning.

Nurse managers’ responses were somewhat surprising, particularly in light of the focus group results and the analysis of nurse manager job postings. These findings will be discussed in more detail later in this report. It should be noted that while the least important competencies scored two or less on the Likert scale (with a score of two indicating “somewhat important”), most competencies described as “least important” nevertheless received a score of two. That is, very few competencies were rated as “not important at all.”

It was hypothesized that university preparation might influence the respondents’ ranking of competencies. When analysed, however, university education appeared to have little or no impact. Nurses across the three groups (executive, manager and staff) consistently chose similar rankings of the most and least...
important competencies regardless of whether they had university education. These data must be interpreted with some caution since the educational level of respondents overall was relatively high compared to the national nurse education profile.

**Table 5 Top Five Most Important Competencies**

<table>
<thead>
<tr>
<th>Competency</th>
<th>VP</th>
<th>Manager</th>
<th>Staff</th>
</tr>
</thead>
<tbody>
<tr>
<td>Accountability for professional practice</td>
<td>x</td>
<td>x</td>
<td>x</td>
</tr>
<tr>
<td>Communication (verbal)</td>
<td>x</td>
<td>x</td>
<td>x</td>
</tr>
<tr>
<td>Team-building</td>
<td>x</td>
<td>x</td>
<td>x</td>
</tr>
<tr>
<td>Leadership skills</td>
<td>x</td>
<td>x</td>
<td>x</td>
</tr>
<tr>
<td>Conflict resolution</td>
<td>x</td>
<td>x</td>
<td></td>
</tr>
<tr>
<td>Legal and ethical issues</td>
<td></td>
<td></td>
<td>x</td>
</tr>
</tbody>
</table>

### 3.3.3 Enablers and Barriers

Respondents ranked 16 variables identified as enablers or barriers to acquiring and maintaining the competencies required by nurse managers. The same Likert scale from one (least important) to four (most important) was used.

**Most important enabling variables**

Again, the three groups of executives, managers and staff had consistent responses. For executives and managers, the five most important enabling variables were identical:

- a supportive work environment;
- clear and reasonable expectations;
- a balanced work life;
- reasonable workload; and
- accessibility to management educational programs.

Staff nurses’ responses were similar with the exception of the “clear and reasonable expectations” variable, which was not ranked in the top five. Instead, they included “accessibility to a mentor.”

**Least important enabling variables**

There was some variability in the ranking of the five least important variables. Executives ranked the five least important as follows:

- flexibility in the delivery of educational programs;
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- IT support;
- financial support;
- institutional incentives; and
- graduate education.

Managers with executives agreed on four of these variables. However, they added “experience” and did not include “flexibility in the delivery of educational programs.”

Staff nurses’ responses to this question were more similar to manager responses than to the executives, although all three groups agreed on three of the variables. Staff nurses identified the following factors:

- graduate education;
- financial support;
- institutional incentives;
- experience; and
- flexibility in the delivery of educational programs.

Again it was noted that all variables were ranked as more or less important although very few had a ranking of one on the scale (“not at all important”). These findings were explored further with focus group participants who willingly elaborated on the variables that encouraged or discouraged the acquisition of competencies.

Table 6 Top Five Most Important Enablers and Barriers

<table>
<thead>
<tr>
<th>Enablers/Barriers</th>
<th>VP</th>
<th>Manager</th>
<th>Staff</th>
</tr>
</thead>
<tbody>
<tr>
<td>Supportive work environment</td>
<td>x</td>
<td>x</td>
<td>x</td>
</tr>
<tr>
<td>Clear &amp; reasonable expectations</td>
<td>x</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Balanced work/life</td>
<td></td>
<td>x</td>
<td>x</td>
</tr>
<tr>
<td>Reasonable workload</td>
<td></td>
<td>x</td>
<td>x</td>
</tr>
<tr>
<td>Access to management education programs</td>
<td>x</td>
<td></td>
<td>x</td>
</tr>
<tr>
<td>Access to a mentor</td>
<td></td>
<td></td>
<td>x</td>
</tr>
</tbody>
</table>

3.4 Focus Group Findings

Although nine questions were pre-circulated, actual focus group discussions were not structured in order of the questions. Participants all were vocal on the subject of nurse manager competencies and often addressed different
questions during the free-flowing discussion. Therefore, the results are reported by themes that emerged from the data analysis and that reflect the predominant issues raised by the groups.

