A CONTINUING EDUCATION PROGRAM FOR IMPROVING
RELATIONSHIPS BETWEEN STAFF NURSES AND NURSE EXECUTIVES

by

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of the requirements for the degree
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APPROVAL

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Nursing is a profession of many “specialties.” One role rarely thought of as a nursing specialty is that of nurse executive. Staff nurses are often unaware of the obligations and expectations of these less traditional nursing roles. Nurse executives are thought of as managers and administrators. The role of the nurse executive requires skill in the management of people, finances, and resources. These nurses must be able to maintain a vision for the future and possess superior communication and problem solving skills. Nurses, patients, and communities rely on the nurse executive to act as their advocate.

Because the roles of staff nurses and nurse executives differ in many ways, positive relationships may be difficult to maintain. Studies have shown that relationships between staff nurses and nurse executives can affect physical health, emotional and mental health, anger and internal conflict in the workplace, decreased job satisfaction, and decreased organizational commitment resulting in high turnover rates, decreased productivity, and decreased quality of patient care.

The purpose of this project was to develop a Continuing Education Program for staff nurses and nurse executives with the goal of fostering improved relationships. Based on a review of the literature a program was designed to increase staff nurses’ understanding of the roles of nurse executives, to review barriers to effective communication, and to make recommendations for improving communication and understanding. A pilot program was presented to a single department of hospital staff. Nurses learned to use familiar nursing tools to identify problems and solutions. Evaluation revealed the participants learned more about nurse executive roles and renewed a commitment to improving relationships between staff nurses and nurse executives.

The role of nurse practitioners in the hospital environment is not yet clearly defined. Nurse practitioners are “specialists” with many new roles. These roles cross over the boundaries which previously separated staff nurses and nurse executives. Blending these once distinct lines between staff nurses and nurse executives will require development of new relationships for all three groups of nurses. Programs such as this may foster improved understanding and communication between the many “specialties” of nursing.
CHAPTER 1

INTRODUCTION

The profession of nursing has many specialties. Droppleman & Thomas (1996) state that nurses may not agree on every issue. However, it is generally accepted that nurses who practice within a particular specialty area do have expertise and skills not perfected by other nurses. Nurse executives, nurse administrators, and nurse managers are often not considered by staff nurses to possess a nursing specialty. They are not, therefore, given similar support for their specialized skills and expertise (Biordi, 1986; Lee & Henderson, 1996). Staff nurses express frustration that nurses in these management positions, known as nurse executives, have “forgotten where they come from” and are not representing nursing interests as they perform their duties. Lack of support, lack of respect, and inadequate communication from nurse executives are frequently cited as sources of low job satisfaction by staff nurses (Droppleman & Thomas, 1996). Negative results of these complaints can be manifested by nurses in “high turnover rates, interpersonal alienation, and ultimately, burnout” (Droppleman & Thomas, 1996). For nurse executives, stress is created by role conflict, role ambiguity, and marginalization. Stress is accentuated by, among other factors, poor support from and communication with staff nurses (Scalzi, 1990, 1988; Lee & Henderson, 1996; Roberts, 1997).

Improving the relationships between nurse executives and staff nurses has advantages for all involved, both on personal and organizational levels. Positive and effective relationships result in increased job satisfaction for both nurse executives and staff nurses (Lee & Henderson, 1996; Scalzi, 1988, 1990; Tonges, Rothstein, & Carter, 1998). Decreases in stress levels and improvements in the alterations of physical and mental health leading to “burn-out” are all linked to positive collaborative working relationships
2

(McNeese-Smith, 1997). Institutional benefits include improved organizational outcomes such as decreased turnover rates, increased productivity, improved delivery of patient care, and improved organizational commitment (Tonges et al., 1998; McNeese-Smith, 1995). Nurse executives and staff nurses with positive attitudes, mutual respect, and a focus on shared direction and decisions can lead to increased independence and responsibility for staff nurses as well as provision of support for the executive nurse in difficult times of change (Grohar-Murray & DiCroce, 1997).

Motivation for this project comes from the author’s personal experience as a staff nurse, nurse manager, and nurse practitioner student. Staff nurse colleagues have been observed expressing frustration and disappointment in actions taken by nurse executives which are perceived as done without regard for the welfare of “nursing.” As a nurse manager, the author learned to approach problems from a different perspective, one that encompassed executive responsibility which required a wider focus than for “clinical nursing” alone. This broader focus led to an “expanded and enlightened” understanding in addition to increased respect for nurse executives.

As a future nurse practitioner, a personal objective of this author included fostering positive relationships with staff nurses and nurse executives who will be crucial to the nurse practitioner’s ability to successfully and comprehensively care for patients in the hospital setting. Many questions will be raised as roles of nurse practitioners are discovered, defined, and redefined. One of the issues will be the relationships between other nurses and the nurse practitioner. Family nurse practitioners who practice in the hospital setting may be considered by staff nurses to be nurse executives because the duties they perform are unfamiliar to traditional clinical nursing specialties. Some nurse practitioners (NP) have expressed concern that nurse administrators do not always understand the practice or issues faced by NPs. Nurse executives may consider nurse practitioners an entirely different specialty of patient care provider, neither staff nurse
nor nurse executive. Another question will be whether the nurse practitioner will function within the framework of nursing or medical administration. There is concern that NPs who report to a medical administration may be seen largely as physician substitutes and be expected to enact a purely medical model role. In some organizations master’s prepared NPs may be more highly educated than the nurse administrator or may even become the nurse administrator of small primary care sites. Addressing these issues will be critically important to the use of nurse practitioners in the most effective and efficient way (Courtney, 1996).

**Purpose**

The purpose of this project was to provide a C.E. program for staff nurses and nurse executives. The objectives of the C.E. program were to foster improved staff nurses’ understanding of the roles of nurse executives, to identify barriers to communication between nurse executives and staff nurses, and to provide recommendations for improving communications and understanding.

The C.E. program included : (a) a theoretical framework for goal attainment, (b) overview of the role of executive nurse (c) overview of barriers to communication between staff nurses and nurse executives based on a review of the literature, (d) review of current communication techniques and strategies. Figure 1 on page 4 contains an overview of the professional project’s purpose, objectives, phases, and expected outcomes.
Figure 1. Overview of Professional Project.

**Professional Project**
A Continuing Education Program for Staff and Executive Nurses

**Objectives of C.E. Program**
* To Increase Staff Nurses’ Understanding of the Roles of the Nurse Executive
* To Identify Barriers to Communication between Nurse Executives, Staff Nurses
* To Provide Recommendations for Improving Communication, Understanding

**Phases of Project**
* Phase 1 - Literature Review
* Phase 2 - Preparation of C.E. Program and Handout Design
* Phase 3 - Application for C.E. Credit
* Phase 4 - Environmental Arrangements and Audio-Visual Aids
* Phase 5 - Delivery of Pilot C.E. Program
* Phase 6 - C.E. Program Data and Evaluation

**Expected Outcome of C.E. program**
* Improved Understanding of the Roles of the Nurse Executive
* Identified Barriers to Communication
* Commitment from Participating Nurse Executives and Staff Nurses to Work on Communication and Understanding
Conceptual Framework

An adaptation of Imogene King’s Theory of Goal Attainment was chosen as the conceptual framework for this project. Although King’s theory was originally written to guide clinical practice, the adaptation made by the author of this project substituted nurse executive and staff nurse for nurse and client in the framework of the theory. The goal of this project was to improve understanding and communication between nurse executives and staff nurses. This adaptation of King’s Theory of Goal Attainment is an appropriate tool toward that goal.

Imogene King was influenced by general systems theory to develop a conceptual framework with three distinct levels of function which she described as “dynamic interacting systems” (Marriner-Tomey, 1994, p. 306). These levels of function represented individuals, groups, and society as dependent on several interrelated concepts which included interaction, perception, and communication “between person and environment and between person and person, represented by verbal and nonverbal behaviors that are goal directed” (King, 1981, p. 145). In this paper, individuals can be viewed as the individual executive or staff nurse, the groups as administrative team or the nursing staff team and society as the organization in which they all are employed. Figure 2 on page 6 contains an overview of the adaptation of King’s Theory.

Nurse executives and staff nurses develop a perception about an issue, situation, environment, or even about one another based on communication. That perception, in turn, generates more communication. That communication influences the transaction which follows. The outcome of a transaction is an altered perception which leads to exploration of the means, or looking at options and alternatives to previously developed perceptions. When the nurse executive and staff nurse agree on the means, they can engage in mutual goal setting.
Nurse executives and staff nurses must “interact, devise mutually agreed-on goals, explore means to achieve goals, transact, and attain goals” (Marriner-Tomey, 1994, p. 315). King identified seven hypotheses of the Goal Attainment Theory which have been adapted for nurse executive-staff nurse relationships:

1. Perceptual congruence in nurse executive-staff nurse interactions increases mutual goal setting.
2. Communication increases mutual goal setting between nurse executives and staff nurses and leads to satisfaction.
3. Satisfactions in nurse executives and staff nurses increase goal attainment.
5. Goal attainment increases... learning and coping ability in nursing situations.
6. Role conflict experienced by nurse executives, staff nurses or both decreases transactions in nurse executive-staff nurse interactions.

Executive nurses and staff nurses working together in organizations need to be able to work well together and to have successful transactions in order to reach the...
mutual goals of organizational and personal achievement, job satisfaction, and quality patient care (Huber, 1996; Marriner-Tomey, 1994; Chinn & Kramer, 1995). Successful transaction which leads to goal attainment is reliant on clear, accurate perceptions and open, clear, constructive communication.

Definitions

A definition section is included to provide the reader with operational definitions of terminology used in this professional paper:

**Burnout.** A state of occupational stress which is described as a variable scale syndrome of emotional exhaustion, depersonalization, and lack of personal accomplishment resulting from constant or repeated emotional pressure associated with an intense involvement with people over long periods of time (Lee, 1996, p. 22). A state of psychological strain often characterized by changes in behavior towards clients or others and changes in quality and involvement in work (Firth & Britton, 1989).

**C.E.** Continuing Education, used with reference to programs of ongoing learning.

**Communication.** The “transfer of understanding from one person to another.” Patterns of transmission including assertive, passive, aggressive, and lateral communications. (Grohar-Murray & DiCroce, 1997, p. 46). Direct or indirect transmission (King, 1981).

**Depersonalization.** “State of unfeeling, impersonal response toward recipients of one’s care or service” (Lee, 1996, p. 22).

