Sources of influence : nursing service administrators in Montana
by Avis Ruth Peterson

A thesis submitted in partial fulfillment of the requirements for the degree of Master of Nursing
Montana State University

Abstract:
This exploratory descriptive study identifies the personal and professional profile of nurse administrators today. These nurse administrators function in nongovernmental acute care hospitals. The conceptual framework of this study was organized around the sources of influence through formal and functional power as identified in the publications of Stevens (1980a; 1980b) and Mersey and Blanchard (1982). Dimensions of the organizational position were derived from national standards. Responsibility, authority, and personal and professional characteristics which contribute to administrative role were studied. Mentor-network relations which contribute to role development were identified.

The study population was 35 nurse administrators in acute care hospitals in Montana. A questionnaire was mailed to nurse administrators in order to identify- the personal and professional characteristics which define the administrative role. All returns were found acceptable for data analyses. Descriptive statistics were used to develop a group profile. Findings were compared with nationwide studies conducted by the American Society of Nursing Service Administrators and the American Hospital Association. The rural nature of Montana hospitals was identified as an extraneous variable in comparisons.

Findings of this study included similarities and differences between the national profile and the profile in Montana. Montana nurse administrators are following the nationwide trend for higher credentialling. There is increased educational preparation in nursing administration, greater participation in corporate affairs, and major responsibility for the department of nursing. Influence within the corporation is equal to, or greater than, the responsibility held by Montana nurse administrators. Professional mentor and network relationships are important concepts for administrative role development.

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Date September 12, 1984

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ABSTRACT

This exploratory descriptive study identifies the personal and professional profile of nurse administrators today. These nurse administrators function in nongovernmental acute care hospitals. The conceptual framework of this study was organized around the sources of influence through formal and functional power as identified in the publications of Stevens (1980a; 1980b) and Hersey and Blanchard (1982). Dimensions of the organizational position were derived from national standards. Responsibility, authority, and personal and professional characteristics which contribute to administrative role were studied. Mentor-network relations which contribute to role development were identified.

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CHAPTER 1

INTRODUCTION

Experience as a nurse executive in a rural Montana hospital has provided the basis of interest for this statewide research study. Professional mentor-network relationships in the practice setting were a powerful influence in career development for this researcher. Personal experience has increased interest in the influence held by nurse administrators and in mentor-network relationships of nurse administrators in Montana.

In order to clarify the setting in which nursing administrators in Montana function, the rural nature of Montana and of the acute care hospitals are identified. Federal rules and regulations, accreditation standards, national nursing and hospital organization standards and guidelines, provide a basis for comparison between roles and responsibilities of nurse administrators in Montana and nurse administrators nationwide. Deviation between national standards and Montana standards may be attributed to the sparse population and the relative isolation of some hospitals and nurse administrators. Data related to the extent and impact of mentor-network relationships on position acquisition and career success validate the concepts as sources of influence for Montana nurse administrators.

The nurse administrator, responsible for the department of nursing, also holds responsibility for the major portion of the institutional

budget and the largest number of organizational employees (Stevens, 1978b). The nursing administrator is a nursing leader functioning within a position which requires both clinical nursing skills and administrative expertise. Increased complexity of health care, exploding medical technology, and the expanding role of the nurse are axiomatic of the dual role of the nurse executive (Stevens, 1980a).

The rural nature of the health care delivery system serves to isolate most of the nursing administrators in Montana. There is a wide diversity in size and services offered by Montana hospitals. Climatic conditions and distance to other acute care facilities serve to magnify health care delivery problems in rural hospitals. To understand the role and responsibilities of nurse administrators in Montana, some perspective of the characteristics of the state, population, hospital size, and management require clarification.

Montana, the fourth largest state in the nation, is rich in natural resources, beauty, and land. Montana is also thinly populated. In the state's 145,392 square mile area there are only 5.4 persons per square mile. Over 47 percent of the population is considered rural (Census, 1980). Areas of Montana are designated as medically underserved due to a maldistribution of health care providers. Coordinated efforts have been made in recent years for upgrading of emergency medical services and the rapid transport of patient from primary to tertiary health centers.

Nationally there are over 7,000 acute care hospitals (AHA, 1981). Approximately 1.2 million professional nurses are employed in the United States, two-thirds are employed in hospitals (The American

Nurse, 1983). In the 56 counties of Montana there are 60 nongovernmental acute care hospitals. The largest acute care hospital has 282 beds, five hospitals have from 200-282 beds, and six hospitals have 100-200 beds. Of the remaining 49 hospitals the average is 28 beds (MSDHES, 1983). Approximately one-half of all acute care hospitals in Montana are combined with long-term facilities or have allocated acute care beds as swing beds (AHA, 1981). Services vary greatly in hospitals in Montana and are totally dependent upon physician population.

Financial viability is increasingly difficult for nonprofit hospitals. Many of Montana's 60 acute care hospitals have entered into management contracts or some other contractual agreement with hospital corporations. Six hospitals operate under church ownership, four are county owned, two have corporate ownership, and the 48 remaining hospitals are nonprofit corporations, districts, or authorities. Only 19 of the 60 hospitals are accredited by the Joint Commission on Accreditation of Hospitals (MSDHES, 1983).

Despite the continual increase of men in the profession, nursing remains a profession dominated by women. Women in management positions are in the majority. The role of women in executive positions will affect any research on aspects of nursing administration at this time. It is recognized that a focus on women's roles is beyond the scope of this research study.

Purpose of the Study

The purpose of this exploratory descriptive study is the development of a professional profile of nursing service administrators in

acute care hospitals in Montana. The professional profile includes personal and professional characteristics and current roles, responsibilities, and influences. Comparison of similarities and differences between Montana nurse administrators and nurse administrators nationwide was made possible, since the instrument used was an adaptation of the 1977 total universe survey of nursing administrators in hospitals by the American Society of Nursing Service Administrators of the American Hospital Association (ASNSA, 1980b). Mentor-network relationships, as a facet of career development and advancement, was a part of the information requested in order to complete the profile. National guidelines provided the framework for considering role enactment within one crucial dimension of administration, that of influence.

Statement of the Problem

The problem was to develop a profile of nurses in nursing administrative positions which provide information salient to the role of nursing administration in acute care hospitals in Montana. The data obtained will aid in answering questions related to level of responsibilities, sources of influence through power bases, educational preparation, employment conditions, and the importance of mentor-network relationships in position acquisition and role development.

Definition of Terms

For the purpose of this study, the definition of terms is a composite from the review of literature.

Nurse administrator: The highest ranking nurse in the organizational structure of an acute care hospital and an active member of executive management.

Influence: Possession of sources of power which affect compliance, motivation, and the behavior of others.

Professional Network: Mutual interaction with professional contacts who provide information, advice, and moral support for career development and advancement.

Professional Mentor: An experienced professional who acts as a guide for a less experienced professional to aid in the development of professional expertise and for career advancement.

Sources of Influences: The formal power granted by the corporate position and the functional power which combines personality, behavior, and perceived expertise and position.

Organizational Position: The hierarchical position occupied by the nurse administrator in the acute care hospital administrative structure.

Career Success: The self-perception of achievement of professional position and goals, as evidenced by acquisition of both formal and functional power.

Formal Power: Power derived from delegated authority and responsibility based on organizational factors.

Functional Power: Power based on the individual characteristics of the leader.

Professional Role: The achieved role of nurse executive which is a synthesis of nursing and management.

Conceptual Framework

The conceptual framework for this study is organized around the concept of influence and is drawn from the publications of Stevens (1980a; 1980b) and Hersey and Blanchard (1982). Major complex variables examined in this study are sources of influence, organizational position, and career success. Career success will be considered only in relation to achievement of the roles and responsibilities as indicated in national guidelines. Network and mentorship linkages are concomitant variables identified to validate their effect on role development and position acquisition.

The Model

The conceptual model in Figure 1 illustrates the constructs, concepts, variables, measures, and their proposed directional relationships. Each arrow represents the direction of the relationship assumed by this researcher to exist. A broken line indicates that a direct effect was postulated, however, it was beyond the scope of this study to validate effect. No effort was made for antecedent ordering of the variables thought by this researcher to influence success in nursing administration.

The model was developed from narrative descriptions by Stevens (1980a; 1980b) and Hersey and Blanchard (1982). The model is an interpretation of concepts of formal and functional power defined in their publications. Organizational position encompasses the role, functions, and qualifications of the nurse administrator as designated by the Health Financing Administration, Department of Health and Human

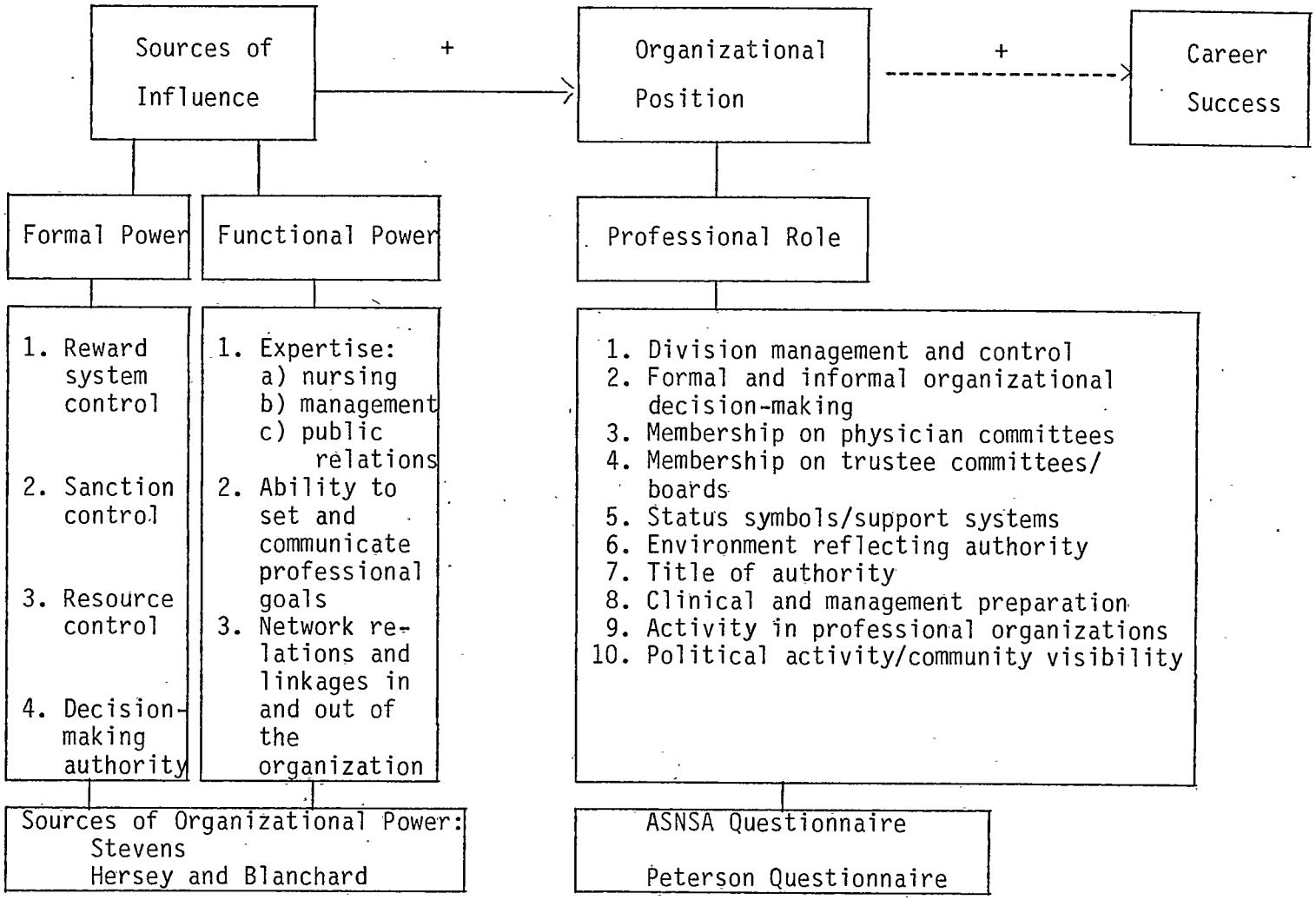

Figure 1. Conceptual Model

Services (1982), Joint Commission for Accreditation of Hospitals (1983), American Nurses' Association (1982), National League for Nursing (1980), American Society of Nursing Administrators of the American Hospital Association (1979; 1980a), and the American Hospital Association (1979). The standards were compressed into ten broad categories. Organizational position was measured using an adaptation of the American Society of Nursing Administrators' 1977 survey of nursing service administrators in acute care hospitals (1980b) and supplemental items developed by the researcher. Sources of influence are assumed to positively affect organizational position and to influence the dependent variable, career success.

Discussion of the Variables

An acute care hospital is a complex social system with interrelated subsystems. In order for administration to control and coordinate organizational activities, there is the assumption of a hierarchal power system. The hospital, considered a functional or-ganization, has two lines of authority; the administrative and professional (Etzionni, 1964). Stevens' (1980a) descriptive model of nursing administration reflects this multiplicity. The model is a synthesis of both nursing and management. Complex problems related to multiple roles in nursing will be discussed in the review of literature.

The nursing administrator combines both formal and functional power in order to increase influence both within and out of the organization. Formal power may be inherent in the organizational position, a

position on powerful committees, reporting relationships, rewards, and status that reflect positional authority. Functional power is derived from the personality and behavior of the leader, perceived expertise, position, leadership, and the knowledge a leader possesses (Stevens, 1980b).

The importance of mentorship and networking is discussed by both Stevens (1980a) and Hersey and Blanchard (1982). They discuss it in terms of information and connection power, and networks and linkages.

Coercive and reward power will not be considered in this study. The instrument was not designed to answer questions related to individual administrative practice.

A formal position in an organization does not guarantee entree into the informal organizational structure. Access by the nursing administrator to both the formal and informal administrative structure is necessary in order to influence organizational decision-making. The nurse administrator is an active participant in the high-level administrative structure, has access to the office of the chief executive officer, and is actively involved in physician and trustee decision-making committees and boards. Organizational influence is reflected in rewards and status symbols of the position. These include not only salary and benefits, but also administrative support services, office, and title that reflect administrative management (Stevens, 1980a).

Influence impacts not only on the division of nursing within the organization, but also on the nursing profession and the overall direction of health care delivery. Managerial control insures control of

the department of nursing, control of finances, and decision and policy-making (Stevens, 1980a).

Access to a position of authority does not insure access to bases of power. Formal sources of influence are directly related to the willingness of the superior officer to delegate authority and responsibility. The superior may also be in a position to withdraw authority. The most important sources of influence are the reward and sanction systems. Power is finite, therefore, the nurse administrator effectively controls organizational influence (Hersey & Blanchard, 1982).

Conclusion

Sources of influence for the nursing administrator are professional, organizational, and personal. In order to develop leadership and management potential, sources of influence are utilized. Influence is dependent upon personal interaction, is multidirectional in nature, and is part of both the formal and functional structure. The assumption is that professional mentor-network relations are an important source of influence and necessary for professional career success. Acquisition of administrative influence and responsibility is studied for its effect on professional achievement.

