NURSING EXCELLENCE: Leadership Development, Culture, and Retention

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As nurse executives, we face challenges every day in our organizations from the mundane to the noteworthy. Results from the 2017 HealthLeaders Media Nursing Excellence Survey are telling regarding the top three nursing challenges that nursing staff face in the healthcare industry. Nurse retention (61%) and nurse recruitment (59%) stand out significantly by respondents as top challenges in the survey results; however, it is important to note that the third and fourth place challenges, nurse engagement (35%) and nurse leadership development (33%), directly impact an organization's ability to recruit and retain top-notch nursing staff.

Measuring nursing performance is a key component to engagement. If our nursing staff do not know how they are doing and what their outcomes are, they have little reason to engage in practice improvement. Seventy-six percent of respondents surveyed cited HCAHPS or other CMS surveys as mechanisms used to measure performance of nursing staff at their organizations.

Ironically, in my experience, the majority of direct care nurses will tell you that a score of 10 on HCAHPS often has no bearing on the clinical care being provided. The direct care nurse’s perception of the measurement tool often reflects a feeling of frustration regarding the mandates around survey scores and his or her ability to do what is medically right for the patient. On the other hand, NDNQI provides nurses with an objective database that can be used to compare their practice among peers, yet this tool is used to a lesser degree than HCAHPS.

This is true in my own organization. Will we be able to engage our nursing staff and elevate the profession if we base their performance on the subjective responses of nonclinicians? I do not think so. I believe HCAHPS is a valuable tool that allows us to evaluate our performance in the art of nursing, while tools such as NDNQI will allow us to give our nursing staff objective feedback to drive performance improvement.

As we discuss HCAHPS, we must consider value-based care and the impact this change has in reimbursement and the vernacular used to discuss interventions that are key to positive clinical outcomes. When we first began discussing core measures, nurses were quick to engage and change practice to ensure their patients had the best possible clinical outcome. It just made sense.
Today, rather than core measures, we talk about value-based purchasing. This terminology leads one to believe that the motivation for the intervention is reimbursement, or money, rather than clinical outcomes. We have disengaged our nursing staff with the evolution of the terminology. That said, I do not believe value-based purchasing itself has had a major impact, rather, the evidence behind the practice leads to improved outcomes and inevitably, compliance with value-based purchasing.

Although RN retention remains one of the biggest challenges for nurse executives according to results in the HealthLeaders Media survey, we all expect to predominantly staff our facilities with permanent staff (in the survey, respondents say that their organizations’ nursing staff profile is currently 92% employed nurses and, in three years, respondents estimate that same group will be at 94%).

There was one nurse retention tactic identified by respondents in the survey that seems to have less success than the others. Whether the funds are not present or the tactic was tried and failed, retention bonuses were not seen as a top solution to RN retention. Ironically, the tactics most commonly used by healthcare organizations for nurse retention can be traced back to leadership development. Without strong frontline leaders, many retention tactics will be difficult to implement and sustain. Investment in the training, education, and mentorship of frontline nurse leaders is the key to success for nurse retention. The strong nurse manager/director will create a positive supportive work environment with strong lines of communication. This work environment will build a professional, engaged, and aligned nursing workforce, thus improving recruitment and retention.
Nursing is an exceedingly demanding profession, typified by long hours and a high-stress work environment as nurses provide care and respond to a multitude of patient needs. But while their role is mostly clinical, increasingly it is also part care coordinator, social worker, therapist, teacher, customer service professional, and executive.

This tug-of-war between nonclinical and clinical requirements exemplifies one of the core challenges facing the nursing profession—delivering improved outcomes to satisfied patient-consumers. A quick look at nurse performance measurement is revealing. Notably, 76% of respondents in our survey say HCAHPS or other CMS surveys are the top nurse performance measurement tools used at their organizations (Figure 2), measuring mostly nonclinical nursing activities. Given that nurses typically remain dedicated to the clinical side of providing care, it is somewhat surprising that a tool such as the National Database of Nursing Quality Indicators (NDNQI) (42%) finishes in the mid-tier of responses.

While nurse performance is measured in a variety of ways, how do nurses rate the career and environments in which they work? Perhaps the answer can be found in the high turnover rates that are found throughout the industry, which are an indication that nurse expectations are clearly not being met.

