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Role conflict, role ambiguity and job satisfaction of the nurse executive

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ROLE CONFLICT, ROLE AMBIGUITY AND
JOB SATISFACTION OF THE
NURSE EXECUTIVE

by

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ABSTRACT

Role Conflict, Role Ambiguity and Job Satisfaction in Nurse Executives

by

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Healthcare organizations have seen remarkable and unprecedented changes over the past two decades. Political and social expectations have risen, drastic changes in payer systems have lead to a focus on controlling costs and profitability and technology and research has exploded. As a result, the role of the Nurse Executive (NE) has expanded significantly. At the same time, the United States is currently undergoing a major nursing and faculty shortage. According to a 2003 study, the average age of a NE is 49 years (Ballein Search Partners, 2003) with many expected to retire over the next 12 years. The potential exists for a leadership vacuum during a critical juncture, in healthcare. Despite drastic changes in healthcare and nursing practice, changes in nursing education have not kept pace.

The purpose of conducting this study was to determine if NEs perceive role conflict and role ambiguity in relation to their expanded responsibilities and if NEs are satisfied with their current position. It is important for nursing education to explore how NEs are faring during this critical juncture so that nursing education outlets many seek both formal and informal ways to provide educational content and skills to both support the current cohort of NEs and provide future leaders the knowledge and environment necessary for clinical skill development and important leadership positions

A national survey of NEs measuring role conflict, role ambiguity, job satisfaction, depression and selected demographics was conducted. Participants had the option of participating electronically or via paper surveys. The data were analyzed using descriptive statistics, MANOVA and *t* test comparisons with a previous survey.

The data revealed low to moderate levels of role conflict (3.04), and role ambiguity (2.91), among NEs surveyed. Measured job satisfaction (4.01), was high while depression scores (7.42) were low among those surveyed. There was no relationship between NE age and any of the four dependent variables; however the results suggest some degree of relationship with educational level. Those with a doctorate non-nursing had higher levels of both role conflict and role ambiguity than some other education levels. Recommendations for practice and further research are also provided.

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CHAPTER 1

BACKGROUND AND INTRODUCTION

Over the past two decades, the health care industry has undergone radical change. In the early 1990s, there was an organized effort at the national level for health care reform, which focused on securing universal access and equity in care as well as support for advancement of primary prevention activities; however, those efforts were eventually defeated. The focus in healthcare then shifted to controlling costs, utilization control and securing profits. Healthcare systems merged and integrated, services expanded over cross-departmental boundaries and the atmosphere became characterized by pursuit of market share. This change in focus led to the increased use of unlicensed personnel, downsizing of the workforce and a shift in care from inpatient acute care to outpatient care. Hospitals have undergone downsizing, reengineering and reorganization, all of which have made an effect on the numbers and types of nurses as well as the areas of influence and capabilities of nurses and nursing (Keepnews & Marullo, 1996). At the same time, technology exploded and changes in government regulation and decreased reimbursement from both government and private payer sources continue to change the face of health care. Despite drastic changes in healthcare and nursing practice, changes in nursing education have lagged. While there have been changes in curriculum, these have often focused on adding or rearranging content rather than significant “paradigm

shift” changes. “Many nurse educators continue to teach as they were taught and for a healthcare system that no longer exists” (National League of Nursing, 2003). Nursing education must be responsive and seek to develop innovative strategies to meet the needs of today’s healthcare system so that nurses at all levels are better able to meet the challenges posed by the significant changes in the healthcare industry.

Historically the role of the Nurse Executive (NE) focused primarily on providing oversight for the nursing care delivered in the health care facility. Yet, as a result of the sweeping transformation of the health care system, the role of this important nurse leader has evolved both formally and informally (Dwore, Murray, Fosbinder, & Parsons, 2000). NEs have experienced changes in their roles and responsibilities. No longer is the primary focus only on nursing, but rather on patient care services throughout the health care organization and continuum. More emphasis is being given to oversight of non nursing patient care departments, as well as governing board responsibilities, participating in budgeting decisions and strategic planning and interacting with the medical staff. Often, the new expectations of the NE also include developing and implementing policies, initiating new product lines and programs, meeting financial goals, possessing business skills and participating in the design and construction of services (Fosbinder et al., 1999; Stichler, 2006). Being a successful NE now requires attaining new and expanding existing skills. As the role of the NE has changed, they are now also seen as respected individuals on the administrative team (Ballein, 1998; Dalley et al., 2000).

Accrediting and professional organizations have also clearly delineated new expectations of the NE. The Joint Commission on Accreditation of Health Care

Organizations (JACHO) mandated formal changes in the role of the NE. It is now expected that the NE actively participate in hospital leadership functions, as well as collaborate with other hospital leaders in designing and providing patient care and services. The NE also has the authority and responsibility to participate with the governing body, management, medical staff and clinical leaders in the organization's structures and processes and in planning, promoting and conducting organization wide performance improvement activities (Joint Commission on Accreditation of Healthcare Organizations, 2002).

The American Organization of Nurse Executives (AONE) stated innovative leadership by the NE is required to shape a positive outlook for the future of health care. Innovative leadership demands the NE be skilled in a variety of competencies necessary for success (American Organization of Nurse Executive, 2005). These competencies include the ability to provide effective communication and relationship building as well as possessing knowledge of the health care environment, and business skills. Finally, strong leadership skills overlap in all of the above. This list of NE competencies is not meant to be exhaustive but rather illustrate the complexity of the new role of the NE (American Organization of Nurse Executive, 2005). It is no longer appropriate, nor possible, for the NE to focus exclusively on the delivery of nursing care. At the same time, it is important for the NE to remain responsive to the needs of nursing. Clinical staff need to be confident in the fact that the NE is sensitive to their needs and are in touch with their work (Ballein, 1998; Manthey, 1994). The NE is the glue that holds the nursing department together by building a common identity among professionals. The

NE is the “missionary of vision, purpose and culture” for nursing in any health care organization (Stichler, 2006).

Considering the significant changes in healthcare, the resultant changes that have occurred in the role of the NE and the importance of nursing leadership at this critical juncture, it is important for nursing to assess how the NE is faring through the changes. Two important concepts to consider are the possibility of role conflict or role ambiguity and how satisfied are these important leaders in the redefined role. A number of studies have identified a relationship between role conflict, ambiguity and job burnout and satisfaction (Bacharach, Bamberger, & Conley, 1991; House, Schuler, & Levanoni, 1983; Rizzo, House, & Lirtzman, 1970). If nursing education is to answer the call by the National League for Nursing (NLN) to be responsive to the changing healthcare environment, then the changing role of the NE must be addressed. Nursing education should explore the presence of role conflict and role ambiguity in this important group so that curriculum changes and innovative strategies can be developed to meet the challenges faced by nursing leaders during these times of significant change.

Role Conflict and Role Ambiguity

Role conflict occurs when an individual is subject to competing or conflicting sets of expectations and demands for one position in the organization or when the principle of chain of command or the principle of unity of command are violated (Rizzo et al., 1970). This situation induces negative emotional reactions and diminishes job satisfaction and effectiveness in ones’ position. Role ambiguity occurs when an individual does not have the necessary information available to complete the required duties of a particular position. This often results in coping behaviors by the holder of that position to avoid

sources of stress including using defense mechanisms to distort the reality of the situation (Rizzo et al., 1970).

Health care organizations are complex and clearly have two hierarchies, the administrative and the medical. In most settings, nurses are responsible for two or more populations including organization authorities, the facility, the patient and family and the physicians who direct the provision of the patients' care (Corley, Elswick, Gorman, & Clor, 2001). As a result, the potential exists for role conflict among all nurses including the NE.

Job Satisfaction

The General Accounting Office (GAO) indicates nursing is the "nation's largest group of health care providers" (General Accounting Office, 2007a); however, it is well known that the United States (US) and much of the civilized world is entrenched in a nursing shortage. Key aspects of this shortage include the estimation by the American Hospital Association (AHA) in 2001 that 118,000 nurses were needed to fill current vacant positions and the fact that 41% of Registered Nurses (RN's) are age 50 or older with an average age of 46.8 years. Only 8% of RNs are under the age of 30 compared with 25% in 1980 (Health Resources and Services Administration, 2004). A survey by *Nursing Management* and the Bernard Hodes Group indicated 55% of nurse respondents plan to retire between 2011 and 2020 (Hader, Saver, & Steltzer, 2006). While the GAO (2004) indicated the supply of RN's seems to be increasing, the demand is also increasing as the baby boomers are now reaching retirement age and Medicare eligibility (General Accounting Office, 2007b). Current estimates of the severity of the nursing shortage are not available. However, there are documented extreme shortages in certain geographic

and specialty areas (General Accounting Office, 2007b). As the nursing profession enters a time of increasing demand for nursing care, the supply is aging and retiring. As a result, there was a great deal of research done to explore job satisfaction of the staff nurse in an effort to improve nursing retention; however, a literature review indicates there are few studies and no recent studies that explore the level of job satisfaction of the NE.

Nursing Education

The nursing shortage is well documented and discussions continue to ensue with the aim of resolving the crisis. Recently, the nursing faculty shortage has also been recognized as a major concern. Strategies to address this secondary shortage are being discussed, debated and developed. In an effort to be proactive, nursing must examine other key subsets of the profession to identify potential or actual issues so strategies for resolution can be addressed. Considering the average age of the NE is 49 years (Ballein Search Partners, 2003) and 55% of practicing RNs are expected to retire in the next 12 years (Hader et al., 2006), nursing must consider that the profession may also be facing a leadership shortage.

The National League for Nursing has called for a reform of nursing education in which educators respond to the significant changes in healthcare. Innovation is required to change both content and curriculum to meet the new requirements and needs of nurses practicing in a recreated healthcare system. As part of this call to reform, the NLN and the Robert Wood Johnson Foundation (RWJF) have challenged educators and nursing practice to work in a collaborative partnership to redesign educational systems that are responsive to the changing healthcare systems (National League of Nursing, 2003; Robert Wood Johnson Foundation, 2002).

NEs are important to nursing education, as they “oversee the only product of health care organizations – patient care delivery” (Ballein Search Partners, 2003 p. 3). The profession needs to be proactive and assess how these important leaders are faring to identify if in fact there is a real or potential issue with this group. Nursing education should explore this potential leadership vacuum for three primary reasons. First, due to the evolving responsibilities of this group, it is important to assess how they are faring through the new and expanded expectations. If it is determined that NEs are experiencing some level of role stress, innovative education opportunities may need to be developed for the current cohort of leaders to provide them with support to meet these demanding roles. Educators may need to further examine the needs of this group to determine what support is necessary to delay their departure from the profession.

Secondly, as the profession continues to gray and retire and leadership positions become vacant, healthcare institutions will seek to fill them with the best possible candidates. With large numbers of experienced nurses leaving, facilities will look to nurses that have less experience with the expectation that they will fill these demanding NE roles. Curriculum reviews may need to be considered and decisions made to ensure that programs are providing students with appropriate content so that students in nursing programs can develop the knowledge and skill sets necessary to flourish in the new important and expanded roles.

Finally, Benner in her Novice to Expert work, has delineated nurses’ progress through five levels of skill development; novice, advanced beginner, competent, proficient, and expert. Her work has asserted that nurses only advance through the first one or two stages during their formal prelicensure education and thus graduate nurses are,

at best, in the advanced beginner stage (Benner, 1984). Her theory then extends that later stages of skill development occur in the workplace and that this development takes years to occur.

Benner believes that learning does not end at graduation but rather extends as a nurse practices and gains experience in the healthcare facility and that it is imperative the facility create an environment that fosters this skill development. The NE is the leader in the workplace and thus plays a pivotal role in ensuring that an environment conducive to skill development is nurtured. However, if the NE is already experiencing role overload and stress, can the NE focus on creating the necessary environment to support the graduate nurse? Before education can ensure these nursing students are being provided with knowledge and skill sets to meet leadership requirements and that NEs are able to provide an environment conducive to clinical skill development, nursing must understand the viewpoint and perspective of the current generation of NEs. This study is a first step in developing that level of understanding.

Problem

The United States is currently undergoing a major nursing shortage which is predicted to worsen since the average age of the RN is 46.8 years and 55% percent of practicing RNs are expected to retire by the year 2020. According to a 2003 national study of NEs, the average of a senior nursing officer is 49 years old (Ballein Search Partners, 2003). It is clear that at least some of those retiring will be nursing leaders including NEs. At the same time, the NE is filling an evolving and redefined role and has many constituencies to which to respond, so the NE is prone to role conflict and ambiguity. The potential for a leadership crisis looms, during a critical juncture within

the profession, if these nursing leaders leave their positions. At the same time, nursing education has been challenged to make significant and innovative changes to respond to the many changes faced by nursing practice. Nursing as a profession must understand how NEs are faring in a stressful and dynamic environment so that steps can be taken to provide educational opportunities which will in turn support and retain NEs in these important positions.

Purpose and Importance of this Study

The purpose of conducting this study was to determine if NEs perceive role conflict and role ambiguity in relation to their expanded responsibilities and if NEs are satisfied with their current position. This study was important because NEs have taken on an expanded role and responsibilities and at the same time, the profession is undergoing a severe shortage. It is important for nursing education to explore how NEs are faring during this critical juncture so that nursing education outlets may seek both formal and informal ways to provide educational content and skills to both support the current cohort of NEs and provide future leaders the knowledge and environment necessary for clinical skill development and important leadership positions.

Research Questions

For this study the following research questions were posed:

1. What are the self-reported levels of role conflict and role ambiguity in nurse executives as measured by the Role Conflict and Ambiguity Scale?
2. What are the self-reported levels of job satisfaction levels of nurse executives with their current position as measured by the Job Satisfaction Index?

3. What are the self-reported levels of depression of nurse executives as measured by the Center for Epidemiological Studies Depression Scale (CES-D)?
4. Is there a relationship between role conflict, or role ambiguity as measured by the Role Conflict and Ambiguity Scale and job satisfaction as measured by the Job Satisfaction Index for nurse executives?
5. Is there a relationship between role conflict or role ambiguity, as measured by the Role Conflict and Ambiguity Scale and depression as measured by the Center for Epidemiological Studies Depression Scale (CES-D) for nurse executives?
6. Is there a relationship between age and role conflict, role ambiguity, job satisfaction or depression?
7. Is there a relationship between educational level and role conflict, role ambiguity, job satisfaction or depression?
8. Is there a relationship between intent to remain in current position for next two years and role conflict, role ambiguity, job satisfaction and depression scores for nurses executives studied?