CHAPTER 2

REVIEW OF SELECTED LITERATURE

Barbara Stevens is a nursing leader, author, educator, and consultant in nursing administration. According to Stevens (1980a), the role perceptions of nurse administrators are reflected in role performance. Typical roles assumed by nursing administrators are those of expert clinician, manager, educator, or expert in human relations. Successful nurse executives exhibit role flexibility and adapt their perceived role to meet organizational needs.

Robert Katz (1974), consultant in corporate strategy, states that the successful administrator develops three basic interrelated managerial skills. These skills are developed in order to direct the activities of others, and for assumption of responsibility for corporate objectives. Required managerial skills, as identified by Katz, are human, conceptual, and technical. First, human skills encompass departmental relationships. Second, conceptual skills, which may be more innate than acquired, are necessary for development of an overall organizational view related to management practice. Third, technical expertise is required in order to comprehend organizational operations and direction, as well as, the ability to properly initiate and analyze communication with subordinates and others.

Administrative Influence

In reviewing literature, empirical studies were found to be lacking in the area of power, influence, and authority. Much has been written in nursing literature, however, confusion exists about concept definition. In nursing and management literature influence and authority are frequently defined as allied concepts of power. Power may be viewed as one aspect of interpersonal relationships. "Power is a dyadic relationship, based on both the strengths of the powerholder and the dependencies of the followers" (Stevens, 1980a, p.183). Hersey and Blanchard (1982) describe power as a "leader's influence potential" (p. 177).

Paul Hersey and Kenneth J. Blanchard (1982), behavioral scientists and specialists in organizational management, state that formal and functional power combine to provide the power base which constitutes the influence-interaction system in administration. There are many classifications of power noted in both management and nursing literature. The most frequently accepted are the five bases of power as defined by French and Raven (1959); coercive, legitimate, expert, reward, and referent. Raven and Kruglanski (1975) later introduced a sixth base of power; information. In 1979 Paul Hersey and Marshall Goldsmith (Hersey & Blanchard, 1982) added connection power as a seventh power base. The seven power bases defined by Hersey and Blanchard (1982) are as follows:

1. Coercive power implies a threat and is based on fear.

2. Legitimate power is based on the leader's position, and implies rights of control.
3. Expert power is based on the leader's expertise and knowledge.
4. Reward power is based on the leader's ability to provide positive rewards for compliance.
5. Referent power is based on the leader's personal character.
6. Information power is based on the ability to gain access to, or possess, information which is deemed valuable by others.
7. Connection power denotes connections with influential or important others, both within and out of the organization.

Sources of power of the nursing administrator proposed by Stevens (1980b) are as follows:

1. Knowledge includes expertise in nursing and administration.
2. Network relations and linkages grant access to information channels both in and out of the organization, and with access to influential people.
3. Control of resources ensures power and knowledge for resource distribution and acquisition.
4. Decision-making or problem-solving ability with authority for problem diagnosis, resolution, and decision-making.
5. Vision and statesmanship in one's profession and the ability to identify and communicate goals and practices to others.

The concept of mentorship is implied by Hersey and Blanchard's (1982) definition of information and connection powers. According to Stevens (1980a), it is the responsibility of practicing nurse

administrators to provide education and experience for nurses who exhibit leadership potential. Future nursing leaders need the guidance and direction of an experienced nursing leader for development of leadership potential and for continuity of management.

Organizational status is reflected in status symbols. Stevens (1980a) cites as examples of executive status symbols, the physical environment which reflects position, title which denotes power, and personal and departmental visibility both in and out of the organization.

Administrative Responsibilities

Responsibilities, duties, and titles of the nurse administrator have changed in the past 100 years. The nurse executive is no longer called the superintendent of nurses or nurse matron. In the past the superintendent of nurses held total responsibility for the hospital and nursing department management. Operation of a school of nursing was an added responsibility. Duties included student training, purchase of supplies, fiscal management, establishment of rules and regulations, supervision of all patient care, and some direct patient care (Erickson, 1980). Erickson postulates that characteristics of the early role remain in some hospitals. This is seen in the immaculate uniform, professional comportment, daily patient rounds, and apparently endless time for solution of employee problems. The provision of direct patient care by the nurse administrator may be a vestige of the past in rural hospitals, both expected and accepted by administration, trustees, and the community.

Federal regulations for hospitals provide minimal guidelines for the department of nursing and for the responsibilities of the nurse administrator. Delegated responsibilities relate almost exclusively to nursing personnel and patient care. Educational qualifications, experience, and demonstrated abilities of the nurse administrator are not clearly defined. Hospital size apparently identifies the need for increased qualifications (HCFA, 1982). The implication is that the larger the hospital, the more qualified the nursing service administrator is expected to be.

The Joint Commission on Accreditation of Hospitals (JCAH), the voluntary accrediting agency for health care institutions, has developed standards for hospital departments and institutional organizations. Standards are specific for evaluation of hospital management. The JCAH recognizes the nurse executive as a member of the total hospital administration with authority and responsibility. Responsibilities include assessment, evaluation, individualization of patient care, total departmental management, and overall institutional planning. Standards expand responsibilities and authorities to include formal liaison with the medical staff, hospital and trustee committees and boards, and coordination with all hospital departments. Responsibilities include the departmental budget and budget allocation. It is recommended by the JCAH that nurse administrators have at least baccalaureate education. Additional standards include advanced education, experience, and demonstrated ability in nursing practice and administration (JCAH, 1983).

The American Nurses' Association (ANA) and National League for Nursing (NLN) have developed standards, policy statements, or criteria for evaluation of nursing service departments and delineation of role and responsibilities of the nursing service administrator. The American Hospital Association (AHA) and the American Society of Nursing Service Administrators of the American Hospital Association (ASNSA) have issued guidelines which also define the role and responsibilities of the nursing administrator. These guidelines parallel JCAH standards (ANA, 1982; AHA, 1979; ASNSA, 1979; NLN, 1980). The ASNSA, ANA, and NLN are specific in recommendation of a master's degree in nursing administration as the required educational preparation. In addition, both strong nursing and administrative preparation are considered essential. Criteria follow JCAH standards in recognition of the nurse administrator as a member of the executive management team. Authorities include reporting directly to the chief executive officer and communication with the board of trustees. The nurse administrator holds responsibility for departmental fiscal and management control and the planning and monitoring of patient care. The three primary functions of the nursing administrator, as defined by the AHA, are patient care, fiscal, and resource management (AHA, 1979).

The Montana Hospital Association (W. Leary, personal correspondence, October 14, 1983) has developed no specific guidelines for defining the role and functions of the nursing administrator. The association is quick to point out that AHA has developed guidelines and not a universal policy statement. Guidelines may be adopted at the discretion of individual hospital members. Each hospital assumes

responsibility for development of position descriptions defining roles and responsibilities for the nurse administrator which are functional for the specific hospital. The Montana Society of Nursing Service Administrators of the Montana Hospital Association (MSNSA) did develop a position statement in 1978 which was adapted from AHA guidelines (MSNSA, 1978). The position statement serves as a guide for Montana nurse administrators.

National guidelines further charge nursing administrators with the responsibility of promoting nursing research and for providing educational opportunities within the institution. The nursing administrator is also expected to assume responsibility for health care direction and promotion in areas within and outside of the institution (ANA, 1982; MSNSA, 1978; ASNSA, 1979; Stevens 1978b).

The following newspaper advertisement appeared in a major Montana daily newspaper during July of 1983. "Director of Nursing for small Hospital-Nursing Home in Eastern Montana--Generous Salary and benefits X-ray exper. helpful . . ." ("Professional Positions", 1983, p. 7-B). The implied responsibilities provide added interest in investigating the question of how closely the recommended role and responsibilities of the nursing service administrator parallel the reality of the role in rural Montana.

National Profile

To obtain a profile of the nursing administrator, the ASNSA conducted a universal survey in 1977. The final summary was published in November of 1980. Of the 7,084 nurse administrators surveyed, 5,325

(75.2 percent) returns were completed (ASNSA, 1980b). The seven page survey provided data for the development of a general profile of the nursing administrator nationwide. The survey revealed that the average nursing administrator is female (94%), married, and between 40-49 years old. The nurse administrator has held the position from one to five years. Upward mobility is a national trend. The nurse administrator previously worked from one to five years in positions ranging from staff nurse to assistant nursing administrator. The nurse administrator reports directly to the chief executive officer and participates in administrative coverage for overall hospital operation. The nurse administrator has held a faculty position and may have been a clinical specialist. The exact role of clinical specialist is not defined in the questionnaire. The nursing administrator has a baccalaureate degree or higher, is pursuing formal education, and has obtained continuing educational units within the previous five years. The nurse administrator is responsible for the departmental budget and may be involved in hospital budget planning. There is total responsibility for the department of nursing. If a bargaining unit exists, the nurse administrator is a part of the negotiating team (ASNSA, 1980b).

Data analysis of the ASNSA 1977 survey has significance beyond the general profile. The largest percentage (45.9 percent) hold a diploma in nursing. The major is unidentified, but 27.5 percent hold master's degrees, and only 0.5 percent are doctorally prepared. The budget is established by 73.1 percent of the nursing administrators, while only 56 percent have full administrative responsibility for that budget.

According to Stevens (1980b), a managerial title denotes power and position. The ASNSA (1980a) survey revealed that despite the recognized administrative position, 77.1 percent of the nurse administrators still hold the title of director of nursing. Correlation of data revealed that men in the position achieved higher positions earlier in their careers and are more concentrated in larger hospitals. Never-married women are in larger hospitals, have higher salaries, and hold more advanced degrees. Younger nurse administrators generally practice in smaller hospitals. Twenty-six benefit categories were compared with hospital size. There appears to be little commonality in benefits offered by individual hospitals.

The ASNSA survey reveals that many nursing administrators work over 44 hours a week and some as many as sixty hours. This illustrates the demands placed upon nursing administrators. There were no questions in the survey related to obtaining the position by advancement within the organization or recruitment from outside of the agency. The annual salary range reported in 1977 was from less than $15,000 to $35,000 or more per year.

National Profile in 1982

In 1982 the ASNSA again conducted a survey of nursing administrators in hospitals (ASNSA, 1984). The purpose was to obtain an update of the profile and to identify changes in the roles, functions, responsibilities, and professional background. This was not a universal sample. The population included only ASNSA members. The sample size was 500 with 343 (68.6 %) responding.

Some characteristics are unchanged from the 1977 survey. The average nurse administrator is, or has been married, is a woman between 40 and 49 years old, and has functioned in their present position from one to five years. Some changes noted are the upward movement for higher credentials within the organization. There is increased involvement in hospital affairs. Changes are noted also in title, corporate responsibility, and appointment to hospital governing boards. The nurse administrator reports to the highest administrative officer, participates in hospital budget planning and priority setting, and attends meetings of the hospital governing board and medical executive committees (ASNSA, 1984).

The salary averages approximately $35,000 and benefits have increased. The average nurse administrator has a master's degree, has taken courses related to administration, and is active in community and professional groups.

The 1982 survey report was received following receipt of permission to use the 1977 ASNSA questionnaire. This research study was in progress. The 1982 survey, by including only a sample population of ASNSA members, may not be totally representative of the average nurse administrator. The results of the survey are of value in interpretation of trends found in this researcher's study.

Administrative Preparation

It is estimated that less than twenty percent of all nursing administrators have a master's degree, many of which may be in fields other than nursing. Only 22 percent have baccalaureate degrees. As a rule,

the majority of nursing administrators have advanced through the ranks and have learned management skills on the job. Power for the nurse administrator is frequently an unresolved issue, and some nurses are advanced because of the fact that they lack influence (Stevens, 1978b). Ruth Kronmiller (1979), assistant professor at Yale University School of Nursing, states that "promoting individuals from within the ranks, although thought to be one of the best ways to fill supervisory positions and a legitimate incentive toward improving competencies has its pitfalls. Being a good staff nurse does not always mean being a good supervisor. Indeed, becoming a good staff nurse does not ensure that one will be an effective executive director either!" (p. 666).

A review of literature leaves no doubt that the practice of nursing service administration must be based on clinical competence and sound managerial skills. What is not agreed upon by some authors, is whether an advanced clinical component in patient care should be a requisite in educational programs for nurse administrators. Dorothy Jones, associate professor at Boston University School of Nursing, and Murial Poulin, professor in administration at Boston University School of Nursing and associate administrator at Beth Israel Hospital (1983), advocate a curriculum with a strong client component in order to remain current in advanced technology today. Nurse administrators require clinical competency in order to address problems related to a changing population profile and for the development of nursing as a science.

Other authors state that as the second ranking officer in the health care institution, the responsibilities of the nursing administrator are to administer nursing care and no longer to provide the

direct patient care (Stevens, 1978a; Rotkovitch, 1979). Stevens refers to the need for "clinical conceptualization" (p. 6). Rachel Rotkovitch, vice-president for nursing at Yale-New Haven Hospital, advocates that the clinical component involve a preceptorship with a practicing nurse administrator. The nurse administrator must be prepared with managerial skills that provide power and the authority of leadership in order to adequately institute both departmental and organizational planning.

Rotkovitch (1979) further states that the nurse administrator must be educationally prepared to communicate nursing to others. They must be prepared to communicate with the administrator, trustees, physicians, and the community at large. In order to enact the executive role, the nurse administrator must learn to be politicly astute and visible. According to Stevens (1978b), the nurse executive must be able to view management related to the total system. The nurse administrator must also be educationally prepared in the management skills of the chief executive officer in order to function in times of his/her absence.

The numbers of students in advanced clinical practice increased from 1968-1977. As functional specialty options in schools of nursing decreased, the numbers of students enrolled in administrative programs also declined. (Fitzpatrick & Heller, 1980). Only recently has there been an increase in master's programs in nursing administration. Increasingly, programs have been developed by corporate hospitals, professional organizations, and universities for the practicing nurse administrator. The ANA and ASNSA recognition programs are examples of encouragement for professional growth by nurse administrators.

According to Stevens (1978b), the increase in organizations for nursing administrators and the sophistication of professional journals is evidence of the awareness of a need for change by nurse administrators.

Of the 111 graduate programs in nursing listed by the NLN in the 1982-1983 publication of master's programs in nursing, there are only 39 programs that offer a major in administration. However, many of the programs do offer functional concentration in that area (NLN, 1983). The NLN Nursing Data Book 1982 lists 142 master's programs, 93 of which are accredited by NLN. Of the 5,026 graduates in the 1980-1981 academic year, only 5.2 percent are listed as graduating in the functional area of administration (NLN, 1982).

Women in Management

According to an analysis of a survey of registered nurses by the Division of Health Professionals, nursing remains a predominantly female occupation. Men in nursing increased from 1.9 percent in 1977 to only 2.7 percent in 1980 (AJN, 1982). By contrast, nurse managers function in an administrative structure dominated by men. Physicians and hospital administrators are primarily men who have traditionally controlled policy and decision-making in health care systems (Ashley, 1976; Meisenhelder, 1982). Attitudes are changing, but there remain disproportional employment opportunities for women in the work force (Roos, 1981; Kanter, 1977; Roberts, 1982). The role of women in nursing is viewed from the standpoint of social concepts related to the role of women both in the past and present (Ashley, 1976).