**Top nursing challenges.** Respondents in our survey say that nurse retention (61%) and nurse recruitment (59%) are the top nursing challenges that their organizations are facing (Figure 1). The next level of responses are nurse engagement (35%) and nurse leadership development (33%). Note that compensation requirements (26%) falls in the middle of the responses, indicating that money is not one of the main drivers in nurse employment, and that factors such as engagement and leadership development play a larger role in nurse retention.

Another driver of nurse retention may involve the length of a typical nursing shift (Figure 7). According to our survey, nearly two-thirds of respondents (62%) say that the typical nursing shift in their organization is 12 hours, and another 29% indicate that the typical shift is eight hours. Interestingly, the data reveals a correlation between longer nurse shift lengths and higher responses for nurse retention as a challenge. For example, a greater share of respondents who say shift lengths are 12 hours mention nurse retention as a challenge (65%)
than respondents who say shift lengths are eight hours (49%). This suggests that fatigue from longer shift lengths may be partly responsible for nurses leaving an organization.

Survey responses reveal the scope of the retention problem—while almost three quarters of respondents (71%) say that their organizations’ RN turnover rate over the past 12 months (Figure 5) is less than 20%, one-quarter (25%) of respondents indicate that their turnover rate is 20% or more. This type of turnover could create difficulties for provider organizations because of the need to be in training mode, which disrupts productivity.

According to Jennifer Gentry, MSN, RN, NEA-BC, chief nursing officer at CHRISTUS Spohn Hospital Corpus Christi - Memorial and CHRISTUS Spohn Hospital Corpus Christi - Shoreline, part of the Texas–based CHRISTUS Spohn Health System with six hospitals and more than 15 medical clinics throughout southeast Texas, and the lead advisor for this Intelligence Report, there are two main factors impacting nurse retention rates.

“I think that we, as healthcare organizations, need to better align with our schools of nursing. I don’t believe that our nurses today are coming out of schools prepared for what the actual role of a professional nurse is. We see that with our nurses in the first year. They get here, they’re overwhelmed, they didn’t think it was going to be like this; it’s a lot of work. They’re just not prepared, and I think that’s a big piece of losing the nurse in the first year.

“What I found interesting in the survey results is that nurse leadership development is number four on the list regarding the top three nursing challenges in healthcare organizations. If we don’t do strong nurse leadership development, then we’re shooting ourselves in the foot when it comes to

WHAT HEALTHCARE LEADERS ARE SAYING

Here are selected comments from leaders regarding some of the most effective techniques their organizations are using to retain nursing staff, and why they think they work.

“We have many initiatives focused on engaging the nurses in the care of the patients as well as the overall work environment. We firmly believe that an engaged workforce is key to patient care and overall organizational mission. We are continuing to meet with our nurses to make sure they have a platform to share their opinions and concerns. We are also providing opportunities for nurses to practice leadership through participation in our Nurse Leadership Development Program.”

— Chief nursing officer at a medium health system

“Shared governance; tuition reimbursement plus annual scholarships for RNs to advance their education at undergraduate, graduate, and doctoral levels; a professional development portfolio program that offers incentives up to $8,000 annually; flexible scheduling; reimbursement for conference attendance and supporting nurses in their podium and poster presentations; supporting nurses for community work, research, and EBP project support, including an organizational in-house foundation that awards funding for innovative programs and/or research open to all employees and physicians. These work because nurses feel valued and supported for their contributions to patient care, the nursing profession, and the organizational mission.”

— Director of nursing at a small health system

“Through our Registered Nurse Professional Development Program—this encourages nurses to improve and also gives them a bonus for achieving milestones. Also through tuition reimbursement—this actively encourages nurses to continue their education, and we provide financial assistance to do so. And through leadership development; we think better leaders make better work environments.”

— Chief nursing officer at a large hospital

“Proper overall staffing to reduce burnout. Peer interviewing prior to hire to bring in staff members that are a good fit. Longer mentorships for new nurses to let them gain confidence.”

— Chief financial officer at a small health system

“Pay and benefits on par with local competition. Nonprofit, faith-based culture provides superior work environment. Excellent nurse training program at all levels. Growth and expansion of facilities and services provides opportunities for advancement.”