CHAPTER 2

REVIEW OF RELATED LITERATURE

History of the Nurse Executive

The history of nursing leadership dates back to Florence Nightingale. While most often associated as the founder of modern nursing, she was also the first nurse executive (NE) (Klakovich, 1994). Nightingale believed in the importance of strong nursing leadership. To that end, she established two groups of nursing leaders: superintendents and head nurses. These nurses tended to have a higher level of education and often came from a higher social class and better financial circumstances than other nurses (Klakovich, 1994). Nightingale's overall plan for hospital leadership envisioned three leaders: a lay administrator, a senior nursing leader and a physician leader. This is not unlike many organizational structures of today (Klakovich, 1994).

In 1927, an American Medical Association survey identified that nurses managed 20% of all hospitals and by 1942 that number rose to 41% (Alexander, 1997). Following WWII, many hospitals experienced growth and underwent expansions. As a result, some hospital boards and trustees began to become concerned about nurses' ability to manage the financial status of the facility, which led to many nurse heads of hospitals being replaced with an administrative position, usually a male or a physician. From that time,

the influence of the nursing leader retreated and tended to be confined to the oversight of nursing care. It was then that the Director of Nursing (DON) title evolved.

By the 1980s, hospitals began to become increasingly complex, patients were sicker and technology expanded. Hospital administrators began to support nurses taking on non-nursing roles such as nutrition, social services, and respiratory therapy (Klakovich, 1994). From the mid 1980s to the early 1990s, the title and scope of responsibility continued to evolve, reflecting the increasing complexity of health care. As a result, the title of the nursing leader evolved to Vice President of Nursing, Patient Care Services, or Chief NE (Garbett, 1998; Klakovich, 1994). Along with the change in title, the role expanded and began to reflect greater equality among other executive level positions in the hospital.

Florence Nightingale was the first to see the importance of a strong nursing leader to the success of healthcare and by 1942, 41% of all hospitals were managed by nurses; however, the end of WWII saw hospitals undergoing a growth spurt which resulted in much of the power of the organization shifting to an administrator or physician and the influence of nursing retreated to primarily oversight of the nursing care delivered. The 1980's saw the explosion of technology and increasing complexity of the hospital environment increasing. This led to nursing being considered for greater responsibility.

Evolution of the Nurse Executive Role

The last two decades have seen an era of remarkable and unprecedented changes in health care. There has been increasing political and social expectations to ensure access and quality of care within an environment which continues to see advances in technology while seeking to control costs and maintaining profitability (Naughton &

Nolan, 1998). The changes are the result of increasing acuity of patients in the hospitals, now only the sickest patients remain the hospital. There has also been a concurrent increase in ambulatory surgical techniques, which have increased the use of off-site locations for procedures that were previously done on an inpatient basis. Mergers and acquisitions have created new health care entities, technology has expanded, the population continues to age and congressional activity (such as the Prospective Payment System (PPS) in the late 1980's and Balanced Budget Act of 1997) has squeezed limited resources (Ballein, 2000; Keepnews & Marullo, 1996). These circumstances have led to hospitals needing to downsize, reengineer and reorganize. All of which have an effect on the numbers and types of nurses as well as the influence and capabilities of nurses (Klakovich, 1994).

After the advent of the PPS and the expansion of managed care, there were predictions of decreased use of RNs. As healthcare facilities looked to decrease costs, RNs, whom occupy the largest portion of full time equivalents (FTEs), seemed to be an easy area for cost savings. Many feared that RN's would be replaced by lesser-trained assistive personnel, resulting in decreased human resources costs to the healthcare facility. In reality, the number of RNs actually increased, with the ratio of RNs to patients increasing by 26% between 1982 and 1986 (Keepnews & Marullo, 1996). There has also been an increase in the number of RN's employed in the late 1990's (General Accounting Office, 2001).

As a result of the changes in the health care system, the role of the NE has evolved both formally and informally from the traditional role of the DON and as a result, the role of this important nurse leader has been forever altered (Dwore et al., 2000;

Gelinas, 2000; Tranbarger, 1988). These new roles have been accompanied by new expectations for the capabilities and responsibilities of the NE.

The Joint Commission on Accreditation of Healthcare Organizations (JACHO) has mandated formal change in the role of the NE. The NE is expected to actively participate in hospital leadership functions and collaborate with other hospital leaders in designating and providing patient care services. In addition, the NE has the authority and responsibility to participate with the governing body, management, medical staff and clinical leaders to develop and implement organizational structures and processes and in planning, promoting and conducting organizational wide performance improvement activities (Joint Commission on Accreditation of Healthcare Organizations, 1996).

Since nursing in most hospitals is the largest employer of FTEs, the department can substantially affect the financial performance of the institution. As this fact has become recognized and accreditation agencies have supported the role nurses play in ensuring quality patient care, it is now expected that NEs will have financial and budgetary expertise. JACHO expects NEs to “develop, present and manage the nursing services portion of the hospitals budget” and to participate with other hospital leaders to “develop an annual operating and long term capital expenditure plan, including a strategy to monitor the plans implementation” (Joint Commission on Accreditation of Healthcare Organizations, 1996).

The American Organization of Nurse Executives (AONE) recommended the NE use innovative leadership to participate in shaping the future of health care. Innovative leadership demands that the NE be skilled in a variety of competencies (American Organization of Nurse Executive, 2005). These competencies include the ability to

provide effective communication and relationship building as well as possessing knowledge of the health care environment, professionalism and business skills. Communication includes building trusting and collaborative relationships with staff, peers, members of other disciplines and physicians along with other key stakeholders. Effective communication is creating a shared vision and communicating that vision. Knowledge of the health care environment includes clinical expertise as well as health care policy, workplace design and health care economics. Professionalism includes both personal and professional accountability but also encompasses career planning, coaching others in career planning and creating an environment in which professional and personal growth is an expectation. Business skills involve financial and human resource management as well as strategic planning, information management and technology. Strong innovative leadership skills involve building thinking skills, and systems thinking as well as change management and succession (American Organization of Nurse Executive, 2005). These competencies are not exhaustive of the skills needed by NEs but rather, illustrate how complex the role has become.

A review of the literature reveals several studies that examine the role of the NE. Some have indicated that the expanded role of the NE includes providing oversight for other patient care departments such as respiratory therapy, pharmacy, laboratories, quality and risk management, hospice and home and long term care (Ballein, 2000; Dwore et al., 2000; Garbett, 1998; Klakovich, 1994). NEs have become more involved in governing board responsibilities, strategic planning, budgeting decisions and medical staff interaction (Dalley et al., 2000; Murray et al., 1998). NEs are now accountable for ensuring positive patient outcomes, meeting productivity targets and financial goals as

well as maintaining retention numbers, customer and physician satisfaction and possessing well developed leadership skills and organization management capability (Stichler, 2006; Wagner, 2003). The position requires skills of persuasion, clear communication and leading by example (Stichler, 2006). The literature also reveals that the NE must possess strong leadership qualities, convey a sense of caring, hope, optimism and be able to recognize and support the best in people, including employees, patients and members of the medical staff. Today, the NE faces increasing challenges to manage multiple and competing priorities in organizations that have diminishing financial and human resources (Stichler, 2006).

Witt-Kielfer completed a national survey in cooperation with AONE to examine the changing role of the NE (Ballein, 2000). The results indicated that the NE's role is changing in a fundamental way. The survey revealed that nurse leaders are now providing oversight to non-nursing clinical areas such as laboratory, radiology and pharmacology. In many cases, the NE has corporate responsibilities. Titles are changing to reflect the change in scope of responsibility. No longer is nursing the key word in the title, many involve patient care, operations or administration. Eighty-five percent of the respondents revealed that the percentage of the budget for which they are responsible has increased in the last five years. A similar number, 88 %, indicated an increase in responsibilities over the past five years. In addition, 69% indicated that responsibilities include many that were previously assigned to the Chief Operating Officer (COO). Many NEs expressed frustration over the struggle to balance competing demands of cost containment and quality of care. The NE, while now being more powerful, has little time for bedside involvement with patient care (Ballein, 2000).

According to Wagner, versatility is a key attribute for a successful nurse leader (2003). Along with clinical and nursing skills, nurse leaders must also possess regulatory expertise including some concept of the legal system and possess a familiarity with new regulations such as Health Insurance Portability and Accountability Act (HIPAA) and guidelines from the Occupational Safety and Health Administration (Wagner, 2003). There is also the expectation that these nurse leaders are available around the clock to respond to both patient care, nursing staff and other emergency issues and that they spend 10 – 14 hours per day in the facility. Many Directors of Nursing identify that a large portion of the day is spent on paperwork, including creating documentation required for regulatory compliance and for ensuring Medicare reimbursement. As a result of the paperwork load, less time is available to be spent on patient care units, visiting with patients and speaking with staff nurses (Wagner, 2003).

Burritt indicates that changes in the current health care environment have led to destabilization of some organizations (2005). In order for these organizations to remain profitable and viable, it is important that they undergo a “turnaround” which involves “effecting fundamental, sweeping change very rapidly” (Burritt, 2005). Since nursing is the largest employee group and the NE leads that group, it is imperative that the NE plays a key role in the process. Inherent in the NE’s role are three elements. First, the NE must work to motivate the workforce. Engagement of the entire workforce is important in any organizational turnaround process. This element includes instilling belief in the need and attainability of the turnaround, inspiring individuals to change and sustaining the momentum towards change. Secondly, it is important to create an environment that supports the change. This process includes ensuring dialogue, respect, collaboration and

initiative among all levels of the organization. Finally, the NE must create, communicate and operationalize the vision for change. The organization must have a clear course of direction that unifies the focus in a meaningful way. Burritt feels that the NE can rally the nursing staff to accomplish the needed changes and set the tone and an example for the remainder of the hospital staff (Burritt, 2005).

Fosbinder, Parsons, Dwore, Murray, Gustafson, Dalley and Vorderer (1999) surveyed 40 NEs and 56 of their influential colleagues to examine and describe the current roles and responsibilities of the NE, the level of job satisfaction, competencies of the NE and their perceptions of advantages and disadvantages of being a NE. The NEs identified most often that they performed best in the category of leadership and human management skills. They also identified that they were least confident about the ability to prioritize their dual responsibilities of administrators and caregivers. This conflict was consistent despite the number years of experience of the NE (Fosbinder et al., 1999).

Dalley, Smith, Fosbinder, Warnick, Murray, Dwore and Parsons interviewed 45 NEs to determine if they perceive themselves and do other members of the administrative team, perceive the NE as a fully integrated member of the hospital administrative team (2000). The study revealed that 71.4% of NEs viewed themselves as fully integrated, but some of those interviewed had reservations as illustrated in statements such as “I do (think I’m integrated) but I’m not sure that they do” (Dalley et al., 2000 p. 34) or indicated that they felt integrated on the local level but not on the corporate level. Seventy-one percent of the NEs reported they were involved with the governing board and felt they had a voice when the board made decisions. As part of the study, the NEs identified one member who was a supporter and one who was a hinderer to their role in

the organization. The identified supporters and hinderers were interviewed and of those who supported the NE, 88.5%, indicated the NE was fully integrated. The researchers describe the NE as a “bridge between quality patient care and related business interests” (Dalley et al., 2000 p. 36).

In a related study, Dwore, Murray, Fosbinder and Parsons (2000) surveyed NEs along with others either identified by the NE as being supporters or hinderers in their career (2000). They found that all three groups identified the NE was now integrated in the executive management team, supporters and hinderers both identified the NE as “broadly oriented executives; rather than discipline based department directors” (Dwore et al., 2000 p. 29). In addition, the NE had greater involvement in hospital wide activities and decision-making and substantial interaction with the governing boards. The study also identified there is support for the NE to have broad autonomy and to deal with hospital wide issues rather than individual patient care matters (Dwore et al., 2000).

The literature review also revealed that NEs have educational responsibilities to themselves and the nursing staff (Pfoutz, Simms, & Price, 1987; Wagner, 2003). Pfoutz, Simms and Price studied the characteristics of the NE in practice and the educational responsibilities of the NE. They found the NE had a broad scope of educational influence both formally and informally. Formal activities include lectures and presentations both within and beyond their own organization. Informal activities related to education included establishing standards for credentialing, preparing for accreditation, policy development, committee meetings as well as planning and support for educational services and staff development (Pfoutz et al., 1987).

Jaco, Price and Davidson studied chief nurses in 172 Veterans Administration Medical Centers throughout the US to determine the perceptions of the chief nurse role, describe leadership qualities associated with the role and examine their level of satisfaction as a NE (1994). The results indicated there were four categories of primary NE role functions and activities: administrative, clinical, education and research. The study revealed administrative functions that rated highest were: being the spokesperson of nursing, corporate thinker and facilitator for goal achievement. Eighty-nine percent of respondents indicated that fiscal responsibility was critical for their roles. NEs were seen as needing to interpret nursing to the Chief Executive Officer (CEO), governing boards and consumers. As for the clinical role, the NE identified primarily with indirect patient care responsibilities such as working collaboratively with physicians and for consultation. The study indicated there has been minimal change in the perception of the NE regarding the importance of the educational role they assume (Jaco, Price, & Davidson, 1994). Educational responsibilities identified include membership in professional organizations, assessment of the educational needs of staff and 64 % of the respondents indicated they had the opportunity to hold faculty appointments and to speak at professional and community events. The NE identified their role in relation to research, included facilitating the use and development of nursing research (Jaco et al., 1994).

Carroll (2005) used a qualitative descriptive study to compare the perception of what general leadership skills and attributes were identified by NEs as necessary for the 21st Century with those identified by other women leaders. The results indicated little difference in the skills and attributes identified by the two groups. The women leaders identified six factors: 1) personal integrity; 2) strategic vision and action orientation; 3)

teambuilding and communication; 4) management and technical competence; 5) people skills; and 6) personal survival skills and attributes. The items rated the highest for both groups were contained in the personal integrity factors. These included ethical standards, trustworthiness and credibility (Carroll, 2005). The NE also agreed with the women leaders about the importance of strategic vision, management and technical competence people skills and personal survival skills and attributes. The NE also admitted to a continuous struggle with competing demands on their time (Carroll, 2005).