Focus groups were held with executive nurses, nurse managers and staff nurses. The executive level focus groups were comprised of nurses who were all RNs. Both the manager and staff focus groups were conducted with RNs, LPNs and RPNs separately. There were no discernible differences between the three regulated nursing groups in their discussions of manager competency requirements, or of enablers and barriers.

Participants largely used the focus groups to express their frustrations and concerns about management, and the challenges facing direct care providers and managers in the current health care environment. Comments from RNs, LPNs and RPNs were disturbingly similar and reflected an overworked, stressed and, to some extent, demoralized workforce. Because of their similarity, the comments are reported here collectively as managers and staff. When one nursing group raised a particular issue, it is attributed to that group in the report. Focus group findings are described according to the position of the respondents, i.e., executive, manager and staff.

### 3.4.1 Nurses in Executive Positions

Seven nurses in vice-president positions from the Maritimes, Central and Western Canada participated in a 1.5-hour teleconference on the competencies required of front-line managers. They also discussed factors in the current health care environment that act as barriers to acquiring those competencies. There was a high level of agreement among the participants on the issues raised.

**Patient care and accountability: Prominent themes**

The most prominent theme in the discussion was the need for managers to manage patient care and be accountable for professional practice. Participants highlighted concerns about managers’ time being consumed by operations such as budgets, scheduling and staffing, and attending endless meetings to “put out fires” and resolve conflicts. The VPs emphasized that many nurse managers and chief nursing officers lost their positions during an extended period of budget cuts in health care. They believed this left many organizations leaderless from the perspective of nursing and patient care. They also agreed emphatically that the front-line manager is key to managing the system, and to retaining and recruiting staff. There was serious concern that today’s managers are unable to devote time to staff, patients and families. They believe quality of care, patient safety and staff morale have all suffered.

There was considerable discussion about the lack of mentorship available both for nurse managers and for staff (by nurse managers). They described how everyone in the system is overextended, with no time to network or to build constructive and supportive relationships. It was noted that people do not even
sit together for coffee or lunch anymore and communication is often via voice mail or e-mail. The consequences are not optimistic for the future because most nurses no longer aspire to management positions, having no positive role models. They see their managers’ lifestyles and want no part of it.

According to the VPs, few people apply for managerial positions; those who do are often inappropriate and unprepared. All participants agreed that front-line managers need more support to manage care and to be a resource and mentor to staff. Most acknowledged that there are limited or no resources to do this.

**Key competencies and barriers**

To conclude, the nurse executives identified several key competencies required by today’s front line-managers in health care: accountability of patient care, communication, mentoring, team-building, conflict resolution, problem-solving and political savvy. There was a high level of agreement that a competency assessment tool would be useful to employers.

They also agreed on the barriers to successful acquisition of these competencies: lack of institutional support, time, role models and accessible learning resources.

The overall tone of the discussions reflected both a tremendous commitment to managers, staff and patient care, as well as serious concern for the future unless there is considerably more support for nursing. They felt there would be a huge void in the management of patient care and deterioration in the accountability and professionalism of direct care providers.

### 3.4.2 Nurses in Managerial Positions

Teleconference focus group discussions included one LPN group of seven participants, one RPN group of six participants and one RN group of six nurse managers. The participants in these focus groups were very articulate and expressed several positive and negative aspects of being a front-line manager. They identified a number of required competencies, which were congruent with the survey responses from this group. Several felt that personal attributes such as kindness and fairness were as important as some of the more technical competencies. There was considerable discussion about the importance of team-building and conflict resolution. All agreed that open and frequent communication with staff and patients were essential to managing patient care. Participants also emphasized that nurse managers must demonstrate leadership skills, not just management competencies. They referred to such things as helping others to develop potential, to see the bigger picture, to actively engage in questioning the status quo, etc.

Although all participants seemed committed, even passionate about their work, they also expressed enormous frustration with current conditions. They admitted to working long hours of overtime, feeling stressed, spending too much time in meetings and doing paperwork, and having less and less time to be with staff,
patients and patients' families. They expressed that they often felt torn in many directions and were not able to support staff to the extent they wanted, often due to lack of resources as well as time. The one exception was a nurse manager from a new community hospital in Ontario, which is well-resourced with modern equipment for staff nurses to provide care.