— CEO at a medium long-term care/SNF
retention, recruitment, and engagement because those frontline nurse leaders, they’re the key to all these things. They’re the ones that are going to create the unit that the nurses want to be on—that strong work environment, those good work relationships, the teamwork, the engagement, the input. And if we’re not developing those nurse leaders, then it will be difficult for us to make any improvement in any of those top three challenges.”

Tactics to improve nurse retention. The top four tactics with which respondents say their organizations have had success in improving nurse retention (Figure 6) are flexible scheduling (53%), communication improvements (51%), orientation programs for new nurses (48%), and salary increases for all nurses (48%). The majority of responses fall in a relatively tight range between 38% and 53%. This is likely because providers may be implementing a broad array of tactics to improve nurse retention in recognition of the fact that successful retention is driven by an assortment of factors.

Note that several tactics are correlated with financial resources. For example, based on net patient revenue, a greater share of large (72%) organizations than small (51%) and medium (50%) organizations cite flexible scheduling as a successful tactic to improve nurse retention, and a greater share of large (69%) organizations than medium (51%) and small (45%) organizations mention orientation programs for new nurses. Further, a greater share of large (62%) organizations than medium (44%) and small (36%) organizations cite tuition reimbursement for advanced education and certification programs as a successful tactic to improve nurse retention, and a greater share of large (64%) organizations than medium (51%) and small (35%) organizations mention shared governance.

One of the tactics with the fewest responses is retention bonuses for new nurses (14%). This either indicates that providers may have difficulty funding bonus programs, or that they find retention bonuses ineffective in improving retention over the longer term (or both). Evidence supporting the case for financial resources constraints as a factor can be found in the following data: based on net patient revenue, a greater share of large (21%) and medium (19%) organizations mention retention bonuses than small (10%) organizations.

“I have to say that this has been my own experience,” says Gentry. “I have two emergency departments that report to me. Texas is not a certificate-of-need state and we had stand-alone, freestanding ERs popping up all over town over the last couple of years. And they can pay more than I can even think about paying. And so we offered retention bonuses as a counter to try to keep those nurses with us and it came with a two-year commitment.

“What I found ironic is one of my EDs was a very stable ED and had little turnover for years—great teamwork, great work environment, good working relationships with the physicians, good relationships with patients. Everybody took the retention bonus and the only people who didn’t stay for their two years had circumstances that were completely beyond their control. Now the other ED, which was not mine at the time, had only about half the nurses accept the retention bonus, and out of those that accepted the
retention bonus, only about half of those even stayed for the two years. And the reasons they cited for leaving were all of the reasons (in Figure 6) except the retention bonus. So that money made absolutely no difference to them—they wanted other things to be fixed for them to stay."

**RN Ambassador program.** Recognizing that the first two years of nurse employment are the most critical in terms of nurse retention, Gentry implemented an RN Ambassador mentoring program at CHRISTUS Spohn Health System in December 2015 that targeted new RNs with fewer than two years of employment. The pilot program focused on CHRISTUS Spohn Hospital Corpus Christi - Memorial and CHRISTUS Spohn Hospital Corpus Christi - Shoreline, with the goal of promoting a culture of mentorship, teamwork, and professional development for the purpose of onboarding and retaining registered nurses. The initial program quickly grew to include two RN Ambassadors.

According to Gentry, one of the key benefits of the program is that an RN Ambassador provides new nurses with a mentor who is not a supervisor, opening the door to a more comfortable environment for sharing job concerns and asking for advice. Nurses in the program meet weekly with the RN Ambassador during the first month of the program, biweekly in months two and three, every three weeks in months four through six, and monthly during months seven through their two-year anniversary.

The main duties of the RN Ambassador focus on the following, says Gentry:

- Developing supportive and encouraging relationships with new nurses
- Guiding new nurses in their professional, personal, and interpersonal growth

Gentry explains the concept of socialization: "I do think that hospitals need to invest in professional socialization. Not just the profession itself, but into the organization and the culture of the organization so that our nurses feel engaged and like we want them there, and that this is what you can do to make things better here. We have to do a good job of engaging them—it’s our responsibility to create an environment that pulls them in and engages them."