**Empowerment.** “Refers to either psychological empowerment, focusing largely on the individual’s self-efficacy, or organizational empowerment, focusing on shared power in the organizational structure and decision-making processes” (Morrison, Jones & Fuller, 1997, p. 28). The sharing of influence and power rather than power derived from dominance over another (Sabiston & Laschinger, 1995).
Job Satisfaction. “Refers to nurses’ perceptions of their job based on professional fulfillment” (Leveck & Jones, 1996, p. 336). “A global construct, including such aspects as satisfaction with work, supervision, conditions, pay, opportunities, and practices of the organization” (McNeese-Smith, 1997, p. 47).

Leadership. A fundamental, creative, and interactive process which utilizes personal skills including communication to influence people for the purpose of accomplishing goals. A process which does not necessarily require a formal managerial position (Grohar-Murray & DiCroce, 1997).

Management. The selection of “actions that use resources effectively and efficiently”. Moving an organization toward achievement of its goals. Requires a formal position in an organization (Grohar-Murray & DiCroce, 1997, p. 17).

Marginalization. State of existence in which “an individual lives in two worlds simultaneously, one of which, by prevailing standards, is regarded as superior” (Biordi, 1986, p. 173). Can apply to role of executives as existing between an administrative and business versus clinical nursing world.

MNA. Montana Nurses’ Association.


Productivity. “Defined as the contribution toward an organizational end result in relation to resources consumed, productivity measures both quantitative and qualitative factors such as goal attainment and work accomplished” (McNeese-Smith, 1997, p. 48).

Organizational commitment. A measure of an individual’s identification with and involvement in a particular organization, a measure of staying intention (McNeese-Smith, 1997).

Conflict. Not enough time for completing work; incongruity of expectations and incompatible requests from several persons; working with several groups who have their
own organizational or personal goals, norms and values (Scalzi, 1988, p. 35 and 1990, p. 86).

Self-efficacy. Relates to the general sense of competence and effectiveness but is not related to age, part-time employment or work-group membership (VanYperen, 1998).

Transactions. “Purposeful interactions that lead to goal attainment” (King, 1981, p. 1).
CHAPTER 2

LITERATURE REVIEW

The purpose of this project was to develop a C.E. program for staff nurses and executive nurses. The objectives of the C.E. program were to provide an opportunity to foster improved staff nurses’ understanding of the roles of nurse executives, identify communication barriers, and provide recommendations for improving communications and understanding. This chapter contains a review of the literature on the role of nurse executive and the effect of the role on staff nurses. Finally, a summary of communication barriers between staff nurses and nurse executives and a review of communication techniques and strategies for improved communication and understanding is presented.

Understanding the Role of the Nurse Executive

Educational Background of the Nurse Executive

The American Association of Colleges of Nursing and the American Organization of Nurse Executives recommend graduate preparation of nurses for executive roles. This recommendation includes a master’s degree core curriculum which “grounds the nurse administrator in research; policy, organization, and financing of health care; ethics; professional role development; theoretical foundations of nursing practice; human diversity and social issues; and health promotion and disease prevention” (Adams, 1994, p. 127).

Nurse executives are expected to learn skills in graduate school which will enable them to assume roles of organizational management and leadership within the executive “team.” Adams (1994) further states that this preparation should include “educational experiences in business, psychology, economics, sociology, and/or health service
administration” (p. 127). Attainment of certain core abilities through completion of programs in collegiate schools of nursing prepares the nurse executive for the role.

The successful nurse executive, however, should be more than an academically educated person. The nurse executive ideally is a “unique combination of values, knowledge, skills, and attitudes . . . resulting from generic and continuing education and administrative, managerial, and clinical experiences. . .” (Beyers, 1997, p. 29).

Role and Performance Requirements of Nurse Executives

Although individuals vary in administrative style, personal attributes, and professional attitudes, there are core abilities which should be included in the nurse executive’s role. These abilities are listed in Table 1.

Table 1. Nurse Executive Core Abilities.

- develop a vision for nursing practice
- employ management skills that encourage collaborative working relationships
- select and use advanced analytical, problem-solving skills
- use communication skills to build corporate, constituent, community relationships
- develop ability to communicate effectively to all educational levels and cultures
- guide shared decisions that value effectiveness and parsimony in use of resources
- support advances in information and communication technology
- assume risk-taking behavior to enhance quality health care
- advocate for consumers and community partners
- model creativity in defining and solving problems
- foster and implement team-building strategies within nursing and across health care disciplines
- embrace change and manage it effectively
- negotiate and resolve conflict
- effectively market nursing practice
- demonstrate effective public speaking
- establish relationships with community around the issue of health

(Adapted from Adams, 1994; Beyers, 1997).
The role of nurse executive is both a public and a political role. This is one of the most obvious differences between the nurse executive and staff nurse. In the hospital setting, the work of a staff nurse primarily involves the patient, the physician, and other staff members. As a part of his or her role, the nurse executive has a much larger circle of interactions both within and outside the organization including administrators from his or her organization, other interacting organizations, physicians, all personnel including nurses, patients, families, and community and professional organizations. (Biordi, 1986). Biordi (1986) states that nurse executives use and indeed need this visibility to gain tools that empower them to do their work. These tools include informal information, opportunity, and power.

Beyers (1997) states that the two “key” role relationships of the nurse executive are those with other administrators and those with the nursing staff. One of the most important functions of the role of nurse executives is representation of nursing at the corporate level. Nurse executives provide the link between staff nurses, nurse leaders, and the corporate leadership staff. The nurse executive works within the professional nursing team to communicate clearly and to implement the nursing service organizations’ philosophy, professional expectations, and standards of care (Bromley, 1997). Nurse executives have historically been in a position to defend the nursing team when criticized by administration or physicians (McNeese-Smith, 1997). The role of nursing is “not as clear cut as it used to be” (Huber, 1996, p. 424) and staff nurses rely on nurse executives to protect their changing, evolving practice. One of the new challenges presented to nurse executives is to safeguard the employment of hospital based nurses in this era of health care reform. Developing and conceptualizing new methods to accomplish this often falls to the nurse executive. McCloskey (1994), for example, proposed “hospital-based nursing centers which would be managed and controlled by nurses who give care, make referrals, and decide on admission and discharge” (p. 67).
A new dimension of the role of executive nurse addresses the realities of combining high-quality patient care with cost-effectiveness. The responsibility for providing staff nurses and middle managers with the information to adjust to these realities and guiding positive responses to the implications lies with the nurse executive (Weaver & Rimar, 1996). Supporting “clinical inquiry” by staff nurses is fundamental to the changes necessary for survival in times of rapid and cost-driven changes. Brock, (1996) states that the business focus of health care delivery has an impact on everyone in an organization, including the bedside nurse. A positive working relationship between staff nurses and nurse executives promotes an environment in which the staff nurse is encouraged to contribute through identification of problems and solutions, cost containment measures, and improvements in practice or technique which contribute to improved patient care. Collaboration of nurse executives and staff nurses, as well as maintaining positive coalitions between employees and departments at all levels is critical in meeting these objectives (Beyers, 1997; Byers, 1997).

Continuous changes in healthcare have resulted in a variety of different organizational structures. Nurse executives provide critical nurse-based input to these corporate-level activities such as quality improvement programs, strategic planning, finance, risk management, human resources, and analyzing epidemiologic and marketing data (Beyers, 1996; Huber, 1996).

The Effects of Nurse Executive Support on Staff Nurses

McNeeSE-Smith (1997) stated that outstanding behaviors of leadership which contribute to increased job satisfaction, increased productivity, and increased organizational commitment of employees include “(1) challenging the process—risk taking, being innovative and change-oriented; (2) inspiring a shared vision—involving others in ideas, interests, and a vision of the possible; (3) enabling others to act
--empowering and building teamwork and trust; (4) *modeling the way*—being role models, setting examples of high standards, and breaking down large tasks into small attainable wins; and (5) *encouraging the heart*—being supportive, caring, and encouraging while recognizing and celebrating accomplishments" (p. 18).

Management style has been described as the most powerful indirect influence on job satisfaction, job stress, quality of nursing care, and organizational satisfaction. Numerous studies identify the benefits to the staff nurse of working in a collaborative relationship with nurse executives. The many benefits include: improved job satisfaction, improved physical health, decreased stress resulting in improved mental health, improvement of delivery of patient care, and increased participation in molding the changes in healthcare which affect work environment. (Tonges, Rothstein, & Carter, 1998; Decker, 1997; Blegen, 1993; Taunton, Boyle, Woods, Hansen, & Bott, 1997)

Droppleman & Thomas (1996) studied anger in nurses and concluded that it is a result of “good reasons.” These reasons include lack of support from nurse executives about concerns of heavy workloads, long hours, sexism, sexual harassment, and disrespect from administration, physicians, coworkers, subordinates, and even from patients. Difficult working conditions can result in internal conflict among nurses which can be manifested as passive aggressive behaviors including fault-finding, name-calling, back-biting, and subtle sabotage of their colleagues and/or superiors. Other methods of coping are even more personally damaging such as inappropriate use of alcohol, tobacco or food, depression, or somatization of negative feelings.

Exclusion of staff nurses from critical decisions which directly affect their work environment have added to the sense of powerlessness that contributes to the negative behaviors discussed above. VanYperen (1998) stated that nurses who have weak self-efficacy beliefs are most negatively affected by lack of informational support from organizational superiors. These nurses suffer higher rates of burnout.
Personal attributes of staff nurses contribute to the influence nurse executives have on them. Collins (1996) conducted a study which found less stress and burnout in individuals who exhibited characteristics of hardiness. She quoted Kobasa (1979) in describing hardiness "as a constellation of attitudes, beliefs, and behavioral tendencies that consist of three components: commitment, control, and challenge. Commitment is the tendency to involve oneself in the experience, rather than alienating oneself from the problem. Control is the ability to feel and act as if one is influential rather than helpless. Challenge is the belief that change is normal and provides incentive for growth rather than a threat to security" (Kobasa, 1979, p. 82). Robinson, Roth, Keim, Levenson, Flentje and Bashor (1991), studied factors which might predict burnout. Variables of age, different factors of employment, such as years in nursing, time in the area of specialty, shift and number of hours worked, and years in that organization were included in their investigation. They concluded that perceptions of support from nurse executives and work pressure were the major predictors of nurse burnout.