A recent survey (AJN, 1983) reveals that the median salary for hospital nursing administrators is $36,727. Of the top 45 hospital management personnel, nursing administrators' salaries rank only sixth. Salaries are five percent less than for men in administrative positions which are organizationally equal. The 171 nursing administrators in this sample supervise an average of 497 employees and have worked an average of nine years with their current employer. The administrators had held their position an average of three years. Nurse administrators receive approximately one-half the salary of the top administrative officer, despite their supervisory responsibilities. The survey revealed they have, on the average, seventeen years of education and hold an average of two academic degrees.

Lucie Young Kelly (1981), professor of nursing at Columbia University, posits that nurses in administration are working through and solving problems related to a prior lack of management training and the difficulty of functioning in power situations traditionally dominated by men. A major source of conflict for the nurse administrator is the dual role of nurse and administrator. The combined power inherent in both roles provides strength for the successful nurse administrator.

A major barrier to management potential is powerlessness within the corporation. Powerlessness results from lack of organizational opportunities, authority without formal power, and accountability for others without informal political influence (Kanter, 1977). According to Mirides and Cote (1980), barriers for women in management are organizational with traditional male-oriented policies and procedures.

Barriers are corporate with the socialization and rapport accorded men. There is also the barrier created by centuries of acculturation and and conditioning of women. Rosen and Jerdee, in 1974, stated that greater support and concern given men in the corporation had a detrimental affect on the self-image and career progress of women (1974). With increasing numbers of women in management positions, this trend may today be viewed from a different perspective.

There has been a plethora of research studies and authors who have attributed success or failure of women in management positions to sex-role stereotyping. The list of differences is interminable. To men are attributed the traits of the "corporate man" with authoritarianism, task orientation, and competitiveness. Women are associated with the "queen bee syndrome", viewing other women as competitors. Women are viewed as cooperative, team oriented, compassionate, passive, accommodating, and less goal directed (Bunker & Bender, 1980; Hennig & Jardim, 1977; Sargent, 1978; Moore & Rickel, 1980).

Social and economic factors have effected change in employment and the role of women in management. The women's movement and related organizations have all collaborated in creating change. Civil rights legislation, affirmative action programs, and the changing profile of the workforce have all contributed to change. Women now constitute 43 percent of the workforce and are entering what have been considered nontraditional fields. This includes organizational executive positions. There is an increased need in both industry and business for competent managers (Mirides & Cote, 1980).

According to Marilyn Ferguson (1980), author of numerous publications on social change, increasing numbers of women are impacting and changing policy making and government. Rather than building on the past male oriented structure, social change must be created by both women and men.

Not all authors agree that sex differences affect women in management today. A more androgynous management model which combines both male and female behaviors has been suggested. In the future training programs, recruitment, and performance appraisals will be generic in nature (Sargent, 1978; Mirides & Cote, 1980).

Candace West (1982), at the University of California, Stevens College, states that success in a man's world is, at least partly, attributed to learning the unspoken rules of men's games. In interaction between men and women the implication of actions change with gender. West states that even if a woman "does learn the rules of the game, she may not be treated as a credible player" (p. 20).

The question that West (1982) presents, is why women should be singled out for management and assertiveness training, rather than addressing the real issues. These issues include not only changing the work structure, but a change in interpersonal interaction patterns as well. There is a difference in communication and influence styles between men and women (West, 1982; Wiley & Eskelson, 1982).

Rather than a focus on an androgenous management model, the research studies of Carol Gilligan (1982), associate professor at Harvard University, affirms that qualities associated with weakness in women are in reality their strengths. Differences in developmental

orientation is reflected in the differences of thought and interpretation. Social status, power, and reproductive biology, shape experiences and the relationships between men and women. The early social environment differs, and relationships and issues of dependency are experienced differently. As a result, women become more relationship oriented and for men, individualization and achievement are important. There are differences in perspective, modes of language, and thought; all of which have implications for women developing their own style of management expertise.

Mentor Connections

Professional mentor and network relationships are relatively new concepts for women in management. The assumption is that mentor connections and professional networks are mutual concepts which have a direct relationship to success for the nurse administrator in a rural state.

Hersey and Blanchard (1982) refer to the training and development of young leaders prior to advancement as "anti-Peter Principle vaccine" (p. 146). The primary purpose of a mentor relationship is in socialization of a younger person into the profession. In this way there is insured continuity and quality of leadership. Professional development is achieved by access to influential persons, entree into inner circles, and socialization into the system (Vance, 1982).

Henry Mitzenberg (1975), associate professor at McGill University, conducted an indepth study of the activities of five American chief executives. Mitzenberg found that the emphasis of the manager is on

verbal media. The manager spends 78 percent of his time in verbal communication. Telephone access is essential, and information seeking behavior is by word-of-mouth. Managers rely on soft communication such as gossip, speculation, and heresay. Mitzenberg states that "today's gossip may be tomorrow's fact" (p. 52). With vital verbal communication stored in the minds of managers, the support for mentorship necessary to pass on leadership knowledge appears to be essential.

Abraham Zaleznik (1977), professor of social psychology of management at Harvard, cites the one-to-one relationship in mentoring. This relationship requires time and emotional expenditure, and may be a major reason for reluctance of executives to enter into mentor relationships. Mentorship offers firsthand experience in the use of power to influence the actions of others. Equally important is to learn what Zaleznik (1977) calls "the important antidotes to the power disease called hubris--performance and integrity" (p. 78).

The concept of mentorship is not new. The term originated in Greek mythology (Atwood, 1979). The most widely reviewed nursing study is Connie Vance's 1977 doctoral research at Teachers College, Columbia University. The mentor connections of 71 identified leaders in nursing were determined. Vance defines a mentor as "someone who serves as a career role model and who actively advises, guides, and promotes another's career and training" (p. 10). Vance found that 83 percent of the influential nurse participants reported one or more mentors. Mentors were predominantly women; 79 percent were women, and 21 percent were men. Ninety percent of the mentors had acted as mentors to younger nurses (1982). Phyllis Owens (1982), in a master's research study at

the University of Colorado, found that 65 percent of the 55 nurse administrator participants had been mentees, and seventy-five percent were mentors to others in nursing.

In non-nursing studies, Margaret Hennig and Anne Jardim (1977) reporting on Hennig's doctoral dissertation at Harvard Business School, found that of the 25 successful women in management under study, all reported having mentors. The successful women developed close relations with a male boss, just as they had with their fathers early in life. Fathers influenced their development, encouraged risk-taking, independence, and competition. The father also provided approval, confirmation, and rewards. Successful women found acceptance later in life from a male superior. Women equated advancement and acceptance with ability and intelligence. According to Hennig and Jardim women fail to assume a mentorship role because they fear loss of organizational position. Later women fail to promote subordinates because of unwillingness to share their unique position within the organization.

Daniel Levinson (Levinson, Darrow, Klein, Levinson & McKee, 1978), of Yale University, conducted a longitudinal study of the career history of forty men. Levinson states that a mentor early in a man's career is instrumental in achievement of career success, and the relationship termination is a painful experience. Levinson reported little mentoring is found among women and postulates there is a lack of qualified women to function in the role. Women are involved in survival in a male work-oriented world, according to Levinson. Levinson did not include women in the study, and assumptions related to mentor relationships for women are not validated.

In a study of 1,250 new executives by Gerald Roche (1979), international management consultant, only a small, unspecified percent were women. Two-thirds of all executives included in the study reported having mentors, and one-third had two or more mentors. Contrary to Levinson's study, men did not view mentors as contributing to career success, and mentors and mentees ended their relationship as friends. Women executives all reported having mentors. Seven out of ten of the mentors were men. A male sponsor was viewed by women participants as being essential for career success.

Nursing literature reveals a general concern that nurses have been unwilling to support professional growth in others. The lack of support is attributed to the socialization of women, power struggles in nursing, competitiveness, and a poor self-image. The decreased numbers of women in leadership positions who also have less power and influence have contributed to the small numbers of nurses in mentorship roles. Mentor relations are seen as being mutually beneficial for both mentor and mentee. Authors agree that as more nurses gain positions of influence and confidence, not only leaders in nursing, but also all nurses will develop mutually satisfying mentor relationships (Pilette, 1980; Shoor, 1978; Cameron, 1982).

Not all authors agree that mentorship relations are essential for professional growth (Cameron, 1982; Pilette, 1980). In Vance's (1981) study, 17 percent of the nurse influentials had no mentors, and there were 35 percent in Owen's (1982) study who were successful without mentorship relations.

Jeanne Speizer (1981), research associate at Wellesly College, reports weaknesses in recent studies which attempt to validate the concept of mentorship. Speizer asserts that research studies have been retrospective in nature. Research has primarily been conducted with business groups and men in management. Findings of the studies are contradictory and varied. Assumptions are presented without necessary support data. While women have generally viewed a mentor as a factor in career success, men have not always agreed.

One consistent finding in research studies has been the prevalence of men who function in the role of mentor for women in management positions. Ruiz (1982) states that the power struggle within nursing and the critical attitude women have of each other has been a contributing factor in women seeking men rather than women as mentors. According to Vance (1981), as more women move into influential positions there will be confidence in abilities and personal value. With more women in management, supportive relations with other women will be available and found equally as effective as men in mentorship roles.

Robert Katz (1974) may have serendipitously provided the major reason for women selecting men as mentors. Katz states that the higher the manager rises in the corporate hierarchy; the more important are conceptual skills. The top executive needs a confidante within the organization with the same conceptual skills, knowledge of corporate operations, key personnel, and corporate change. Only with a confidant within the corporation is there a well-informed, objective, and supportive person with whom to freely discuss fears, doubts, and

aspirations. Subordinates are unable to provide unanimous or continual support.

The nurse administrator is dependent upon the hospital administrator for reward and sanction powers. In small rural hospitals, most nurse administrators have male supervisors, but no peer within the internal environment on whom to depend for support and encouragement. The chief executive officer becomes the influential mentor who provides sources of organizational influence.

Professional Networks

Social anthropologist J. A. Barnes (1954) studying social fields in Bremnes, Norway during 1952-53, first used the term web to explain social phenomenon. Barnes developed the image of a network which more clearly identified the multidimensional concept of social relations found in his work. People represented the knots, lines identified personal interactions. Claude Fischer, (Fischer et al., 1977) author of studies in social relations, more succinctly defines a social network by saying, "We are each a center of a web of social bonds that radiates outward to the people whom we know intimately, those whom we know well, those whom we know casually, and the wider society beyond. These are our personal social networks" (p. vii).

According to Marilyn Ferguson (1980), the recent proliferation of networks is a powerful force in social and personal transformation of modern society. Ferguson describes a network as the modern version of an ancient family system. Today's family are those persons with bonds of commonly held values, assumptions, and goals. Everyone within the

network is perceived as the center of a flexible, open network system. Ferguson also states that a network is a grass roots phenomena. Not only is a network self-generating, but it also may be self-destructing. Each network has its own identity depending upon the need. "Just as a bureaucracy is less than the sum of its parts, a network is many times greater than the sum of its parts" (pp. 216-217).

According to Stevens (1978b), there are increasing numbers of nursing administrators who are joining informally to provide education and problem-solving assistance. An unofficial survey by the ASNSA listed 42 such organizations for nurse administrators.

Sue DeWine, associate professor in the School of Interpersonal Communications at Ohio University, and Diane Casbolt, in management training at Ross Laboratories (1983), conducted a research of network activities of 158 professional women. Although the subjects were primarily in middle and lower management positions, some findings are applicable to any social network. DeWine and Casbolt found that men traditionally used informal social networks as a source of professional advancement. Good old boy networks have traditionally been available but good old girl networks have been nonexistent for women. As more women obtain managerial positions, networks are proving to be the link to peers who are able to aid in professional advancement. Networking for men has provided for establishment of contacts for self-promotion. Relationships are a part of the social as well as business milieu. By contrast, women establish network relationships for specific goals related to development of professional contacts.

Women executives have previously been excluded from the informal corporate network which extends beyond the walls of the institution. The informal network influences corporate policy making and provides promotional opportunities (Puetz, 1983; Warihay, 1980).

Janice Meisenhelder (1982), instructor at Boston University School of Nursing, states that women in business are "aliens in a male, corporate world" (p. 77). Managers use social, professional networks for support, assistance, social contacts, and advancement. The professional network increases self-esteem for the nurse who functions in isolation and promotes understanding and support from other nurse executives. Nurse administrators are drawn together by mutual frustrations and problems. According to Meisenhelder, lack of cohesiveness in national nursing associations indicates a need for informal rather than formal network associations. This indicates a need for informal networks for all professional nurses.

One of the inconsistencies found in network studies is the actual amount of support perceived as given and received by women in management positions. Philomena Warihay (1980), management development consultant, conducted a national cross-sectional study of 500 women in management positions. Thirty percent of the women in top level administrative positions reported no woman superior on whom to depend for support. Women in all positions perceived that they did provide needed support for others. However, approximately one-half of the women in lower management levels experienced little, if any, support from women in superior positions.

Networking for nurses is an old concept with a new name according to Andrea O'Connor, associate professor at Columbia University School of Nursing (1982), and Lucie Young Kelly (1980). Nurses have always used professional contacts and have valued knowing who to know. Contacts are viewed as necessary for communication of vital information and in influencing change. Kelly (1980) states that "contacts isn't a dirty word; it's a reality. Until nurses use it better, they will linger on the fringes of power" (p. 396).

Professional networks for nurse executives provide access to information, advice, ideas, and moral support. The referral system inherent in a network insures contact not only on a one-to-one basis, but also access to the entire network system. A network for nurse executives is reciprocal, every person in the network is affected. It requires initiative to reach out to others. It also involves an exchange of talents (O'Connor, 1982).

For a network to be successful, O'Connor (1982) presents several caveats. There must be a realization of an investiture of time. Utilization of telephone contact is essential, as is face-to-face contact at professional, formal, and social meetings. Areas of expertise and credentials of all members must be known. Every person must be an expert in some area, and be able to share that expertise with others.

Conclusion

A need for this study is demonstrated by a review of literature which reveals few studies specific to nursing administration. Many studies are retrospective in nature. Knowledge of personal and

professional characteristics of nursing administrators in Montana is unknown.

There are multiple factors which contribute to power and influence of those in management positions, and particularly for women. Many factors have not been considered in studies of nurses which are integral to the role of the nurse in management. In this study, there is inclusion of mentor connections, professional networks, and some consideration given to the role of women in management. This reflects an effort to gain a realistic perspective of the multiplexity of sources of influence in nursing administration.