There are currently 91 nurses in the program and, over the past year, only nine nurses have left the organization. Prior to the program’s creation, the retention rate for new nurses...
during their first two years was approximately 65%. As of November 2016, the retention rate was 89%, Gentry says.

**Tactics to improve shift coverage.** It perhaps comes as no surprise that one of the drawbacks of high nurse turnover is shift coverage problems caused by nursing staff shortages (Figure 8). The top tactic that respondents say their organizations use to successfully address shift coverage problems caused by nursing staff shortages is overtime (78%), followed by flexible scheduling (55%) and internal float pools (49%). The use of agency nurses (42%) and travel nurses (32%) round out the list of tactics.

Note that, based on net patient revenue, a greater share of small (80%) organizations than medium (75%) and large (69%) organizations cite using overtime to successfully address shift coverage problems caused by nursing staff shortages. On the other hand, a greater share of large (72%) organizations than small (56%) and medium (53%) organizations mention flexible scheduling, and a greater share of large (67%) organizations than medium (60%) and small (40%) organizations cite internal float pools. This series of correlations is likely because small organizations could have fewer options available because of their smaller nursing staffs, forcing them to rely more on overtime.

Agency and travel nurses form a relatively small portion of total nursing staff, and are used when providers are unable to cover staff shortages through other means. Respondents indicate that their organizations’ current nursing staff profile is 92% employed nurses, 5% agency nurses, and 4% travel nurses (Figure 4). In three years, respondents say employed nurses will represent 94% of their nursing staff, with agency nurses representing 4%, and travel nurses at 3%, demonstrating an overall flat result for how nursing is staffed now and in the future.

"[The retention bonus] made absolutely no difference to them—they wanted other things to be fixed for them to stay.”

**Nurse staff performance.** According to respondents, the primary method of tracking and measuring nursing staff performance at their organizations (Figure 2) is HCAHPS or other CMS surveys (76%). This is followed by postdischarge phone calls (50%), in-house survey activity (non-CMS) (46%), and Press Ganey (45%). Note that the top two responses are used mainly to track nurse performance in terms of patient experience and satisfaction, compared with the more clinically oriented measurement offered by the National Database of Nursing Quality Indicators (NDNQI) (42%), which falls in the middle of the response range.

“In our organization, we measure compliance with the bedside shift report, purposeful rounding, as well as the things we measure through the nursing domain of HCAHPS,” says Gentry. But she acknowledges that HCAHPS is flawed in terms of nursing’s clinical mission, and that it is viewed mostly as a patient satisfaction survey by her staff. For this reason, CHRISTUS Spohn Health System also relies on the NDNQI tool.

Survey responses reveal that organizational size is correlated with how organizations track and measure the performance of their nursing staff. For example, based on net patient revenue, a greater share of large (85%) organizations than medium (76%) and small (69%) organizations mention HCAHPS or other CMS surveys as ways to track and measure the performance, and a greater share of large organizations (59%) than medium (49%) and
small organizations (49%) cite postdischarge phone calls. Further, a greater share of medium (56%) and large (56%) organizations than small (37%) organizations mention Press Ganey, and a greater share of medium (53%) and large organizations (51%) than small organizations (31%) cite the National Database of Nursing Quality Indicators (NDNQI).

Note that the one exception to the organizational size correlation is for in-house survey activity (non-CMS) where, based on net patient revenue, a greater share of small organizations (55%) than medium (43%) and large (28%) organizations mention it as a way to track and measure nursing staff performance. This is likely because small organizations, due to their smaller footprint and lower nursing staff levels, may more easily track nurses using in-house staff than larger organizations that have more locations and higher nursing staff levels.

**Impact of value-based care.** The majority of respondents (54%) expect that the impact from the transition from fee-for-service to value-based care at their organization (Figure 3) will either have a major positive impact (18%) or a minor positive impact (36%) on nursing performance. A far more modest number (20%) of respondents expect that this will have a major negative impact (6%) or a minor negative impact (14%). Another 12% say they expect it will have no impact, and 13% don’t know.

Gentry points out that one of the factors respondents may see negatively about value-based care is the need for more reporting. “It’s not uncommon that at our corporate level, our electronic health record will be changed so that it is easier for them to abstract the data that they need to measure one of the components of value-based purchasing. But in doing that, they’ve now created triple documentation for the RN. I also think so much of capturing the data and the documentation is falling on the RN, and that’s taking time away from providing care.”