Studies have shown that organizational commitment is strongly influenced by feelings of appreciation or support from executive nurses (McNeese-Smith, 1997; Pearson, & Chong, 1997; Droppleman & Thomas, 1996; Simoni & Paterson, 1997). Consideration of staff nurses by executive nurses (evidenced by a demonstration of personal and professional concern, support for professional career development, and valuing their opinions) has a direct impact on retention. In addition, leadership behaviors of nurse executives also influence staff retention indirectly through the executives’ work ethics that represent consistency, competent decision making, communication of essential information, and positive relationships with co-workers (Taunton, Boyle, Woods, Hansen, & Bott, 1997). One positive outcome of increased organizational commitment is decreased staff turnover. Decreased turnover has been related to increased patient satisfaction which, in turn, is associated with increased care regime
compliance (Tonges, Rothstein, & Carter, 1998). Feelings of depersonalization among staff nurses have been positively associated with increased turnover rates (Firth & Britton, 1989).

Firth and Britton (1989) found that absenteeism is positively correlated with increased burnout. Their study indicated a relationship between perceived lack of support with short absences and emotional exhaustion with longer absences. In the same study, staff absence was also positively correlated with perceived impatience or defensiveness on the part of the immediate supervisory nurse executive. Negative feelings were expressed by staff nurses when nurse executives criticized in times of crisis, did not follow through on problems, showed no recognition or support, and were not approachable (poor communication). Other studies reinforce these findings that productivity and retention are positively affected by nurse executives who provide recognition and thanks and who create a positive work climate (McNeese-Smith, 1997; Leveck & Jones, 1996; Blegen, 1993; Taunton, Boyle, Woods, Hansen, & Bott, 1997).

Nurse executives may influence staff nurse job satisfaction positively by guiding staff nurses to learn leadership skills and by providing opportunities that empower. Rapid, frequent, and sometimes unwelcome change promote staff nurse concerns and questions. They may regard changes in organizational attitudes and the work environment as potential threats to existing role values, professional and educational growth, and promotional opportunities (Martin & Shell, 1988, p. 259). Numerous studies have found that empowerment of nurses resulted in improved patient and organizational outcomes, such as, improved staff and nurse executive performance, customer satisfaction, organizational commitment, satisfaction with nurse executives, satisfaction with work as well as innovative behavior, improved capacity to change, and increased independence (Morrison, Jones & Fuller, 1997; Grohar-Murray & DiCroce, 1997; Leveck & Jones, 1996; Sabiston & Laschinger, 1995; Martin & Shell, 1988; Lucas, 1991;
Kramer and Hafner (1989) hypothesized that increased staff nurse job satisfaction and production of quality nursing care could result from increased frequency of interaction with nurse executives in their environment. This hypothesis was credited to increased congruence in work values and shared institutional value systems. Numerous variables affecting job satisfaction were commonly identified by staff nurses in this study, i.e., adequate staffing, competent coworkers, primary care nursing, having to float, working on a highly specialized unit, and control or input into flexible work schedules. Two criteria identified as most important to job satisfaction were supportive executive nursing staff and organizationally (nurse executive) generated public acknowledgement of contributions made to patient care. Giving recognition and thanks for hard work in busy times or jobs well done were found to be simple steps that nurse executives could recognize as core to staff nurse job satisfaction.

Effects of the Role on Nurse Executives

Frequent turnover of nurse executives may result in decreases in organizational development and stability, unstable nursing departments, and decreased quality of services (Lee & Henderson, 1996). Many research studies have been done to identify the factors responsible for the job satisfaction of staff nurses, however, little research has been published that assesses the job pressures, challenges, and difficulties which influence job satisfaction among nurse executives. (Lee & Henderson, 1996; Scalzi, 1988, 1990). Lee & Henderson (1996) state, “nurse administrators are subject to the same intra- and interpersonal experiences of distress and burnout that result in staff nurse turnover” (p. 21). Nurse executives primarily identify frustrations with constant change, ambiguity, and loss of control in their jobs (McNeese-Smith, 1995).
An additional cause of decreased job satisfaction among nurse executives in rural areas is the lack of frequent contact with peers (identified as other nurse executives), the lack of support from other non-nurse administrators, and from the staff nurses who may not understand the role of nurse executive. Shreffler (1988) conducted a study of nurse executives which confirmed the isolation and loneliness of nurse executives in small, rural Montana hospitals. Nurse executives do not always feel that their staff nurse constituents are appropriate persons with whom to share their burden of responsibility (Grohar-Murray & DiCroce, 1997). Barriers to sharing include fear of loss of control, a perceived threat to authority and position, and not knowing if the staff is “mature enough, smart enough, or motivated enough” to deal with issues that affect organizational and clinical nursing concerns (Grohar-Murray & DiCroce, 1997, p. 221).

Top level nursing executives tend to be oriented to broad policy issues and cost containment. In larger institutions supervision of the day-to-day operations and clinical nursing practice are delegated to other nurses. This shift has changed the nurse executives’ alliances within the hospital setting from other nurses to other hospital administrators (Biordi, 1986), a shift which further isolates nurse executives from their nursing constituency. In smaller institutions nurse executives may “pinch-hit” wherever they are needed, even for patient care. They are still considered by staff nurses as “different,” promoting their isolation in a different but equally painful way. Participative management may buffer isolation for nurse executives when it is characterized by confidence and trust, communication up, down, and laterally, decision making at all levels, and control which is shared by nurse executives and staff nurses. One benefit of well informed staff who are included in group decisions is support for changes in nursing. This may make the roles of nurse executives less isolated, less stressful, and more personally and professionally satisfying (Lucas, 1991).
Barriers to Communication

"Leaders and managers always communicate two things to others whether they want to or not: they always communicate their attitude and their goals and expectations. Trust or distrust is communicated" (Huber, 1996, p. 349). Lack of a respectful attitude by nurse executives or staff nurses for the rights of one another leads to blocked communications, working relationships, and professional and personal job satisfaction. Recognition of basic rights, identified in Table 2, by staff nurses and nurse executives could improve communication, improve working relationships and job satisfaction.

Table 2. The Nurses’ Bill of Rights.

- The right to be treated with respect
- The right to be listened to
- The right to have and to express thoughts, feelings, and opinions
- The right to ask questions and to challenge
- The right to understand job expectations as well as have them written
- The right to say no and not feel guilty
- The right to be treated as an equal member of the health team
- The right to ask for change in the system
- The right to have a reasonable workload
- The right to make a mistake
- The right to made decisions regarding health and nursing care
- The right to initiate health teaching
- The right to be a patient advocate or to help a patient speak for himself or herself
- The right to change one’s mind


Staff nurses’ access to nurse executives has become more difficult with the trend toward assignment of responsibility for multiple units to one manager (Tonges, Rothstein, & Carter, 1998). Other barriers to successful communication by staff nurses and nurse executives are actions that distract, cut off communication, insert unhelpful
advice, remove the other person’s decision making power, or negate the importance of the other person or his or her message (Huber, 1996).

The most common blocks to communication include poor listening habits, distraction, misused or misunderstood semantics or context, and stressful situations or environments (Grohar-Murray & DiCroce, 1997). Studies have shown that specific behaviors of aggression, rejecting, stereotyping, making racial or sexual statements, belittling, or offering insincere agreement or reassurance hinder communication (Grant, 1994). In addition, conflict is a natural response to change and the insecurity which change can provoke. Table 3 on page 21 identifies some commonly employed methods of dealing with conflict that may negatively affect communication.

Anger is a common response to having a goal denied or blocked. It may be accompanied by physical symptoms such as: tension, diaphoresis, constipation or diarrhea, nausea, increased blood pressure, heart rate, and respiratory rate. Reactions to anger include open or passive aggression, manipulation, frustration, and open or thinly veiled disrespect. O’Sullivan-Mott (1996) states that people who are aggressive, hostile, and intimidating do so in response to their own anger. She advises that understanding the dynamics of anger can strengthen one’s ability to interact positively with aggressive people. O’Sullivan-Mott states that it helps to understand that frustration precipitates insecurity and angry disappointment, aggression indicates a lack of respect for the rights of others, and passive-aggressive behavior results from lack of self efficacy which contributes to unresolved anger. Dealing with nurse executives or staff nurses who exhibit these negative, angry, behaviors requires superior communication skills and empathy (Huber, 1996).
Table 3. Negative Methods or Strategies for Conflict Resolution.

- **Avoiding.** The strategy of avoiding conflict at all costs. Some people never acknowledge that a conflict exists. Sometimes reflected in the phrase, “leave well enough alone”. Occasionally these problems resolve if left alone, usually they resurface later. Can be a situation in which a very complex situation needs time or time is needed for the “wheels of bureaucracy to turn”.

- **Withholding or Withdrawing.** In this avoidance strategy, one party opts out of participation. This does not resolve the conflict. However, this strategy does allow time for individuals to calm down or to avoid a confrontation.

- **Smoothing Over or Reassuring.** This is the strategy of saying that “everything will be OK.” By maintaining surface harmony, parties do not withdraw but simply attempt to make everyone feel good. It is like smoothing ruffled feathers. Smoothing over or reassuring strategies use verbal communication to defuse strong emotions.

- **Accommodating.** This strategy is used when there is a large power differential. The more powerful party is accommodated to preserve harmony or build up social credits. What this means is that the party of less power give up their position in deference to the more powerful party. Accommodation may be used when one party has a vested interest that is relatively unimportant to the other party. Kill the enemy with kindness is the operative phrase.

- **Forcing.** This technique is a dominance move and an arbitrary way to manage conflict. An issue may be forced on the table by issuing orders or by putting it to a majority-rules vote. Let’s vote on it is an all-out power strategy to win while the other party loses.

- **Competing.** This is an assertive strategy where one party’s needs are satisfied at the other’s expense. Competing is an all-out effort to win at any cost.

(Huber, 1996).

**Techniques and Strategies for Improved Communication and Understanding**

Huber (1996) states that “communication is the art of being able to structure and transmit a message in a way that another can easily understand and/or accept” (p. 335).
She credits effective communication with improved working and interpersonal relationships. Steps to successful communication include the use of simplicity, clarity, good timing, relevance, adaptation to circumstances, and credibility. Even negative criticism can be made positive communication when the steps include asking for more or better information, agreeing with a person’s right to ownership of concern, and listening to those critical concerns (Deering, 1993; Huber, 1996).