Healthcare organizations have seen remarkable and unprecedented changes over the past two decades. Political and social expectations altered the industry. Drastic changes in payer systems have lead to a focus on controlling costs and profitability. Technology and research have exploded and care is no longer delivered primarily in acute care inpatient settings. These factors have all played a role in the changing responsibilities of the NE, both formally and informally. Both JCAHO and the AONE have mandated changes in the NE and its area of influence. The literature indicates the NE must now possess expanded skill sets including strong leadership skills (Carol, 2004; Fosbinder et al., 1999; Stichler, 2006), increased communication and knowledge of organizational management (Stichler, 2006), versatility (Wagner, 2003), be able to motivate the workforce (Burritt, 2005). and accept educational responsibilities (Benner, 1984; Jaco et al., 1994; Pfoutz et al., 1987). The NE now has responsibilities over non nursing patient care departments within the healthcare institution such as radiology, laboratory, physical therapy as well as dietary and other duties previously assigned to the COO (Ballein, 2000; Dalley et al., 2000). Both NEs and non nursing supporters state the NE is now more fully integrated into the administrative team (Dalley et al., 2000).

The Nurse Executive as Nurse Leader

Providing the Vision

One important role of the NE is that of the nursing leader for the organization. Effective nursing leadership provides vision and inspiration to the staff, encourages innovation, facilitates the journey to skill development and self-actualization and promotes excellent nursing practice (Pfoutz et al., 1987). Part of this process is developing strategies that promote the delivery of quality patient care to ensure the achievement of good patient care outcomes (Neuman, 2001). At the same time, leaders have the ability to control some and influence other variables that are related to nurse dissatisfaction and turnover. Some of the variables include: 1) setting the philosophy of nursing and identifying the values and beliefs of the nursing department; 2) participating in the values and mission of the organization as a whole; 3) strengthening nursing leadership; 4) securing appropriate staffing; 5) designing practice models; 6) practice recognition programs; 7) supporting education and staff development; 8) developing extern and other orientation programs; 9) self governance; and 10) interfacing with local schools of nursing in a collaborative stance (Burritt, 2005). Changing behavior in organizations is a responsibility of the NE and this includes changing how experienced nurses perceive, react to and support new graduate nurses (Neuman, 2001; Pfoutz et al., 1987). According to Stichler (2006), the nurse leader is responsible for creating and fostering a vision and to do so in a manner that compels others to feel passionately enough about the vision and to direct their efforts to achieve that vision.

A Robert Wood Johnson (RWJ) report indicates that organizations must have authentic leadership that nurtures a healthy work environment (Hatcher et al., 2006). A

satisfying work environment encourages nurses to bestow the virtues of their facility to peers and often results in an excellent recruitment tool for a health care facility (Neuman, 2001). Similarly, several studies identify ineffective leadership as a dissatisfier and is related to nurse turnover (Bamford & Hall, 2007; Bowles & Candela, 2005; Paschke, 2007).

Dixon describes a case study of a NE who was able to inspire others by using transformational leadership to guide her staff and went on to become Chief Operating Officer (COO) of one of the top 100 integrated health systems (Dixon, 1999). The former NE was initially tasked with leading her facility through a cultural transformation. The NE first spent a year trying to study the resistance and create a vision of participative decision-making. Afterwards, she developed a strategy for implementing the vision, which included recognizing the value of teamwork and getting the physicians to “buy into” the change. A key element in the success of the program was increasing communication by utilizing a variety of approaches, but most importantly the nurse leader created a learning network to provide a culture of education, training and skill development throughout the facility (Dixon, 1999). Key in her success was the ability to build effective relationships while also focusing on results. The challenge is to balance multiple demands in an increasingly turbulent environment (Dixon, 1999).

Balancing Values

Stanley (2006) completed a qualitative study to explore clinical leadership and what participants understood about the differences between leadership and management. For the study, the researcher interviewed 42 nurses with various levels of experience and subsequently interviewed eight clinical leaders identified during the initial interviews.

The staff nurses perceived the nurse leaders as no longer being clinically oriented and at least some of the participants indicated that their nurse leaders do not consistently support the staff and were seen as “distant” from the ward (Stanley, 2006).

Fedoruk and Pincombe (2000) describe the concept of the management service gap. This is the divide between the nurse at the bedside providing direct care to the patient population and the NE or other nurse leaders whom the bedside nurse now perceives as being irrelevant and nonessential to the nursing function (2000). In the struggle to become respected and to be considered a significant player in the hierarchy of the health care system, the NE has adapted her language and behaviors to more closely mimic the stakeholders and those who control power in the health care system. The NE, by the nature of her rank and responsibilities, has become situated both physically and culturally distant from the bedside nurse (Fedoruk & Pincombe, 2000).

Naughton and Nolan (1998) identify the drive for nursing to gain more power has led to tension between nursing values and those values of the new managerial cultures that it has entered . There are areas of incompatibility between the priorities set by corporate health care and those set by the nursing profession. Often the goals of profitability set a tone of technical skills, task completion and conformity while nursing focuses on the goals of humanism, holism and treating patients as unique individuals and developing a nurse patient relationship (Naughton & Nolan, 1998).

NEs walk a fine line between non-nursing organizational values and responsibilities and those of the nursing profession. Klakovich (1994) indicates that in order for nursing to preserve the caring values of nursing in today’s environment , nursing leaders must be allowed to function effectively within the organization’s culture

while empowering nursing staff through the provision of a caring professional practice environment (Klakovich, 1994). These nursing leaders must balance the hard issues such as financial and organizational responsibilities with the soft issues of human relations, staff development and customer service (Dixon, 1999).

The NE is the leader for nursing within any healthcare organization. Medicare and many state regulations require healthcare organizations to identify the “chief nurse” and all nursing staff must report through that identified individual. Successful nursing leaders provide inspiration and vision to the staff, nurture a healthy work environment and guide staff in the development of clinical and leadership skills. Some studies have identified that as nursing has gained expanded influence over other areas, there has been some loss of influence within nursing. Some see the drive for power and expanded influence to have resulted in widening of the distance between the NE and the bedside nurse resulting in tension between nursing and organizational values. This phenomenon is called the management-practice gap (Fedoruk and Pincombe, 2000, Stanley, 2006). Many studies identified poor nursing leadership (Stanley, 2006) as leading to nurse dissatisfaction and related to nurse turnover (Bamford and Hall, 2007; Bowles & Candela, 2005; and Paschke, 2007). The most successful nursing leaders learned to walk the fine line between organizational and traditional nursing values and even align those values.

Role Conflict and Role Ambiguity

Within classic organizational theory, the principles of chain of command and unity of command have important implications for success of the organization. The principle of chain of command indicates organizations that are structured on the basis of

hierarchy with a single and clear flow of authority are more effective, profitable and satisfying to the members (Rizzo et al., 1970). The single line of authority allows for effective control and coordination of resources and personnel. The principle of unity of command states that for any action, employees should receive orders from one and only one superior and there should be one plan for activities with agreed upon objectives (Rizzo et al., 1970). Role conflict occurs when an individual is subject to competing or conflicting sets of expectations and demands in the organization. Or when the principle of chain of command or the principle of unity of command are violated (Rizzo et al., 1970). This situation induces negative emotional reactions and diminishes job satisfaction and effectiveness in ones position. Classic organizational theory also indicates each position in the organizational structure should have a specified set of tasks or responsibilities, which is intended to be used by management to hold individuals accountable for specified performances (Rizzo et al., 1970). Role ambiguity results when the individual does not have this information. This often results in coping behaviors by the holder of that position to avoid sources of stress including using defense mechanisms to distort the reality of the situation (Rizzo et al., 1970). According to role theory, as ones role ambiguity increases, the individual's job satisfaction decreases, reality becomes distorted and as a result, effectiveness and efficiency within the position decreases.

Health care organizations are complex and clearly have two hierarchies: the administrative and medical. In most settings, nurses respond either formally or informally to two or more constituencies including organizational authorities, the facility, the patient and family and the physicians who direct the provision of their care (Corley et al., 2001). Professional organizations can also interfere with the chain of command

principle. Two sources of authority can exist when one individual is responsible for the formal requirements of their organizational position and to “professional expertise, which is enforced by collegial authority” (Rizzo et al, 1970 p. 151). As a result, the potential exists for role conflict among all nurses including the NE.

Role conflict and role ambiguity are not uncommon in nursing. Other reasons for the presence of these role stressors include the rise in technology, the demise of the generalist nurse coupled with the ongoing creation of nursing specialists and the decrease focus in patient centered care (Pearson, 2003). Studies have identified role conflict in nursing students (Wu & Norman, 2006), new graduate nurses (Kilpatrick & Frunchak, 2006), school nurses (Zimmerman, Wagoner, & Kelly, 1996), advanced practitioners (Bryant-Lukosius, DiCenso, Browne, & Pinelli, 2004; Yao-Mei, Sue-Hui, Chiu-Yueh, & Liang-Yueh, 2007), nurse researchers (Fitzsimons & McAloon, 2004) and NEs (Scalzi, 1990). Some studies have identified role conflict and role ambiguity are related to unfavorable outcomes (House & Rizzo, 1972; Rizzo et al., 1970; Scalzi, 1990).

O’Baugh, Wilkes, Vaughan and O’Donohue (2007) used a quantitative method to examine the role and scope of practice of the clinical nurse consultant (CNC) in New South Wales. The CNC was first developed in 1986 to be similar to the Clinical Nurse Specialist (CNS) in the United States. Since its inception, CNCs have met with different levels of expectations among the public, the employers and themselves and as a result have experienced role conflict (O’Baugh, Wilkes, Vaughan, & O’Donohue, 2007). There are three levels of CNCs: Grade 1, 2 and 3. A survey consisting of both open and closed questions was distributed to 42 CNCs employed in the health service in December 2002 (O’Baugh et al., 2007). Twenty-four participants (57 %) returned the completed surveys.

The results from the survey were compared to the health service expectations of each grade. The results of the survey revealed five domains of practice: clinical services planning and management, clinical services and consultancy, clinical leadership, research and education. All grades of the CNCs participated in the study; however, different grades participated in each domain at different levels and often not within the established expectations for that grade. The majority of the time was spent in the clinical service and consultant role. Both Grade 2 and 3 involved in the leadership domain but their participation in this area did not match expectations of this domain attached to their grades. Those in Grade 3 identified strongly with research but 50% of those in Grade 1 and 2 were only occasionally involved in this domain. All of the CNC grades were involved in the education domain with those in the higher grades having greater level of involvement. All grades were involved in a similar portion of time in the clinical services and management domain; however, those in Grade 1 and 2 felt these areas should play a larger part in their role. These different levels of practice within the domains clearly contribute to the role conflict and confusion with the CNC role (O'Baugh et al., 2007).

Bryant-Lukosius, DiCenso, Brown and Pinelli (2004) discuss the advanced practice nurse (APN) roles and six issues that influence the practice of APNs in Canada. Changes in health care have led to substantial increases in the different types and numbers which have led to role conflict, role overload and variable levels of acceptance (Bryant-Lukosius et al., 2004). These issues include the confusion with the terminology used to describe the role of the APN and the failure to define APN roles based on systematic identification of needs and goals. Organizations often initiate new APN roles in a reactionary manner to meet a specific health care issue rather than from a systematic

need assessment, leading to well-defined goals and determination of how the new role will meet the identified needs. Secondly, there is an emphasis on using APNs to replace or support physicians rather than providing a holistic nursing centered orientation to practice (Bryant-Lukosius et al., 2004). There is also been an insufficient administrative support and competing demands. A lack of planning and inattention to the environmental factors including local, social, health care system and governmental factors that influence and potentially undermine APN roles. There is also limited use of research and evidenced based approaches documenting the need to guide the systematic development and implementation of the APN role. As a result, there is an underutilization of the APN and this added to job dissatisfaction. The authors contend that while the APN role has great potential for health care, these issues have created barriers to the realization of the full potential of the APN and have also contributed to role confusion and role conflict for these important health care providers (Bryant-Lukosius et al., 2004).

Wu and Norman (2006) explored the relationship between job satisfaction, organizational commitment, role conflict and ambiguity and demographic variables in the Chinese health care workforce. A survey was sent to 75 nursing students in their final year of study at a nursing department in a medical university in China. The survey included three instruments: the Job Satisfaction Scale, Organizational Commitment Scale and the Role Conflict and Ambiguity Scale. Seventy-one students completed the survey for completion rate of 95%.

Job satisfaction scores ranged from 34-75, with a possible score range of 15-75 (mean of 46.6). The students identified that they were most satisfied with recognition from work, their immediate boss and relationship between academic staff and students.

Of those who responded, 96 % (mean score 52.9) were committed to the Chinese health care service. Scores on the commitment scale ranged from 36-69, with a possible range of 15-75. Overall, role conflict and role ambiguity were lower than the midpoint on the scale indicating lower levels of role conflict or ambiguity. Possible scores on these instruments ranged from 14-70, with actual score ranging from 17-53, with a mean of 30.4. The three dimensions of role conflict that had the highest scores included having to do things without agreement, receiving incompatible requests from people and working on unnecessary things. The results also indicate that there was a positive correlation between job satisfaction and organizational commitment and a negative correlation between job satisfaction and role conflict and ambiguity (Wu & Norman, 2006).

Glasberg, Norberg and Soderberg (2007) used a qualitative explanatory approach to investigate managers' perspectives for factors that lead to burnout . To collect data, 30 nurse managers in Sweden were interviewed. The results indicated organizational changes such as reorganization and downsizing lead to a "lack of peace and a sense of insecurity" (Glasberg, Norberg, & Saderberg, 2007). Frequent organizational changes, caused by budgetary cutbacks, led to vagueness in the organization and a feeling of instability and then to role ambiguity. The interviewees also described the increasingly incompatible demands of society and of the organization, coupled with the increasing complexity of the patients and the care needs by patient populations as adding to role strain. With decreasing resources and increasing demands, personnel began to question their abilities leading to feelings of uncertainty and worthlessness (Glasberg et al., 2007).