The emphasis on metrics and the collection of data associated with value-based care creates a need for informatics expertise to analyze the data, both for nursing staff as well as the greater organization. However, not all organizations are financially able to support a chief nursing informatics officer. For example, the majority of respondents (62%) say that their organizations do not have a chief nursing informatics officer and they don’t plan to have one (Figure 10). Another one-third (34%) of respondents say they either have a chief nursing informatics officer (23%) or don’t have one but plan to in three years (11%).

Note that, based on net patient revenue, a greater share of small (70%) organizations than medium (56%) and large (49%) organizations say that they do not have a chief nursing informatics officer and they don’t plan to have one. This is likely because small organizations may be less able to justify the expense of having a dedicated nursing informatics position and could rely on an organizationwide chief informatics officer as an option, while large organizations may have the financial resources necessary to support this type of executive-level specialization.
The importance of organizational culture. A well-known organizational management saying suggests that culture eats strategy for breakfast. Nearly one-third (32%) of respondents say that difficulty changing organizational culture is the biggest stumbling block to creating an effective nursing program at their organization (Figure 13). This response is followed by a second tier of tightly clustered responses including abundance of other priorities (17%), abundance of higher priorities (14%), and lack of funding (12%). Note that 8% of respondents say that they have no stumbling block.

To Gentry, creating a good nursing culture begins with providing a professional career path for nurses. “It begins with really working on professional development of the nurses. Our nurses understand their professional responsibility, and accept that professional responsibility. It’s that the nursing profession is not just about a job, it’s not just about coming in and clocking in and out. They have a responsibility to their profession, to their license, to excellent patient care, to improving outcomes, to process improvement, all of those things. And we try to balance that professional expectation and professional development with the limitations of the current financial landscape.”

Jonathan Bees is senior research analyst for HealthLeaders Media. He may be contacted at jbees@healthleadersmedia.com.

“So much of capturing the data and the documentation is falling on the RN, and that’s taking time away from providing care.”
Nurse retention (61%) and nurse recruitment (59%) are the top nursing challenges that respondents say their organizations are facing. The second tier of responses consists of nurse engagement (35%) and nurse leadership development (33%). Note that compensation requirements (26%) falls in the middle of the responses, suggesting that money is not one of the main challenges in nurse employment, and that factors such as engagement and leadership development play a larger role in nurse retention.

Interestingly, there is a correlation between longer nurse shift lengths and higher responses for nurse retention as a challenge. A greater share of respondents who say shift lengths are 12 hours mention nurse retention as a challenge (65%) than respondents who say shift lengths are eight hours (49%). This is an indication that fatigue from longer shift lengths may be partly responsible for nurses leaving an organization.
According to respondents, the predominant method of tracking and measuring nursing staff performance at their organization is HCAHPS or other CMS surveys (76%). This is followed by postdischarge phone calls (50%), in-house survey activity (non-CMS) (46%), and Press Ganey (45%). Note that the top two responses are used mainly to track nurse performance in terms of patient experience and satisfaction, compared with the more clinically oriented measurement offered by the National Database of Nursing Quality Indicators (NDNQI) (42%), which places in the middle of the response range.

Survey responses also reveal that organizational size is correlated with how organizations track and measure the performance of their nursing staff. For example, based on net patient revenue, a greater share of large (85%) organizations than medium (76%) and small (69%) organizations mention HCAHPS or other CMS surveys as ways to track and measure performance, and a greater share of large organizations (59%) than medium (49%) and small organizations (49%) cite postdischarge phone calls. Further, a greater share of medium (56%) and large (56%) organizations than small (37%) organizations mention Press Ganey, and a greater share of medium (53%) and large organizations (51%) than small organizations (31%) cite the National Database of Nursing Quality Indicators (NDNQI).

Note that the one exception to the organizational size correlation is for in-house survey activity (non-CMS) where, based on net patient revenue, a greater share of small organizations (55%) than medium (43%) and large (28%) organizations mention it as a way to track and measure nursing staff performance. This is likely because small organizations, due to their smaller footprint and lower nursing staff levels, may more easily track nurses using in-house staff than larger organizations that have more locations and higher nursing staff levels.
What impact do you expect the transition to value-based care will have on your organization’s overall nursing performance?