Martin and Shell (1988) state that communication is “the major determinant of the supervisory-subordinate relationship...” (p. 149). They advise that communication is an important influence on both motivational level of employees and the understanding that employees have of organizational purpose and goals. Peterson, Halsey, Albrecht and McGough (1995) studied perception of support and how it affects trust between staff nurses and nurse managers. They found that levels of trust and certainty were strongest between staff nurses and nurse executives who both gave and received support. In addition, staff nurses who felt supported by nurse executives were more likely to become involved in issues involving improved patient care and unit management. Peterson, et al. (1995) conducted a study to evaluate the most effective communication strategies. They identified three general styles of messages called design logics: expressive messages, conventional messages, and rhetorical messages. Expressive design logics (which could also be called opinionated) are the most ineffective, simple, and straightforward; they state what is on the sender’s mind without regard for the situation. Conventional messages view communication as interaction which follows the rules, those that are imbedded in tradition. Rhetorical messages are the most effective of the three styles. These messages strive for interpersonal harmony and consensus which usually means negotiating, reframing, or altering the situation. They invite input of all involved in the outcome. Rhetorical communicators are able to reconstruct messages sent by expressive or conventional message senders. Being direct and truthful is still a part of the message
sent by rhetorical design. Most important with rhetorical communication is the concept of sending a message which decreases stress and anxiety and promotes self-worth for the recipient of the message. Some factors of structuring a message include choosing appropriate dress, verbal or nonverbal behavior, written or oral communication, and personal delivery versus memo or written note (Grant, 1994). Table 4 contains helpful guidelines for successfully communicating ideas.

Table 4. Basics for Good Communication.

- Clarify your ideas before communicating to others
- Consider the physical setting
- Consider the psychological environment. Also referred to as the communication climate which can be positive, open and supportive or negative, defensive and hostile
- Be mindful of the tone, as well as the words of the message. Emotional levels of messages can convey angry, friendly, and/or dictatorial tones
- Take the opportunity to convey something of help, value, or praise to the receiver
- Follow up your communication. Be sure what you have said is accurately understood
- Nonverbal behavior should support communication. Be conscious of facial expressions and body posture. Be an active listener
- Be assertive, not aggressive or passive, when expressing your views or making statements

(Grohar-Murray & DiCroce, 1997; Martin & Shell, 1988).

“Conflict management techniques stress the importance of communication, assertive dialogue, and coming from a point of empathy” (Huber, 1996, p. 420). Using positive communication techniques can help move individuals toward resolution of
conflict and anger. The following table reviews techniques which enhance conflict resolution and improving communication.

Table 5. Positive Strategies for Resolving Conflict and Improving Communication.

- **Compromising.** Splitting the difference. Division of rewards, power, or benefits so everyone gets something. Useful when goals or values are markedly different. Requires back and forth effort in a formal or informal process.

- **Confronting.** Assertive problem solving that is focused on the issues. Individuals speak for themselves, but in a way that decreases defensiveness and allows another person to hear the message. It is a staple of conflict management but requires courage. “I” messages are used and “you” messages are avoided.

- **Collaborating.** This is assertive and cooperative strategy where the parties work together to find a mutually acceptable solution. Designed to generate feelings of gain by all parties.

(O'Sullivan-Mott, 1996).

O’Sullivan-Mott (1996) states “the reason many of us have difficulty communicating with our administrators...is that we aren’t speaking the same language” (p. 130). She recommends use of a familiar model, the nursing process; assess, plan, implement, and evaluate. She suggests modification to discuss issues in a business model; observation, proposal, implementation, evaluation:

1. state the observation (always put the patient first)
2. do your research (a lit review to support the observation)
3. identify the problem (including hypothesized reason for the problem)
4. suggest a well-planned solution (have an alternate suggestion)
5. state the expected outcome and a method for evaluation

“Probably the most important concept in communicating with others is listening” (O’Sullivan-Mott, 1996, p.119). Factors that affect the willingness and ability to listen
are time restraints, age, sex, education, physiological conditions, social and economic background, and status. Even when staff nurses are in autonomous, self-governing roles, they must trust in top managements’ willingness to listen, responsiveness to, and respect for role and value differences (Kramer & Hafner, 1989). Table 6 includes guidelines which can improve active listening skills for nurse executives and staff nurses.

Table 6. Active Listening Skills.

- Stop talking-stop what you are doing, eliminate distraction
- Put the other person at ease-try to be relaxed yourself, be nonthreatening
- Don’t interrupt-especially important if the other person is upset
- Empathize-state your effort to understand
- Paraphrase-summarize and restate to satisfaction
- Ask open-ended questions-allows more clarification and points of view
- Use silence-may be necessary to insist that the other person respond
- Allow reflection-act as a sounding board

(Grohar-Murray & DiCroce, 1997).

Summary of Literature Review

Communication affects our ability to survive in current times of rapid change. It is important to remember that the amount and the importance of information which needs to be shared is greater than ever before. The changes which are occurring in healthcare may be global, but the impact on individuals is still a very personal issue. Current working relationships between nurse executives and staff nurses need to be continually evaluated and subject to change (Keeling and Linnen, 1997). Changes in existing work patterns, values, and beliefs which require a desire to change are facilitated by improved
understanding and communication. Understanding barriers common to communication and understanding, and learning effective methods to overcome those barriers will guide nurse executives and staff nurses to mutual goal setting.
CHAPTER 3

METHODOLOGY

The purpose of this professional project was to provide a C.E. program with the following objectives: to foster improved staff nurses’ understanding of the role of the nurse executive, to identify barriers to communication, and to provide recommendations for improving communication and understanding between nurse executives and staff nurses.

A presentation was chosen as a vehicle to deliver face-to-face information to a group consisting of staff and executive nurses. This format allowed for two-way dialog including discussion of the use of nursing theory to stimulate efforts toward mutual goal setting between executive and staff nurses. Communication barriers and current strategies and techniques for improving communication were reviewed and discussed. The plan included demonstration of participants’ new knowledge through application to anecdotal stories and personal experiences.

This chapter describes the steps taken to meet the objectives of this project. Completion of this project was accomplished in six phases:

- **Phase I** included a literature review;
- **Phase II** included preparation of a C.E. program and handout design;
- **Phase III** required application for C.E. credits;
- **Phase IV** included environmental arrangements and audio-visual aids;
- **Phase V** included delivery of a pilot C.E. program;
- **Phase VI** included C.E. program results and evaluation.
Phase I - Literature Review

Phase I included a literature review pertinent to (a) nurse executive roles, (b) effects of nurse executives on staff nurse job satisfaction, (c) barriers to communication between staff nurses and nurse executives, and (d) strategies and techniques for improved communication and understanding. The literature search began with an intent to discover how staff nurses and nurse executives could improve their professional relationships. This author was seeking information to help understand the physical and psychological influences which negative and positive relationships exert on both staff nurses and executive nurses. Factors influencing job satisfaction among nurses are a well addressed phenomenon. Through the process of review, factors contributing to job satisfaction and dissatisfaction among nurses were identified. Communication was identified as a major factor. A review of communication barriers and methods for improvement led to the remainder of the literature upon which this professional project was based.

The literature review was conducted at Montana State University-Bozeman, MT, Missoula Campus (Mansfield Library and College of Nursing), Montana State University-Bozeman, MT (Renne Library), University of Washington-Seattle, WA (Health Sciences Library), Kalispell Regional Medical Center Library, Kalispell, MT, St. Patrick Hospital Health Library-Missoula, MT, and through several medical and nursing websites on the Internet.

Phase II - C.E. Program and Handout Design

The C.E. program was prepared as a slide presentation with the use of computerized software and displayed using a projection screen. Subheadings which addressed the major topics of this professional paper were presented in outline format.
Those topics included an overview of the role of nurse executives, the rights of all nurses, the effects of relationships between staff nurses and nurse executives, barriers to communication, and strategies and tools for improving communication. Specific details of the slide presentation and content are discussed under Phases IV and V. The handouts were prepared using the same outline format with expanded textual detail. The author’s personal knowledge of the audience provided motivation to include the use of humor in the slide presentation and handouts.

**Phase III - Application for Continuing Education Credit**

The Montana Nurses’ Association (MNA) was contacted three weeks prior to the scheduled program presentation for an application to obtain Continuing Education Credit for this program. The MNA required receipt of a completed application forty-five days prior to delivery of a C.E. program. To assure credit for the participants, the author coordinated approval of the program through the hospital where the pilot was presented. The hospital is an MNA approved provider for continuing education in nursing. Arrangements were made to approve the C.E. program for 1.0 contact hours. An offering number was assigned by the provider. The provider agreed to keep attendance records for the pilot program and future presentations on file for the required length of time. No application review fee was required. All criteria required of the approved continuing education provider were completed and are included in Appendix A on page 54.

**Phase IV - Environmental Arrangements and Audio-Visual Aids**

The setting was a large, comfortable, conference room near the nursing department to facilitate attendance by all possible staff. Seating was arranged in a semicircular fashion so that all participants could view the projection screen. Attention
was paid to the room temperature, to avoid an environment perceived as too warm or too cool.

The C.E. program was projected via computerized software. The computer was provided by the presenter. Arrangements for the screen were made with the hospital prior to the presentation date. The C.E. program was previewed prior to the scheduled delivery time to assure compatibility of the computer and projector.

A pocket folder with handouts (Appendix D on page 66) was prepared for each program participant. Participants were encouraged to take the handout packet home for use as a resource guide. The packet included a cover page with the title of the C.E. program, and the name of the presenter and the College of Nursing, Montana State University, Bozeman. Continuing Education Credit information was provided. All pages of the handout were prepared in outline form. Included in the outline was a brief pretest, a description of the participant learning objectives, an overview of the role of nurse executives, a copy of the Nurses Rights, and a diagram of the adaptation of Goal Attainment Theory. Lists of effects of negative relationships between staff nurses and executive nurses, barriers to communication, and strategies for improving communication were also included. An opening participative exercise was included. A review of the content presented, a posttest, and a participant evaluation form were added. Lastly, a reference list was placed in the handouts to support the content presented and provide sources for additional information to the participants.
Phase V - Pilot C.E. Program

The pilot was planned at the time of a regularly scheduled departmental staff meeting in a rural Montana hospital. A facility familiar to the author of this professional project was chosen for the pilot because of convenience for the author and knowledge of staff interest in the topic. The C.E. program was arranged for delivery on February 17, 1999 from 6:10 p.m. to 7:00 p.m. A fifty minute C.E. program was chosen to facilitate inclusion in the staff meeting. The motivation for presentation at a staff meeting was to maximize interest from the hospital through cost efficiency and to maximize staff nurse attendance. The C.E. program was scheduled with the nurse executive of the department three weeks prior to the delivery date. Notification of the C.E. program (Appendix B on page 58) was posted in the department on the staff communication board two weeks prior to the scheduled presentation date. Replacement staff were prearranged for all on-duty staff RNs to facilitate attendance. Attendance was encouraged by the departmental nurse executive but not mandatory. There were 10 of the 12 departmental staff RNs and the nurse executive present for the C.E. program.