Most participants felt they received support from directors/VP of nursing but commented that the institution or health care facility was less supportive. They remarked on the lack of support for their own career development and lack of recognition for the work they were doing. They emphasized the lack of incentives, including salary, for people to be attracted to nurse management positions and for managers to stay in their positions. One LPN manager participant had just resigned her position because she could no longer cope with “the excessive and unreasonable demands placed on me,” which included an inordinate amount of “on call” time.

When asked about barriers to the acquisition or ongoing sustainability of competencies most participants agreed that lack of time and institutional support were the most significant. However, some managers noted that recent changes had occurred to try to provide some support to managers to be able to master the expectations of work. Many rebutted that this was primarily peer support and that what they really needed were mentors in the system.

3.4.3 Staff nurses

Thirty-four nurses (four RNs, 12 RPNs and 18 LPNs) participated in six separate focus groups. The most common competency themes included visibility, mentorship, clinical expertise and leadership. Several comments related to the lack of manager visibility at point-of-care. Staff nurses felt that managers, overloaded with operational issues, had to spend their days and often evenings in meetings and at a computer. They wanted managers to be available for advice and guidance related to patient care. All participants believed that nurse managers must have clinical expertise to be a resource to staff and to earn staff respect.

Staff clearly looked to managers for their own professional development and continuing clinical education. They reported, however, that these characteristics were seldom available due to the manager’s absence. One RPN noted that he had not received a performance evaluation in the past 10 years. Clearly, from a staff perspective, there are serious problems in the current work environment.

Participants agreed that managers also need “people skills.” When prompted to elaborate on what they meant, they included communication, team building, empathy and fairness in dealing with people. A participant RPN from a community mental health service noted that managers in that facility need strong interpersonal skills to deal with multiple community agencies.
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Participants were asked to comment on managers’ need for competencies related to ethical and legal issues. This query was based on the results of the top five competencies rated by staff on the web survey. One of the top five was related to ethical and legal knowledge. The respondents were not certain what this might mean but suggested two areas that were important. One was related to “end of life” situations where ethical and legal knowledge was critical; the other was staff and union relations.

Staff nurses were less emphatic about how managers acquire these competencies. They mentioned the need for specific courses or programs to address more technical or specialized competencies, such as labour relations and conflict resolution. Overwhelmingly, staff felt that managers get little support from their institutions and organizations. While most participants stated they personally did not aspire to be managers because of workload stress, they did not believe the system gave much support to potential managers.

Staff thought it would be important for a staff nurse to sit on the selection committee to evaluate potential manager competencies. They would ask candidates questions to determine their level of commitment to staff development and to ascertain the candidate’s “people skills.”
Perhaps the most significant finding in this research was the unanimous agreement among all participants. Whether an RN, RPN or LPN, an executive, a manager or a staff nurse, all participants had a high level of consensus on the key competencies and on the current role of front-line nurse managers in the health system. The manager is seen as key to successful health care delivery. From the perspective of health care nurse executives, the manager's main roles are to manage patient care, be a role model for staff, and serve as a resource for staff, patients and families. They are seen as a significant influence in the retention of staff and the recruitment of new staff.

As one vice-president noted, “The word gets out across the city as to who the really great managers are, and that is where staff nurses gravitate.” They all apply for openings on units with popular managers, regardless of the clinical specialty.

While staff nurses used somewhat different language, their message was clear. They want their managers to be visible, present and available to them. They want a manager who has clinical expertise, and can manage patient care, mentor staff and actively support staff development. They want managers to be good communicators and have excellent “people skills.” Managers themselves agree that these competencies and roles are the main focus of their work, although the survey results for managers did not rank clinical expertise among the top five competencies.

The findings of this project are closely aligned with the literature. Several authors reported the importance of communication and people skills. In Calhoun et al.’s (2002) analysis of a number of studies on competencies, the two top-ranked positions of importance were communication skills and interpersonal skills. These research studies included a variety of groups and people in different positions, from front-line workers to managers. Similar to the findings in the present study, communication and interpersonal skills were predominant competencies associated with managers, regardless of profession or position.