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*Base = 266*

The majority of respondents (54%) expect that the impact from the transition to value-based care at their organization will either have a major positive impact (18%) or a minor positive impact (36%) on nursing performance. A more modest number (20%) expect that this will have a major negative impact (6%) or a minor negative impact (14%). Another 12% say they expect it will have no impact, and 13% don’t know.

A greater share of rural organizations (57%) expect value-based care will either have a major positive impact (10%) or a minor positive impact (47%) than non-rural organizations (48%) expect it will have a major positive impact (22%) or a minor positive impact (26%). Conversely, a greater share of non-rural organizations (30%) expect value-based care will have a major negative impact (11%) or a minor negative impact (19%) than rural organizations (10%) expect it will have a major negative impact (2%) or a minor negative impact (8%). The results for no impact are relatively close for rural (12%) and non-rural (16%).
What percent of your nursing staff is employed, travel, and agency?

**CURRENTLY**
- Employed nurses: 92%
- Travel nurses: 4%
- Agency nurses: 5%

**IN THREE YEARS**
- Employed nurses: 94%
- Travel nurses: 3%
- Agency nurses: 4%

Base = 249

Base = 226

Respondents say that their organizations’ current nursing staff profile is 92% employed nurses, 5% agency nurses, and 4% travel nurses. In three years, respondents say employed nurses will represent 94% of their nursing staff, with agency nurses representing 4%, and travel nurses at 3%, demonstrating an overall flat result for how nursing is staffed now and in the future.
Almost three-quarters of respondents (71%) say that their organizations’ RN turnover rate over the past 12 months is less than 20%, and one-quarter (25%) of respondents indicate that their turnover rate is 20% or more. Turnover greater than 20% per year could create difficulties for provider organizations because of the need to be in training mode, which disrupts productivity.

A greater share of nonprofit organizations (76%) than for-profit organizations (57%) say that their RN turnover rate is less than 20%, and a greater share of for-profit organizations (38%) than nonprofit organizations (20%) indicate that their turnover rate is 20% or more.

A greater share of rural organizations (78%) than non-rural organizations (71%) say that their RN turnover rate is less than 20%, and a greater share of non-rural organizations (27%) than rural organizations (18%) indicate that their turnover rate is 20% or more.
What tactics have been successful in improving nurse retention at your organization?

- Flexible scheduling: 53%
- Communication improvements: 51%
- Orientation programs for new nurses: 48%
- Salary increases for all nurses: 48%
- Work environment improvements: 42%
- Tuition reimbursement for advanced education and certification programs: 42%
- Shared governance: 41%
- Nurse training: 38%
- Retention bonuses for new nurses: 14%
- Other: 8%

The top four tactics with which respondents say their organizations have had success in improving nurse retention are flexible scheduling (53%), communication improvements (51%), orientation programs for new nurses (48%), and salary increases for all nurses (48%). The majority of responses fall in a relatively tight range between 38% and 53%. This is likely because providers may be implementing a broad array of tactics to improve nurse retention in recognition of the fact that successful retention is driven by an assortment of factors.

Note that several tactics are correlated with financial resources. For example, based on net patient revenue, a greater share of large (72%) organizations than small (51%) and medium (50%) organizations cite flexible scheduling as a successful tactic to improve nurse retention, and a greater share of large (69%) organizations than medium (51%) and small (45%) organizations mention orientation programs for new nurses. Further, a greater share of large (62%) organizations than medium (44%) and small (36%) organizations cite tuition reimbursement for advanced education and certification programs as a successful tactic to improve nurse retention, and a greater share of large (64%) organizations than medium (51%) and small (35%) organizations mention shared governance.

One of the tactics with the fewest responses is retention bonuses for new nurses (14%). This either indicates that providers may have difficulty funding bonus programs, or that they find retention bonuses ineffective in improving retention over the longer term (or both). Evidence supporting the case for financial resources constraints as a factor can be found in the following data: based on net patient revenue, a greater share of large (21%) and medium (19%) organizations mention retention bonuses than small (10%) organizations.
Nearly two-thirds of respondents (62%) say that the typical nursing shift in their organization is 12 hours. Another 29% indicate that the typical shift is eight hours, 5% say 10 hours, and 1% say four hours.