CHAPTER 3

METHODOLOGY

An exploratory descriptive study was designed to develop a profile of Montana nursing service administrators, functioning in acute care hospitals today. The method was selected to identify the roles, responsibilities, authorities, and demographic variables which determine sources of influence of Montana nurse administrators. There was a lack of published research specific to nurse administrators functioning in rural areas. The design allowed for a comparison study between Montana nurse administrators and with nurse administrators nationwide. No attempt was made to prove a relationship between sources of influence and success in the role of nursing administration.

Population

The target population for this study consisted of the total population of nursing administrators employed by the 60 nongovernmental hospitals in Montana. A list of all acute care hospitals and hospital bed size was first obtained from the Montana State Department of Health and Environmental Sciences (MSDHES, 1983). Specifically excluded from the study were the nursing service administrators employed by long-term facilities, special treatment centers, hospice, mental health, or chemical dependency centers. Warm Springs State Hospital, the U. S. Public Health Service Indian Hospitals, Veteran Administration Medical

Centers, and the U. S. Air Force Hospital at Malmstrom Air Force Base were also excluded. Administrative structure, employment, advancement policies, admission, and patient populations in these facilities differ from general, short-term, acute care facilities. Population selection was made in an effort to control for homogeneity in order to eliminate a possible source of bias. A response rate was a consideration in population size. A fifty percent response rate would eliminate the risk of response bias and would allow for comparison with the nationwide survey (Polit & Hungler, 1978).

Protection of Human Rights

The Human Rights Committee approved the study, and all human rights requirements of Montana State University were met. In the cover letter accompanying the questionnaire, all nursing administrators were invited to participate. No formal consent form was used. Consent to participate was implied by participation in the study and return of the questionnaire. Confidentiality was assured in the cover letter and maintained throughout the study.

Data Collection and Instrument Design

The instrument was designed to examine three major variables in this study; formal and functional power and professional role. Data were collected by the use of a mailed questionnaire to each of the 60 nursing administrators in specified acute care hospitals.

A mailed questionnaire was selected for this study because it offered anonymity, eliminated possible response bias, and because of the

time and distance considerations (Polit & Hungler, 1978). The questionnaire cover letter explained the study objectives. Questionnaires were mailed on March 16, 1984 with a request for return by April 6, 1984. A postage-paid envelope addressed to the researcher was enclosed. Questionnaires were not coded and identification could only be made through hospital size. All returns were received by April 17.

The instrument was developed from items obtained from the 1977 Survey of Nursing Service Administrators in Hospitals. The survey was developed by the American Society of Nursing Service Administrators of the American Hospital Association (ASNSA, 1980b). The 1977 survey was a universal study used to develop a national profile of nursing administrators. The survey was used to analyze the functions, roles, responsibilities, and authorities of nurse administrators. Additions to the questionnaire were made by the researcher to obtain data for variables in the study not included in the ASNSA survey. The ASNSA questionnaire is not under copyright. Written permission to use the instrument was obtained prior to instrument development.

The 1977 ASNSA questionnaire was used in order to make comparisons between Montana nurse administrators and nurse administrators nationwide. Items in the ASNSA survey reformulated to conform to current trends, or by suggestions generated during pretest, may affect some comparisons.

The instrument was divided into three parts. Part I was designed to identify administrative practice. The roles, functions, authorities, and responsibilities were identified by items related to reporting

level, administrative coverage, nursing department and corporate responsibility, and span of control. Drawn from the ASNSA survey were items 1, 2, 3, 4, 5, 6, 7, 9, 10, 14, 18, and 19. Deletions or additions were made in questions 3, 10, 14, 18, and 19 to obtain information on current administrative practice. (See Appendix B.)

Part II of the instrument was designed to include items to study the variables of mentorship and networking. These concepts were not explored in the ASNSA survey. Items were developed by the researcher.

Part III of the instrument contained items to examine personal and professional variables included in the study. Included in Part III are items to identify age, sex, and marital status; professional and community activities; educational preparation and route to the top nursing position; salaries and benefits. Drawn from the ASNSA survey were items 23, 24, 28, 30, 31, 32, 35, 36, 37, 38, and 39. The additions to questions 23, 28, 30, 32, 37, and 38 were made in order to conform to current practice. Items on promotion from within the institution or Montana residency were included to identify the characteristics of practice in a rural state for a possible relationship to variables in the study. The instrument contains open-ended and fixed-alternative items.

Reliability and Validity

The ASNSA (1980b) instrument is a survey for the stated purpose of obtaining information on the personal and professional background, scope of responsibilities, skill levels, educational preparation, functions, and roles of nurse administrators. There is no information

related to reliability or validity of the ASNSA national survey questionnaire. The 1977 survey was universal and not restricted to members of ASNSA. The survey included only the top nursing service administrators in 7,084 acute care hospitals. There was a 75.2 percent response rate. A previous study had been done in 1973. Some instrument limitations and comparisons in the 1977 survey were available in published reports of analysis of data. Items drawn from the ASNSA questionnaire were evaluated to determine reliability in measurement of variables included in this study (Polit & Hungler, 1978).

Prior to beginning the research study, three key informants considered experts in nursing administration in Montana were consulted. The key informants identified components in the role of the nurse administrator in Montana, mentor-network relationships, and administrative practice. Identified components were used to guide instrument development. Questions were also developed from review of literature and added to the questionnaire.

Approximately two months prior to administration of the questionnaire, the researcher met with five graduate nursing students and four nursing faculty members in the graduate nursing program of Montana State University to pretest the instrument. The instrument was revised based on faculty and student evaluation. The instrument was again pretested by one former nurse administrator working in an administrative position and one nurse administrator who functions in a Veterans Administration Medical Center in Montana. The instrument was further refined in accord with recommended changes. The small

population of nurse administrators in Montana precluded pretesting the instrument with the population under study.

Analysis of Data

Due to the exploratory descriptive nature of the study, descriptive analysis was used to order and clarify data that were obtained. Data summary was done by relative frequency distribution, and measures of central tendency. Content analysis was done on all open-ended items. Cross-classification was done for some data to determine possible relationships. Comparison of data from the 1977 ASNSA (1980b) survey was done when appropriate. In order to perform comparisons with nationwide studies, analyses of data were done by rounding to the nearest tenth using statistical convention (Kviz & Knafl, 1980).

CHAPTER 4

FINDINGS

Results of data analyses from the Montana nurse administrator study are presented in this chapter. The results are presented in three sections: administrative practice, mentor-network relations, and demographic information. This corresponds with the organization of the questionnaire and the summary of findings from the study used for comparison. Data obtained in this study are used to identify a profile of nursing administrators functioning in Montana today. The data were analyzed to answer questions related to the major complex variables found in the conceptual framework. These variables are sources of influence, organizational position, and the concomitant variables of mentor-network relations. Data generated from the study further determine the formal and functional powers and administrative role of the nurse administrator.

Population

The target population for this study were the 60 nurse administrators currently holding the top administrative position in nongovernmental, acute care hospitals in Montana. Special treatment centers were also excluded from the study. The hospital may, or may not, contain extended care term or swing beds. There were 35 (58.3%) who returned questionnaires, and 25 (41.7%) who did not. Only one respondent was male.

This eliminated any possibility for comparison between the profiles of male and female nurse administrators. All questionnaires were returned completed and were usable for this study. No questionnaire was returned undelivered.

Comparisons of some data were made using the American Society of Nursing Service Administrators of the American Hospital Association (ASNSA) 1977 survey of nursing service administrators in acute care hospitals (1980b). Selected comparisons were made with some findings of the ASNSA 1982 survey (1984). Consideration must be made for the large numbers of returns in the 1977 survey. One return changed the data analysis in the Montana study, one return has little effect on analysis in the ASNSA survey. The 1977 ASNSA nationwide universal study included all acute care hospitals. The population numbered 7,084, with a return of 5,326 (75.2%). There were 66 hospitals in Montana included in the 1977 ASNSA study with a 63.6 percent return. The 1982 ASNSA sample population included only nurse administrators in acute care hospitals who are members of the ASNSA. The sample size was 500 with a return of 343 (68.6%).

Administrative Practice

Of interest and concern for nurse administrators and other leaders, has been the administrative role and span of control of nurse administrators. Of further concern is the possible lack of allocated authority for the increasing responsibility in acute care hospitals. In this section the roles, authorities, responsibilities, and

accountabilities of the nursing administrator are covered. Also included are the reporting relationships, and level of participation in overall organizational affairs.

Reporting Relationships

Thirty-five nurse administrators responded to item one which asked if the nursing administrator reports directly to the top administrative officer. Thirty-three (94.3%) respondents report to the top administrative officer in the institution. There were 5.7 percent who report to the second level in the hospital administrative hierarchy. There is an apparent trend for nurse administrators in larger medical centers to report to an administrative officer at the second level of the administrative structure. The officer may hold the title of executive vice-president or chief operating officer. Some nurse administrators first indicated a reporting relationship to the top administrative officer. The indicated person was then listed in a second or third level of authority with no other officer listed as a superior. In assessing hospital size, it can only be concluded that the respondent considered the governing board to be the top level of authority.

In comparison with the 1977 ASNSA survey, 84.9 percent of the nurse administrators nationwide report to the top administrative officer. There are significantly greater numbers of nurse administrators in large hospitals in the ASNSA survey with reporting relationships to lower levels in the organization.

Administrative Hospital Coverage

Item two asked if the nurse administrator personally participated in hospital coverage. Thirty-one (88.6%) of the 35 respondents participate in administrative coverage of the hospital. Four (11.4%) did not assist in administrative coverage. In the 1977 ASNSA study, 67.3 percent of the administrative coverage was provided by the nurse administrator or the nursing staff.

Span of Control

There were 27 units or special departments listed in item three. The item requested information on the span of control within the institution. There were 34 nurse administrators who responded to this item. One questionnaire contained a response unusable for analysis. Of the 27 units or departments listed, not all hospitals report having all units or departments in their facility. There were three of the special services for which no nurse administrator reported responsibility the laboratory, radiology, or school of nursing.

An analysis was made of the numbers of hospital units or departments under the span of control of the nurse administrator. There were 17.6 percent who stated responsibility for 1-4 departments, 55.9 percent were responsible for 5-8 departments, 17.6 percent held responsibility for 9-12 departments, and 8.9 percent were responsible for 13-14 special departments or units.

Information on the span of control within the hospital indicates the extensive control held by nurse administrators in Montana. Responses also indicate the extent of institutional accountability by

control of such diverse departments as the dietary, housekeeping, laundry, social work, pharmacy, ambulance service, or occupational, physical and speech therapy.

The 1977 ASNSA survey data are analyzed for nurse administrators who report to the top three administrative levels. An average of 22 percent reported responsibility for 1-4 departments, 51.2 percent were responsible for 5-8 departments, 23.7 were responsible for 9-12 departments, 1.5 percent were responsible for 13-16 departments, and 0.1 percent reported responsibility for 17-20 departments. A valid comparison cannot be made with the ASNSA survey. Some nurse administrators in the 1977 survey report to lower levels of authority. Span of control is somewhat less for nurse administrators in the Montana study, but is comparable with nurse administrators nationwide.

Hospital Bed Size

Item number four requested information on the numbers of acute care beds in the institution. The 35 hospitals were classified by bed size, 6-24, 25-49, 50-99, 100-199 or 200-299 acute care beds. Of the reporting hospitals, 14 (40%) were between 6-24 beds, 9 (25.7%) had between 25-49 beds, 3 (8.6%) had between 50-99 beds, 4 (11.4%) were between 100-199 beds, and 5 (14.3%) were between 200-299 acute care beds.

The rural nature of Montana hospitals is apparent when comparing hospital size to the national survey. Only 29.2 percent of the reporting hospitals in the 1977 ASNSA survey had less than 50 acute care beds, and 32.8 percent were over 299 beds.

A large number of nurse administrators (14 or 40%) in this study held added responsibility for extended care beds. Three of the 14 (21.4%) stated a swing bed concept was used for extended care. Data analysis excluded hospitals with designated acute care beds as swing beds. The range of extended care beds was from 13-55 with a mean of approximately 27.

Budget Setting and Planning

There is increased concentration in hospitals today on cost containment and fiscal responsibility. Maintaining quality patient care with careful financial controls is a major national concern. Responsibility for fiscal management is a designated authority for nurse administrators in accord with national standards. Control of resources is also a recognized formal power. Administrative responsibility for departmental and for overall organizational budget planning and priority-setting is an important facet of nurse administrative authority.

Items 5-8 in the instrument were designed to obtain information on budget control. Thirty-five nurse administrators responded to the questions on participation in planning for the overall hospital budget. There were 26 (74.3%) who do participate and 9 (25.7%) who stated they do not participate in hospital planning. Thirty-four nurse administrators answered the question on priority-setting for the institutional budget. There were 28 (82.4%) who responded they do participate in institutional priority-setting and only 6 (17.6%) who do not have this authority.

There were 34 nurse administrators who responded to the item concerning establishment of the nursing budget. Twenty-six (76.5%) have authority to establish the budget for the department of nursing, and 8 (23.5%) stated they do not plan the departmental budget. Following formal approval of the nursing budget, 22 (62.9%) stated they do have full responsibility for development of the departmental budget and 13 (37.1%) stated they do not have full responsibility.

Comparison with the 1977 ASNSA survey revealed that only 50.8 percent of the nurse administrators nationwide were involved in planning the overall hospital budget, and 48 percent were involved in hospital priority-setting. The nursing budget was established by 73.1 percent of the nurse administrators, and 56.1 percent had full administrative responsibility following budget approval. The 1982 ASNSA survey shows a trend for greater participation by nurse administrators in both institutional and nursing department participation in budget control. Montana nurse administrators appear to be following the national trend for greater participation in institutional and departmental budget control.

Time Allocation

Six categories were established for analysis of hours in the normal workweek of the nurse administrator (item 9). Three respondents stated they worked more than the indicated hours, and one reported extra on-call hours. These returns were calculated as even hours worked for data analysis. Thirty-five nurse administrators responded to this item. Only one (2.9%) reported working less than 35 hours, 13 (37.1%) worked from 40-44 hours, 7 (20%) reported working 45-49 hours,

9 (25.7%) worked 50-59 hours, 4 (11.4%) worked 60 hours, and 1 (2.9%) reportedly worked over 60 hours each week.

For the nurse administrator to work more than 40 hours in an average workweek follows the trend nationwide. This reflects the demands of the position. There is also a need for reward mechanisms, status, and formal and functional powers to meet indicated responsibilities.

Nurse administrators were requested in item 10 to indicate the percentage of time in the workweek allocated to various functions. The percentage of allocation of time is identified in Table 1. Analysis of data revealed that over 33 percent of the nurse administrators spend no time in direct patient care activities (n=33). Forty-two percent of the nurse administrators spend greater than 70 percent of their work-week in administrative activities. Considering the span of control of most nurse administrators in Montana, the 24 percent who indicated research activities appears to reflect an upward trend in professional interest.

An item-by-item comparison with the 1977 nationwide survey was not possible because of item revision. In the nationwide survey, 69.4 percent of the nurse administrators report spending 76 to 100 percent of their workweek in administrative functions. Consideration must be made for the increased numbers of large hospitals in this study.

