Health care leaders, including nurses, frequently learn needed business skills on the job and do not always have a good understanding of what they are practicing. Administration will often ask nurses to lead but rarely supplies the tools or time to achieve the tasks of leadership (Harkins, Butz, & Taheri, 2006). Kerfoot (2008) states that many nurses become formal leaders without formal leadership or on-the-job education or experience needed to succeed. Even organizations that provide for leadership development frequently forget that there are leaders at every level, including the bedside, as in charge nurses or team leaders (Gaguski, 2008).

In the author’s experience, many supervisors expect new nurse leaders to learn the same way that they did: through trial and error. In today’s fast-paced climate, trial-and-error learning in leadership often equates to failure for nursing leaders. Supervisors who are encouraging at the beginning of the relationship often claim leaders are just not a good fit and do not demonstrate the leadership skills needed to remain in a leadership position. Formal orientation or training for a leadership position in nursing is often scanty, if not totally absent.

This article is targeted at facilities that need or want to develop their nursing leaders to improve staff satisfaction, patient outcomes, fiscal status, and overall organizational success.

WHY LEADERSHIP DEVELOPMENT IS IMPORTANT TO NURSING

Staff Retention

The continuing nursing shortage presents a need for strong, innovative leaders to attract and retain the nursing workforce, deliver quality patient care, and ensure fiscally sound health care providers (Blanchard & Player, 2008). Retention of nursing employees is a strong reason for good leadership. On the basis of research that found a statistically significant relationship between leadership style and staff nurses’ intent to stay, Ribelin (2003) states that “nurses don’t leave hospitals, they leave managers” (p. 18). The study revealed the better the staff’s perception of the leader, the greater their intent to stay (Ribelin). The best way to impact turnover is to give leaders the knowledge needed to create a work climate that motivates and engages employees (Bernthal, Wellins, & Walker, 2004).
Jones (2004) published an economic analysis of the cost of turnover for registered nurses and found that at one 600-bed acute care facility, turnover costs $62,100 to $67,100 per staff nurse. Given the difference in salaries between staff nurses and those in leadership positions, the cost of leadership turnover increases exponentially. Compared to other industries, turnover in healthcare is higher among first-level leaders such as charge nurses, assistant nurse managers, and nurse managers than it is among senior-level leaders such as directors, chief nursing officers, vice presidents, and patient care administrators (Bernthal et al., 2004). Jones and Gates (2007) found that to improve nurse retention, strong, top-level nursing leadership must transform the workplace and supportive nursing supervision must be present at all levels of the organization.

**Patient Outcomes**

Wong and Cummings (2007) performed a systematic review of studies to determine the relationship between patient outcomes and nursing leadership. After completing their search and retrieval process, they retained seven quantitative articles. Literature reviews found evidence of significant relationships between positive leadership behaviors and patient outcomes. Nurse leaders who used their leadership skills to transform the strategy of patient care delivery in an organization improved patient outcomes, which included reducing patient mortality and adverse events and increasing patient satisfaction. Effective nursing leadership is essential in establishing positive practice environments. The nurse leader plays a key role in managing staff and financial resources needed to deliver effective patient care (Patrick & White, 2005).

**Fiscal Impact**

Nursing managers have fiscal responsibility for millions of dollars in revenue and expenses associated with running a nursing unit. In most institutions, nursing is the largest cost center. Nursing leaders must control their budget and make sound fiscal decisions about issues that affect patient safety, care, outcomes, and satisfaction and staff satisfaction. Nurse leaders must spend their allotted budget wisely. In addition, nursing leaders cannot separate high-quality patient care from effective fiscal practices (Pearce, 2008).

A study performed by Pappas (2008) regarding the costs of adverse events and effective levels of nurse staffing established that poor patient care outcomes are correlated with increased costs. Because nursing leadership has a direct impact on patient care outcomes (Wong & Cummings, 2007), it also has a direct impact on the costs associated with caring for patients. The lower the quality of nursing leadership, the higher the costs for the organization. This is especially relevant if lower-quality health care results in adverse patient events. Synchronized enhancements in patient care and hospital costs are essential to hospital success in this era of declining reimbursements, staffing shortages, and published outcomes (Pappas).

**WHAT CAN BE DONE TO STRENGTHEN NURSING LEADERSHIP**

There are many ways to strengthen nursing leadership teams at most institutions, including continuing education at the master’s level or higher, as undergraduate programs may have only one or two leadership classes. Organizations can send nurse leaders to external programs sponsored by nursing schools, private companies, or nursing professional associations. In these programs, participants usually receive days or weeks of intense leadership training that may or may not fit the culture of their organization. Additionally, if the new leaders return to organizations that do not have methodologies that support them as they test their new skills, sustainability and application of their training may not be evident.