Chang, Hancock, Johnson, Daly and Jackson (2005) completed a review of literature to explore role stress in nurses and strategies for addressing the role stress. Stress occurs when a situation exceeds one's resources or when the individual's expectation for the role exceeds what is actually achieved in the role. Factors associated with role stress include high demands, low supportive relationships and having little control in one's job (Chang, Hancock, Johnson, Daly, & Jackson, 2005). The authors identify a need to study the various aspects of the nurses' responsibilities and work environment to determine which factors affect role stress and job satisfaction and which contribute to the delivery of quality of care. The goal is to identify innovative ways to support nurses at all levels, to deal with role conflict and role stress, including teambuilding strategies and enhancing social support of nurses (Chang et al., 2005).

Fitzsimmons and McAloon (2004) completed a mixed quantitative and qualitative study to analyze patient experiences while on the waiting list for coronary bypass surgery in the United Kingdom. During this study, the researcher experienced ethical conflicts based upon the non-interventional protocol of the study. The researcher witnessed participants whose clinical situation was deteriorating and some who died while on the waiting list. The researcher was also an experienced cardiac nurse who found herself wanting to intervene as the patients' conditions worsened. She found great difficulty trying to separate the roles of a cardiac nurse wanting to care for the participants and the role of impartial, non-interventional researcher (Fitzsimmons & McAloon, 2004). As a result, the researcher experienced stress displayed as both role conflict and ethical conflict in the research setting.

Corley, Elswick, Gorman and Clor (2001) utilized House and Rizzo's Role Conflict Theory to develop an instrument to examine moral distress experienced by nurses and the degree with which moral distress is an element of nurses' professional experience. The study examined the effect of moral distress on previous decisions about resigning a nursing position. The instrument was created with 32 items that were developed reviewing research on moral problems in hospital settings and by creating items from a content analysis of interviews conducted with three staff nurses at US hospitals. To determine content validity, the instrument was reviewed by two experts in the field, who suggested minor changes in terminology. The moral distress scale (MDS) was then submitted to a panel of three PhD nurses who had expertise in nursing ethics who concurred of the relevancy of the items (Corley et al., 2001).

To test the tool, the researchers used a convenience sample of 214 nurses from several US hospitals in a variety of specialties. The results of the MDS were analyzed descriptively and then subjected to factor analysis. After forced rotation of the factors, a three-factor solution was identified. Fifteen percent of the nurses identified they had left a previous position because of moral distress. The results reflected role conflict as related to items identified in Factor One including individual responsibility, apprehension about taking individual responsibility or actions assuming responsibility, primarily because nurses' roles convey more responsibility than rights. Factor Two was titled "not in patients' best interest" which involves acting in ways that nurses believe do not benefit the patient. This factor indicated the presence of role conflict, as the nurses were unable to reflect their own value of truth telling. Factor Three was referred to as "actions to deceive or deception through failure to take action". The nurses surveyed felt moral

responsibility to not deceive patients yet their organizations defined roles within the institution that placed constraints upon them. The last two factors illustrated that the nurses were prohibited from carrying out their values, resulting in moral distress.

McGillis-Hall (2003) studied the relationship between staff mix models and quality outcomes. The researchers recognize that health care settings have undergone a great deal of change and transition and organizations have sought to provide the most cost efficient and cost effective care model to deliver nursing services. One of these changes is the utilization of different staffing mix models, which change the numbers and percentages of licensed and non-licensed personnel. The purpose of the study was to investigate the relationship between the staff model used and the nursing and quality outcomes achieved and to explore if there is role conflict for the RNs because of these models.

A comparative correlational study was conducted with random sample of 30 adult inpatient care units in Toronto, Canada. The researchers compared units that had all regulated staff versus those who used a mix model of both regulated and unregulated staff. The sample included 15 hospitals that used exclusively regulated staff and 15 hospitals that use both the regulated and non-regulated staff. Mean scores for units that used a regulated staff mix for role conflict, role ambiguity and job satisfaction were 5.16 (SD of .80), 4.21 (SD= .73) and 31.22 (SD= 2.24) respectively. Those that employed a mixed model were 5.11 (SD=. 86), 4.11 (SD= .84) and 31.19 (SD=3.30) respectively. The results revealed that RNs experienced high levels of role conflict regardless of the staff model utilized. Role conflict and role ambiguity showed no correlation to the type of staff model used. There was a statistically significant positive relationship between

job satisfaction and being on a unit using a mixed model. Conversely, on units that used a mixed model, the RN perceived lower quality outcomes; however, both groups only identified a fair rating of quality outcomes at best. The researcher discusses the fact that hospitals in the area were undergoing a large restructuring effort, which resulted in mergers between hospitals, units closing and the layoffs of RNs. Uncertainty generated by these factors may have contributed to the high levels of role conflict (McGillis- Hall, 2003).

Biton and Tabak (2003) used a quantitative approach to study the relationship between the application of the nurses' ethical code and the level of work satisfaction of the nurse. The study also examined the correlation between role conflict and work satisfaction level. For the study, the researchers used a sample of 158 practical and registered nurses who work in a large general hospital in Israel. To collect data, the participants were surveyed using a questionnaire with four sub questionnaires to measure: demographics, desirable work situations, role characteristics and conflict and working conditions. A Likert type scale was used to measure role conflict with participants being asked to rate how often they experience seven items with a scale of 1 through 6. Average scores on these questions varied from 2.33-2.83 with a SD of 1.15. The work satisfaction scores were measured on the same scale as role conflict and varied, from 2.62- 4.70 with SD from .8 – 1.82. The results indicated there was no correlation between gaps in compliance with ethical code and work satisfaction. There was, however, negative correlation between role conflict and work satisfaction. As role conflict rose, work satisfaction decreased. There was also a positive correlation between the gaps of desirable work conditions and available work conditions and role conflict, as the gaps

between available and desirable conditions increased, role conflict increased (Biton & Tabak, 2003).

Piko (2006) utilized a questionnaire to study the interrelationships among burnout, role conflict and job satisfaction in Hungarian health care staff. To collect data, surveys were distributed to 450 health care staff, of which 55.7% were registered nurses, from two major hospitals in Szeged, Hungary. Two hundred and one surveys were returned for a response rate of 44.6%. The questionnaire included the Maslach Burnout Inventory (MBI) along with four items to measure job satisfaction and an additional four items to measure role conflict. Respondents were asked to rate, on a Likert type scale, how often they experience the four items, with 1 through 5 response categories: very often (5), fairly often (4), sometimes (3) occasionally (2) and rarely (1). The items for role conflict were summed for a possible role conflict score of 4-20. The results indicated role conflict scores had a mean of 8.8 with a standard deviation of 3.3. The results indicated role conflict scores were positively correlated with emotional exhaustion and there was a negative correlation between emotional exhaustion and job satisfaction. Personal accomplishment was positively correlated with job satisfaction and negatively correlated to role conflict (Piko, 2006).

Zimmerman, Wagoner and Kelly (1996) used a descriptive survey to explore role ambiguity and role strain in school nurses that occurs because of the discontinuity of the expectations of the school board and expectations of the professional role as defined by the Nurse Practice Act. For the study, a survey was sent to a random sample of 329 certified school nurses in Pennsylvania. While there was large agreement in many of the statements of the typical functions of a school nurse, there was also less agreement for

other items that were not consistent for traditional school nurse practice. Teaching was identified by many as a prominent aspect of their role, yet it was also clear the time spent doing mandated screening and administering first aid left little time for teaching opportunities with students. The nurses overwhelmingly perceived mandated activities were an important part of the role and that health assessment activities were necessary to plan care for children. The majority of the respondents indicated they would report pertinent findings regarding a student to the appropriate agency only after the principal or other school authorities had been notified.

These results indicate role strain and ambiguity in school nurses due to a variety of factors. State mandated tasks define the role of the school nurse and interferes with the ability of these nurses to practice holistic nursing. Nursing education instills these professionals with the knowledge and skills to address the many and complex needs of the school aged population but the control lies with the educators (Zimmerman et al., 1996). Similarly, while teaching is central to any nurse's role, the school nurse's ability to teach is limited by guidelines of the department of education requiring a nurse to hold certification within a specific teaching area. As a result, the school nurse who is clearly a valuable educational resource is not able to fulfill this aspect of their role. Furthermore, the school nurse practices in an environment in which she is isolated from other members of her profession, which limits opportunities for role socialization and collaborative strategies for role expansion (Zimmerman et al., 1996).

McKenna, Kenney and Bradley (2003) completed a multi-method using focus group, the Delphi Technique and semi-structured interviews, to study the role and function of community nurses in Northern Ireland and the Republic of Ireland. Five

focus groups, each with 8-12 community health and generalist nurse participants were used to collect data. The Delphi Technique method is a “structured process that uses questionnaires or rounds to gather information and is continued until group consensus is reached” (McKenna, Keeney, & Bradley, 2003 p. 540). Thirty-four individuals, primarily senior strategists and policy makers, were also interviewed with questions derived from results of the review of literature, the focus groups and the responses from the Delphi Technique.

The results revealed a number of themes including the fact that many of the community nurses expressed concern that there was too much specialization and the benefits of a generalist nurse are in danger of becoming lost. As a result, they felt there is an increased risk of patients falling through the cracks. There was confusion over role definition including identifying where one specialist role ended and a new specialist role began. This led to role conflict with other community nurses, general practitioners and social workers. The number of titles and definitions of the community nurses was found to be a major contributor to role conflict and confusion.

During the Delphi phase of the study, 69% of the participants agreed that “increased specialization in nursing has greater potential for role conflict” (McKenna, Keeney, & Bradley, 2003). Adding to this finding, 69% of the participants also indicated “there is a risk of developing too many specialists and not enough generalists” (McKenna et al., 2003). The final stage of the study, the interviews with the senior strategists and policy makers, indicated both advantages and disadvantages of the specialists’ roles including the expertise held by the specialists and lack of continuity of care. They recognized the potential of the specialist to get out of control leading to role confusion

and conflict. As an answer, they stressed the importance of striking and maintaining a balance between the specialists and generalist role (McKenna et al., 2003).

Scalzi (1990) used a descriptive design to examine the levels of role conflict, role ambiguity and depressive symptoms among top level NEs. The study examined the following areas: the levels of job related stress, the relationships among role conflict; role ambiguity and depression; job satisfaction: and other major factors of job related stress in top-level NEs (1990). The study was completed in two phases. For Phase 1, a survey was sent to 124 top level NEs in all general surgical hospitals in a large metropolitan county. The survey included three instruments: a demographic questionnaire, Rizzo's Role Conflict and Ambiguity Scales and the Center for Epidemiologic Studies Depression Scale (CES-D). Seventy-five nurses (60%) responded. For Phase 2, a random sample of 30 respondents, from those who responded in Phase 1, was selected for interviews. Major areas of the interview included job satisfaction, perceived sources and intensities of job satisfaction and social support network (Scalzi, 1990).

The results indicated the level of role conflict ranged from 1.4 – 6.9, out of a possible 1.0 – 7.0 with a mean of 4.0 and a SD of 1.2. Role ambiguity scores had a mean of 2.7 with a SD of .9 with an overall range of 1.7-5.0. The median CES-D score was 6.0, with a mean of 8.9, SD of 8.9 and a range of 0-46. During the interview, subjects were asked about 25 specific individual job stress items. The most common job stressors identified were overload stressor, quality of concern and lack of support. There was a positive correlation among role conflict and role ambiguity and with depressive symptoms. Higher levels of depressive symptoms were correlated with lower levels of job satisfaction and higher levels of quality of care concern (Scalzi, 1990). This study

however is nearly 20 years old and should be repeated in the near future to reevaluate prior results.

Organization theory and role theory focus on the design of organizations as well as expectations for behaviors of individuals within effective organizations. Due to the significant changes in healthcare organizations, these institutions tend to be complex. Role stress occurs when the structure of the organization is complex or violates the assumptions of organizational or role theory. Role conflict and role ambiguity are two forms of role stress and are not uncommon in nursing. Studies have identified role stress in various forms in nursing students (Wu & Norman, 2006), new graduate nurses (Kilpatrick & Frunchak, 2006), school nurses (Zimmerman et al., 1996), advanced practitioners (Bryant-Lukosius et al., 2004; Yao-Mei et al., 2007), nurse researchers (Fitzsimons & McAloon, 2004) and NEs (Scalzi, 1990).

Job Satisfaction

The General Accounting Office (GAO) indicates nursing is the “nations’ largest group of health care providers” (General Accounting Office, 2001, 2007b); however, it is well known that the United States and much of the civilized world is entrenched in a nursing shortage and one that seems to be like none before. Past shortages were the result of a decreased number of employed nurses. In contrast, the nursing unemployment rate is currently at a low of 1%. In addition, 82.7 % of licensed RNs are employed in nursing which is up from the 76.0 %– 80.0% rates of the 1980’s (General Accounting Office, 2001). This shortage is the result of a lack of educated nurses. In April 2001, the AHA estimated 118,000 nurses were needed to fill current vacant positions (General Accounting Office, 2007b). Current estimates of the severity of the nursing shortage are

not available; however, there are documented extreme shortages in certain geographic and specialty areas (General Accounting Office, 2007b). It is also projected that there will be an undersupply of qualified nurse executives.

The Health Resources and Service Administration's (HRSA) survey in 2004, estimated 41% of RNs are 50 years or older with an average age of 46.8 years. Only 8% of RNs were under the age of 30 compared with 25% in 1980 (Health Resources and Services Administration, 2004). A survey by *Nursing Management* and the Bernard Hodes Group indicated 55% of nurse respondents plan on retiring between 2011 and 2020 (Hader et al., 2006; Haggard, 2006). Critical in this timing is the baby boomers have begun entering retirement age with Medicare eligibility and will add to the health care burden. As the profession enters a time of increasing demand for nursing care, nurse supply is aging and retiring. As a result, there was a great deal of research done to explore job satisfaction of the staff nurse in an effort to combat the nursing shortage by improving nurse retention (Bacharach et al., 1991; Kinney, 1990; McGillis Hall, Doran, Sidani, & Pink, 2006). However, a literature review indicates few studies and no recent studies that explore the job satisfaction of the NE.

Garbett (1998) reports on a study completed by the Royal College of Nursing (RCN) that surveyed chief nurses in the National Health System (NHS) trust in the United Kingdom. Two hundred and thirty-eight nurse leaders returned the completed survey. The report does not indicate a rate of return. While just over half of the respondents indicated they were happy with their position, many indicated that because of the stresses and strains of the work, they would not remain in the position long. In fact, 25% were actively looking for a new job, one-third stated they would be leaving

within one year and 47% hope to change jobs within 2 years (Garbett, 1998).