While many of the competencies here can be considered generic to managers and leaders, some were definitely profession specific. All respondents in this study agreed that nurse managers must be clinically competent and be a clinical role model and resource to the staff they manage. Urden and Rogers (2002), in a survey of registered nurses and physicians, found that clinical competence ranked second only to cross-departmental collaboration in terms of importance.

These findings have implications for how the health care industry might provide educational opportunities to all health professionals to develop management and leadership competencies. Since many of the competencies are generic, they could be developed in interdisciplinary programs. Clinical competencies, on the other hand, are more profession-specific and are likely derived through
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Objective C: Competencies Required of Nurse Managers

basic professional education and continuing education programs along with clinical experience. Another theme that emerged as critically important in this project was the whole issue of mentorship. Staff nurses want their managers to be visible and supportive mentors. This finding, along with the importance attached to the clinical role model, is similar to the results of others. Stevenson-Dykstra (2003) noted that “all nurses expected their leaders to be visible, to be supportive.”

The literature identified mentorship as one of the most important variables in the development of leadership competencies. Nurse managers in this study agreed that continuing mentorship was important to them in their management roles. According to Sanders et al. (1996), mentoring is one of the most effective means of developing managers. Grindel (2003) cites increasing evidence that mentoring is associated with increased job satisfaction and enhanced preparation for assuming leadership roles. She also emphasizes that the use of mentor relationships should be a career-long activity.

In this study, nurse managers cited the lack of available mentors as a barrier to their ongoing development. Given the importance of mentorship to the preparation of future health care leaders, this is an area where Canada may require a targeted initiative. Given the lack and availability of senior people in the system due, in part, to reductions in positions and to enormous demands on the people left, innovative approaches to mentorship may be required to ensure a cohort of managers and leaders for the future. Grindel (2003) mentions the possibility of long distance mentorship and the use of more than one mentor as viable approaches.

Sadly, all participants in this study agreed that today’s health care environment has had a dramatic impact on nurse managers, such that the care role described above is seldom achievable. Significantly fewer front-line managers work in the system, and those remaining have enormous demands on their time and expertise. The role has expanded to include business and operational competencies, which supersede the manager’s role with staff and patients. Common themes related to manager roles included an increasing distance between the manager and the point-of-care. Staff felt leaderless, managers felt stressed and overextended and, in the absence of more resources, nurse executives felt powerless to enact the changes required to improve the managers’ plight.

Nurse managers in today’s health care environment require an increasing number of competencies because their roles are far more complex than they were 10 years ago. This is supported by the analysis of job advertisements that required high-level conceptual competencies, as well as several specialized and more technical skills. The survey results also support this trend: few of the 44 competencies comprising the survey scale were ranked as “not important.” As well, several authors emphasize that competencies are not static; they are dynamic and will change over time in response to changes in health care,
Leadership
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technology, etc. These findings lead to critical questions: How can the system support front-line managers to continue to develop competencies and to maintain their focus on the management of patient care? How can the system/institution prevent managers from becoming everything from “paper pushers,” data entry clerks, scheduling experts and resource/finance managers?

All respondents in the focus groups emphasized that front-line managers need more support to make their roles more meaningful and their work lives more manageable. Strong front-line managers, who can focus on management of patient care, will have a direct and positive impact on the quality of care and patient safety. They will also provide the leadership/mentorship for the next generation of nurse managers. The future sustainability of the health care system depends on them.

Acquiring and maintaining competencies for management were considered directly related to a supportive work environment and a balanced work life. Other factors, such as availability of management educational programs, were also considered important. Most respondents felt that graduate education was not an important factor for manager competencies. This may not be surprising since graduate studies generally focus on the development of more generic high-level conceptual skills such as problem-solving, critical thinking, analytical capacity, etc. While these skills would greatly contribute to the manager’s potential for continuous learning, they are not specific to the technical or institutional demands of various management tasks. Also, required competencies change over time as new management procedures and processes are introduced. It is more likely that these competencies will be learned in specifically designed continuing education offerings or job-specific training. It is also true that graduate programs are not designed in all cases to prepare nurse managers. They may also focus on preparation of advanced practice nurses, researchers and educators.
5 RECOMMENDATIONS

Based on the findings of this study, the following recommendations are offered with the ultimate aim of improving access to and quality of patient care by strengthening the competencies and roles of front-line nurse managers.