Corporate Participation

The aggregate analysis of participation on corporate committees and boards by nurse administrators is presented in Table 2. Thirty-four

Table 1. Percentage of time spent in normal workweek.

	Percentage of time					
Function	0	1-4	5-25	26-50	51-75	76-100
Community	15.2	33.3	51.5			
Administration			3.0	18.2	42.4	36.4
Direct patient care	30.3	9.1	51.5	6.1	3.0	
Teaching:						
Patients	51.5	9.1	39.4			
Staff	18.2	12.1	63.6	6.1		
Students	87.9		12.1			
Outside	72.7	18.2	9.1			
Research	75.7	18.2	6.1			
Outside consult	69.7	24.2	6.1			
Professional	51.5	21.2	27.3			
Other	97.0		3.0			

Total n=33

nurse administrators responded to item 11. Only 3 (8.8%) stated they had no participation on any corporate committee or board. Of equal importance is the fact that no nurse administrator stated they hold voting privileges on the governing board. There are a majority of the nurse administrators in this survey who had some participation in corporate activities. Over 50 percent had membership or voting privileges on the accreditation or licensure (57.2%), administrative staff (84.9%), governing board (53.8%), corporate planning and development (78.2%), and executive medical staff (67.9%) committees.

Table 2. Participation on corporate committees or boards.

Committee/ Board	n	Percentage participating			
		None	Occasionally	Member	Voting member
Accreditation/ Licensure	28	32.1	10.7	39.3	17.9
Administrative Staff	33	9.1	6.0	27.3	57.6
Board of Trustees	26	30.8	15.4	53.8	
Corporate Planning	32	15.6	6.2	46.9	31.3
Executive Medical	28	17.8	14.3	64.3	3.6
Interdepartmental Research	17	52.9	11.9	17.6	17.6

Total n=34

Items related to corporate activities were not included in the 1977 nationwide survey. The 1982 ASNSA survey contains some items related to participation in corporate activities. Data analysis revealed that 21.6 percent of nurse administrators report membership on the hospital governing board and 3.9 percent were voting members. Greater participation is in activities of governing board committees, than on the governing board itself.

Institutional Committee Participation

Active participation on institutional committees increases the influence of nurse administrators within the organization. Item 12 was included to analyze authorities identified in national standards for nursing service administrators. Thirty-five nurse administrators responded to this item. All respondents stated they participated on at least 30 percent of the identified hospital committees. Not all committees included in this item are operationalized in the reporting hospitals.

Over 51 percent of the nursing administrators stated active participation on all of the hospital committees included in this item. Data were analyzed for committee participation. Aggregate data analysis is presented in Table 3. Two (5.7%) nurse administrators participated on from 1-3 committees, 8 (22.9%) participated on 4-6 committees, 7 (20%) participated on 7-9 committees, and 18 (51.4%) actively participated on greater than 10 committees within the hospital.

Table 3. Participation on hospital committees.

Institutional committee	n	Percentage participating		
		No hospital committee	No participation	Active participation
Emergency Care	34	14.7		85.3
Infection Control	34			100.0
Disaster Planning	35		2.9	97.1
Medical Records	31	9.7	22.6	67.7
Pharmacy and Therapeutics	33	3.0	6.1	90.9
Professional Library	31	51.6	9.7	38.7
Quality Assurance	35	14.3	5.7	80.0
Safety	32	12.5	9.4	78.1
Special Care Unit	33	21.2	3.0	75.8
Standing Medical Staff	32	3.1	6.3	90.6
Risk Management	32	25.0	12.5	62.5

Total n=35

Nursing Theory for Professional Practice

Nursing administrators were asked in item 13 to identify a nursing theory which had been developed or adopted by the department of nursing. Of the nurse administrators who responded to this item (N=32), only 1 (3.1%) had a fully developed nursing theory for professional practice. A nursing theory had been developed by a

collaborative effort of the nursing staff following an indepth study of existing nursing theories. There were 3 (9.4%) who stated that the nursing departments was in the process of adopting a theory for nursing practice. One department had selected Dorthea E. Orem's theory for nursing practice, one department selected Martha E. Rogers' theory for nursing practice, and one respondent indicated no specific nursing theory. This may reflect a growing trend for departments of nursing in Montana.

Level of Responsibility for the Department of Nursing

Information was requested to determine the level of responsibility the nurse administrator in Montana holds for nursing practice in the department of nursing (item 14). Analysis of data is shown in Table 4. The 1977 ASNSA survey item was changed to include responsibilities identified in national standards. Data analysis indicates a trend for increased responsibility in some areas. Montana nurse administrators had greater responsibility for changing nursing policies and procedures, development of nursing research, implementing new nursing roles, and increasing or decreasing nursing staff. Montana nurse administrators had less responsibility for the elimination of non-nursing duties from nursing service than did the nurse administrators included in the 1977 nationwide study.

There are only 33.3 percent of the nurse administrators in Montana who hold responsibility for contractual agreements with nursing schools. It must be noted that the low response reflects few hospitals in Montana with nursing school affiliation.

Table 4. Level of responsibility in the nursing department.

Function	n	Percentage of responsibility		
		Full	Partial	None
Contractual agreement with nursing school	33	15.1	18.2	66.7
Changing basic organization of nursing care on units	35	85.7	8.6	5.7
Changing nursing procedure and policies	35	91.4	8.6	
Developing and/or implementing nursing research projects	35	68.6	14.3	17.1
Development of departmental educational programs	35	62.9	37.1	
Eliminating non-nursing duties	34	29.4	61.8	8.8
Establishing individual practice workload	35	71.4	25.7	2.9
Implementing new nursing roles as they develop	34	91.1	5.9	3.0
Increasing or decreasing nursing staff	34	79.4	20.6	

Total n=35

Administrative Support Services

Span of control and levels of responsibilities inherent in the position of nursing administrator increases the need for support services for nurse administrators. The availability of adequate support services has been an increasing concern for nurses in administrative practice. Support services available for nurse administrators are a reflection of working conditions and of formal and functional powers of the administrative position. Items 15 and 18 requested information related to support services. Only 16 (45.7%) of the total reporting hospitals have institutional computer services. The discrepancy in reported data in a supplemental item is apparently due to contractual computer services when no in-house service is available. Analysis of data for support services through use of computer programs and other support services are presented in Table 5. Nurse administrators in this study state that major support services are available in total or in part. Additional computer assisted data collection and analysis included word processing, data filing, productivity reports, policies and procedures, and emergency room acuity profiles.

Personnel Management

Collective bargaining. Only 7 (20%) of the 35 nurse administrators stated there is collective bargaining for professional nurses in their hospital (item 17). Of the hospitals who reported collective bargaining units, 5 (71.4%) of the nurse administrators participated as

members of the management negotiating team. Two (28.6%) served in an advisory capacity for the negotiating team.

Table 5. Administrative support services.

Support services	n	Percent available
Computer Services		
Audit	6	27.3
Fiscal data	21	95.5
Patient and staff instruction		
Manpower data	9	40.9
Nursing diagnosis	1	4.5
Patient profile	6	27.3
Payroll	18	81.8
Scheduling		
Statistical Analysis	14	63.6
Other	4	18.2
Total n reporting=22		
Access to other support services		
Access to data from other departments	29	85.3
Computer	18	52.9
Materials management	26	76.5
Record keeping	26	76.5
Secretarial	25	73.5
Staff coordinator	14	41.2
Quality reports	22	64.7
Cost center financial reports	30	88.2
Other	6	17.6
Total n reporting = 34		

In the 1977 ASNSA nationwide survey only 15.6 percent of reporting hospitals had collective bargaining units for professional nurses. There were reportedly 53.5 percent of nurse administrators who served

on the negotiating team, and 33.1 percent served in an advisory capacity.

Nurses With Other Reporting Levels. There were thirty-five nurse administrators who responded to item 16. Twenty-one (60%) stated there were professional nurses functioning in the hospital who reported directly to an administrative officer other than the nursing administrator. The administrative officer may be the top administrative officer, vice-president of technical services, a member of the medical staff, or some other administrative officer. Practice areas may include oncology, cardio-pulmonary, cardiac rehabilitation or catheterization, quality assurance, surgery, anesthesia, education, emergency service, diagnosis related groupings, or risk management. One certified nurse practitioner was reported as functioning with a reporting relationship other than to the nurse administrator.

Personnel Responsibility. There were 35 nurse administrators who responded to item 19 requesting information on full-time and part-time employees for whom the nurse administrator was delegated responsibility. A generalization only was made in analysis of data generated, due to the methods used in reporting numbers of employees. Employees were reported by numbers of employees, by full-time equivalents, and by approximations. Analysis of data comparing personnel to bed size is included in Table 6. Bed size is listed in five categories as follows: 6-24 beds, 25-49 beds, 50-99 beds, 100-199 beds, and 200-299 beds. Comparison with the 1977 nationwide study was not done.

Table 6. Comparison of number of employees with hospital bed size.

	Employees			
Hospital bed size	n	Percent reporting	Mean	Range
6-24	14	40.0	29	13-52
25-49	9	25.7	49	33-78
50-99	3	8.6	130	32-209
100-199	4	11.4	218	128-285
200-299	5	14.3	415	265-556

Total n=35

Nurse administrators were requested to provide information on percentage of total hospital employees for which they hold delegated responsibility. Percentages of employees were analyzed by categories of less than 24 percent, 25-49 percent, 50-74 percent, 75-80 percent, and over 80 percent of all hospital employees. One (3%) nurse administrator held responsibility for less than 24 percent of the total hospital employees, 9 (27.4%) of the nurse administrators were responsible for 25-49 percent of all hospital employees, 21 (63.6%) of the nurse administrators were responsible for 50-74 percent of all hospital employees, one nurse administrator (3%) reported responsibility for 75-80 percent of all employees, and one nurse administrator (3%) held responsibility for over 80 percent of al employees. The larger the hospital, the greater are the numbers of employees for which the nurse administrator is held accountable. In hospitals with greater than 50

beds, no general pattern emerges of numbers of employees reporting to the nurse administrator, and for whom they hold accountability. Relatively small hospitals report percentages of overall hospital employees for whom the nurse administrator is accountable are as great, or greater, than in the larger hospitals. Actual numbers of employees are understandably smaller.

Mentor-Network Relationships

It is suggested that mentor and network relationships are contributing factors in role development and success in an administrative position. Items were selected to measure the importance of mentor-network relations for nurse administrators in Montana. Content analyses were used to identify categories of responses. Analysis of data included the occupation and sex of the mentor or mentee, and the assistance received from a mentor or provided to a mentee. These items were requested following search of literature to identify key factors in mentor and network relationships. Content analyses were also used to identify categories of management expertise shared through networking by nurse administrators. It should be noted in this study, mentor and network relationships were used almost exclusively for development of management expertise and role development. The acquisition of administrative expertise was considered to be the primary facet of mentor-network relationships.

Mentor Relations

Thirty-three nurse administrators responded to item 20 requesting information on the presence of mentors who had aided in development of

professional expertise and career role development. There were 20 (60.6%) who stated there had been mentor relationships earlier in their careers. Thirteen (39.4%) stated they had not had a professional with whom they had developed a mentor relationship.

Summary analysis of data revealed that 25 (59.5%) of the mentors were female and 17 (40.5%) were male. Approximately two-thirds of the mentors for both male and female nurse administrators were female. Five (25%) of the nurse administrators had one mentor, 11 (55%) reportedly had two mentors, and 3 (15%) reported having three mentors. The greatest number of mentors was six, reported by one respondent (5%).

Research indicated that fathers and men in administrative positions frequently function as mentors for women in management positions. Men functioning as mentors in this study included one executive/father (5.9%), six hospital administrators (35.3%), one associate administrator (5.9%), six physicians (35.3%), and three other health professionals (17.6%).

Mentors for nurse administrators in this study were almost exclusively professionals in health occupations. Twenty-two (52.4%) were nurse professionals, 19 (45.2%) were health professionals other than nurses, and 1 (2.4%) was identified only as an executive. Professional nurses who had functioned as mentors were nurse supervisors (19%), nursing service administrators (16.7%), professional nurse peers (16.7%), and one dean of a school of nursing (2.4%). Other health professionals who had provided mentorship were hospital administrators (16.7%), physicians (7.1%) and others (21.4%). Health professionals listed as other were associate administrator, pharmacist,

materials manager, controller, physical therapist, hospital dietitian, and consultant.

The assistance provided by the mentor was identified as management expertise, goal setting/guidance, psychosocial support, employment, role model/inspiration, and feedback. The analysis of data are presented in Table 7. Psychosocial support was provided by offering encouragement, support, self-confidence, "strokes", and financial assistance.

Table 7. Assistance provided by mentor.

Category of assistance	n	Percentage
Management expertise	20	40.8
Goal setting/guidance	13	26.5
Psychosocial support	10	20.4
Employment	2	4.1
Role Model/inspiration	2	4.1
Feedback	2	4.1

Total n=49

Nurse Administrators as Mentors

Thirty-four nurse administrators responded to item 21 requesting information related to mentorship by the nurse administrator. Only 50 percent stated that they had been, or were, mentors to others. Mentees identified were all nurse professionals. The greatest numbers were staff nurses (61.5%), supervisors (15.4%), or other nurse administrators

(12.8%). Students (7.7%) and one assistant nurse administrator (2.6%) were also listed.

Analysis of data showed that 74.4 percent of the mentees were female and 25.6 percent were male. One (5.9%) respondent reported mentor relationships with 10 other professions, 2 (11.8%) had been mentors for three other professionals. The majority stated they had functioned as mentor to two other professionals (52.9%) or to one other professional (29.4%). Approximately two-thirds (65.2%) of all assistance provided the mentee had been administrative assistance or professional development. Other assistance was identified as psychosocial support (34.8%). Psychosocial support was provided by encouragement, listening, advice, counsel, and "self-motivation through autonomy".

Network Relationships

Thirty-four nurse administrators responded to item 22 which requested information on the network relationships of nurse administrators in Montana. Support and assistance through network relations is apparent in responses to this item. Thirty nurse administrators (88.2%) reportedly do participate in a network system with other nurse administrators. Only 4 (11.8%) stated they had no network participation. Networking is a critical facet of influence for this group of nurse administrators.

There were 72 separate areas of expertise reportedly shared with other professionals. Shared expertise included management skills (43%), professional development (26.4%), staff development (18.1%), patient care management (8.3%), and psychological or emotional support

(4.2%). The small amount of emotional support provided may reflect the increasing autonomy of nurse administrators. This may also be attributed to distance to other nurse administrators in Montana which would preclude utilization of other nurse administrators for emotional support.

Areas of expertise shared most frequently by nurse administrators are management skills/career development, staffing patterns, policies and procedures, and development of new services. Other areas of expertise reportedly shared are in areas of problem solving, accreditation standards, fiscal management, staff motivation, staff education, and retention and recruitment of personnel. Emotional support and advice were considered by only three of the respondents.

Thirty-six areas of expertise were identified as having been requested from other network members. Administrative assistance included management skills (36%), professional development (22.2%), staff development (22.2%), patient care management (14%), and emotional support (5.6%).