Dissatisfaction with the position was highest in respondents who were under 44 years of age, which comprised nearly half all respondents.

Being valued for ones' own contribution was identified as being the most important factor in job satisfaction. Other important motives in job satisfaction included having a positive relationship with the CEOs as well as relationships with other directors and the perception of having the "ability to make things happen". Thirty-nine percent indicated they were unhappy with the support they received from support staff. There was also an indication of tension between clinical responsibilities and administrative responsibilities (Garbett, 1998).

Kinney (1990) used a comparative survey method to compare the job satisfaction of NEs in rehabilitation hospitals and the job satisfaction of NEs in acute care hospitals. To gather data, a survey including the Job Descriptive Index was distributed to NEs in 12 rehabilitation hospitals and 12 acute care hospitals in the state of Pennsylvania. The results indicated the NEs in the acute care hospitals have a significantly higher education level and a higher rate of pay. NEs in rehabilitation hospitals had higher satisfaction ratings in promotion, supervisor support and relationship with coworkers and lower satisfaction in areas of work and pay. However, when a *t* test was calculated, there was no significant difference between the two groups. The small sample size of this study may have limited the results and thus the researcher suggests replication (Kinney, 1990).

Upenieks (2002) utilized both a quantitative and qualitative study to determine if there is a difference in job satisfaction in clinical nurses employed at magnet hospital versus those employed at non-magnet hospitals and was this perception linked to

leadership provided by the NE. A convenience sample of 2 magnet hospitals and 2 non-magnet hospitals was utilized. Seven hundred questionnaires were distributed to all medical surgical registered nurses in the identified hospitals. Three hundred and five (44%) returned the questionnaires. The questionnaire included the Revised Nursing Work Index (NWRI), which measures job satisfaction and related organizational attributes relevant to clinical nursing. It contains three subscales that measure autonomy, nurse control over practice setting and relations between nurses and physicians (Upenieks, 2002). To collect qualitative data, interviews were held with one NE and two or three manager level nurses at each participating institution. Interviews were opened ended with core set of questions aimed at gaining an understanding of nurse leader attributes.

Scores for all aspects of the NWIR were higher for magnet hospital nurses when compared to scores from non-magnet hospital nurses. Magnet hospital nurses felt they had greater autonomy ($M=3.10$ vs. $M=2.64$, $t=7.284$ $p<.001$) and control over practice ($M=2.79$ vs. $M=2.34$, $t=8.163$ $p<.001$) than non-magnet hospitals. The greatest difference in scores between the two groups was in the area of organizational attributes with magnet hospitals ($M=2.93$) scoring higher than non-magnet hospital ($M=2.40$, $t=9.049$, $p<.001$). When looking at total scores on the NWRI, the magnet hospitals ($M=147.0$) exceeded that of the non-magnet hospital ($M=124.83$, $t=5.80$, $p<.001$) (Upenieks, 2002).

Analysis of the qualitative data revealed seven prominent categories that fostered and influenced their leadership success. They included: support from nurse leaders, effective leadership, ensuring adequate staffing, autonomy, participatory management,

collaborative teamwork and appropriate compensation of the nursing staff. Leadership traits were identified as most important including being visible and accessible to the staff and understanding the environment in which the clinical nurse practices. Managers reported the NE was less visible at non-magnet hospitals than at magnet hospitals. Both magnet and non-magnet leaders identified an autonomous climate lends itself to a professional practice, however many non-magnet nurse leaders (33%) questioned if medical surgical nurses desired an autonomous climate. When considering which environmental factors fosters nursing satisfaction and retention, most leaders identified supplies, equipment, leadership visibility, recognition, clinical ladders and compensation. In addition, non-magnet leaders expressed adequate staffing while magnet leaders identified additional education services (Upenieks, 2002).

The GAO stated nurses are the nations' largest group of healthcare providers and it is well recognized that nursing is imbedded in a widespread nursing shortage. With the baby boomers now entering traditional retirement age and Medicare eligibility, the demand for nursing care will increase. Therefore, it is important to examine job satisfaction levels in nursing, including the nurse executive, to prevent further loss of these important healthcare providers. Garbett (1998) completed a study that indicated that while over half of the nurse leaders were happy with their job, nearly one third stated they would be leaving their position within one year and they identified being recognized for contributions as the most important factor in job satisfaction (Garbett, 1998). Other studies found no difference in job satisfaction among acute care and rehabilitation hospitals (Kinney, 1990; Upenieks, 2002) but nurses at magnet hospitals have higher

levels of job satisfaction and organization commitment than those at non magnet hospitals (Upenieks, 2002).

Summary of Review of Literature

The history of nursing leadership and the position of the NE date back to the advent of modern nursing. Over the past several decades, health care has become more complex and as a result, the position of the NE has been redefined, resulting in new roles and responsibilities. Accrediting bodies and professional organizations have increased expectations for the role. Many of these leaders are now responsible for oversight of non nursing areas of the health care facility (Ballein, 2000; Dwore et al., 2000). The NE has, in many cases, taken on responsibilities that previously were the purview of the COO including financial responsibilities (Dalley et al., 2000; Jaco et al., 1994; Murray et al., 1998). NEs must have well developed communication skills (Stichler, 2006), expanded leadership skills, (Burritt, 2005; Carroll, 2005; Stichler, 2006; Wagner, 2003), meet educational needs of staff (Jaco et al., 1994; Pfoutz et al., 1987) and have indirect patient care responsibilities (Jaco et al., 1994; Wagner, 2003). The successful NE of today must be versatile, able to balance multiple and competing responsibilities (Stichler, 2006) and is now perceived as a full fledge member of the administrative team (Dalley et al., 2000).

At the same time, the NE is the most important and influential nursing leader in the health care institution and sets the tone for the success of nursing. Several studies emphasized the importance of leadership to provide the vision to facilitate the journey of the nurse (Pfoutz et al., 1987), and authentic leadership nourishes a healthy work environment (Hatcher et al., 2006). Conversely, ineffective leadership has been demonstrated to be a dissatisfier and is related to nurse turnover (Bamford & Hall, 2007;

Bowles & Candela, 2005). Jaco et al. (1994) found NEs have the responsibility of facilitating the use and development of research (1994).

The perception of the NE role among staff nurses has also changed (Fedoruk & Pincombe, 2000; Stanley, 2006). Fedoruk & Pincombe (2000) describes the divide between the nurse at the bedside providing the direct care to the patient population and the NE, whom the bedside nurse perceives as irrelevant and nonessential. The NE, by the nature of her rank and responsibilities, has become situated both physically and culturally distant from the bedside nurse.

Role conflict is a type of stress that results when the managers of an organization hold competing or conflicting sets of expectations for one position in the organization. Studies indicate that nurses in a variety of clinical areas have experienced role stress in some form (Chang et al., 2005; Glasberg et al., 2007; McGillis-Hall, 2003; Yao-Mei et al., 2007; Zimmerman et al., 1996). However, a review of literature identified only one study, exploring role conflict and ambiguity among nurse executives and this study identified levels of role conflict and role ambiguity are related to poor outcomes including depression (Scalzi).

NEs walk a fine line between non-nursing organizational values and responsibilities and those of the nursing profession. The literature reveals the presence of some level of conflict about being able to prioritize dual responsibilities of the organization's administration and those of the nursing profession (Dixon, 1999; Fosbinder et al., 1999; Klakovich, 1994; Naughton & Nolan, 1998). Nurses are the largest group of health care employees with the NE as their leader. NEs have a vital and strategic role in health care. However, role conflict, ambiguity and decreased job

satisfaction may limit their ability to be effective leaders. Nurses in turn care for a great deal of patients. It is therefore imperative to support these nursing leaders so they can adequately support the nursing staff as they strive to provide for quality patient care. The support and leadership nursing receives should never be compromised.

A primary goal of nursing education is to ensure that students as well as nurses at all levels receive pertinent and necessary knowledge and skills to meet the expectations and requirements of the nursing roles they seek. A part of this process must be ongoing assessment of the changes in the healthcare environment and in turn the evolution of nursing roles. It is imperative for nurse educators to reach out to the practice environment to assess if modifications in curriculum are warranted to ensure delivery of applicable content for both current and future cohorts of nursing leaders so they may appropriately deal with role conflict and role ambiguity.

CHAPTER 3

THEORETICAL FRAMEWORK

The purpose for this study was to explore the status of the NE. For this inquiry, the study was designed in a framework that includes both organizational behavior and role theory components. These theories provide structure for understanding how any organization, including healthcare, operates and how individuals function within the context and processes of organizations. The theories posit principles and relationships among concepts that illustrate how successful organizations and individuals' practice. As the positions that NEs occupy have expanded in both complexity of responsibilities and required skills it is important to determine if the roles they occupy comply with the tenets of these theories.

The purpose for this study was to explore the status of the NE in a framework that includes both organizational behavior and role theory components. Organizational theory posits that organizations are "a collection of people working together under a specific structure for the purpose of achieving predetermined outcomes" (Sullivan & Decker, 2001). The structure is designed to permit the organization to endure and prosper and will vary depending upon a number of factors including its size, the environment in which it operates as well as the tasks and desired outcomes of the organization. The labor to complete the tasks of the organization is divided so every position within the

formal structure of the organization should have a specific set of duties for which the individual is responsible and should be held accountable for by the supervisor. These should be delineated in a formal manner such as a job description.

Role theory focuses on the characteristics of persons and behaviors and is concerned with the context and processes that affect those behaviors (Biddle, 1979; Rizzo et al., 1970). Propositions involved in role theory include an individual occupying a role must be taught or socialized in appropriate behavior for that role, some behaviors are patterned within context, roles are associated with sets of individuals that share common identities and there are expectations of roles and sometimes these expectations govern the role. Role theory states roles exist because of their consequences and often are imbedded in larger social systems such as organizations (Biddle, 1979).

The term role, meaning “patterns of behavior which are found in real life situations”, originated from the theater (Biddle, 1979). The definition has since evolved and for the purpose of the theory, role is defined as the set of activities, duties, responsibilities and specific behaviors, both expected and actual, associated with and required of a particular position” (Champoux, 2003). These activities and behaviors have some specific contextual meaning. A role does not cover all the behaviors exhibited by one individual; there are some boundaries beyond which, behaviors are not included in the role. For example, while in a place of employment an individual “plays” one role and while in the home, exhibits behaviors of a different role. A role set is the multiple relationships that one position maintains in the daily performance of the role. These relationships will vary based upon the role and the essence of the occupation. Role set diversity extends this concept by describing the diversity of the relationships that one

position must maintain within an organization to accomplish the tasks of the position (Rizzo et al., 1970).

Within classic organizational theory, the principles of chain of command and unity of command have important implications for success of the organization. The principle of chain of command indicates that organizations that are structured on the basis of hierarchy with a single and clear flow of authority are more effective, profitable and satisfying to the members (Rizzo et al., 1970). The single line of authority allows for effective control and coordination of resources and personnel. The principle of unity of command states that for any action, employees should receive orders from one and only one superior and there should be one plan for activities with agreed upon expected outcomes (Rizzo et al., 1970).

Role theory addresses the concept that there are behaviors expected of individuals in specific roles. However, when structural factors of the organization result in competing sections of the organization there is conflicting or inconsistent expectations of a single, specific role than meeting the expectation of the role will be increasingly difficult. As a result, the individual(s) within the role or position will experience stress and if that stress is not resolved, the individual can become dissatisfied with the role or position (Hardy & Conway, 1978; Rizzo et al., 1970). Role stress may also occur when the principles of chain of command and unity of command are violated. Role stress involves six general areas: role conflict, role ambiguity, role incongruity, role overload, role incompetence and role over qualification (Hardy & Conway, 1978).

Role conflict occurs when expectations are incongruent or mutually exclusive meaning expectations are clear but one or more expectations of a single position are

opposing. Conflicting expectations may come from different reference groups or when an individual occupies multiple positions. Role ambiguity is associated with a lack of clarity of role expectations or if the employee does not have the information necessary to meet the expectations of the role. This can result in the individual seeking out unusual methods to solve the problems of the role, which often distorts the situation and may lead to decreased satisfaction with the role and the organization (Hardy & Conway, 1978; Rizzo et al., 1970).

Role incongruity occurs when expectations for a role or position or a role runs counter to the individuals self perception, disposition, attitude and values. This may occur when an individual moves from one position to another and change requires a significant modification in attitudes or values and the individual is not able or willing to make the required modifications (Hardy & Conway, 1978). Role overload is when one individual is confronted with too many demands and cannot satisfy them all. Role overqualification and role incompetence relate to resources that are inadequate to meet the demands of the role or exceed the necessary demands of the role (Hardy & Conway, 1978).

When an individual in a specific role or position experiences increased role stress, for extended periods of time, the situation can result in a variety of negative outcomes for the individual (Biddle, 1979; Hardy & Conway, 1978; Rizzo et al., 1970; Scalzi, 1990). Among these negative outcomes can be the experience of failure, decreased productivity, the individual leaving the position, feelings of insecurity, as well as somatic complaints such as difficulty sleeping, headaches and ulcers (Biddle, 1979; Hardy & Conway, 1978;

Scalzi, 1990). Scalzi (1990) studied depression as a negative outcome related to role conflict and role ambiguity.

In professional organizations there are often two chains of authority – the one delineated on the organizational chart but also one based on “professional expertise which is enforced by collegial authority” (Rizzo et al., 1970). With the changes over the past decades, the environment in which healthcare organizations function has resulted in additional complexity to their structure. Because of the presence of two chains of authority and the increased complexity, healthcare organizations violate the principles of chain of command and unity of command. Healthcare organizations have multiple lines of authority, one line based on formal organizational structure and another based on professional collegial authority. NEs function and lead within these complex and diverse structures. With the increasing focus of healthcare as a business, there are additional expectations of NEs made by other reference sources including patients, physicians, administrators, board of directors as well as staff nurses and accrediting agencies, all leading to potential role stress for NE. Understanding the role NEs play within this structure is key to ensuring their continued success.

Over the past two decades, as healthcare organizations have evolved and increased in complexity, the role of the NE has been altered. According to Rizzo (1970), one of the primary propositions of role theory is an individual occupying a role must be taught or socialized in appropriate behavior for that role. This includes attaining the knowledge and skills necessary for the role. The NLN has declared nursing education must react to changes in the healthcare system and adjust educational objectives to meet the current needs of nursing (NLN 2003). This includes meeting the changing

requirements of nursing roles including the knowledge and skills necessary to fulfill roles within increasingly complex healthcare organizations.