Based on net patient revenue, a greater share of respondents from large (72%) and medium (68%) organizations than small organizations (55%) cite 12 hours as a typical nursing shift, and a greater share of respondents from small (33%) organizations than medium (22%) and large organizations (18%) mention eight-hour shifts.

A greater share of nonprofit organizations (67%) than for-profit organizations (49%) mention 12 hours as a typical nursing shift, and a greater share of for-profit organizations (38%) than nonprofit organizations (26%) cite eight-hour shifts.
Overtime (78%) is the top tactic that respondents say their organizations use to successfully address shift coverage problems caused by nursing staff shortages. Flexible scheduling (55%) and internal float pools (49%) round out the top three responses.

Based on net patient revenue, a greater share of small (80%) organizations than medium (75%) and large (69%) organizations cite using overtime to successfully address shift coverage problems caused by nursing staff shortages. On the other hand, a greater share of large (72%) organizations than small (56%) and medium (53%) organizations mention flexible scheduling, and a greater share of large (67%) organizations than medium (60%) and small (40%) organizations cite internal float pools. This series of correlations is likely because small organizations could have fewer options available because of smaller nursing staffs, forcing them to rely more on overtime.
A plurality of respondents (42%) say that their organization’s cost containment initiatives have resulted in no change to the overall quality of its nursing care. Approximately one-third (31%) of respondents say that cost containment initiatives are responsible for either a minor decline (26%) or major decline (5%) in quality, and conversely, roughly one-quarter (23%) say that cost containment initiatives are responsible for either a minor improvement (18%) or a major improvement (5%).

Based on net patient revenue, a greater share of respondents from large organizations (43%) say that their organization’s cost containment initiatives are responsible for either a minor decline (38%) or major decline (5%) in the overall quality of its nursing care than medium (31%) organizations (minor decline 25%/major decline 6%) and small (23%) organizations (minor decline 19%/major decline 4%).
The majority of respondents (62%) say that their organizations do not have a chief nursing informatics officer and they don't plan to have one. Another one-third (34%) of respondents say they either have a chief nursing informatics officer (23%) or don’t have one but plan to in three years (11%).

Based on net patient revenue, a greater share of small (70%) organizations than medium (56%) and large (49%) organizations say that they do not have a chief nursing informatics officer and they don't plan to have one. This is likely because small organizations may be less able to justify the expense of having a dedicated nursing informatics position and could rely on an organizationwide chief informatics officer as an option, while large organizations may have the financial resources necessary to support this type of executive-level specialization.
Ninety-five percent of respondents report that their organization’s nursing staff uses evidence-based practice to some degree, with nearly one-quarter (24%) saying they use evidence-based care for all of their care, 42% saying they do this for most of their care, and 29% saying they use this for some of their care. Only 4% say that their organization’s nursing staff does not actively use evidence-based practice.
Three-quarters (76%) of respondents indicate that their organization's employed nurses are not members of a union, and almost one-quarter (23%) say that either all of them (14%) or some of them (9%) are union members.

A greater share of for-profit organizations (85%) than nonprofit organizations (72%) say that their employed nurses are not members of a union. Conversely, a greater share of nonprofit organizations (27%) than for-profit organizations (11%) say that either all of them or some of them are union members.

A greater share of respondents who say that their employed nurses are not members of a union are from the South (91%) and Midwest (80%) than the Northeast (60%) and West (57%).
What is the biggest stumbling block to creating an effective nursing program at your organization?

- Difficulty changing organizational culture: 32%
- Abundance of other priorities: 17%
- Abundance of higher priorities: 14%
- Lack of funding: 12%
- None; we have no stumbling blocks: 8%
- Lack of specific strategy: 5%
- Lack of leadership commitment: 5%
- Lack of useful metrics: 2%
- Other: 5%

Base = 266

Nearly one-third (32%) of respondents say that difficulty changing organizational culture is the biggest stumbling block to creating an effective nursing program at their organization. This response is followed by a second tier of tightly clustered responses, including abundance of other priorities (17%), abundance of higher priorities (14%), and lack of funding (12%). Note that 8% of respondents say that they have no stumbling blocks.
The 2017 Nursing Excellence Survey was conducted by the HealthLeaders Media Intelligence Unit, powered by the HealthLeaders Media Council. It is part of a series of monthly thought leadership studies. In December 2016, an online survey was sent to the HealthLeaders Media Council and select members of the HealthLeaders Media audience at healthcare provider organizations. A total of 266 completed surveys are included in the analysis. Base size varies between 226 and 266 according to respondents’ knowledge of the question. The margin of error for a base of 266 is +/-6.0% at the 95% confidence interval. Totals do not always add to 100% due to rounding.