After trying many of the alternatives, the author’s hospital decided to fund a nursing leadership development department to focus on building a program to develop and manage nursing talent at the hospital’s eight campuses. The total bed count for the eight hospitals is more than 2,000, and approximately 4,800 registered nurses, with 500 or more being in a formal leadership role at any one time, work at these institutions. Despite the large number of nursing leaders, the program started with only one registered nurse serving as coordinator. Although the program currently provides more than 3,000 hours of education annually to nursing staff in leadership, it only requires two full-time equivalents as its core staff.

Cost does not have to be the deciding factor in providing in-house nursing leadership education. Formation of a nursing leadership development program requires a good plan, hard work, and a desire to make nurses the best leaders possible.

**HOW TO DESIGN A LEADERSHIP DEVELOPMENT PROGRAM**

**Assessment**

Assessment is the starting point for all patient care activities. It is also the starting point when designing a leadership development program. The organization must be assessed to determine what needs to be taught imme-
diately, what needs to be taught within the next year, and what needs to be taught eventually.

Many tools exist for assessing the needs of nursing departments and their nurses. Nursing leaders should be asked what they think they need to learn. Executive leadership should be asked what they expect nursing leaders to know. Assessment can be accomplished through written questionnaires, Internet surveys, interviews of staff and executives, review of previous in-service education forms to determine interest in continuing education in leadership topics, and casual conversations. Once individuals in the department have expressed what they want in relation to leadership education, the next step is to examine outcomes demonstrated by leaders. Table 1 lists questions that organizations must answer to build leadership development programs tailored to their needs.

**Building the Curriculum**

Once assessment is complete, it should be decided which employees should be educated first. The author recommends that the building of curriculum begin at the lowest level of front-line nursing leadership in an organization. This will allow curriculum to be built up to meet the needs of increasing levels of leadership responsibility.

Experience and job function are determinants of levels of education for leaders. The levels, built around Benner’s (1984) novice to expert framework, range from 100 to 600. Table 2 details the framework used for nursing leadership development at the author’s hospital. Experienced nurse managers who are in leadership orientation in a new organization will be designated as novices. They must learn the tasks and expectations of their current role. Leaders must pass through the novice stage of education with each new job or organization.

The 100-level curriculum begins with the Nurse Leader Task Resource, a program that demonstrates new leaders’ tasks (e.g., what computer programs to use, what meetings to attend, and other responsibilities). This ensures success of the new leaders.
This level also includes a Grass Roots Initiative program for informal leaders in the nursing department. The Grass Roots Initiative, directed at Nurse Practice Councils, is part of the organization’s strategy to promote shared governance for nursing staff. This intensive program is offered to individual unit practice councils over three 8-hour days. The Grass Roots Initiative teaches staff-level nurses initial leadership skills such as team building and DMIAC (design, measure, improve, analyze, and control) process improvement concepts. DMIAC is a Six Sigma problem-solving methodology. Teams, in cooperation with unit managers, identify three areas of concern on their specific unit directed at patient safety and quality care. Teams choose which area to focus on and begin the process of problem solving using the DMIAC process improvement format. The leadership development department electronically tracks solutions implemented by unit-based teams to ensure their sustainability. If issues arise during the course of implementation, the leadership development department assists the teams in overcoming obstacles to success. Teams achieve success when established metrics are positively affected.

The program designates charge nurses or team leaders as novices at the 200 level. They must understand the organizational culture and therefore require education regarding the organization’s mission, vision, values, and philosophy. Individuals at the 200 level typically want to learn skills to help them handle daily issues in their assigned units. If education does not pertain to their day-to-day work, they will not engage in learning. Those at the 200 level do not relate well to intense theory and broad leadership concepts.

Conflict management, staff assignments, delegation, team building, generational diversity, assertiveness, communication, ethics, and patient satisfaction are topics that most individuals at the 200 level can quickly learn about and apply. The 200-level curriculum is a total of 24 hours. It consists of one 8-hour class per month over the course of 3 months. Thus, this curriculum is available four times a year.

The 300 level is for assistant nurse managers. It consists of one 8-hour class per month over the course of 12 months. This level builds on the curriculum offered at the 200 level. Individuals begin learning responsibilities associated with this level of leadership through didactic education, interaction, and role-playing. Staff development, empowerment, leadership qualities, budgeting and finance, regulation, progressive discipline, physician relations, performance improvement, and cultural diver-