Operational Definitions

For purposes of this study, the following definitions will be used:

Nurse Executive

A nurse in a leadership position that establishes department directions and strategies, plans programs and administers budgets to meet the overall institution or agency goals. The actual title of this individual may be Chief Nursing Officer, Vice President of Nursing, Director of Nurses, or Director of Patient Services as well as other possible titles.

Role Conflict

A stress reaction that occurs when an individual is subject to competing or conflicting sets of expectations and demands for one role or position in the organization. For purposes of this study, role conflict will be measured using the Role Conflict Scale as developed by House, Schuler and Levanoni 1983.

Role Ambiguity

A stress reaction that occurs when a role or position does not have a specified set of tasks or responsibilities or when the individual holding the role or position lacks this necessary information available for the organizational position. For purposes of this study, role ambiguity will be measured using the Role Ambiguity Scale as developed by House, Schuler and Levanoni 1983.

Job Satisfaction

The degree to which an individual reports satisfaction with the intrinsic and extrinsic aspects of their current work role or position. For purposes of this study, job satisfaction will be measured using the Job Satisfaction Index as developed by Tsui, Egan and O'Reilly 1992.

Depression

A psychological disorder, which may include one or more of the following symptoms: depressed mood, feelings of guilt and worthlessness, helplessness and hopeless, loss of appetite and sleep disturbance. For the purpose of this study, it will be measured using the Center for Epidemiological Studies – Depression Scale as developed by Lenore Radloff in 1977

CHAPTER 4

METHODOLOGY

Study Design

The research design used for this study was a cross sectional survey design to explore the level of role conflict, role ambiguity and the degree of job satisfaction among NEs who are members of the American Organization of Nurse Executives (AONE). The methodology of the study was correlational. The population studied was NEs who are members of AONE.

Population and Sample

The population studied was NEs who are members of the AONE. A sample of 1000 members was selected on a random basis from the total AONE membership, to achieve a mix of subjects from a cross section of private, public, government, teaching and non-teaching institutions. Bias was introduced because the survey did not include NEs who were not members of AONE at the time of the survey. Those who have not made the financial commitment or do not have an interest in this particular professional organization were excluded from the study.

AONE estimated the total membership of the organization was approximately 5000. Considering a desired margin of error at 5% and a confidence interval of 95 %, it was calculated that a sample size of 357 subjects was necessary to reflect the distribution

of the overall target population. Therefore, 1000 individuals were surveyed with a goal of a 36% response rate

To obtain the sample, the membership list from AONE was rented. After the request for rental was made to the organization, the Member Services Coordinator of AONE randomly chose 1000 members. When interviewing the coordinator on the method used to determine randomization, she explained that she choose approximately one of every five members on the list until 1000 names were identified.

Instruments

To collect data, a survey was developed that included four instruments, three of which were previously established. The first instrument was a questionnaire created to gather demographic data to describe the sample studied. Demographic information collected included: gender, age, educational preparation, current enrollment in education program, number of years of experience in nursing, number of years of experience in a management position, number of years in current position, position title, type of institution, number of FTEs supervised, geographic location and classification of the health care facility as urban, suburban or rural. Since a choice of two avenues for participation were offered, electronically and via a paper survey, two additional questions were added with the goal of identifying possible multiple entries by a single respondent. These two questions were, "What is the first letter of your mothers' maiden name and "Please indicate the last two numbers of your social security number?

The second instrument was the Role Conflict and Ambiguity Scale developed by House, Schuler and Levanoni (1983). This scale was a revision of the Role Conflict and Ambiguity Scale originally developed by Rizzo, House and Lirtzman and addressed the

concern regarding the role conflict items were “stress worded” and the ambiguity items were “comfort worded”. This instrument contains seven role conflict items and 11 role ambiguity items and utilizes a Likert type scale where 1 = strongly disagree and 7 = strongly agree. Although the Role Conflict and Ambiguity Scale is described as one tool, it uses separate scales that are “factorially identifiable and independent” (Rizzo et al, 1970). As such, role conflict and role ambiguity were reported separately for this study with a possible range of scores of 1 – 7 for both role conflict and role ambiguity. The higher the scores, the greater the levels of role conflict and ambiguity are respectfully. Reliability for this tool was established by O’Driscoll and Beehr (1994) and Westman (1992) and ranged from .79-.86 (Fields, 2002). Validity was established by O’Driscoll and Beehr and Westman where role ambiguity correlated positively with role conflict, employee uncertainty, psychological strain, turnover and job dissatisfaction (Fields, 2002; O’Driscoll & Beehr, 1994; Westman, 1992). Role conflict and role ambiguity correlated negatively with job dissatisfaction (House et al., 1983).

The third instrument was the Job Satisfaction Index developed by Schriesheim and Tsui (Fields, 2002). It uses six items to form an index that describe overall job satisfaction. The tool utilizes a Likert type scale where 1= strongly disagree and 5 = strongly agree. Reliability was established by Cohen and Tsui, Egan and O’Reilly (1992) and ranged from .73-.78 (Cohen, 1997; Fields, 2002; Tsui, Egan, & O’Reilly, 1992). Validity was also established by Tsui, Egan and O’Reilly who found overall job satisfaction correlated positively with age, tenure, psychological commitment to the organization, personal coping ability and organizational support for non-work activities.

There was a negative correlation with frequency of absences, job level, role conflict and years in occupation (Tsui et al., 1992).

The fourth instrument used was the Center for Epidemiological Studies Depression Scale (CES-D). This instrument was developed by Lenore Radloff at the National Institute of Mental Health. It is a short self reporting tool that measures symptoms associated with depression in the general population (Radloff, 1977). Respondents are asked to consider how they felt over the past week, as they respond to 20 short questions about their mood and psychological well-being. Possible answers include rarely, occasional, some of the time or most of the time. For each answer, points from 0-3 are assigned. The sum for the points from the 20 questions was calculated with total possible points being 0-60 with the higher the score, the greater the depression level. Internal reliability for this tool was reported by Scalzi to be at .85 and .87 (Radloff, 1977; Scalzi, 1990)

Permission to use the Role Conflict and Ambiguity Scale developed by House, Schuler and Levanoni was obtained from the American Psychological Association. Since some of the items are identical to items from the Role Conflict and Ambiguity Scale originally developed by Rizzo, House and Lirtzman, permission for the use of the original tool was also requested and received from *Administrative Science Quarterly*. Permission to utilize the Job Satisfaction Index was requested and received from *Administrative Science Quarterly*. Permission to utilize the Center for Epidemiological Studies Depression Scale (CES-D) was requested and received from *Sage Publications*. (Appendix B).

Human Subjects Considerations

The proposed study was submitted for review and approval by the University of Nevada, Las Vegas Institutional Review Board (IRB) before being initiated. After review, the IRB identified the study as exempt. A letter introducing the survey was sent to the randomly selected participants. The letter also served to inform them of the nature and purpose of the study and that participation is voluntary. In order to maintain confidentiality and anonymity no identifying information was collected regarding the participants or the facilities for which they were employed.

Data Collection Procedures

Data collection took place over a two-month period, which began on May 10, 2008 and ended on July 5, 2008. To recruit participants, 1000 members of the AONE were randomly selected by the organization. AONE estimated the total membership of the organization was approximately 5000. Considering a desired margin of error at 5% and a confidence interval of 95 %, it was calculated that 357 subjects were necessary to reflect the distribution of the overall target population. Therefore, 1000 individuals were surveyed with a goal of a 36 % response rate.

After approval by the IRB, a letter eliciting participation in this research project was mailed via United States Postal Service (USPS) to each participant chosen. Included in the letter was a written copy of the survey and a self addressed stamped envelope, along with instructions to participate on line via SurveyMonkey, if the participant prefers. SurveyMonkey is an online service that provides links to surveys so they can be easily accessible to participants. This service utilizes updated firewall and intrusion prevention technology and employs a third party to conduct daily audits of security to ensure all data

obtained is secure, confidential and private (SurveyMonkey, 2007). Results are gathered and assembled into a format which can be downloaded (Glat, 2007). The participants in this research were provided with a URL to access and complete the survey. By offering two avenues for participation, the likelihood for participation in the survey was increased.

On May 21 2008, approximately three weeks after the initial letter and survey were mailed, a reminder postcard was sent to each participant. A second and final reminder postcard was sent on June 14, 2008 to all participants, approximately six weeks after data collection began. Data collection ended on July 5, 2008, eight weeks after the initial invitation letter was sent. For those participants who choose to use the written copy of the survey, the results were mailed back via an enclosed self-addressed, stamped envelope.

Handling of the Data

Of the original 1000 surveys mailed, nine were returned via the USPS stamped, “undeliverable, occupant” moved. Four of those had forwarding addresses and surveys were mailed to the forwarding addresses provided. AONE was contacted in an effort to determine if the remaining five returned by the Post Office had provided updated addresses. AONE was unable to provide updates for these members. Seventy-four responses were made directly to the online SurveyMonkey data collection. An additional 349 paper surveys were completed and returned via the USPS resulting in an initial return rate of 423 or 42.3%.

In an effort to maintain one database, all paper surveys were manually entered into the SurveyMonkey database by the researcher. As each survey was entered, the data were manually screened for accuracy in data entry and missing values. After all surveys

were entered and the data collection was closed, the data were downloaded into an Excel spreadsheet. The data underwent a final review for accuracy. The review of the data revealed 14 returned surveys in which one or more of the tools were not completed and 27 returned surveys in which all tools were addressed but one or more responses were missing. Finally, when sorting the data by the questions designed to detect possible duplicate responses, “What is the first letter of your mothers’ maiden name” and “Please indicate the last two numbers of your social security number”, a potential issue was noted. The review revealed four suspect cases, in which the same first letter and same two social security numbers were repeated twice. Further exploration of these cases noted that the same title and same geographic location were also noted. It was determined that these may be duplicates and the last responses in both pairs were removed from the data. These 43 surveys were then eliminated from the data analysis resulting in a final response rate of 380 or 38%.

Assumptions:

For this study, the following assumptions were made:

1. It was assumed that the participants would receive the survey.
2. Those who chose to participate answered the questions honestly, freely and without bias.

CHAPTER 5

FINDINGS OF THE STUDY

The findings of the research study are presented in this chapter in three sections. The first section describes the demographic attributes of the sample studied. Secondly, there is a review of the research questions and how they are answered by the data analysis. Finally, although this study is not a replication of the Scalzi study, a comparison of the results of this study to those from the Scalzi study is provided.

Demographics of Study Sample

The first instrument in the survey was included to describe the demographics of the respondents and the facilities where they currently work. The sample studied was overwhelmingly female, 353 (92.9%) (Table C1) with approximately one half of the respondents indicating their age was between 45-54 (Table C2). The majority of the participants, (87.%) had earned at least a master's degree, either in nursing or another discipline (Table C3). With nearly 16% currently working on a degree or enrolled in an educational program. The results would indicate a population that values education. (Table C4).

The next three questions asked the respondents to identify their level of nursing experience and time in current position. For nursing experience, over 85% of the respondents indicated they have 21 or more years of nursing experience (Table C5). One

hundred and five indicated they had 16-20 years of management experience (Table C6) and the majority of the respondents 138 (36.3%) indicated 2-5 years of tenure in their current position (Table C7). The population studied has a great deal of nursing and management experience and some level of experience in the NE position.

The next several questions were focused on the current position occupied by the NE and the facility in which they work. The respondents were asked “which most closely resembles your title for your current position”. The majority indicated either a Director or a Vice President category (Table C8). The respondents were then asked “which best describe your organization”. The possible choices included private, public and government, teaching and non-teaching and for profit and non for profit. The respondents were requested to choose all that apply to their institution. These results can be found in Table C9.

The survey sought to describe the types of institutions in which NEs are employed. The majority of the respondents, 307 (80.8%) indicated that they worked in an Inpatient Acute Care facility while 29 (7.6%) indicated a multi-facility organization. (Table C10.) The respondents were asked, “indicate the number of full-time employees supervised”. Two hundred and eight (54.7%) indicated they had greater than 200 employees (Table C11).

Respondents were asked to choose the geographic location of their facility. More than half of the respondents, a total of 240 (63.1%) were from the east coast with 129 (33.9%) from the Northeast, eight (2.1%) from Midatlantic and 103 (27.1%) from the Southeast (Table C13).

The final questions on the demographic tool asked the participants to indicate if they are planning to remain in their current position for the next two years. To this question, 315 (82.9%) answered yes (Table C14). Of the 65 (17.1%) that responded no, the survey asked why? Of these, 30 (46.2%) expressed dissatisfaction with their position (Table C15).

Reliability of Survey Tools

In order to determine reliability of the pre-established instruments used in this study, a Cronbach's alpha was calculated for each of the tools. For the Role Conflict and Ambiguity Scale, an alpha of .801 was calculated for the role conflict questions and an alpha of .771 for the role ambiguity questions. This is consistent with the reliability scores of .79-.86 reported for the composite score tool and with a breakdown of .62-.82 for role conflict and .75-.84 for role ambiguity (Fields, 2002; Scalzi, 1990). In the present study, the Job Satisfaction Index had an alpha of .803. This exceeds the alpha of .73 reported by Tsui, Egan and O'Reilly (Fields, 2002). An alpha of .856 was calculated for the Center for Epidemiological Studies Depression Scale. This was consistent with the alpha of .85-.90 reported by Radloff (1977). (Table D1).

Statistical Methods Used

For this study, there were four dependent variables: Role Conflict, Role Ambiguity, Job Satisfaction and Depression scores. Three different instruments were used to measure these variables. The Role Conflict and Ambiguity Scale developed by House, Schuler and Levanoni (1983) were used to measure both role conflict and role ambiguity. This instrument contains 11 role ambiguity items and 7 role conflict items. It utilizes a Likert type scale where 1 = strongly disagree and 7 = strongly agree. Scores

for each item are summed and averaged to obtain final scores. Although this is described as one tool, it uses separate scales that are “factorially identifiable and independent” (Rizzo et al, 1970). As such, role conflict and ambiguity will be reported separately for this study with a possible range of scores of 1 – 7 for both role conflict and role ambiguity. The higher the scores, the greater the levels of conflict and ambiguity respectfully. In this study, role conflict had a mean score of 3.04 with a standard deviation of .71 and a range of 1-5.43. Role ambiguity had a mean score of 2.91 with a standard deviation of .79 and a range of 1-5.91.