1. Health care employers should invest in front-line manager positions. They may see returns on this investment if they focus on patient care management. This study and the related literature suggest that a visible, knowledgeable front-line nurse manager can improve the quality and efficiency of patient care, the morale and motivation of staff, and patient safety and satisfaction.

2. Employers should provide technical and clerical support to front-line managers to give them time to work with staff, patients and families.

3. Health care employers should provide support for managers and potential managers to access educational programs to increase and strengthen competencies. A supportive work environment was found to be the most important enabling factor for managers to acquire and maintain competencies.

4. National and regional mentorship programs should be supported to ensure adequate numbers of qualified front-line managers to sustain the health care delivery system. Several reports over the past few years have predicted a serious shortage of nurses in Canada in the near future. According to this project’s findings, in addition to fewer providers, there will be fewer staff interested in management positions. Staff nurses did not aspire to be managers who were overworked and not close to patient care.

5. Given that employers require more complex competency profiles for front-line managers, local educational programs should be available to support the development of these competencies. The analysis of job descriptions for nurse managers suggested a growing trend toward requiring more complex conceptual skills and knowledge. If these competencies are important, training should be readily available.

6. Health care employers and educators should consider interdisciplinary educational programs to teach core health care management/leadership competencies. The literature and the research reported here identify a number of important competencies for nurse managers that are more generic and not discipline-specific. These competencies include communication, team-building and resource management. Several positive outcomes may result from having different health care professionals learn together; working better together would be one of them. More intensive mentorship programs for nurse managers could provide discipline-specific competencies such as managing nursing care.
APPENDIX A: INTERVIEW GUIDES / SURVEY QUESTIONS

Letter of Invitation

February 2004

As part of this project, we are seeking your input as a nurse manager with respect to competencies pertaining to your role, and regarding workload measurement tools you are using or have used. Please visit http://209.217.65.7 between February 5 and February 19, 2004 to participate in a quick on-line survey that should take 5 to 10 minutes to complete. All responses will be anonymous and kept confidential. 

Dear Colleague:

Please participate. Your voice is important.

Thank you

The final report of the Canadian Nursing Advisory Committee (CNAC) included 51 recommendations designed to create healthy workplace environments for nurses. Seven national organizations are collaborating to facilitate the implementation of a number of these recommendations. The seven are the Academy of Chief Executive Nurses, Canadian Association of Schools of Nursing, Canadian Federation of Nurses Unions, Canadian Healthcare Association, Canadian Nurses Association, Canadian Practical Nurses Association, and Registered Psychiatric Nurses of Canada.

Lucille Auffrey, RN, MN/inf., M.Sc. inf.
Executive Director/Directrice générale
Canadian Nurses Association/Association des infirmières et infirmiers du Canada.
Leadership
Objective C: Competencies Required of Nurse Managers

Canada
On behalf of the seven organizations/ Au nom des sept organismes
Leadership
Objective C: Competencies Required of Nurse Managers

Letter of Invitation
February 2004

Dear Colleague:

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As part of this project, we are seeking your input as the senior nurse executive in the areas of staff mix decision tools, direct care equipment needs and nurse manager competencies. Please visit www.aldenweb.com/senior_nursing_survey between February 2 and February 16, 2004 to participate in a quick online survey, which should take 5 to 10 minutes to complete. All responses will be anonymous and kept confidential.

Please participate. Your voice is important.

Thank you / Merci

Lucille Auffrey, RN, MN/ inf., M. Sc. inf.
Executive Director/Directrice générale
Canadian Nurses Association/ Association des infirmières et infirmiers du Canada.

31 March 2004
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Objective C: Competencies Required of Nurse Managers

Canada
On behalf of the seven organizations/ Au nom des sept organismes
Leadership
Objective C: Competencies Required of Nurse Managers

**NURSE MANAGER COMPETENCY SURVEY (1a.)**

**Directed to Nurses**

This is a survey to solicit your input on the required competencies for nurse managers.

For the purposes of this study,

- Nurse manager is defined as an individual in a first-level administrative position who manages staff providing direct care.
- Competencies are defined as the knowledge, skills and personal attributes. (CNA, 1995).

In your opinion, how important are the following categories of competencies for nurse managers?