Principles of adult learning were utilized in preparation of the C.E. program. Straka (1996) states that the audience must be assessed. This C.E. program was delivered to an audience of registered nurses known to the author of this professional project. Their experience in nursing ranged from three to twenty years. They had all encountered negative experiences in communications between staff nurses and executive nurses. These experiences had stimulated an interest in improving those relationships. No member of the group could be accurately described as an expert in communication.

The computerized slide presentation and the printed handouts were designed using the following format:
Why are we here?

An introductory participative exercise was utilized to identify why nurses were attending the C.E. program. The author opened the exercise with a self introduction and a brief explanation of a professional project. The author outlined motivation for the topic of this C.E. program by relating observations made as a staff nurse, nurse executive, and in her developing role as nurse practitioner. The participants were then asked to identify what they “wanted to get” from the C.E. program. With the permission of the participants, these items were written on the chalkboard.

Why do we care?

Effects of negative relationships between staff nurses and nurse executives were outlined, i.e., alterations in physical health, mental health, anger, decreased job satisfaction, internal conflict in the workplace, and increased organizational conflict. Each topic was expanded based on the review of the literature.

What is a nurse executive?

A definition of nurse executive was given. The definition utilized for the purpose of this professional paper and for the C.E. program included first-line managers, middle managers, and administrative nurses. Varying backgrounds of nurse executives found in rural states such as Montana were explained. An extensive list of the core abilities (obligations and expectations) of nurse executives was presented.

Using nursing theory.

The function and ability of the adaptation of the Theory of Goal Attainment to guide staff nurses and executive nurses to mutual goal setting was explained. The author felt it important that the C.E. program include the use of nursing theory. Although all
participants were registered nurses, their educational backgrounds varied, therefore familiarity with nursing theory could not be assumed.

**Barriers to communications between staff nurses and executive nurses.**

Barriers were divided into three components; most common blocks to communication, negative methods and strategies for conflict resolution, and the failure to recognize the Nurses' Bill of Rights. Each component was presented as important for both staff nurses and nurse executives. Examples were offered for emphasis.

**Strategies and techniques for improving communications.**

Two components were presented; basics for good communication, and positive strategies and techniques for resolving conflict and improving communication. Again, all recommendations addressed actions of both staff nurses and executive nurses.

**What can I do to make things better?**

This portion of the C.E. program was designed to stimulate problem solving through use of two familiar nursing tools. The first was the nursing process. The steps of the nursing process, assessment, plan, intervention, and evaluation, were reviewed and adapted to help participants see their value in this context. The second tool was the art of listening. Key steps of the listening process were reviewed.

**A review.**

The role of the nurse executive, use of nursing theory, effects of relationships between staff nurses and nurse executives, and strategies and techniques which can improve relationships between staff nurses and nurse executives were reviewed. The participant objectives were reviewed and an open discussion was facilitated by the
author. Comments, personal experiences and anecdotal stories were encouraged. A posttest was completed for comparison to the pretest to assess learning.

**Participant course evaluation.**

Structured questions were directed at learning whether the information presented was of interest, comprehensive, accurate, and helpful. Two open ended questions asked for most and least helpful information presented. There was space left for comments and suggestions. Participants were given a Certificate of Participation indicating 1.0 contact hours of C.E. credit upon completion of the course evaluation.

Finally, participants were directed to a recommended reference list which was included in the handout. The list represented a limited selection of the cited references of this professional project.

**Phase VI - Pilot C.E. Program Results**

**Attendance.**

Ten of twelve departmental staff nurses were present. The nurse executive of the department was present.

**C.E. Program Materials.**

Information was presented to each participant in a pocket folder which included the handouts (Appendix D), the pretest and posttests, and the participant evaluation form (Appendix E).

**Time.**

The C.E. program was condensed to fifty minutes per request of the departmental manager to facilitate the business segment of the staff meeting. The C.E. program preceded the business meeting.
Interactive exercises.

The interactive exercises were shortened and/or deleted to meet the requested time limitation. The participants were asked “what do you want to get” from this C.E. program. Only one participant offered a personal objective, which was “to improve communication between staff nurses and nurse executives”. At the end of the slide presentation participants agreed that the objective had been satisfactorily met. At the end of the review, open discussion and comments were solicited. No comments were made other than appreciation to the author for the C.E. program. Because of the time limitation no discussion was initiated by the author.

Pretest.

Participants were asked to complete the pretest at the beginning of the meeting. The pretest was a combination of two questions allowing free text answers and four true or false responses to components of one question. All staff nurses completed the pretest, the nurse executive did not.

Participants’ knowledge was screened for three subtopics included in the C.E. program. Participants were asked to list two professional expectations for the role of nurse executive. Responses are reported in Table 7. The number of responses is indicated in parentheses.

Table 7. Pretest professional expectations for the role of nurse executive.

- (N=6) staff advocate, including provision of professional growth and development
- (N=5) honesty, fairness and respect when dealing with staff
- (N=4) facilitate communication to staff (3), and between staff and administration (1)
- (N=3) maintaining departmental organization and operation, including budget
• (N=2) providing leadership to the staff
• (N=1) maintain clinical skills

Secondly, participants were asked if relationships between staff nurses and nurse executives can positively and/or negatively affect physical health, emotional/mental health, organizational commitment, and patient care. The pretest allowed True or False answers. All nurses responded True to each possible negative effect on personal or professional health. One nurse commented that he/she hoped that patient care was not affected by negative relationships between staff nurses and nurse executives, but he/she circled the True answer.

Lastly, participants were asked to list two strategies for improving communication between staff nurses and nurse executives. Most nurses responded with one or two strategies. Two nurses listed three strategies. Two nurses elected not to respond. Responses are reported in Table 8. The number of responses is indicated in parentheses.

Table 8. Pretest strategies for improving communication.

• (N=5) regular meetings which allow specific staff nurse:nurse executive time
• (N=4) communication which is directed toward night and weekend shifts
• (N=3) use of communication tools such as clear directives, open communication, “don’t kill the messenger,” posted communications and communication books, problem solving after input from all individuals involved
• (N=3) role share, staff nurses assume some administrative duties, nurse executives share clinical assignment, share problem solving
• (N=1) share social time
Slide presentation.

During the slide presentation, participants were uncharacteristically silent. The graphics, music, and animations included in the Power Point presentation were appreciated. During those portions of the presentation the staff nurses and nurse executive laughed, verbalized enjoyment, curiosity, and entertainment. The comments made during other portions of the slide presentation were primarily agreement with the speaker, rather than comments about the program content. The nurse executive reinforced selected items on the Nurses’ Bill of Rights slide, specifically the right to a reasonable work assignment. The nurse executive answered questions from the author regarding the obligations of his role.

Posttest.

At the end of the slide presentation, participants were asked to complete the posttest. Once again participants’ knowledge was assessed for three subtopics included in the C.E. program. The pretest and posttest were identical. All ten staff nurses present completed the posttest, the nurse executive present did not. Participants were asked to list two professional expectations for the role of nurse executive. Most nurses listed two expectations, some listed three. Responses are reported in Table 9. The number of responses is indicated in parentheses.

Table 9. Posttest professional expectations for the role of nurse executive.

- (N=6) act as advocate for nurses
- (N=5) demonstrate good communication skills
- (N=3) effective management of financial resources
- (N=2) act as an advocate for patients
- (N=2) develop a vision for nursing practice
• (N=2) effectively manage staff issues
• (N=1) show respect and fairness
• (N=1) display trust, honesty
• (N=1) maintain knowledge of current technology

Participants were again asked if relationships between staff nurses and executive nurses can positively and/or negatively affect physical health, emotional/mental health, organizational commitment, and patient care. All nurses again responded True to each possible negative effect on personal or professional health.

Participants were asked to list two strategies for improving communication between staff nurses and nurse executives. Most nurses listed one or two strategies, two nurses gave three strategies. Responses are reported in Table 10. The number of responses is indicated in parentheses.

Table 10. Posttest strategies for improving communication.

• (N=12) Communication
  - in appropriate settings
  - through uninterrupted staff meetings
  - at meetings designated for staff nurses and nurse executives
  - clarify directives
  - with night shift and weekend staff
  - clarify own ideas before communicating
  - use open, nonhostile approach
  - use reflection
• (N=5) use positive strategies for resolving conflict
  - confrontation
- be a good listener
- use the nursing process

• (N=2) role exchange/sharing and appreciate one another’s perspective
• (N=1) make an appointment
• (N=1) embrace change

Participant Evaluation Form.

After the posttest, questions or comments were invited. There were none.
Participants were asked to complete the participant evaluation form. There were eleven questions. Nine questions contained scaled answers with check boxes. Two questions allowed free text for most and least helpful information presented. A section for comments or suggestions was included. Responses are reported in Table 11.

Table 11. Participant Evaluation responses.

• 1. The program contained information which was:
   (N=0) All new   (N=11) Partially new   (N=0) Not new

• 2. Did you feel the identified barriers to communication presented in this program were:
   (N=10) Accurate   (N=1) Incomplete   (N=0) Inaccurate

• 3. Did you feel the strategies for improving communication presented in this program were:
   (N=6) Very helpful   (N=5) Somewhat helpful   (N=0) Not helpful

• 4. This program has increased your understanding of the role of nurse executives:
   (N=4) A lot   (N=6) Somewhat   (N=1) Not at all

• 5. This program has provided helpful strategies for improving communication efforts with nurse executives in your workplace:
   (N=3) A lot   (N=8) Somewhat   (N=0) Not at all
• 6. Were your personal objectives regarding this topic were satisfactorily met:
  (N=8) Completely    (N=3) Partially    (N=0) Not at all

• 7. The most helpful information you learned from this program was:
  (N=1) “Compromise!”
  (N=1) “Look at topic from both sides”
  (N=1) “To try to see things from the other persons’ position”
  (N=1) “Need to examine both sides for better communications”
  (N=1) “Techniques for communication”
  (N=1) “How to use the nursing process for problem solving”
  (N=1) “To use the nursing process to help solve problems”
  (N=1) “Positive attitude for change”
  (N=1) “Inspiration to do a multimedia presentation with a computer”
  (N=2) No comment

• 8. The least helpful information presented today was:
  (N=2) Nothing
  (N=9) No comment

• 9. The presenter facilitated your understanding of the material presented:
  (N=8) Very much    (N=3) Somewhat    (N=0) Not at all

• 10. The presenter stimulated your interest in working on improving relationships
  between nurse executives and staff nurses:
  (N=6) Very much    (N=5) Somewhat    (N=0) Not at all

• 11. Would additional information on this topic be helpful to you:
  (N=1) A lot        (N=10) Somewhat    (N=0) Not at all

Comments or suggestions:
  (N=1) “Thank you”
  (N=1) “Very professional presentation”
  (N=1) “Well presented”
  (N=1) “Good job”
  (N=1) “Great job”
  (N=1) “Pretest and posttest should be different. Test taking is a learning
  experience-double the learning”
  (N=5) No comment
Pilot C.E. Program Evaluation

Notification of the C.E. Program was posted in the department for which it was presented three weeks prior to the scheduled date. During those three weeks, several staff members asked the author what content would be included in the C.E. program. Discussions among nurses regarding the content in the authors’ presence indicated strong interest and opinions by staff nurses. Ten staff nurses attended the C.E. program. Only two of the regular departmental staff were absent. The nurse executive responsible for the department was present. Since this attendance represented a greater than usual staff meeting attendance, the author presumed the staff nurses had an interest in the C.E. program topic. The staff lounge was chosen for delivery of the pilot C.E. program. The number of participants contributed to minor difficulty seeing the projection screen by a few participants. A larger room would have afforded more comfort for the participants and improved visualization of the slide presentation.