The Job Satisfaction Index developed by Schriesheim and Tsui is comprised of six items to form an index that describe overall job satisfaction. The tool utilizes a Likert type scale where 1= strongly disagree and 5 = strongly agree. Scores for each item are summed and averaged to each a single score for the tool. There is a possible score of 1.00 – 5.00. The higher the scores, the greater the level of job satisfaction. The score calculated for the sample studied had a mean of 4.01 with a standard deviation of .65 and a range of 1.00 – 5.00.

The final instrument used was the Center for Epidemiological Studies Depression Scale (CES-D). This instrument was developed by Lenore Radloff at the Center for Epidemiologic Studies at the National Institute of Mental Health. It is a self-reporting 20 question tool that measure symptoms associated with depression in the general population (Radloff, 1977). For each question, the respondents are asked to consider how often they experienced the indicated symptom over the past week. For each answer, points from 0-3 are assigned. The points for each item are summed to reach the score for the CES- Depression scale. Possible scores range from 0-60, with higher scores

indicating higher levels of depression. The mean of the scores for the sample studied was 7.42 with a standard deviation of 7.67 and a range of 0 -50. (Table D2).

Data Tests for Normality

Before examining the data for possible relationships among the scores for the instruments, the data was tested for normality. Normality of distribution, is an assumption in multivariate data analysis, especially when the analysis uses inferences (Tabachnick & Fidell, 2007). A Shapiro-Wilks' test indicated the data collected for role conflict, role ambiguity, job satisfaction and depression were not normally distributed, ($p < .05$). Many statistical techniques are robust enough they can withstand violation of the assumption of normality, especially with large sample sizes (Pallant, 2005).

Testing of Research Questions

Question 1: What are the self-reported levels of role conflict and role ambiguity in nurse executives as measured by the Role Conflict and Ambiguity Scale?

Role conflict scores for the sample studied were calculated to have a mean = 3.04 with a SD = .71 and a range of 1.00-5.43. The possible range of role conflict scores with the tool used was 1.00 – 7.00 and the higher the number indicating the higher the rate of role conflict. Therefore, the sample studied had moderate amounts of role conflict. Role ambiguity scores were calculated to be mean = 2.91 with a SD = .79 with a range of 1.00 - 5.91. The possible range of scores for role ambiguity was 1.00- 7.00, with the higher the number the greater the level of role ambiguity. As a result, the sample studied had low to moderate amounts of role ambiguity.

Question 2: What are the self-reported levels of job satisfaction levels of nurse executives with their current position as measured by the Job Satisfaction Index?

Job satisfaction scores for the sample studied were calculated to be mean = 4.01, SD = .653 with a range of 1.00 – 5.00. The possible range of job satisfaction scores with the tool used is 1.00 -5.00 with the higher the score the greater the job satisfaction. The sample studied had high levels of job satisfaction.

Question 3: What are the self-reported levels of depression of nurse executives, as measured by the Center for Epidemiological Studies Depression Scale (CES-D)?

Depression scores for the sample studied were calculated to be mean= 7.42, SD= 7.67, with a range from 0.00 – 50.00. The possible depression scores with the CES-D tool was 0.00 – 60.00 with the higher the number the greater the level of depression. The calculated sample scores indicate that overall the sample had low levels of depression.

Question 4: Is there a relationship between role conflict, or role ambiguity as measured by the Role Conflict and Ambiguity Scale and job satisfaction as measured by the Job Satisfaction Index for nurse executives?

Before examining the data for possible relationships among the scores for the instruments, the data was tested for normality. Normality of distribution, is an assumption in multivariate data analysis, especially when the analysis uses inferences (Tabachnick & Fidell, 2007). A Shapiro-Wilks' test indicated the data collected for role conflict, role ambiguity, job satisfaction and depression were not normally distributed, ($p < .05$).

Correlations were then calculated using Pearson Product Moment Coefficient, a parametric statistic, as well as Spearman's Rho, a non-parametric test. The magnitude and the direction of the relationships examined were similar for both of the tests. So, for purposes of this study a Pearson Product Moment Coefficient, r was utilized to determine the relationship among the dependent variables.

To determine if a statistically significant relationship exists between role conflict and job satisfaction, a Pearson Product Moment Correlation was calculated with $r = -.490$, $p < .01$, revealing a moderate negative relationship between role conflict and job satisfaction indicating that as role conflict increases, job satisfaction decreases for the respondents studied.

To examine if a relationship exists between role ambiguity and job satisfaction a Pearson Product Moment Correlation was calculated with $r = -.544$, $p < .01$, revealing a moderate negative relationship between role ambiguity and job satisfaction. This indicates that as role ambiguity increased, job satisfaction decreased for the respondents studied. (Table D3)

Question 5: Is there a relationship between role conflict or role ambiguity, as measured by the Role Conflict and Ambiguity Scale and depression as measured by the Center for Epidemiological Studies Depression Scale (CES-D) for nurse executives?

To examine if a relationship exists between role conflict and depression the calculated Pearson Product Moment Correlation Coefficient was $r = .453$, $p < .01$, indicating a moderate positive relationship between role conflict and depression indicating that as role conflict increased depression level increased. When exploring the

relationship between role ambiguity and depression, $r = .464, p < .01$ revealing a moderate positive relationship between role ambiguity and depression. This indicated as role ambiguity increased, depression increased for the respondents studied.

Question 6: Is there a relationship between age and role conflict, role ambiguity, job satisfaction or depression?

A multivariate analysis of variance was calculated to determine if age had any effect on the four dependent variables role conflict, role ambiguity, job satisfaction and depression. The Wilks' Lambda examining the effect for age was $F = 1.351, p = .159$. This indicates that the null hypothesis was not rejected, meaning that age does not have an effect on the dependent variables among the respondents in this study. (Table D4)

Question 7: Is there a relationship between educational level and role conflict, role ambiguity, job satisfaction or depression?

In order to determine if there was relationship between subjects' education level and scores on role conflict, role ambiguity, job satisfaction and depression a multivariate analysis of variance was calculated. The Wilks' Lambda calculated was $F = 1.652, p < .05$ indicating a significant difference based on educational level and at least one of the four dependent variable. (Table D4). On post hoc analysis, Tukey HSD indicated a significant difference in role conflict levels when comparing subjects who had a doctorate-non nursing with those who had a master's in nursing (mean difference (MD) = 1.5474, $p < .05$) and to those with a master's- non-nursing (MD = 1.6797, $p < .05$) and a doctorate-nursing (MD = 1.6538, $p < .05$). In each case, those with a doctorate- non-nursing had

higher levels of role conflict. However, the study included only two participants with doctorates-non-nursing so these results lack enough power to allow for inferences to be drawn. (Table D5).

The Tukey HSD also revealed a significant difference on role ambiguity scores when comparing subjects who had a doctorate- non nursing when compared to subjects who reported having a bachelor's -non nursing ($MD = 1.8787, p < .05$) and those with a master's-non nursing ($MD = 1.7410, p < .05$). Again, in each case those with a doctorate-non-nursing had higher levels of role ambiguity. There were no significant differences found based on educational level for job satisfaction and depression scores among the study respondents. (Table D6).

Question 8: Is there a relationship between intent to remain in current position for next two years and role conflict, role ambiguity, job satisfaction and depression scores for nurses executives studied?

In order to determine if there was a relationship between intent to remain in position for the next two years and subject's scores on role conflict, role ambiguity, job satisfaction and depression, a MANOVA was calculated. On the original survey, 65 subjects indicated they did not plan to remain in their current position for the next two years. This subset was compared to a random sample of 65 of those who did plan to remain in their position. When comparing these two groups, a Wilks' Lambda indicated a significant difference, $F = 4.762, df = 125, p < .001$. For those planning to remain in their position, job satisfaction was higher and role conflict, role ambiguity and depression

scores were all lower than those not planning to remain in current position for the next two years. (Table D7).

Comparison to Results of Previous Study

The literature revealed a paucity of research on role stress in nurse executives. The only study identified was one completed by Scalzi (1990), which studied role conflict, role ambiguity and depression in NEs. While the current study uses some of the same scales as the Scalzi Study, it was not designed to be a duplication of the earlier study. However, the two studies are similar and warrant a result comparison. In an effort to analyze the differences of the two studies, a *t*-test was calculated comparing the results of this study to those obtained in the Scalzi Study in 1990. Normality of distribution is an assumption for *t* – tests and since this data were not normally distributed, this assumption was violated. However, the *t*- test tends to be robust enough to withstand a violation of this assumption especially considering the large sample sizes involved in the analysis (Sokal & Rohlf, 1995). A review of the data indicated the current study had lower role conflict scores, (N=380, M 3.04, SD=. 71) when compared to the score from the earlier study (N= 124, M=4.0, SD=1.2). The *t*- test indicated the difference was statistically significant, *t* –value = -2.32, *p*<.05. (Table D8)

Role ambiguity scores from the current study (N= 380, M= 2.91, SD=.79) were higher than the scores from the previous study (N=124, M= 2.7, SD=.9). T test analysis indicated the differences were found to be statistically significant (*t*=8.44, *p*<.0001, *df* 152). While the depression scores on the current study (N= 380, M = 7.42, SD=7.67) were lower than the Scalzi Study (N= 124, M= 8.70 and SD= 8.90) the difference was not found to be statistically significant, *t* –value = 1.44 *p*= 0.152. (Table D8).

Summary

This chapter presented the data analysis for the study. The demographics of the respondents were described including information about both the subject and the facility in which they are currently employed. The reliability for the instruments utilized as well as the descriptive statistics for the Role Conflict and Ambiguity Scale, the Job Satisfaction Index and the Center for Epidemiologic Studies Depression Scale were all presented. Tests of the research questions were analyzed and the differences of the scores obtained from the current study and a similar previous study were discussed.

CHAPTER 6

SUMMARY, CONCLUSIONS AND RECOMMENDATIONS

This chapter presents a summary of the research purpose and method, discussion of the findings, as well as a review of the limitations of the study. Recommendations for future research are also provided.

Summary of Research Purpose and Method

The average age of an RN continues to increase and large numbers of the profession are looking towards retirement in the next 12 years. This comes at a time when the US and much of the world is in the midst of a well-publicized nursing shortage and recognition of a nursing faculty shortage. Meanwhile healthcare has undergone drastic changes over the past two decades, which have resulted in increased complexity of the healthcare environment and in turn expanded the role and responsibilities of the NE. The merging of some of these key events has been termed the perfect storm (Brown, 2007; Curtin, 2007; Simpson & Bolton, 2007). Still, nursing as a profession must also look to other subsets of the profession to identify other at risk areas. When one considers the average age of the NE is 49 years and at least some, if not many, will be facing retirement in the next 12 years, the potential for a major loss of these important nursing leaders exists.

The NLN has called for a reform of nursing education to respond to the significant changes in healthcare. Innovation is required to change both content and curriculum to provide updated skills and knowledge necessary to succeed in the modern healthcare environment. As part of this call to reform, the NLN and the RWJF have challenged educators and nursing practice to work in a collaborative partnership to redesign educational systems that are responsive to the changing healthcare systems (National League of Nursing, 2003; Robert Wood Johnson Foundation, 2002). Before making changes, nursing educators need to assess how nurses at all levels are faring. A major loss of NEs could create a leadership vacuum, so examining how NEs are faring, as a preamble to examining any potential educational role, is imperative.

The purpose of conducting this research was to study the current state of NEs by determining the levels of role conflict and role ambiguity in NEs in relation to their expanded responsibilities. Since the literature indicates that increased levels of role stress are related to decreased job satisfaction and increased levels of depression, the levels of these two concepts were also explored.

The theoretical foundation of this study was based on organizational and role theory components. Organizational theory states that within the formal structure of an organization, the labor to complete the tasks of the organization is divided so that every position should have a specific set of duties for which the individual is responsible and should be held accountable for by the supervisor. Role theory focuses on the characteristics of persons and behaviors of these identified positions and is concerned with the context and processes that affect those behaviors. Other tenets of organizational theory are the principles of chain of command and unity of command. These principles

suggest organizations structured on the basis of hierarchy, with a single and clear flow of authority, are more effective, profitable and satisfying to the members. Employees should receive orders from one and only one superior with one plan for activities based on agreed upon objectives (Rizzo et al., 1970). However, when structural factors of the organization result in competing sections of the organization having conflicting or inconsistent expectations of a single, specific role, than meeting the expectations of that role will be increasingly difficult and this can lead to role stress. Role conflict and role ambiguity are two types of role stress.

Professional organizations, including many healthcare organizations, often have two chains of authority – the one delineated on the organizational chart but also one based on “professional expertise which is enforced by collegial authority” (Rizzo et al., 1970). In addition, wide spread changes in the healthcare environment have resulted in additional complexity to the healthcare organizational structure with increased expectations of NEs made by a variety of reference sources, all leading to potential role stress for NE. Understanding how NEs are faring within this structure is key to ensuring their continued success. In order for nursing education to respond to the changing healthcare environment and design innovative education methods to provide nurses at all levels with the new and necessary knowledge and skills, nursing education must work in collaboration with NE to explore the needs of these nurses. This study was a first step in that process.

Demographics of the Population

A review of the demographic data collected indicated that the sample of NEs studied is overwhelming female with an age range likely between 45-54 years. This is

consistent with the Ballein Survey (2003), which identified the average age of a NE was 49 and the Scalzi Study (2000), which indicated 40-49 years of age.

The data revealed over 87 % of the NEs studied earned at least a master's degree and 15.8% are currently enrolled in a degree program. This would indicate a group that is well educated and seeks out educational opportunities. In the Scalzi Study (1990), 44.7 % of the participants had a master's degree and none had a doctorate. In the more recent Ballein Survey (2003), 83% indicate the highest level of education was a master degree with 8% of the respondents having a doctorate. The education profile of the current sample is more similar to the Ballein Survey and this may indicate the educational level of the NE is increasing. In addition, nearly 16% of this sample is currently pursuing a higher degree, which is consistent with the sample in the Ballein Survey.