UPCOMING INTELLIGENCE REPORT TOPICS

APRIL
Mergers, Acquisitions, and Partnerships

MAY
Value-Based Readiness

JUNE
Cost and Revenue Strategies

ABOUT THE HEALTHLEADERS MEDIA INTELLIGENCE UNIT

The HealthLeaders Media Intelligence Unit, a division of HealthLeaders Media, is the premier source for executive healthcare business research. It provides analysis and forecasts through digital platforms, print publications, custom reports, white papers, conferences, roundtables, peer networking opportunities, and presentations for senior management.

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RESPONDENT PROFILE

TITLE

Respondents represent titles from hospitals; health systems; long-term care/SNFs; physician organizations; and ancillaries, allied providers.

Base = 266

48% Senior leaders
27% Clinical leaders
20% Operations leaders
3% Financial leaders
2% Marketing leaders
1% Information leaders

SENIOR LEADERS
CEO, Administrator, Chief Operations Officer, Chief Medical Officer, Chief Financial Officer, Executive Dir., Partner, Board Member, Principal Owner, President, Chief of Staff, Chief Information Officer, Chief Nursing Officer, Chief Medical Information Officer

CLINICAL LEADERS
Chief of Cardiology, Chief of Neurology, Chief of Oncology, Chief of Orthopedics, Chief of Radiology, Dir. of Ambulatory Services, Dir. of Clinical Services, Dir. of Emergency Services, Dir. of Inpatient Services, Dir. of Intensive Care Services, Dir. of Nursing, Dir. of Rehabilitation Services, Service Line Director, Dir. of Surgical/Perioperative Services, Medical Director, VP Clinical Informatics, VP Clinical Quality, VP Clinical Services, VP Medical Affairs (Physician Mgmt/MD), VP Nursing

OPERATIONS LEADERS
Chief Compliance Officer, Chief Purchasing Officer, Asst. Administrator, Chief Counsel, Dir. of Patient Safety, Dir. of Purchasing, Dir. of Quality, Dir. of Safety, VP/Dir. Compliance, VP/Dir. Human Resources, VP/Dir. Operations, Administration, Other VP

FINANCIAL LEADERS
VP/Dir. Finance, HIM Director, Director of Case Management, Director of Patient Financial Services, Director of RAC, Director of Reimbursement, Director of Revenue Cycle

MARKETING LEADERS
VP/Dir. Marketing/Sales, VP/Dir. Media Relations

INFORMATION LEADERS
Chief Technology Officer, VP/Dir. Technology/MIS/IT

TYPE OF ORGANIZATION
Base = 266
Hospital 49%
Health System (IDN/IDS) 25%
Long-term Care/SNF 17%
Physician Org. (MSO, IPA, PHO, Clinic) 6%
Ancillary, Allied Provider (Home Health, Lab, Rehab Postacute, etc.) 3%

NUMBER OF BEDS
Base = 130 (Hospitals)
1-199 (Small) 55%
200-499 (Medium) 30%
500+ (Large) 15%

NUMBER OF SITES
Base = 66 (Health systems)
1-5 (Small) 17%
6-20 (Medium) 33%
21+ (Large) 50%

NUMBER OF PHYSICIANS
Base = 16 (Physician org)
1-9 (Small) 6%
10-49 (Medium) 38%
50+ (Large) 56%

REGION


MIDWEST: North Dakota, South Dakota, Nebraska, Kansas, Missouri, Iowa, Minnesota, Illinois, Indiana, Michigan, Ohio, Wisconsin

SOUTH: Texas, Oklahoma, Arkansas, Louisiana, Mississippi, Alabama, Tennessee, Kentucky, Florida, Georgia, South Carolina, North Carolina, Virginia, West Virginia, DC, Maryland, Delaware

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