The pretest was initiated prior to any lecture content. Several questions were asked regarding the definition of nurse executive. In future presentations, it may clarify the pretest and make the results more meaningful if the introduction to the presentation was completed and nurse executive was defined before the pretest was administered.

The computerized slide presentation was a series of colorful slides including animations, graphics, and sound tracks. Although several of the staff nurses present were regular users of computer programs, none had experience with computerized presentations. The nurse executive present was proficient at computerized presentations. All staff nurses present verbalized “amazement” at what a computer software program could do to enhance interest in serious information. Prior to beginning the slide presentation, participants were asked to add comments or ask questions at any time. The author asked questions occasionally and answers were offered by a few individuals.
At the end of the slide presentation, discussion was solicited. No comments were made directly related to the content. Numerous comments of appreciation to the author were made.

Comparison of responses on the pretest and posttest indicated an increased knowledge of the role of the nurse executive. The responses on the pretest were primarily expectations for the role of nurse executive which affected the work environment of the staff nurse directly, such as: communication with staff; staff advocate; honesty, fairness, and respect when dealing with staff; and providing leadership and organizational guidance to the staff. The posttest reflected an increased understanding of the role of nurse executive with inclusions such as: effective communication with all levels of hospital personnel and the community; management of financial resources; advocate for patients; developing a vision for nursing; and maintaining knowledge of current technology.

Comparison of the effects of positive and negative relationships between staff nurses and nurse executives on physical health, emotional/mental health, organizational commitment, and patient care showed no change. The pretest and posttest both indicated an awareness of the influence of these relationships.

Comparison of pretest and posttest answers directed at strategies for improving communication showed an improved willingness by staff nurses to participate actively in the improvements. The pretest indicated that staff nurses felt the responsibility for improvements belonged to the nurse executives. Comments on the pretest included: conduct regular meetings; provide written and visual communication for staff; improve communication toward night shift and weekend staff; and “don’t kill the messenger,” have open communication. The posttest included a greater number of responses than the pretest. Included were: numerous positive techniques for two-way communication such as use of open, non-hostile communication; use of appropriate settings; use of reflection;
and clarifying ideas before communicating them; use of positive strategies for problem solving such as listening; using the nursing process and confrontation; and role "sharing" to improve appreciation of one another's perspective. One participant indicated on the participant evaluation form that learning would be enhanced by having different questions on the pretest and posttest. This author found comparison of the pretest and posttest answers revealed changes which clearly indicated positive learning of the C.E. program content. Most importantly, comparison indicated clearly an increased commitment to improve relationships between staff nurses and nurse executives.

The participant evaluation form indicated that all participants received some information from the C.E. program which was new for them. Nearly all of the participants felt the C.E. program increased their understanding of the role of nurse executives. In varying degrees, all nurses present indicated that the C.E. program was helpful in providing useful strategies for improving communication and had stimulated an interest in improving relationships between staff nurses and nurse executives. Although during the slide presentation only one nurse verbally shared what she hoped to learn by attending the C.E. program, 73% of the nurses indicated that their personal objectives regarding the topic had been completely satisfied and 27% stated that their objectives were partially met. The question which asked participants to state the most helpful information learned from the C.E. program reinforced the author's conclusion that nurses present were making a commitment for improvement in relationships between staff nurses and nurse executives. The comments included: compromise; see things from both sides; communicate; use the nursing process; and keep a positive attitude for change. No comments for least helpful information were offered. Comments at the end of the participant evaluation tool were directed at appreciation to the author for presenting the C.E. program.
CHAPTER 4

DISCUSSION

Limitations

Limitations of the pilot C.E. program should be considered in evaluating the results. Although design of the C.E. program included a time limitation of one hour to facilitate inclusion at staff meetings, decreasing the time to fifty minutes required minimization of the interactive components of the program. Although evaluation results indicated that learning occurred and that nurse participants were motivated to work on improving relationships between staff nurses and nurse executives, the limitation in time prevented application of information learned to case studies, discussion, or anecdotal situations. Discussion of learned information allows participants to synthesize content of a learning program. Increased discussion time would allow the group to share anecdotal situations. Role playing with guided application of positive strategies for resolving conflict, and nursing tools for improving communication may have contributed to increased understanding and retention of learning.

No attempt was made to assess the level of comfort staff nurses had in openly discussing relationships between staff nurses and nurse executives. The staff nurses, who were known to the author, were uncharacteristically quiet during the slide presentation. No staff nurse chose to ask questions or make comments related to the content at the conclusion of the slide presentation. Presence of the nurse executive may have influenced comments and inhibited open discussion.

The author was unaware of the requirement by the MNA that materials for C.E. programs which require review and approval for continuing education credits must be submitted 45 days prior to presentation. Because of shorter time constraints for this
project, arrangements were made to present the program through review and approval by the hospital in which the pilot program was scheduled. The hospital is approved as a provider of continuing education in nursing by the Montana Nurses' Association Commission on Continuing Education.

**Implications for future C.E. Programs**

For future program presentations, the required lead time should be considered when arranging for continuing education approval and C.E. credit. Dealing directly with an approval organization would allow freedom to repeat the program in other settings without the provider hospital required as an intermediary.

Modifications to the C.E. program should include presentation of sufficient definitions of selected terms and conditions prior to administration of the pretest so that participants feel they are answering pretest questions accurately. The information could be given verbally or printed on the pretest.

A larger number of staff members attended the pilot C.E. program than expected. Expected attendance was based on the number of staff nurses who ordinarily attend a regular staff meeting. As a result, the room chosen was inappropriately small. This resulted in difficulty viewing the slide presentation for some participants. Knowing an accurate number of participants in advance would allow for more appropriate selection of presentation environment. Preregistration would give a more accurate attendance number.

Time allowances for future programs could be extended to allow discussion and encourage interaction between staff nurses and nurse executives present. Case studies, role playing, and anecdotal situations would allow reinforcement of learned information through practical application. Evaluation of the learning needs specific to potential
participant groups by the presenter may serve as a guide for scheduling adequate time for presentation of this C.E. program.

Another finding which could guide future programs was the uncharacteristic silence of staff nurse participants. The presence of a nurse executive may have inhibited discussion by the staff nurses. Although the author advocates groups including staff nurses and nurse executives, programs designed for segregated groups may be considered.

**Implications for staff nurses and nurse executives**

Based on evaluation of the data, the C.E. program met the objectives identified by this professional project. Following the C.E. program, all nurses present indicated some degree of commitment to improving relationships between staff nurses and nurse executives. Nearly all staff nurses present indicated an expanded understanding of the role of nurse executives. Staff nurses verbally indicated that remembering the “negative barriers and positive strategies” would help them to approach nurse executives with problems in a different way. Using the adaptation of the Theory of Goal Attainment in the slide presentation was an effective visual tool for outlining the process of altering perceptions through transactions and means exploration. Nurse participants stated that they understood the use of nursing theory in the context presented. Due to time constraints, the theory was not applied to specific situations. Use of the theory in role playing and evaluation of its’ usefulness for problem solving during discussion would have contributed to increased understanding. Nurses in all roles occasionally need reminders of positive and negative methods of dealing with issues, problems, and each other. This C.E. program served that purpose for the participants. Although much research has been conducted on the causes of discord between staff nurses and nurse
executives, more research may be warranted to evaluate outcomes for nurses who have made an active commitment to improving relationships.

**Implications for nurse practitioners**

The roles of nurse practitioners in hospital environments are still unclear. Whether nurse practitioners are a “different” nurse executive or an “advanced” version of staff nurse is undecided by many, including staff nurses and nurse executives. Nurse practitioners could be considered “specialty” nurses who have roles in occupational health, emergent care services, case management, home health, managed care, and quality assurance programs. They function as coordinators, consultants, and primary care providers with admitting privileges. Nurse practitioners are clinical caregivers and patient advocates. They assume responsibility for finances, strategic planning, and conservation of resources. The roles of nurse practitioners cross over boundaries which previously separated staff nurses and nurse executives.

With reference to dealings with advanced practice nurses, Courtney (1996, p. 51) challenges nurse executives to be “willing, even eager to promote the exploration of new roles within their system.” This author extends that challenge to staff nurses. Studies on nurse practitioner relationships have focused primarily on relationships with physicians. More research to investigate and evaluate the interactions and relationships between nurse practitioners and other nurses is needed. Nurse practitioners in the hospital environment depend on positive, productive relationships with staff nurses and nurse executives to pave the road to successful outcomes in their new roles. C.E. programs such as this one may benefit the relationships between all “specialties” of nursing.

*We are all nurses.*
REFERENCES CITED


APPENDIX A

Application for C.E. Program Approval
Planning Document for Nursing Continuing Education

Kalispell Regional Medical Center
Education Department
310 Sunnyview Lane
Kalispell, MT 59901
Phone: 406/752-1775
FAX: 406/751-2962

Administrative Officer: ___________________________ (Education Manager) signature when document is complete

KRH #: 99-002

1. Title of CE activity: IMPROVING RELATIONSHIPS BETWEEN STAFF NURSES AND NURSE EXECUTIVES

2. Date(s) of CE activity: FEBRUARY 17, 1999

3. Type of CE activity: Individual Offering

4. Location of CE activity: STAFF CONFERENCE ROOM — EMERGENCY DEPARTMENT — KRMC

5. Number of contact hours awarded: 1.0

6. Target audience: (RNs must be included) STAFF NURSES AND NURSE EXECUTIVE

7. Names, titles, credentials (academic degrees), and professional qualifications of Planning Committee members: (A minimum of two registered nurses must be involved in the planning process and at least one of them must hold a baccalaureate or higher degree in nursing.)