Only two nurse administrators reportedly had requested any type of emotional support or advice. One nurse administrator stated there had been network advice requested, but not received. The numbers of nurse administrators in this study actively participating in a network does validate that one or more networks exist in Montana. There is a general willingness to share administrative expertise. The most frequently requested skills were in areas of problem solving, staffing patterns and acuity systems, policies and procedures, and fiscal management.

Demographic Information

In order to complete the profile of nurse administrators in Montana's acute care hospitals, personal and professional information was requested. Data requested included demographic information.

Administrative Title

The response to item 23 requesting information on administrative title (n=35) indicated the most common title is still director of nursing. Twenty-three (65.7%) stated they hold this title. The next most common titles are nursing administrator (8.6%), vice-president of nursing (8.6%), and assistant administrator (2.8%). Titles listed as other (14.3%) included director of nursing services, assistant administrator/director of nursing, and director of professional services.

Data corresponds with title designation determined by the 1977 nationwide survey. However, nationwide the second greatest percentage listed chief of nursing as professional title. It should be noted that governmental hospitals which use the title of chief nurse are not included in this research study. Administrative title has remained relatively unchanged since the 1977 nationwide study was completed. Nurse administrators who function in hospitals with greater numbers of beds, generally hold titles reflective of status within the corporation.

Employment, Recruitment, Time in Position

Thirty-five nurse administrators responded to item 24 requesting

information on years in current position. Years in present position are reported by five-year segments. The range was from three days to 13 years. The greatest percentage of nurse administrators reported holding their present position from 1-5 years. Time indicated in months was calculated by rounding months to years for data analysis. In increasing order, time in present position was 11-15 years (2.9%), less than one year (20%), 6-10 years (22.8%), 1-5 years (54.3%).

Comparison with the 1977 nationwide survey corresponds with these findings. In the ASNSA study there are greater numbers who have held their position over 10 years.

Data analysis related to recruitment and promotion from within the institution is found in Table 8. Of 35 respondents, 60 percent stated they had been promoted from within their present place of employment. Most of the nurse administrators (51.4%) are native of Montana, and most (68.2%) are not natives of the area in which they now reside. A breakdown of the 12 respondents who listed state of origin other than Montana is as follows: 66.7 percent are from the Midwest, 16.7 percent are from Eastern states, 8.3 percent are from the South, and 8.3 percent are from the far West. Nurse administrators were requested to provide information on areas of residency (n=8). Fifty percent were from rural areas, 25 percent were from areas considered suburban, and 25 percent from urban areas.

The majority of those reporting (n=34), stated they were not recruited for their present position from another area of Montana (61.8%). Some nurse administrators stated they had applied for the position, rather than being recruited for their position.

Clarification in these items would be essential in further studies.

Table 8. Recruitment and promotion of nurse administrators.

Category	Total n reporting	Percentage yes	Percentage no
Native of Montana	35	51.4	48.6
Promoted from within the organization	35	60.0	40.0
Native of present residence	22	31.8	68.2
Recruitment from within Montana	34	38.2	61.8

Years of Experience, Certification, Specialization

Analysis of data in response to item 28 requesting information on experience by the nurse administrator in other professional positions is presented in Table 9. There were 100 percent of those responding (n=35) with experience as a staff nurse. There was some discrepancy in reporting prior years of experience as a nurse administrator. There were 56.5 percent who reported years which did not correspond to years in present position, and 43.5 percent did correspond to the stated years in present position. Some revision of this item would be needed for further studies. Prior experience listed as other included experience in physicians' offices, in-service education, assistant nursing administration, emergency room, Professional Standards Review Organization, industrial nursing, nursing home administration, and anesthesia.

Table 9. Years of experience in prior positions.

Position category	n	Percentage reporting experience	Years	
			Range	Mode
Staff nurse	35	100.0	1-20	2
Head nurse	19	54.3	1-20	2
Nursing supervisor	11	31.4	1-7	3
Clinical specialist	2	5.7	2-3	1
Nurse practitioner	1	2.9	5	1
Nurse administrator	23	65.7	1-10	2
Faculty	7	2.0	1-4	2
Other	10	28.6	1-5	1

Total n reporting = 35

Data corresponds with the experience of nurse administrators reported in the 1977 survey. One exception noted in the 1977 survey is the greater numbers of nurse administrators who had functioned as assistant nursing administrators.

In response to item 29, only four nurse administrators stated they were nurse clinicians or specialists. Two reported a master of nursing major, one had a one year university certificate, and one listed "on-the-job-training". Questions related to clinical specialization in both the 1977 and 1982 ASNSA surveys obtained questionable data. This item again needs careful evaluation for clarification.

Nurse administrators were asked in item 29 to identify national certification in nursing administration. Only four of the nurse

administrators (n=35) stated they were certified in nursing service administration. Certification for two nurse administrators is through ANA, and two did not indicate the certifying organization.

Educational Preparation and Continuing Education

Analysis of data in item 30 related to highest degree earned is shown in Table 10. The data are compared with the 1977 and 1982 ASNSA studies (ASNSA, 1984, p. 11). Major field of study from national surveys is not indicated in the table due to the great numbers of professional fields reported in both nationwide studies.

Table 10. Comparison of percentages of respondents reporting highest degree attained.

	Montana nurse administrators [a]1984		1977 ASNSA [b]survey		1982 ASNSA [c]survey	
Degree attained	n	Percentage	n	Percentage	n	Percentage
Associate Degree	6	17.1	128	2.5	1	0.4
Diploma	10	28.6	2,345	45.9		
Baccalaureate			1,204	23.6	63	25.2
B.S.	1	2.9				
B.S.N.	13	37.1				
Master's			1,402	27.5	154	61.6
M.A.	2	5.7				
M.N./M.S.N.	3	8.6				
Doctorate			25	0.5	5	2.0
Other					27	10.8

[a] n= 35
[b] n=5,104
[c] n= 250

In Montana, master's or baccalaureate degrees earned in fields other than nursing have all been earned in health care administration. One nurse administrator reported current enrollment in a master's program in health care administration. The area of education following basic nursing preparation reflects the upward trend nationwide for advanced preparation in administrative practice.

Despite full-time employment, increased responsibilities, and distance to educational centers, this study indicates an awareness of need for continuing education. Continuing educational credits earned are considerably less than the numbers of continuing educational hours earned within the last five years. This appears to follow the trend of the nationwide ASNSA survey.

Sixteen (48.5%) of the respondents reported earning no academic credits within the past five years, 8 (24.2%) have earned over 12, and some report 30-50 academic credits earned within the past five years. Of the 17 who stated they have earned academic credits, 11 reported almost all were directly related to nursing administration. There were 75.8 percent of the nurse administrators who report earning over 30 continuing education hours in the past five years. The range was from 30-114. Only three of the nurse administrators reported that some education hours were in nursing areas other than administration.

Professional and Community Activities

There were 33 nurse administrators who responded to item 32 requesting information related to professional activities. The majority (78.8%) held membership in some professional nursing organization.

By contrast, only 14.7 percent held an office in these nursing organizations, and 85.3 percent held no office. Of the 26 nurse administrators who indicated membership in a professional nursing organization (n=67), the greatest percentage of membership is in ASNSA (28.4%) and 13.4 percent in the Montana Society of Nursing Service Administrators (MSNSA). This item requires clarification and may not have provided valid information related to ASNSA membership. ASNSA membership does not include membership in the Montana Society as does the American Nurses' Association (ANA) or National League for Nursing (NLN). MSNSA membership has historically been greater in Montana than in the national organization ASNSA.

In other professional organizations, 16.4 percent of the total membership was in ANA, 4.4 percent in NLN, and 3.1 percent in Sigma Theta Tau. The remaining 34.3 percent of organizational participation was designated as membership in state or local organizations of ANA and NLN.

There was less participation in other professional organizations by the nurse administrators in this study. There were 34 persons who responded to these items, 61.8 percent belong to no other professional organizations. If membership was identified, the numbers of organizations ranged from one to four, with a mode of one. Over 85 percent of the nurse administrators stated they held no office in the organization of which they are a member.

Analysis of data related to community activities from 34 respondents, showed that only 50 percent are presently active in community affairs. There were 41.2 percent of the respondents who reported

previous community activity. The numbers of community organizations listed by responding nurse administrators covers a broad spectrum of community activities. There were 41 separate organizations listed, and only 15 were indicated more than one time. The greatest number of responses identified the Emergency Medical Services Council (n=5), women's church organizations (n=7), and advisory boards for educational institutions (n=5).

Community activities are listed as follows: advisory committees for educational institutions, health related social service and welfare, nonhealth related social service and welfare, nonservice related, and religious organizations. There were 22 health related organizations identified. Only the American Red Cross, City-County Health, Emergency Medical Services Council, hospital auxiliary, ambulance services, Childbirth-Prenatal Education Council, and American Heart Association were specified more than one time.

There were 23 nonhealth related social and welfare organizations identified. The Soroptomist, City-County Planning Council, Girl Scouts, Chamber of Commerce, and Lionettes were specified more than one time. Of interest, is the membership by nurse administrators in the Academy of Political Science, National Organization of Women, and the League of Women Voters. Only three organizations were classified as nonservice. Two separate religious organizations were specified. Of all organizations identified, 92.7 percent were service or health related.

Data were not available for comparison with the 1977 ASNSA survey. The great numbers of community organizations listed by Montana nursing

administrators made comparison with the 1982 ASNSA survey difficult.

Analysis of responses to items requesting information on the research activities of nurse administrators in Montana is shown in Table 11. Involvement has been greatest in areas of participation at symposia or conferences. Two respondents stated they have published texts, one is specific for a Montana health care agency.

Table 11. Professional Activities.

Professional Activity	n	Percentage of Participation
Research Activities		
Principle investigator n=24	5	20.8
Co-investigator n=23	2	8.7
Research assistant n=23	3	13.0
Participant n=27	16	59.3
Contributions to professional activities		
Journal article n=29	1	3.4
Media publication n=28	3	10.7
Symposium/conference presentation n=28	11	39.3
Other n=32	2	6.3

Age, Sex, and Marital Status

Age, sex, and marital status are included in items 35 and 36. Montana nurse administrators who participated in this research study are overwhelmingly female. Thirty-three nurse administrators responded to the item related to sex, 97 percent are female and 3 percent male. Age was reported as less than 30 years of age, 30-39 years of age, 40-49 years of age, 50-59 years of age. Analysis of data showed that 14.3 percent were less than 30 years of age, 37.1 percent between 30-39, 28.6 percent between 40-49, and 20 percent between 50-59 years of age.

Thirty-five nurse administrators responded to the item requesting information on current marital status. Categories were never-married, married, widow/widower, separated, or divorced. The majority of nurse administrators reported they are married (65.7%), divorced (22.9%), or never-married (11.4%).

Comparison with the 1977 ASNSA nationwide survey reveals that the greatest single reporting age was between 40-49 years (36.4%). The single greatest percentages are married (60.8%), and only 9.7 percent overall reported being divorced. Comparison indicates that Montana nurse administrators who participated in this study are younger and a greater percentage are divorced.

Salaries and Benefits

Items 37 and 38 requested information on salaries and benefits of nurse administrators. A comparison with both the 1977 and 1982 ASNSA surveys (ASNSA, 1984, p. 20) is shown in Table 12. Reporting increments

are the same, however, the range in each survey differs. Increased salaries for Montana nurse administrators follows the national trend for increased salaries for nurse administrators, despite the rural nature of Montana hospitals. Analysis of data in this study shows that increased salary does correspond with increased hospital size and also with responsibilities for greater numbers of nursing service employees.

Table 12. Comparison of salary ranges.

Salary range in dollars	[a]Montana study	[b]1977 Survey	[c]1982 Survey
	Percentage	Percentage	Percentage
Less than $15,000	6.2	26.4	
$15,000 - $19,999	9.4	32.7	0.6
$20,000 - $24,999	25.0	23.4	6.7
$25,000 - $29,999	31.3	11.6	12.1
$30,000 - $34,999	12.5	4.4	28.2
$35,000 - $39,999	3.1	1.5	7.6
$40,000 - $44,999	9.4		20.6
$45,000 - $49,999			13.3
$50,000 - $54,999	3.1		5.2
$55,000 - $59,999			2.4
$60,000 - $64,999			0.6
Over $65,999			2.7

[a]Total $\underline{n}$= 32 Range = Under $15,000 - Over $50,000
[b]Total $\underline{n}$=5,224 Range = Under $15,000 - Over $35,000
[c]Total $\underline{n}$= 330 Range = Under $15,000 - Over $65,000

There were 33 nurse administrators who reported benefits provided by the institution. Thirty benefit categories are listed in this item. Some nurse administrators indicated the benefit was "partially" a benefit provided by the employer. Partial benefits for data analysis were considered to be benefits. Professional meeting expenses and major medical plans were reported by 75-85 percent of those responding. Pension/retirement plans, life insurance, greater than 10 annual sick leave days, and greater than 7 paid holidays were specified by 63-73 percent of the respondents. Payment of professional organization dues, tuition reimbursement, social security, gas mileage, free or reduced parking, professional journal expense, and greater than three weeks vacation were included as benefits for 45-60 percent of nurse adminsitrators. Meals, disability plans, tax sheltered annuity/deferred compensation, and moving expenses upon hiring were provided for 30-43 percent of nurse administrators in Montana. No housing allowance was granted to nursing administrators in the Montana study. All other benefits were reported by lesser numbers of nurse administrators and correspond with increased hospital bed size.

Items in this question were analyzed differently than in the 1977 ASNSA nationwide survey. There is some correspondence with those benefits which are also received by the largest percentage of nurse administrators in Montana.

Success Defined

The concept of success was explored in this research study by requesting nurse administrators to define this concept related to

professional practice. Twenty-eight (80%) of the nurse administrators responded to item 34. There were 54 items generated by their responses. Obviously, success is a difficult concept to define. One response not included in analysis was "ambiguous question unable to answer". The researcher was unable to categorize two responses, "improved" and "above average". There were only three responses considered negative by this researcher. Negative responses were "survival", "I'm not sure there is such a thing!", and "avoiding burnout". It is worth noting that only one nurse administrator stated participation in a professional network, and none reported mentor relationships.

Major themes in responses were classified as administrative recognition and support, professional quality care for patients, staff support and staff development, and goal achievement and recognized responsibility. Administrative recognition as a member of organizational management was defined in numbers of ways. Some of the responses were "respect by staff, physicians, and administrator", "being involved in all activities of hospital management", "decisions supported by administrator and nursing staff", "recognition as authority", "keeping open communication with administration and other departments", and "to have peer status with other administrative staff".

Quality patient care was the most frequent item identified with success by nurse administrators in this study. Thirteen (46.4%) of the nurse administrators attributed success to provision of excellence in patient care under their leadership. The nurse administrators stated success was "a feeling of accomplishment in delivering the best

possible care to patients," "high quality care," and "to provide leadership to allow for quality patient care in a cost effective manner."