<table>
<thead>
<tr>
<th>Benner Designation</th>
<th>Level of Leadership Development and Offerings</th>
<th>Target Audience</th>
<th>Curriculum Focus</th>
</tr>
</thead>
<tbody>
<tr>
<td>Novice</td>
<td>100—4 sessions per year/16 hours per session</td>
<td>New leaders in the organization</td>
<td>Tasks of the job</td>
</tr>
<tr>
<td></td>
<td>100—3-day sessions held 2 to 3 times per month</td>
<td>Grass Roots Initiative</td>
<td>Basic problem solving, Team building</td>
</tr>
<tr>
<td></td>
<td>200—4 sessions per year/24 hours per session</td>
<td>Charge nurses and team leaders</td>
<td>Initial team leadership skills, Basic skills needed for shift leadership responsibilities</td>
</tr>
<tr>
<td>Advanced beginner</td>
<td>300—2 sessions per year/8 hours per month for 12 months/96 hours per session</td>
<td>Assistant nurse managers</td>
<td>Advanced skills needed for shift leadership and initial skills needed for unit-based leadership</td>
</tr>
<tr>
<td>Competent</td>
<td>400—1 session per year/8 hours per month for 12 months/96 hours per session</td>
<td>Nurse managers</td>
<td>Unit-based leadership skills and initial skills needed for leadership across service lines</td>
</tr>
<tr>
<td>Proficient</td>
<td>500—2 to 4 workshops per year/4 hours each</td>
<td>Directors</td>
<td>Leadership skills based on service line</td>
</tr>
<tr>
<td></td>
<td>Self-study packets for “on-the-go” learning</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Expert</td>
<td>600—2 to 4 workshops per year/4 hours each</td>
<td>Executives</td>
<td>Broad, strategy-building leadership development skills</td>
</tr>
<tr>
<td></td>
<td>Self-study packets for “on-the-go” learning</td>
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TABLE 2: LEADERSHIP DEVELOPMENT FRAMEWORK USED BY ONE HOSPITAL
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Leadership development is a dynamic, ever-changing process directed at improving leaders and their organizations. Leadership development is not a rapid process; it takes time to build and implement a core curriculum. Several years may pass before leadership development outcomes are realized in an organization.

**Teaching**

Most educators quickly realize that they cannot teach leadership at all of the levels. At the author’s hospital, all current leaders are responsible for developing new leaders, regardless of discipline. Leaders are required to participate in an established speakers’ bureau to share their knowledge and help new leaders learn skills needed to be effective. Experts in each area (e.g., finance, executive leadership, strategic management, or human resources) develop and teach courses to the nursing leadership staff. This requires a time commitment from some of the organization’s busiest individuals. These experts help strengthen overall leadership in the organization.

Advanced classes at the 500 and 600 levels often require outside consultants, programs, or speakers. These classes are sensitive to strategic goals of the organization. They encompass national or global changes in health care that immediately impact the organization.

**Evaluation**

Continual evaluation of the educational process is planned to ensure that the learning experience results in established learning outcomes. The main purpose of evaluation is to gain understanding of the impact of student education and to improve the leaders’ learning (Billings & Halstead, 2009). In leadership development, projects and demonstrations are some of the methods of evaluation. Indicators of retention, staff satisfaction, and attainment of strategic goals are used to determine the effectiveness of the program and its impact on the organization.

**Outcomes**

The nursing leadership development program, in place for less than 24 months, is beginning to demonstrate measurable outcomes. The biggest impact to date has related to nursing retention rates. Although leadership development is not the only entity addressing retention at the organization, training in retention methodologies is the driving force at the unit level. During the past year, the organization has experienced a 4% overall improvement in retention and as much as a 24% improvement in retention in selected units.

There is also a larger pool of nursing staff available for promotion to higher-level positions. Promotion on the basis of seniority or favoritism has been replaced by promotion on the basis of participation in the leadership program. Upper-level management staff frequently contact nursing leadership development staff to inquire about such participation before making hiring decisions. The program has led to a baseline standard for leadership education and ability.

The focus of leadership development is metrics-driven. Therefore, the leadership team, including the informal leaders of the Nurse Practice Councils, is experiencing an increased awareness of the impact of its decisions and actions in relation to patient safety and outcomes. By allowing them to monitor progress, staff can quantify the impact of their patient care decisions. Through projects completed at the 300 and 400 levels, nursing leadership is able to implement and monitor new ideas affecting not only patient care but also staff satisfaction.

**CONCLUSION**

Leadership development is a dynamic, ever-changing process directed at improving leaders and their organizations. Leadership development is not a rapid process; it takes time to build and implement a core curriculum. Several years may pass before leadership development outcomes are realized in an organiza-
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key points

**Nursing Leadership Development**


1. Nursing does not consistently develop nursing leaders and many nursing leaders fail due to lack of leadership knowledge.

2. Nursing leadership has a direct impact on retention and recruitment of the nursing work force, the delivery of quality patient care, and the financial stability of a health care organization.

3. Individual health care organizations can institute nursing leadership programs that will develop their nursing leadership talent.

REFERENCES