   Judith Munsell, RN, BSN, CEN
   MSU Master of Nursing Student, Grad 1999/Summer

   Jean Shreffler, RN, PhD
   MSU College of Nursing Instructor/Professor

8. Describe how the need for this CE activity was assessed:

   XX Other: Observed interactions/comments between staff nurses and exec nurses by the author of this presentation

9. State the purpose of CE activity and attach agenda.

   1. Foster improved understanding of the role of nurse executive
   2. Identify barriers to communication between staff/exec. nurses
   3. Provide recommendations for improving communication/understand

10. Complete the Individual Offering Documentation Form (I.O.D.F.) which describes objectives, content, time frames, teaching methods and presenter(s)/speaker(s). For programs complete I.O.D.F./Program Document form for three (3) sample sessions.
11. Attach biographical data form for each presenter/speaker.

12. Describe the method(s) to evaluate the education activity.
   - teaching effectiveness of each faculty member
   - relevance of content to the objectives
   - effectiveness of teaching methods
   - appropriateness of physical facilities
   - learners achievement of each objective

   Evaluation Tool (check all that apply)

<table>
<thead>
<tr>
<th>Evaluation Tool to be utilized</th>
<th>Individual Offering or Program Offering</th>
<th>Program Offering Sample Session #1</th>
<th>Program Offering Sample Session #2</th>
<th>Program Offering Sample Session #3</th>
</tr>
</thead>
<tbody>
<tr>
<td>Rating Scale</td>
<td>XX</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pre/Post Test Comparison</td>
<td>XX</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Performance checklist/return demo</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Role Playing Evaluation</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other:</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

   (attach copy of evaluation tool(s))

13. Attach sample of the certificate of attendance.

14. Attach coprovidership agreement (if applicable).

15. Attach summary of participants evaluations.

16. Attach names and addresses of participants and number of contact hours awarded to each.
Title/Subject: IMPROVING RELATIONSHIPS BETWEEN NURSE EXECUTIVES AND STAFF NURSES

Date: FEBRUARY 17 1999  Location: Staff Conference-Emergency Dept.

Target Audience: Staff RNs/Exec (ED)

Have verification slips been passed out? Yes

Time(s): 1800-1850  Length of Program: 50 minutes

Instructors: Judith Munsell, RN, BSN, CEN

Objectives: Purpose

1. Foster improved understanding of the role of nurse executive.

2. Identify barriers to communication between staff nurses and executive nurses.

3. Provide recommendations for improving communication and understanding between staff nurses and nurse executives.

Specific Learning Objectives

1. Demonstrate increased understanding of the role of nurse executive by listing major components of role.

2. Review and discuss application of nursing theory for mutual goal setting.

3. Identify communication barriers.

4. Identify and apply strategies & techniques for improving communication and understanding.

Employee Name

Discipline

Dept/Unit

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2. 

3. 

4. 

5. 

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24. 

25. 

26.
APPENDIX B

Notification of C.E. Program Presentation
Improving Relationships Between Staff Nurses and Nurse Executives

A Continuing Education Presentation Approved for 1.0 MNA Contact Hours through KRMC - MNA/KRMC 99-002

presented by

Judith Munsell, RN, BSN

Montana State University Master of Nursing Program

February 17, 1999
Emergency Department Staff Meeting 1800
APPENDIX C

C.E. PROGRAM SLIDE PRESENTATION
**WHY DO WE CARE?**

- Alterations in physical health
- Alterations in mental health
- Anger
- Decreased job satisfaction
- Internal conflict
- Decreased organizational commitment

**IDENTIFY THE ONE MOST IMPORTANT THING ON YOUR LIST**

**WHY ARE WE HERE**

**OBJECTIVES**

- Demonstrate increased understanding of the nurse executive role
- Review application of nursing theory for mutual goal-setting
- Identify communication barriers between staff nurses and executive nurses
- Identify and apply strategies for improving communication and understanding between staff nurses and nurse executives

---

**WHY DID I CHOOSE TO PRESENT THIS TOPIC?**

**WHAT DO YOU WANT TO GET FROM THIS HOUR?**

(make a short list - you have two minutes)

**IDENTIFY THE ONE MOST IMPORTANT THING ON YOUR LIST**

**cruising**
**WHAT IS A NURSE EXECUTIVE?**

- **Definition**: Nurses in management positions from first-line managers to top-level administrators.

- **Background**: In rural areas, education and experience varies.

**CORE ROLE ABILITIES**

(OBLIGATIONS AND EXPECTATIONS)

- Develop a vision for nursing practice
- Management skills that encourage collaborative working relationships
- Analytical, problem-solving skills
- Communication skills
- Ability to reach all education/cultural levels
- Efficient management of resources

- Stay current in information and technology
- Enhance quality health care through assuming risk-taking
- Advocate for consumers, the community and for nursing
- Embrace and Manage change effectively
- Negotiate and resolve conflict
- Foster team-building in nursing and across health care disciplines

**USING NURSING THEORY**

<table>
<thead>
<tr>
<th>STAFF NURSE</th>
<th>NURSE EXECUTIVE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Perception</td>
<td>Perception</td>
</tr>
<tr>
<td>Communication</td>
<td>Transaction</td>
</tr>
<tr>
<td>Transcend</td>
<td>Altering Perception</td>
</tr>
<tr>
<td>Explore Means</td>
<td>Agree to Means</td>
</tr>
</tbody>
</table>

**MUTUAL GOAL SETTING**

“*The greatest problem in communication is the illusion that it's been accomplished*”

George Bernard Shaw
BARRIERS TO COMMUNICATION

- Poor Listening Habits
- Distraction
- Semantics & Context
- Stressful Situations
- Rejecting & Belittling
- Stereotyping-Racial or Sexual statements
- Insecurity

Examples of Negative Results of Communication Blocks

1. Have they forgotten?
2. Isolation
3. Loss of trust
4. Inappropriate approach to problems
5. Unresolved problems
6. Our own worst enemy?

Negative Strategies for Resolving Conflict and Improving Communications

- Avoiding
- Withholding or Withdrawing
- Smoothing Over or Reassuring
- Accommodating
- Forcing
- Competing

Nurse’s Bill of Rights

- To have a reasonable workload
- To make a mistake
- To be a patient advocate
- To be involved in decisions re: nursing and patient care
- To change one’s mind

Basics for Good Communication

- Clarify your ideas before communicating to others
- Consider the physical setting
- Consider the communication climate: open or hostile
- Be mindful of the tone
- Offer help, praise or thanks
- Be sure you have been heard accurately
- Be aware of body language
- Be assertive; never aggressive or passive

Strategies & Techniques

For Improving Communications
Positive Strategies for Resolving Conflict & Improving Communication

- Compromising
- Confronting
- Collaborating

Remember to listen as well as to speak
- Make an appointment
- Dress appropriately
- Put the other person at ease, relax, be nonthreatening
- Stop talking - don’t interrupt, listen
- Empathize
- Paraphrase
- Use silence
- Allow reflection

USE THE NURSING PROCESS
ASSESS, PLAN, IMPLEMENT, EVALUATE
1. State the observation
2. Do your research
3. Identify the problem
4. Suggest a well-planned solution
5. State the expected outcome and a method for evaluation

WHAT CAN I DO?
to make things better?
The role of nurse executives includes:
- Patient advocate
- Development of a vision for nursing practice
- Act as advocate for nursing practice
- Encouragement of collaborative working relationships
- Communication skills effective for all levels of staff
- Management of financial and human resources
- Provide role model for identifying and solving problems.

Use of nursing theory can help staff nurses and executive nurses to:
- Identify personal perceptions
- Guide us to altered perceptions
- Mutual goal setting

Relationships between staff nurses and nurse executives can positively or negatively affect:
- Physical Health
- Mental Health
- Job Satisfaction
- Workplace Behaviors
- Organizational Commitment
- Patient Care

Positive relationships between staff nurses and nurse executives can be encouraged by using:
- Basics for Good Communication
- Positive Strategies for Resolving Conflict
- The Nursing Process
- Listening!

“Diversity in nursing is our strength. Our ability to collaborate brings our best to the patient and strengthens our profession. This strength and energy allows us to enter into collegial relationships that produce extraordinary results.”

(The End is Here)
APPENDIX D

C.E. Program Participant Handout
IMPROVING RELATIONSHIPS BETWEEN STAFF NURSES AND NURSE EXECUTIVES

A Continuing Education Presentation by Judith A. Munsell designed as partial fulfillment of the degree of Master of Nursing Montana State University, Bozeman
This offering for 1.0 contact hours is provided by

Kalispell Regional Medical Center

which is accredited as a provider of continuing education in nursing by

The Montana Nurses' Association
Commission on Continuing Education

Offering Number: MNA/KRMC 99-002
WHY ARE WE HERE?

PARTICIPANT LEARNING OBJECTIVES

* Demonstrate increased understanding of the nurse executive role by listing major components of the role.

* Review and discuss application of nursing theory for mutual goal setting.

* Identify communication barriers between staff nurses and executive nurses.

* Identify and apply strategies/techniques for improving communication and understanding between staff nurses and nurse executives.

MOOOOOVE 'EM OUT
1. WHY DID I CHOOSE TO PRESENT THIS TOPIC?

2. WHAT DO YOU WANT TO GET FROM THIS HOUR?  
   (make a short list - you have two minutes)

3. IDENTIFY THE ONE MOST IMPORTANT THING ON YOUR LIST.

WE’RE CRUISING NOW!
WHY DO WE CARE?

Numerous research studies have been conducted to discover the reasons behind positive and negative job satisfaction of staff nurses. These studies have repeatedly confirmed the connection between staff nurse and nurse executive relationships and job satisfaction. Although many other variables have also been identified in these studies, it remains clear that one of the most important, if not the most important factor in job satisfaction is the link between these two groups of nurses. Although fewer studies have been published examining similar variables affecting job satisfaction of nurse executives, the results are the same; job satisfaction is definitely affected by nurse to nurse interactions. Listed below are some of the effects of negative relationships.

- **Alterations in physical health** manifested as: hypertension, chronic headaches, backaches, chronic abdominal pain, nausea, diarrhea, ulcerative colitis, ulcers, and chest pain and *more!*

- **Alterations in mental health** manifested as depression, alterations of sleep, unhealthy lifestyle behaviors such as excessive use of alcohol, tobacco or medications, eating disorders, family dysfunction.