Staff development was identified as "job satisfaction for staff," "to observe the growth and level of expertise among subordinates," "directing a hospital that has an excellent reputation for good nursing care," and "maintaining competent nursing staff." Other respondents related success to "the ability to meet staffing needs of the facility plus the needs of the staff in order to provide quality patient care" and "ability to advance a nursing department with changing health trends by working through subordinates."

Goal achievement and recognition of responsibilities were described in numbers of ways. Success was "to listen before making decisions and to be responsible for making final decisions," "fiscal stability in the nursing department," "a continuing education process whereby goals are developed and achieved," "being an enabler," "achieving goals," and "productive reaching of most annual goals, development of new relationships in field of endeavor."

Responses to this item identify the complexity of the concept of success in the role of nursing administrator. Nurse administrators have identified the importance of influence within the institution and the responsibilities inherent in the administrative role.

Additional Comments

An opportunity was provided for additional comments following completion of the instrument used to develop a profile of nurse

administrators in Montana. Three of the respondents made additional comments on the questionnaire. One nurse administrator stated the questionnaire was very time consuming and further stated that "I hope it is worth my time not like many I have participated in and never had any feedback" (emphasis by respondent) "I still love my job as DNS (director of nursing service) after 10 years," and "very thought provoking process".

Summary

The findings of this research study were used to identify a profile of nurse administrators who function in rural hospitals in Montana today. Comparison with nationwide surveys of nurse administrators by the American Society of Nursing Service Administrators of the American Hospital Association (ASNSA, 1980b; ASNSA, 1984) provided a base for comparisons with hospital nursing administrators nationwide. Sources of influence both within and out of the hospital and the scope of the organizational position were explored.

CHAPTER 5

DISCUSSION

Summary and Discussion

The purpose of this study was to develop a profile of the personal and professional characteristics of the nurse administrator in acute care hospitals in Montana. The conceptual framework for this study was organized around the concept of sources of influence through formal and functional power and included the dimensions of the organizational role. The responsibilities, authorities, and personal characteristics which contribute to administrative role development were studied. These three domains constitute the administrative role.

The rural characteristics of the acute care hospitals were identified in order to include this extraneous variable in comparison of data with nationwide studies. Rural characteristics were a consideration in their effect on administrative practice of nurse administrators in Montana.

Prior to this study, the researcher assumed there was little administrative support within the organization for nurse administrators in Montana. She also assumed that mentor-network relations were a critical facet of role development. One further assumption made, was that nurse administrators in a rural state had expanded responsibility without delegated authority. The preparation for administrative practice and the concepts of mentor and network relations were studied

because they are important in development of the administrative role within the organization. The route to top management has generally been through upward mobility within nursing with little prior administrative practice or educational preparation. These considerations and the review of literature formed the background of this study.

A review of literature suggested that management skills are multiple and multifaceted. Educational preparation is suggested by nationally recognized nursing leaders and national standards for nurse administrators. Without administrative preparation, the nurse administrator is unable to assume responsibility for fiscal, resource, and patient care management. In order to function effectively, the nurse administrator possesses both formal and functional power. These sources of influence are critical in order to affect decision-making, to assume delegated responsibility within the organization, to direct the organization, and to deliver health care.

National rules and regulations, standards, and guidelines define the administrative role. These standards clarify the professional and administrative aspects of the dual role in nursing administration. The numbers of women in administrative positions in nursing are significantly higher than men. By contrast, there is a predominance of men in administrative positions within the hospital hierarchy. Social and economic factors have, in the past, been attributed to lack of management potential for women in management. Administrative support services, organizational status, and active participation in corporate decision-making are important sources of influence and are considered essential for success in nursing management.

Nursing administrators are leaders in nursing. The acknowledged influence held by the nurse administrator actively affects change in health care delivery and insures increasing professionalism within nursing. The visibility of the nurse administrator is a potential source of influence and insures the right to address the issues in nursing today.

This researcher was interested in exploring the span of control and the overall responsibility and power of nurse administrators in a rural state. A comparison population was essential, so that identified characteristics were attributed to nurse administrators functioning in acute care hospitals in general. Comparison was also necessary to identify those variables unique to hospitals and nursing practice in a rural state. The variables identified in the conceptual framework of the study provided the structure for instrument development.

Differences between this study and the two ASNSA studies must be considered. All studies included only nurses in the top administrative position in acute care hospitals. The population in this research study included only those 60 acute care hospitals which were nongovernmental or were not special treatment centers. There were 35 returns (58.3%) which were all found to be acceptable for data analysis. Comparability with the 1977 study was possible since most items were retained for use from the tool developed by the ASNSA. Because of differences in the 1982 study in both sampling and changes in the questionnaire, comparability was limited.

Montana Nurse Administrator Profile

A profile of the Montana nursing service administrator was developed from an analysis of the personal and professional characteristics found in this research study. The comparisons with nationwide studies found many similarities and some differences between Montana nurse administrators and nurse administrators nationally. The current trends in a changing administrative role for Montana nurse administrators appears to follow the national trend for change. The profile developed can only be generalized for the total population studied and may not be valid if data were available from the total population.

Based on analysis of data from this research study, the average nurse administrator was female (97%), between 30 to 39 years of age (37.1%), and was married (65.7%). The nurse administrator received a salary of between $30,000 and $34,999 (31.3%), or possibly between $25,000 and $29,999 (25%). Increased salary was directly related to responsibility for greater numbers of nursing personnel and increased hospital size.

The nurse administrator achieved the position through upward mobility, first as a staff nurse (100%) and then as a head nurse or supervisor (85.7%). Certification in nursing administration (11.4%) may indicate a trend in Montana. The greatest percentage of nurse administrators earned a baccalaureate degree (40%). The next highest percent was a diploma in nursing (28.6%). A few hold master's degrees (14.3%). A baccalaureate or master's degree other than in nursing was in the field of health care administration. The trend toward higher

education for nurse administrators in Montana reflects the national trend.

Slightly over half of the nurse administrators (51.5%) had earned academic credits within the last five years. The focus of continual preparation for the administrative role has been greater in continuing education hours earned (97%) than in academic credits. Most nurse administrators (75.8%) earned well over 30 continuing education hours which are almost totally applicable to nursing administration (87.9%).

Most nurse administrators belonged to a professional nursing organization (78.8%), but did not hold an office in that organization (85.3%). Professional organizations in which the nurse administrator was a member, included the ASNSA (28.4%), MSNSA (13.4%), or the ANA (16.4%). Most nurse administrators belonged to no other professional organization (61.8%), and those who did, held no office in that organization (85.3%). The nurse administrator was active in community affairs (50%), and if so, they were overwhelmingly health or welfare and service related organizations (92.7%).

Some nurse administrators were involved in research activities (24.3%). The major involvement in other professional activities was in presentations at conferences or symposia (39.3%) or for media publication (10.7%). Two nurse administrators have published professional texts. The nursing departments were following a trend in planning for development of, or adopting, a nursing theory for professional practice. While these nursing administrators were few in number, they indicate a trend which may be much more evident in the next decade.

Professional development for the nurse administrator was aided by a mentor in 60.6 percent of the cases. There probably has not been a mentor relationship with greater than two experienced professionals (55%). The mentor was usually a woman in a professional role (59.5%). Occupation of mentors included nursing supervisor (19%), nurse administrator (16.7%), or hospital administrator (16.7%). Although the nurse administrators had a mentor for professional development, there was a fifty percent chance they had not functioned in the role of mentor to others. If the nurse administrator had functioned as a mentor to another professional, the mentee was a female (74.4%). The assistance given was generally related to administrative skills (65.2%). The mentee was usually a staff nurse (61.5%) but was sometimes a nursing supervisor (15.4%) or another nurse administrator (12.8%).

The nurse administrator was actively participating in a professional network for support, advice, and development of professional expertise (88.2%). The advice and support shared with other network members was almost totally related to development of management expertise (95.8%). Support requested from professional network members was also related to development of management skills and problem-solving (94.4%).

Nursing service administrators in Montana viewed success from the perspective of organizational role, patient, nursing staff, and professional role. Success in the role of administrator was directly related to recognition as a member of organizational management, provision of quality patient care by the department of nursing, development

of skills and expertise by the nursing staff, and personal goal achievement and recognition of professional responsibility.

Nurse administrators reported directly to the top executive officer (94.3%), unless they functioned in a large medical center. There was shared administrative coverage of the overall institution (88.6%). The span of control included responsibility and designated authority for special units or other departments within the hospital. The authority included five to eight special units or departments (55.9%). The departments were as diverse as dietary, social work, pharmacy, ambulance service, laundry, and occupational, physical, respiratory, or speech therapy.

There was active participation in planning of the hospital budget (74.3%) and for priority-setting for the hospital budget (82.4%). There was control of the establishment of the nursing department budget (76.5%) and in some cases there was total control of that budget (62.9%).

The nurse administrator actively participated on all corporate committees or boards. The nurse administrator was not a voting member of the governing board but was often a member (53.8%). Active participation on the administrative staff committee was frequent (84.9%), as were corporate planning and development (78.2%), and the executive medical staff committee (67.9%).

Active participation in all institutional committees was frequent (51.4%). The nurse administrator was actively involved in over four of the committees which guided the direction of care within the hospital

(94.3%). The nurse administrator generally had major control over decision-making and management of the department of nursing (66.1%).

Administrative support services were generally available for the nurse administrator. The majority of that support was available for data access, materials management, record keeping, and financial reports. When computer services were available, computer access was primarily for financial, statistical, and audit analysis and for personnel payroll. If there was a bargaining unit for professional nurses, the nurse administrator usually participated as a member of the bargaining team (71.4%) or as an advisor (28.6%) to the bargaining committee.

The nurse administrator generally functioned in a hospital with less than 50 acute care beds (65.7%), which included an average of 27 extended care beds. The nurse administrator was responsible for 50 to 74 percent of the total number of institutional employees. Responsibilities of the position as nursing administrator required that the workweek included greater than 40 hours and sometimes 60 or more hours (14.3%). Administrative responsibilities required the major portion of the nurse administrator's time. Greater than 70 percent of the time was spent on administrative responsibilities (55%). There was little, if any, time allocated for direct patient care.

Conclusion

This research study indicated a shift toward more professionalism and more authority for the nurse administrator over the department of nursing. Nurse administrators in Montana followed the nationwide trend

for increased credentialling within the corporation. There was, on the average, active participation in the planning and direction of the corporation as well as control of the department of nursing. Responsibility within the institution was extensive, but sources of organizational influence were guaranteed by the organizational position.

Mentor and network relationships proved to be valid concepts in development of expertise in nursing administration. There was also validation that serving as a mentor was a role not usually assumed. However, having a mentor was an important influence in role development. The importance of a professional network for nurse administrators was evident. Sharing and receiving administrative assistance and support from others was also an important aspect of role development. The use of the network for professional needs, rather than emotional support, validated the assumptions proposed in the review of previous studies. In this study population the role of nurse administrator in Montana did meet the requirement for authority and responsibility of that role.

Limitations

The nurse administrators who participated in this research study could be those nurse administrators who had an established place in administrative management. They also could have been the population involved in change, who were active in professional organizations, and who developed a network of peers for support and guidance. One limitation is that the small sample of nurse administrators in this study may

not be representative of the total population of nurse administrators in Montana.

Another limitation is that the population selected to insure homogeneity made comparison with the selected nationwide study difficult. In the case of the 1982 ASNSA (1984) study, comparability is questionable. The use of a mailed questionnaire imposed some limitation by limiting response rate.

Recommendations

Recommendations for further study include the following:

1. Repeat the study using a larger population to further validate the identified concepts in other rural states.
2. Refine the instrument in order to eliminate or clarify questionable items for greater precision in comparison with other studies.
3. Narrow the focus of the study to provide a more indepth validation of major concepts in this study.

Implications for Nursing

The results of this study clearly have implications for nurse administrators in any rural state. Little has been known of administrative practice, the role, responsibility, and authority. Influence through both formal and functional power insures the authority to meet administrative responsibility. Equally important are mentor and network relationships. These relationships provide support for administrative role development and for nurse administrators with little or no peer support within the organization.

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APPENDICES

APPENDIX A

COVER LETTER TO NURSING ADMINISTRATORS

525 So. 5th East, Apt. 5C
Missoula, Montana 59801
March 16, 1984

Dear Nursing Service Administrator:

I am writing to invite you to participate in a study of sources of influence of nursing service administrators in Montana. The study will compare similarities and differences in the profile of nurse administrators in Montana and between nursing administrators nationwide. The concepts of professional network-mentorship relationships as they contribute to role success will be investigated.

Sources of influence have been developed from the standards, guidelines, or policies of the American Hospital Association, American Society of Nursing Service Administrators of the American Hospital Association, Joint Commission on Accreditation of Hospitals, American Nurses' Association, and National League for Nursing. With permission of the American Society of Nursing Service Administrators and the American Hospital Association, a replication or an adaptation of some questions from the Survey of Nursing Service Administrators in Hospitals has been used in this questionnaire. In this way, comparison studies may be made.

The questionnaire is in three parts. Part I explores the roles, responsibilities, and authorities of the nursing administrator. Part II explores mentorship and network relationships, and Part III is for the development of a personal professional profile of all nurse administrators.

This study is for my master's thesis at Montana State University. My interest in the topic is derived from working as a nurse administrator in a rural hospital in Montana. It is hoped that the findings of this study will be of value to the hospital nursing administrators practicing in Montana today. Your participation, therefore, is critical in development of an accurate profile of nurse administrators in our state.

The questionnaire is confidential. Your name will not be used in any way in the thesis or in the findings. Consent to participate is therefore implied by your completion of this questionnaire. Due to the time necessary for tabulation of results, I would appreciate that the questionnaire be returned by April 6.

Please return the questionnaire in the enclosed envelope. The completed thesis will be available through the Montana State University library. If you are interested in receiving an abstract of the results, please send a self-addressed stamped envelope to the above address. If there are any questions you may have during questionnaire completion, please feel free to contact me. If you choose to participate, I appreciate your time and assistance.

Sincerely,
Avis Peterson, R.N.
Montana State University
Missoula Extended Campus
(406) 721-5673

Enclosure

APPENDIX B

MAILED QUESTIONNAIRE

HOSPITAL NURSING SERVICE ADMINISTRATOR QUESTIONNAIRE

DIRECTIONS FOR COMPLETING THE QUESTIONNAIRE:

In order for your answers to be accurately analyzed please:

(1) print numbers or letters clearly
(2) place a well-defined check mark in the box beside the most appropriate answer
(3) if a written answer is requested, very brief answers are expected in the space provided

Part I. Administrative Practice

We are interested in administrative functions which will help to define your role, responsibilities, and accountabilities as a nursing service administrator.

1a. Do you report directly to the top administrative officer of the hospital? [ ] YES [ ] NO

b. If NO, to whom do you report? (Title)_____

c. At what level of the organizational structure is she/he?
[ ] 2nd [ ] 3rd [ ] 4th [ ] other (please specify)_____

2. Do you personally participate in administrative coverage for the overall hospital operation? [ ] YES [ ] NO

3a. Which of the following units or departments are in your hospital, and which are you accountable for?