Please rate their importance according to the following scale:

1 = not at all important
2 = somewhat important
3 = important
4 = very important

1 2 3 4

1. accountability for professional practice
2. knowledge of workplace policies
3. policy development
4. human resource management
5. budget development and oversight
6. strategic planning
7. understanding and use of the research process (evidence-based decision-making)
8. risk management
9. staff development
10. succession planning
11. knowledge of work and scope of practice of other disciplines
12. coordination with other disciplines
13. marketing
14. accountability for and evaluation of patient/client/resident outcomes
15. management of information systems/information technology
Leadership
Objective C: Competencies Required of Nurse Managers

16. staffing and scheduling
17. legal and ethical issues
18. preceptorship
19. mentorship
20. communication skills
   a. verbal
   b. written
21. team-building
22. networking
23. conflict resolution
24. analytic skills
25. computer literacy
26. organizational skills
27. awareness of “big picture” issues
28. working knowledge of and expertise in the clinical area
29. change management skills
30. negotiating skills
31. performance appraisal/evaluation
32. knowledge of emerging trends and issues
33. self-awareness
34. intuition
35. empathy
36. labour relations
37. program planning
38. project management
39. knowledge of quality control processes
40. leadership skills
41. innovative thinking
42. teaching skills
43. presentation skills
44. knowledge of workload management tools
45. other (please specify) (input field)
FACTORS INFLUENCING THE DEVELOPMENT OF COMPETENCIES FOR NURSE MANAGERS (1b.)

Directed to Nurses

For the purposes of this study,

Nurse manager is defined as an individual in a first-level administrative position who manages staff providing direct care.

Competencies are defined as the knowledge, skills and personal attributes. (CNA, 1995).

In your opinion, how important are the following factors in the development of competence for nurse managers?

Please rate the importance of each factor according to the following scale:

1 = not at all important
2 = somewhat important
3 = important
4 = very important

1 2 3 4

1. graduate education
2. time
3. financial support
4. accessibility to management/leadership courses
5. accessibility to a mentor
6. peer support
7. supportive working environment
8. organizational plan for continuous learning
9. institutional incentives
10. reasonable workload
11. experience
12. clear and reasonable expectations
13. work/life balance
14. IT support
15. flexibility in delivery of educational programs
16. access to information services e.g. internet
17. Other (please specify) (input field)
LEADERSHIP
Objective C: Competencies Required of Nurse Managers

NURSE MANAGER COMPETENCY SURVEY (1a.)

Directed to Nurse Managers

This is a survey to solicit your input on the required competencies for nurse managers.

For the purposes of this study,

Nurse manager is defined as an individual in a first-level administrative position who manages staff providing direct care.

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10. succession planning
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12. coordination with other disciplines
13. marketing
14. accountability for and evaluation of patient/client/resident outcomes
15. management of information systems/information technology
Leadership
Objective C: Competencies Required of Nurse Managers

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17. legal and ethical issues
18. preceptorship
19. mentorship
20. communication skills
   a. verbal
   b. written
21. team-building
22. networking
23. conflict resolution
24. analytic skills
25. computer literacy
26. organizational skills
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38. project management
39. knowledge of quality control processes
40. leadership skills
41. innovative thinking
42. teaching skills
43. presentation skills
44. knowledge of workload management tools
45. other (please specify) (input field)
Leadership
Objective C: Competencies Required of Nurse Managers

FACTORS INFLUENCING THE DEVELOPMENT OF COMPETENCIES FOR NURSE MANAGERS (1b.)

Directed to Nurse Managers

For the purposes of this study,

Nurse manager is defined as an individual in a first-level administrative position who manages staff providing direct care.

Competencies are defined as the knowledge, skills and personal attributes. (CNA, 1995).

In your opinion, how important are the following factors in the development of competence for nurse managers?