- **Anger** is a common response to having a goal denied or blocked. It may be accompanied by symptoms such as: tension; diaphoresis; constipation or diarrhea; nausea, increased blood pressure, heart rate, and respiratory rate. Reactions to anger include open or passive aggression; manipulation; frustration; and open or thinly veiled disrespect.

- **Decreased Job Satisfaction** is manifested as burnout in staff nurses and nurse executives. Burnout is a variable state of occupational stress which includes emotional exhaustion, depersonalization, and lack of personal accomplishment. It is the result of constant or repeated emotional pressure associated with intense involvement with people over long periods of time. It is often characterized by changes in behavior towards clients or others and changes in quality and involvement in work.
• **Internal Conflict** in the workplace manifested as fault-finding, name-calling, back-biting, and subtle sabotage of both colleagues and/or superiors.

• **Decreased Organizational Commitment** resulting in high turnover rates, decreased productivity, and **decreased quality of patient care**.
• model creativity in defining and solving problems

• foster/implement team-building strategies in nursing and across health care disciplines

• embrace change and manage it effectively

• negotiate and resolve conflict

• act as nursing advocate

• effectively market nursing practice

• demonstrate effective public speaking

• establish relationships with community around the issue of health
Nurse executives and staff nurses with positive attitudes, mutual respect, and a focus on shared direction and decisions can lead to increased independence and responsibility for staff nurses as well as provision of support for the executive nurse in difficult times of change.

**MUTUAL GOAL SETTING**
BARRIERS TO COMMUNICATIONS
BETWEEN STAFF NURSES AND EXECUTIVE NURSES

Most common blocks to communication

- Poor listening habits
- Distraction
- Misused or misunderstood semantics or context
- Stressful situations or environments
- Aggressive behavior
- Rejecting or belittling behavior
- Stereotyping, making racial or sexual statements
- Offering insincere agreement or reassurance

Examples of negative results of communication blocks

- Staff nurses feeling that nurse executives have forgotten their origins in nursing
- Isolation of nurse executives from other nurses
- Nurse executives not trusting staff nurses with information regarding organizational difficulties
- Staff nurses not trusting nurse executives’ ability or interest in helping to solve problems
- Issues presented in inappropriate settings (hallways, cafeterias)
- Issues presented and left unresolved
- Staff nurses criticizing other nurses
Negative Methods and Strategies for Conflict Resolution

- **Avoiding.** Avoiding conflict at all costs. Some people never acknowledge that a conflict exists. The individual’s posture is, if I do not acknowledge there is a problem, then there is no problem. It is sometimes reflected in the phrase, “leave well enough alone”. Occasionally these problems resolve themselves if left alone, usually they resurface later. Can be a situation in which a very complex situation needs time or time is needed for the “wheels of bureaucracy to turn”.

- **Withholding or Withdrawing.** Another avoidance strategy, one party opts out of participation. They remove themselves from the situation. This does not resolve the conflict. However, this strategy does give individuals a chance to calm down or to avoid a confrontation.

- **Smoothing Over or Reassuring.** Strategy of saying that “everything will be OK.” By maintaining surface harmony, parties do not withdraw but simply attempt to make everyone feel good. It is like smoothing ruffled feathers. Smoothing over or reassuring strategies use verbal communication to defuse strong emotions.

- **Accommodating.** Strategy used when there is a large power differential. The more powerful party is accommodated to preserve harmony or build up social credits. What this means is that the party of less power gives up their position in deference to the more powerful party. Accommodation may be used when one party has a vested interest that is relatively unimportant to the other party. Kill the enemy with kindness is the operative phrase.

- **Forcing.** A dominance move and an arbitrary way to manage conflict. An issue may be forced on the table by issuing orders or by putting it to a majority-rules vote. Let’s vote on it is an all-out power strategy to win while the other party loses.

- **Competing.** Assertive strategy where one party’s needs are satisfied at the other’s expense. Competing is an all-out effort to win at any cost.
Failure to Recognize The Nurse’s Bill of Rights

- The right to be treated with respect
- The right to be listened to
- The right to have and to express thoughts, feelings, and opinions
- The right to ask questions and to challenge
- The right to understand job expectations as well as have them written
- The right to say no and not feel guilty
- The right to be treated as an equal member of the health team
- The right to ask for change in the system
- The right to have a reasonable workload
- The right to make a mistake
- The right to make decisions regarding health and nursing care
- The right to initiate health teaching
- The right to be a patient advocate or to help a patient speak for himself or herself
- The right to change one’s mind
Basics for Good Communication

- Clarify your ideas before communicating to others.

- Consider the physical setting.

- Consider the psychological environment. Also referred to as the communication climate which can be positive, open and supportive or negative, defensive and hostile.

- Be mindful of the tone, as well as the words of the message. Emotional levels of messages can convey angry, friendly, and/or dictatorial tones.

- Take the opportunity to convey something of help, value, or praise to the receiver.

- Follow up your communication. Be sure what you have said is accurately understood.

- Nonverbal behavior should support communication. Be conscious of facial expressions and body posture. Be an active listener.

- Be assertive, not aggressive or passive, when expressing your views or making statements.
Positive Strategies for Resolving Conflict and Improving Communication

- **Compromising.** Splitting the difference. Division of rewards, power, or benefits so everyone gets something. Useful when goals or values are markedly different. Requires back and forth effort in a formal or informal process.

- **Confronting.** Assertive problem solving that is focused on the issues. Individuals speak for themselves, but in a way that decreases defensiveness and allows another person to hear the message. It is a staple of conflict management but requires courage. “I” messages are used and “you” messages are avoided.

- **Collaborating.** This is assertive and cooperative strategy where the parties work together to find a mutually acceptable solution. Designed to generate feelings of gain by all parties.
WHAT CAN I DO TO MAKE THINGS BETTER?

When Staff Nurses Communicate with Executive Nurses

USE A FAMILIAR TOOL -- USE THE NURSING PROCESS!

Assess, Plan, Implement, Evaluate

(1) state the observation (assessment, if possible put the patient first).
(2) do your research (a lit review to support your observation).
(3) identify the problem (including your hypothesized reason for the problem).
(4) suggest a well-planned solution (have an alternate suggestion).
(5) state the expected outcome and a method for evaluation (offer to help).
HERE IS A \textit{REALLY BIG KEY}

\begin{itemize}
  \item Make an appointment
  \item Dress appropriately for your meeting
  \item Put the other person at ease-try to be relaxed yourself, be nonthreatening
  \item Stop talking
  \item Don’t interrupt-especially important if the other person is upset
  \item Empathize-state your effort to understand
  \item Paraphrase-summarize and restate to satisfaction
  \item Ask open-ended questions-allows more clarification and points of view
  \item Use silence-may be necessary to insist the other person respond
  \item Allow reflection-act as a sounding board
\end{itemize}
1. The role of nurse executives includes:
   - Development of a vision for nursing practice
   - Act as advocate for nursing practice
   - Encouragement of collaborative working relationships
   - Communication skills effective for all levels of staff
   - Management of financial and human resources
   - Provide role model for identifying and solving problems
   - Patient advocate

2. Use of nursing theory can help staff nurses and executive nurses to:
   - Identify personal perceptions
   - Guide us to altered perceptions
   - Mutual goal setting

3. Relationships between staff nurses and nurse executives can positively or negatively affect:
   - Physical Health
   - Mental Health
   - Job Satisfaction
   - Workplace Behaviors
   - Organizational Commitment
   - Patient Care

4. Positive relationships between staff nurses and nurse executives can be encouraged by using:
   - Basics for Good Communication
   - Positive Strategies for Resolving Conflict
   - The Nursing Process
   - Listening!

5. Review of participant objectives - are all answered satisfactorily?
Recommended References


APPENDIX E

C.E. Program Pretest and Posttest,
Participant Evaluation and Certificate of Completion
PRETEST

List two professional expectations of the role of nurse executive.

1. ____________________________________________
2. ____________________________________________

Relationships between staff nurses and nurse executives can positively and/or negatively affect:

1. T / F Physical health?
2. T / F Emotional/mental health?
3. T / F Organizational commitment?
4. T / F Patient care?

List two strategies/techniques for improving communication between staff nurses and nurse executives.

1. ____________________________________________
2. ____________________________________________
POSTTEST

List two professional expectations of the role of nurse executive.

1. ________________________________
2. ________________________________

Relationships between staff nurses can positively and/or negatively affect:

1. T / F Physical health?
2. T / F Emotional/mental health?
3. T / F Organizational commitment?
4. T / F Patient care?

List two strategies/techniques for improving communication between staff nurses and nurse executives.

1. ________________________________
2. ________________________________
PARTICIPANT EVALUATION FORM

Thank you for attending this presentation today. Your evaluation of the presentation would be appreciated.

1. The presentation contained information which was:
   □ All new    □ Partially new    □ Not new

2. Did you feel the identified barriers to communication presented in this program were:
   □ Accurate    □ Incomplete    □ Inaccurate

3. Did you feel the strategies for improving communication presented in this program were:
   □ Very helpful    □ Somewhat helpful    □ Not helpful

4. This presentation has increased your understanding of the role of nurse executives:
   □ A lot    □ Somewhat    □ Not at all

5. This presentation has provided helpful strategies for improving communication efforts with nurse executives in your workplace:
   □ A lot    □ Somewhat    □ Not at all
6. Were your personal objectives regarding this topic were satisfactorily met:
□ Completely  □ Partially  □ Not at all

7. The most helpful information you learned from this presentation was:

8. The least helpful information presented today was:

9. The presenter facilitated your understanding of the material presented:
□ Very much  □ Somewhat  □ Not at all

10. The presenter stimulated your interest in working on improving relationships between nurse executives and staff nurses:
□ Very much  □ Somewhat  □ Not at all

11. Would additional information on this topic be helpful to you:
□ A lot  □ Somewhat  □ Not at all

Comments or suggestions:

Thank you!
IMPROVING RELATIONSHIPS BETWEEN STAFF NURSES AND NURSE EXECUTIVES

CERTIFICATE OF ATTENDANCE AND PARTICIPATION

PROVIDED AT KALISPELL REGIONAL MEDICAL CENTER
KALISPELL, MONTANA
FEBRUARY 17, 1999

This educational activity has been approved by Kalispell Regional Medical Center which is accredited as a provider of continuing education in nursing by the Montana Nurses’ Association Commission on Continuing Education

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