IN HOSPITAL	ACCOUNTABLE FOR	IN HOSPITAL	ACCOUNTABLE FOR
[ ]	[ ] Central Supply	[ ]	[ ] Rehabilitation
[ ]	[ ] Chemical Dependency	[ ]	[ ] Psychiatric
[ ]	[ ] Dietary	[ ]	[ ] Radiology
[ ]	[ ] Emergency Department	[ ]	[ ] Recovery Room
[ ]	[ ] Extended Care	[ ]	[ ] Renal-dialysis
[ ]	[ ] Home Care	[ ]	[ ] Respiratory Therapy
[ ]	[ ] Housekeeping		
[ ]	[ ] Laundry	[ ]	[ ] School of Nursing
[ ]	[ ] Intensive/Coronary Care	[ ]	[ ] Self-care
		[ ]	[ ] Speech Therapy
[ ]	[ ] Laboratory	[ ]	[ ] Social Work
[ ]	[ ] Occupational Therapy	[ ]	[ ] Staff Development
[ ]	[ ] Operating Room	[ ]	[ ] Volunteer Service
[ ]	[ ] Outpatient Surgery	[ ]	[ ] Other (specify)
[ ]	[ ] Pharmacy	[ ]	[ ] _____
[ ]	[ ] Physical Therapy	[ ]	[ ] _____

4a. What is the number of acute care beds in your hospital?_____

b. Is an extended care facility a part of your responsibility?
[ ] YES [ ] NO

c. If YES, how many extended care beds do you have administrative responsibility for. _____

5. Do you participate in the planning for the overall hospital budget? [ ] YES [ ] NO

6. Do you participate in the priority-setting for the overall hospital budget? [ ] YES [ ] NO

7. Do you have major responsibility for the establishment of the nursing service operational budget? [ ] YES [ ] NO

8. Once your nursing budget is approved, do you have full responsibility for the budget? [ ] YES [ ] NO

9. How many hours are there in your normal workweek? _____

10. Please estimate the percentage of your time spent during your normal work week in the following areas:

_____% Job-related community activities
_____% Administrative functions
_____% Giving direct patient care
_____% Teaching patients or families within the institution
_____% Teaching staff within the institution
_____% Teaching students within the institution
_____% Teaching outside of the organization
_____% Research
_____% Consultation outside of the institution
_____% State or national professional activities
_____% Other (please specify)_____

100.0 %

11. On which of the following corporate committees/boards do you actively participate?

	NONE	OCCASIONALLY	MEMBER	VOTING MEMBER
Accreditation/licensure	[ ]	[ ]	[ ]	[ ]
Administrative Staff	[ ]	[ ]	[ ]	[ ]
Board of Trustees	[ ]	[ ]	[ ]	[ ]
Corporate Planning/Development	[ ]	[ ]	[ ]	[ ]
Executive Medical Staff	[ ]	[ ]	[ ]	[ ]
Interdepartmental Research	[ ]	[ ]	[ ]	[ ]
Other (please specify)	[ ]	[ ]	[ ]	[ ]

12. On which of the following institutional committees do you or your designated representative participate?

	PARTICIPATION		
	NO COMMITTEE	NONE	ACTIVE
Emergency care	[ ]	[ ]	[ ]
Infection control	[ ]	[ ]	[ ]
Disaster planning	[ ]	[ ]	[ ]
Medical records	[ ]	[ ]	[ ]
Pharmacy and therapeutics	[ ]	[ ]	[ ]
Professional library	[ ]	[ ]	[ ]
Quality assurance	[ ]	[ ]	[ ]
Safety	[ ]	[ ]	[ ]
Special care unit	[ ]	[ ]	[ ]
Standing medical staff committees	[ ]	[ ]	[ ]
Risk management	[ ]	[ ]	[ ]

13a. Has your nursing department(s) developed/adopted a nursing theory for professional practice (excluding the departmental philosophy statement)? [ ] YES [ ] NO

b. If YES, please specify_____

14. Check the level of responsibility that the Department of Nursing at your hospital has for the activities listed below.

	RESPONSIBILITY		
	FULL	PARTIAL	NONE
Contractual agreement with nursing school	[ ]	[ ]	[ ]
Changing basic organization of nursing care on units	[ ]	[ ]	[ ]
Changing nursing procedures and policies	[ ]	[ ]	[ ]
Developing and/or implementing nursing research projects	[ ]	[ ]	[ ]
Development of departmental educational programs	[ ]	[ ]	[ ]
Eliminating nonnursing duties from nursing dept.	[ ]	[ ]	[ ]
Establishing individual practice work load	[ ]	[ ]	[ ]

	RESPONSIBILITY		
	FULL	PARTIAL	NONE
Implementing new nursing roles as they develop	[ ]	[ ]	[ ]
Increasing or decreasing nursing staff	[ ]	[ ]	[ ]

15. Please check administrative support services made available to you:

[ ] Access to data from other departments
[ ] Computer
[ ] Materials management
[ ] Record keeping
[ ] Secretarial
[ ] Staffing coordination
[ ] Quality reports
[ ] Cost center financial reports
[ ] Other (please specify) _____
[ ] _____
[ ] _____

16a. Are any nurses not responsible to nursing service? [ ] YES [ ] NO

b. If YES, to whom do they report? (please specify) _____

c. What is their professional responsibility? (please specify) _____

17a. Are any nurses in your hospital members of a collective bargaining unit(s) that have contract(s) with your hospital? [ ] YES [ ] NO

b. If YES, as a nursing administrator, what is your degree of participation with the management negotiating team for collective bargaining?

[ ] Participation on the management negotiating team
[ ] Serve as an advisor to the management negotiating team
[ ] No involvement with the management negotiating team

18a. Are computers used by your institution? [ ] YES [ ] NO

b. If YES, please indicate the nursing service functions that are assisted by computer services:

[ ] Audit
[ ] Fiscal data
[ ] Instruction (patient or staff)
[ ] Manpower data
[ ] Nursing diagnosis
[ ] Patient profile
[ ] Payroll
[ ] Scheduling
[ ] Statistical analysis
[ ] Other (please specify)
[ ] _____
[ ] _____

19a. Please indicate the number of full-time and part-time hospital employees in each of the following categories who are under your direct/indirect management:

	NUMBER REPORTING	
	Full time (35 hr/wk or more)	Part time (less than 35 hr/wk)
RN		
LPN/LVN		
Aide/Orderly		
Unit manager		
Clerks/Secretary		
Tech. (OR, OB, etc.)		
Other (please specify)		
_____		
_____		

b. What percentage of total hospital personnel does the above personnel represent? _____%

Part II. Professional Mentor-Network Relationship

20a. It has been suggested that the presence of an experienced professional who acts as a mentor (guide) to a less experienced professional, is important in development of professional expertise and career role achievement. In your professional career development, have there been professional mentors? [ ] YES [ ] NO

b. If YES, please list:

OCCUPATION OF MENTOR	SEX	MENTOR'S RELATIONSHIP TO YOU	ASSISTANCE GIVEN BY MENTOR
_____	___	_____	_____
_____	___	_____	_____
_____	___	_____	_____
_____	___	_____	_____

21a. Have you served as a mentor for other professional nurses in the development of their career goals? [ ] YES [ ] NO

b. If YES, please list:

MENTEE'S RELATIONSHIP TO YOU	SEX	SPECIFIC ASSISTANCE GIVEN BY YOU
_____	___	_____
_____	___	_____
_____	___	_____
_____	___	_____

22a. It is generally recognized that a professional network provides information, advice, and moral support for career development and advancement. A social network is a mutual interaction with professional contacts (peers).

Do you consider that you participate in a professional network which is essential to you in your professional practice?
[ ] YES [ ] NO

b. If YES, what administrative expertise do you share with other network members? (please be specific)

_____
_____
_____
_____

c. What administrative expertise have you requested from other network members? (please specify)

_____
_____
_____
_____

Part III. Demographic Information

We are interested in information about you and your professional background.

23. Please indicate your present job title (check one only):

[ ] Nursing Administrator
[ ] Vice-President of Nursing
[ ] Associate Administrator
[ ] Assistant Administrator
[ ] Director of Nursing
[ ] Other (please specify)_____
[ ] _____
[ ] _____

24. How long have you been employed in your present position?_____

25a. Are you a native of Montana (e.g., born, raised, spent most of your life in)? [ ] YES [ ] NO

b. In NO, what state are you a native of?_____

26a. Were you promoted to your position from within your present place of employment? [ ] YES [ ] NO

b. If YES, are you a native of the area in which you are now living (e.g., born, raised, spent most of your life)? [ ] YES [ ] NO

27a. Were you recruited for your present position from another position within Montana? [ ] YES [ ] NO

b. If NO, were you recruited from an area in another state which would be considered:

[ ] Rural
[ ] Suburban
[ ] Urban

28a. Please indicate the years of experience you have had in each of the following positions:

	YEARS		YEARS
[ ] Staff nurse		[ ] Nurse practitioner	
[ ] Head nurse		[ ] Nursing administrator	
[ ] Nursing supervisor		[ ] Faculty	
[ ] Clinical specialist		[ ] Other (please specify)	
		[ ] _____	

b. If you have faculty status, what is your title?_____

29a. If you have had experience as a nurse clinician/specialist, or nurse practitioner, please indicate your area of practice:

_____

b. Please indicate certification or educational preparation for the role of nurse clinician/specialist, or nurse practitioner:

_____

c. Have you received certification or recognition by a national professional organization in nursing administration (e.g., ASNSA or ANA)? [ ] YES [ ] NO

d. If YES, please specify.

_____

30. Please indicate all diplomas and degrees earned:

[ ] LPN/LVN
[ ] Associated Arts/Associate Degree
[ ] Diploma from Hospital School of Nursing

	MAJOR FIELD OF STUDY	MINOR FIELD OF STUDY
[ ] B.S.N.		
[ ] B.A.		
[ ] M.A.		
[ ] M.S.		
[ ] M.N. /M.S.N.		
[ ] D.S.N.		
[ ] Ed.D.		
[ ] Ph.D.		
Other (please specify)		
[ ] _____		
[ ] _____		

31a. Please indicate the academic credits you have earned in the last five years:
[ ] 0 [ ] 1-6 [ ] 7-12 [ ] over 12

b. Please indicate the number of continuing education hours you have accrued in the last five years:

[ ] 0 [ ] 1-10 [ ] 11-20 [ ] 21-30 [ ] over 30

c. Of the academic credits or continuing education hours earned, please indicate the number that are directly related to nursing administration (e.g., fiscal, resource, patient care management).

Academic credits_____
Continuing education nours_____
Other (please specify)_____

32a. In what professional organizations are you a member?

		NUMBER OF OFFICES HELD
American Academy of Nursing	[ ] YES [ ] NO	_____
American Society of Nursing Service Administrators	[ ] YES [ ] NO	_____
National League for Nursing	[ ] YES [ ] NO	_____
Montana League for Nursing	[ ] YES [ ] NO	_____
American Nurses' Association	[ ] YES [ ] NO	_____
State Nurses' Association	[ ] YES [ ] NO	_____
District Nurses' Association	[ ] YES [ ] NO	_____
Sigma Theta Tau Honor Society	[ ] YES [ ] NO	_____
Other (please specify)_____	[ ] YES [ ] NO	_____
_____	[ ] YES [ ] NO	_____

b. In what nonnursing professional organizations are you a member?

ORGANIZATION	NUMBER OF OFFICES HELD
_____	_____
_____	_____
_____	_____
_____	_____

c. On what community programs or committees do you/have you served?

PRESENTLY SERVE	FORMERLY SERVED
_____	_____
_____	_____
_____	_____

33a. Please indicate involvement you have had in research activities:

Principal investigator	[ ] YES	[ ] NO
Co-investigator	[ ] YES	[ ] NO
Research Assistant	[ ] YES	[ ] NO
Participate	[ ] YES	[ ] NO

b. What contributions have you made to nursing literature, media publications, or presentations at conferences or symposiums:

			NUMBER
Journal article	[ ] YES	[ ] NO	_____
Media publication	[ ] YES	[ ] NO	_____
Symposium or conference presentation	[ ] YES	[ ] NO	_____
Other (please specify)___			_____
_____			_____

34. How would you describe "success" in the role of nursing administration?_____

_____

35. Please indicate your age group and sex:

[ ] under 30 [ ] 30-39 [ ] 40-49 [ ] 50-59 [ ] over 59

[ ] Female [ ] Male

36. Please indicate your current marital status:

[ ] Never married [ ] Married [ ] Widow/Widower

[ ] Separated [ ] Divorced

37. Please indicate your present salary range per year:

[ ] under $15,000
[ ] $15,000 - $19,999
[ ] $20,000 - $24,999
[ ] $25,000 - $29,999
[ ] $30,000 - $34,999
[ ] $35,000 - $39,999
[ ] $40,000 - $44,999
[ ] $45,000 - $49,999
[ ] $50,000 - or more

38. Which of the following benefits are provided by your institution? (check all that apply)

[ ] Expense account
[ ] Professional organization dues or membership fees
[ ] Nonnursing organizational dues
[ ] Expenses for professional meetings
[ ] Tuition reimbursement
[ ] Meals
[ ] Housing/home allowance
[ ] Major medical plan
[ ] Disability plan
[ ] Social security
[ ] Pension/retirement plan
[ ] Life insurance
[ ] Stock option/profit sharing
[ ] Tax-sheltered annuity deferred compensation
[ ] Club membership
[ ] Credit cards
[ ] Bonus incentive
[ ] Clothing allowance
[ ] Gas mileage
[ ] Automobile
[ ] Free or reduced parking
[ ] Moving expenses (at hiring)
[ ] Professional journal subscriptions
[ ] Sabbatical option
[ ] More than 10 annual paid sick leave days
[ ] More than 7 paid holidays
[ ] Military leave
[ ] More than 3 weeks vacation
[ ] Loan/financing option
[ ] Other (please specify)____
[ ] _____

39. Are you a member of a religious order? [ ] YES [ ] NO

40. Additional comments: _____

_____

_____

THANK YOU FOR YOUR PARTICIPATION IN THIS RESEARCH STUDY

APPENDIX C

LETTER OF RESPONSE TO USE ASNSA QUESTIONNAIRE

American Society for
Nursing Service Administrators
of the American
Hospital Association

840 North Lake Shore Drive
Chicago, Illinois 60611
Telephone 312.280.6410

December 5, 1983

Avis Peterson
525 South Fifth St. East
Apartment C
Missoula, MT 59801

Dear Avis

Enclosed is a copy of the questionnaire used for the 1977 Survey of Nursing Service Administrators in Hospitals. The questionnaire is not copyrighted so there is no problem in your using the questions. May I suggest that if you use the questions you indicate that they were adapted from the ASNSA and AHA survey.

For the 1977 survey, questionnaires were sent to 7,084 hospitals and 5,326 responded. Questionnaires were sent to 66 hospitals in Montana and 42 responded. This was a 63.6 percent response.

Best of luck on your study of Montana nursing service administrators. We would greatly appreciate knowing the results of your study when they are available.

Sincerely

Janine A. Swent, R.N.
Director

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