Please rate the importance of each factor according to the following scale:

1 = not at all important
2 = somewhat important
3 = important
4 = very important

1 2 3 4

1. graduate education
2. time
3. financial support
4. accessibility to management/leadership courses
5. accessibility to a mentor
6. peer support
7. supportive working environment
8. organizational plan for continuous learning
9. institutional incentives
10. reasonable workload
11. experience
12. clear and reasonable expectations
13. work/life balance
14. IT support
15. flexibility in delivery of educational programs
16. access to information services e.g. Internet
17. other (please specify) (input field)
**DEMOGRAPHICS**

**Nurse Manager Competency Survey**

**Directed to Nurse Managers**

1. What best describes your area of employment: (choose only one of the following options - 1.1 to 1.12)

**Facility-Based**

1.1 Teaching Hospital
1.2 Community Hospital
1.3 Rehabilitation
1.4 Mental Health
1.5 Long-term Care

**Community-Based**

1.6 Home Care e.g. VON, St. Elizabeth’s, Centre Local de Services Communautaires (CLSC), Community Access Care Centre (CCAC), Red Cross
1.7 Public Health
1.8 Community Health Centre
1.9 Rehabilitation
1.10 Mental Health
1.11 District/Regional Health Authority
1.12 Other: (please specify)

2. Province/Territory you work in:

   What is your professional designation:
   - Registered Nurse (RN)
   - Registered Psychiatric Nurse (RPN)
   - Licensed/Registered Practical Nurse (LPN/RPN)

3. Approximate number of nursing staff in your organization: (choose one number for each type of staff)

   - RN: 50-250
   - RPN (Psych): 50-250
   - LPN/RPN: 50-250

   RN: Registered Nurse, RPN: Registered Psychiatric Nurse, LPN/RPN: Licensed/Registered Practical Nurse
4. What is your present age:
   <25 years 31-35 41-45 51-55 >60
   26-30 36-40 46-50 56-60

5. What is your gender:
   Female
   Male

6. What is your title within the organization: (choose one)
   Patient/Client/Resident-Care Manager
   Clinical Services Manager
   Nurse Manager
   Program Manager
   Manager
   Other (please specify)

7. How many years have you held your current title:
   <1 year
   1-3 years
   4-6 years
   >6 years

8. What level of education have you completed: (select the highest)
   Diploma
   Certificate (RPN-Psych, LPN/RPN)
   Baccalaureate
   Graduate
   Doctorate
Leadership
Objective C: Competencies Required of Nurse Managers

DEMOGRAPHICS

NURSE MANAGER COMPETENCY SURVEY

Directed at Nursing Directors/VPs

1. What best describes your area of employment: (choose only one of the following options - 1.1 to 1.14)

Facility-Based
  1.1 Teaching Hospital
  1.2 Community Hospital
  1.3 Rehabilitation
  1.4 Mental Health
  1.5 Long-term Care
  1.6 Other: (please specify) (input field)

Community-Based
  1.7 Home Care e.g. VON, St. Elizabeth’s, Centre Local de Services Communautaires (CLSC), Community Access Care Centre (CCAC), Red Cross
  1.8 Public Health
  1.9 Community Health Centre
  1.10 Rehabilitation
  1.11 Mental Health
  1.12 Other: (please specify) (input field)
  1.13 District/Regional Health Authority
  1.14 Other: (please specify) (input field)

2. Province/Territory you work in: (drop down list)

3. What is your professional designation:
   Registered Nurse (RN)
   Registered Psychiatric Nurse (RPN)
   Licensed/Registered Practical Nurse (LPN/RPN)

4. Approximate number of nursing staff in your organization: (choose one number for each type of staff)
   RN  <50  50-250  >250
   RPN(Psych)  <50  50-250  >250
Leadership
Objective C: Competencies Required of Nurse Managers

LPN/RPN   <50  50-250  >250
RN: Registered Nurse, RPN: Registered Psychiatric Nurse,
LPN/RPN: Licensed/Registered Practical Nurse

5. What is your present age:
   <25 years  31-35  41-45  51-55  >60
   26-30  36-40  46-50  56-60

6. What is your gender:
   Female
   Male

7. What is your title within the organization: (choose one)
   Nursing
   Director of Nursing
   Program Director
   VP Patient Services
   Clinical Director
   Other (please specify) (input field)

8. How many years have you held your current title:
   <1 year
   1-3 years
   4-6 years
   >6 years

9. What level of education have you completed: (select the highest)
   Diploma
   Certificate
   Baccalaureate
   Graduate
   Doctorate
APPENDIX B: REFERENCES


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Objective C: Competencies Required of Nurse Managers


Rudan, V. (2002). Where have all the nursing administration students gone? Journal of Nursing Administration, 32(4), 185-188.


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Objective C: Competencies Required of Nurse Managers