The sample, in this study also has a great deal of experience. A total of 86.1 % have greater than 21 years of experience with 73.2% over 25 years of experience in nursing. Over 72% have 16 years or more management experience and 36.3% have been in their current position between 2 – 5 years with a total of over 79 % being in their current position for more than 2 years. These numbers do indicate the population of NEs studied has a great deal of experience in nursing, in management and in their current position.

The respondents in the study have identified several different titles with the majority identifying their title as Director of Nursing, Vice President of Patient Services or Chief of Nursing Services. The study also included nurses with the titles of Chief Operating Officer and Chief Executive Officer. This is consistent with the literature that

indicated the NE is no longer seen simply and primarily as the “Director of Nursing” but rather holds titles that indicate expanded and elevated responsibility.

Other data regarding the institution in which the NE was employed was collected. In regards to the type of institution, the majority of the respondents identified they currently work in an inpatient acute care institution. However, 29 respondents (7.6%), identified they work in a multi-facility organization. Data collected regarding number of employees supervised indicate that the majority of respondents supervise 200 or more full-time employees. The results from these two questions are in support of the literature, which revealed the depth and breadth of changes that have occurred in healthcare over the past decades and the increase in the complexity of healthcare institutions and the roles and responsibilities of the NE.

The breakdown of the geographic location where the participants were currently employed is very interesting. While the number of respondents from urban and suburban areas were nearly identical, 136 and 135 respectfully, it was interesting to see the number of rural or frontier to be not far behind at 109. It seems from experience there would be fewer respondents from rural or frontier areas; however, since there was no definition provided for these descriptive terms, it is difficult to further analyze the distribution of these responses.

To summarize, the average NE surveyed in this study was a female, aged 45-54, with a master’s degree. The average NE had over 25 years of nursing experience with 16-20 years management experience and was in her current position for 2-5 years. She worked for a public, teaching, not for profit, inpatient acute care institution and had responsibility for 200 or more employees. She lived on the East Coast in either an Urban

or Suburban area and planned on remaining in her current position for at least the next two years.

Discussion of Findings

An analysis of the data collected during this study revealed the sample had a mean role conflict score of 3.04 with a SD of .71, indicating overall NEs have moderate to low levels of role conflict. The data also revealed that the population had even lower levels of role ambiguity with mean scores on the Role Conflict and Ambiguity Scale of 2.91 with a standard deviation is .79

The mean score on the Job Satisfaction Index was 4.01 with a SD = .653 with a possible range of 1.00-5.00. This would indicate high levels of job satisfaction for the population studied. Similarly, the data indicated very low levels of depression with mean scores on the Center for Epidemiologic Studies Depression Scale of 7.42 with a SD of 7.67 on a scale with a range of 0.00 – 50.00.

The current study examined if age or educational level of the respondents had any relationship to the scores of the dependent variables. The analysis indicated that there was not a significant relationship between age and the dependent variables. Conversely, the data analysis did indicate there was at least some relationship between education levels and subject score on role conflict and role ambiguity. More specifically, those with a doctorate- non nursing had higher levels of role conflict than those with a master's- nursing, master's- non nursing and doctorate- nursing. Similarly, the data analysis indicated that subjects with doctorate- non-nursing had higher levels of role ambiguity than those with a bachelor's- non-nursing and a master's- non-nursing. In each case, those with doctorate non-nursing had higher levels of role stress. However,

the study included only two participants with doctorate non-nursing so these results may not have sufficient power to allow for inferences to be drawn; but, this relationship warrants further exploration through future research. There was no significant difference found based on educational level for job satisfaction and depression scores.

Job Satisfaction

Despite the increasing complexity of the NE position, the average job satisfaction score for the sample studied was high with an average score of 4.01. While exploring this variable, it is important to note the literature indicates that the nurse executive is now taking a place at the decision table within healthcare (JACHO, 1996; Ballein, 2000; Dalley et al, 2000; Murray, 1998). Perhaps the recognition of participating at the upper levels of the healthcare institution and having a voice in decision making provides a level of satisfaction for the NE which overcomes the extensive expectations of this complex role. It also must be considered that NEs occupy the highest levels of the profession and this elevated level may provide some level of satisfaction for these individuals.

While the job satisfaction scores for the study sample was high at 4.01, when considering job satisfaction the intention to stay in the current position must also be considered. While the majority of the respondents indicated that they planned on remaining in their current position for two years, 65 (17.1%) indicated they were not. Of those, nearly half 46.2% denoted the reason for leaving as dissatisfaction with the position. Another 16.9% indicated they were retiring. These two responses need greater exploration. First of all, it is important to further investigate why these individuals are dissatisfied and to determine what strategies can be developed to encourage these NEs to remain in the position. Secondly, reasons for retirement need to be investigated. One of

the strategies considered to combat the nursing shortage and the potential leadership vacuum is delaying or deferring retirement of at least some of those planning to retire. The goal of this strategy is to provide more time for less experienced nurses to garner the wisdom and experience of the seasoned NE. There is the possibility that some of the NEs have decided to pursue retirement at this time because of difficulties in their current position or lack of flexibility in work responsibilities. Some NEs might postpone retirement if innovative options such as flexible work weeks or new limited roles developed with a goal to provide support to less experienced nurse leaders were created.

Of the remaining, who stated they were leaving the position, 26.2% indicated they were looking for career advancement. While on the surface this would seem to be a positive factor, further exploration into which positions these individuals were seeking to advance to would help confirm that impression. Similarly, further analysis of those indicating they were leaving due to relocation may reveal that for some the desire to relocate is related to dissatisfaction in their current position, with relocation being a secondary reason.

Comparison of Results to Previous Research

A review of the literature revealed several studies concerning role conflict and role ambiguity in nursing. Studies have identified role conflict in nursing students (Wu & Norman, 2006), new graduate nurses (Kilpatrick & Frunchak, 2006), school nurses (Zimmerman et al., 1996), advanced practitioners (Bryant-Lukosius et al., 2004; Yao-Mei et al., 2007) and nurse researchers (Fitzsimons & McAloon, 2004). The review only identified one study which concerned role conflict in the NE and that study was completed nearly 20 years ago (Scalzi, 1990).

A comparison of the results of the present study to that of the Scalzi Study indicate that despite an increase in the complexity of the NE position since the Scalzi study in 1990, the sample in the current study had lower role conflict scores and higher role ambiguity scores and that these differences were statistically significant. These results need further examination. One possible reason may be the difference in the education level between the two samples. While the sample studied by Scalzi had 44% of NEs with a masters degree and none had a doctorate, 87% of the sample in the current study had at least a masters degree with 7.3 % having a doctorate.

When reviewing the resultant scores from the Center for Epidemiological Studies Depression Scale (CES-D) the current study had a mean score of 7.42 with a SD of 7.67. The scores from the Scalzi Study had a mean score of 8.70 with a SD = 8.9. A *t*-test comparing the depression scores from both studies found the difference to not be statistically significant ($t=1.44, p=0.152$). Therefore, while the scores on the current study were less than those from the Scalzi Study, the difference was not statistically significant. So while there has been increasing complexity of the NE position and a significant increase in role ambiguity, there has been no significant change in the depression score. Depression scores were utilized by Scalzi to identify negative outcomes of role stress. However in the current study there was a decrease in role conflict with an increase in role ambiguity. This result may indicate that negative outcomes may be more closely related to role conflict than role ambiguity. Secondly, when considering changes in depression over the past twenty years the increased use of antidepressants should be considered as their use may affect results on a depression scale. This study did not collect data on antidepressant use and as such further examination

while warranted, is beyond the scope of this discussion. This study defined role conflict as a stress reaction that occurs when an individual is subject to competing or conflicting sets of expectations and demands for one position in the organization. Since the results indicate statistically significant lower levels of role conflict, it follows that despite the growing complexity of the healthcare environment expectations; the NEs in this study perceive expectations of them are clearer and less competing than in the past.

Similarly, role ambiguity is defined as a stress reaction that occurs when a position does not have a specified set of tasks or responsibilities or when the individual holding a position lacks this necessary information available for a given organizational position. This study indicates the levels of role ambiguity have risen while levels of role conflict have declined, it follows that NEs in this study perceive less specificity in tasks or lack some information regarding their position at some level.

When examining the variance in the results from the two studies, the design and sample studied must be considered. First, the sample studied by Scalzi was localized to one metropolitan area in one state, Los Angeles, California with an N = 124. The current study, examined a national cross section of NEs with a much larger sample size, N=380. In addition, data analysis from this study did indicate educational level had some relationship to role conflict and role ambiguity. The participants in this study had higher education levels compared to the Scalzi Study where 44.7 % of the participants had a master's degree and none had a doctorate. This may account for at least some of the decreased levels of role conflict in the current study; however, this relationship remains unclear and warrants further exploration.

The number of respondents who indicated they were planning to leave their position within the next two years was 65 or 17.1%. This does not support the research by Garbett (1998) that indicated that a third of the NEs interviewed were planning on leaving their job within one year. There are differences in the two populations including the fact that the Garbett Study was done in the United Kingdom (UK) about ten years ago. Therefore, the possibility exists that either conditions in the UK do not mirror those in the US or the numbers have changed over the past ten years.

Glasberg, Norberg and Saderberg (2007) used a qualitative approach to study 30 nurse managers in northern Sweden and identified changes in healthcare have led to increased complexity in the role of the nurse managers within this group which has led to increasing amounts of role conflict, along with feeling of inadequacy and powerlessness (Glasberg et al., 2007). Since the levels of role conflict and role ambiguity are relatively low and levels of job satisfaction are high in the current study, it does not support the Glasberg et al findings. It should be noted that in the previous study, when the interviews took place, the first question asked was, "From your experience, what changes in healthcare might have contributed to the increase in sickness and absence of healthcare staff due to burnout?" The wording of this question can lead the respondent to a negative answer resulting in bias. If the question was worded more objectively or neutrally, the responses might have been different. The difference in results may also be related to variances in the Swedish and American healthcare environments. There may be other factors in Sweden, which may have led to the increasing role conflict and feelings of inadequacy among the nurses studied.

Piko (2006), studied health care staff in Hungary and found a relationship between job satisfaction and education levels. The researcher identified that educational level may be a protective factor against some job related experiences. This relationship was not supported in the current study, which indicated that while there was a relationship between education and role conflict and role ambiguity, there was no relationship between education and job satisfaction or depression. Healthcare workers overall tend to be an educated sample but many do not have graduate degrees. Therefore, it is possible that if a minimal level of education is obtained it might provide some “protective factor”, but at higher levels of education, there is no additional protection. This should be further examined in future studies.

Carver (2008) studied organizational commitment based upon generational differences in nursing faculty. The study identified different generations have differing levels of organization commitment. Cohort generations are individuals born at a similar period of history, so these individuals would be somewhat of similar age (Carver, 2008). The generations were defined primarily based upon year of birth. Veterans were born between 1925-1942, Baby Boomers between 1943 – 1960, Generation X’ers between 1961-1981 and Millennials were born between 1982-2002. The age categories offered in this current study were: 65 and over, 55-64, 45-54, 35-44, 25-34 and less than 25. When comparing these categories to the generations as defined by Carver, there is some similarity if not a clear match. Clearly, the 65 and over are consistent with the Veteran Generation and the under 25 category is consistent with the Millennial. The Baby Boomers fall in the 45-54 and the 55-64 categories. Generation X is similar to the 25-34 and 35-44 category. In the current study, the data were analyzed to determine if there

was a relationship between age and the four dependent variables. The analysis indicated that there was not a significant relationship. However, this study was not designed to consider generational differences or differences in age based on generations. Another study, which looks at actual generations and role conflict and role ambiguity scores among the generations, might result in different findings.

Correlations Among Dependent Variables

Using a Pearson Product Moment Coefficient this study identified that role conflict was positively correlated with both role ambiguity and depression. There is also a negative correlation between role conflict and job satisfaction. When considering role ambiguity there is negative correlation with job satisfaction and a positive correlation with depression. These findings were consistent with the study conducted by Wu and Norman (2006). In that study, role conflict and role ambiguity were reported as a single score. This score was found to be negatively correlated with job satisfaction.

Other Discussion

The results of the current study indicated there was both role conflict and role ambiguity in the sample studied, but levels of both of these concepts seem to be at a moderate level in this group. Role conflict and role ambiguity are both forms of role stress. High levels of role stress or stress that exists for an extended period of time are related to a variety of negative outcomes such as depression (Hardy & Conway, 1978; Scalzi, 1990). However, stress at some level is required for an individual to grow, to master past skills and cultivate new skills. Therefore, the goal should not be to eliminate all stress but to ensure that the tension and anxiety that accompany stress are not overwhelming to the individual (Hardy & Conway, 1978). The results of this study seem

to indicate the stress levels are not overwhelming to the NE and actually may be encouraging development of skills required for the position.

The study by Scalzi included a qualitative phase in which a sub sample of NEs were interviewed. Data collected from this phase identified NEs have a variety of methods to deal with role stress. These included identifying problem solving resources, changing activities including doing something they enjoy when the stress gets high, as well as conferring with other NEs to share resources and manage stress. While the current study did not consider strategies for coping with role stress, this important avenue needs to be considered. This is an important factor as nursing education looks to develop innovative methods to teach new skills required of nurses at all levels to succeed in the new and evolving healthcare environment.

Another consideration for role conflict among nurses is that nurses are often “trained” to manage different expectations from competing groups. Even from the beginning, the novice nurse often has to balance different expectations. Consider the clinical site where nursing faculty have one set of expectations for performance, staff nurses often have a different set of expectations and patients and physicians may also have varying expectations of skill levels and knowledge from the novice nurse. This has been labeled the theory practice gap (Wu and Norman, 2006). As the student graduates and eventually advances through skill levels, one must consider that they learn to master this balance while developing compromising skills in an effort to meet the needs of competing reference groups. This may affect the levels of role conflict and ambiguity in this population. Wu and Norman studied role conflict and role ambiguity in nursing students within the Chinese workforce; however, additional exploration of these concepts

in American nursing students might provide some insight as to how nurses learn to manage conflicting expectations. While the cultural differences between the United States and Chinese workforce are well known, additional evaluation of how nurses learn to manage conflicting expectations may be interesting and provide additional insight for the development of innovative teaching methods. This insight could be useful for educators and practice leaders to work collaboratively to narrow the theory practice gap.

Implications For Practice

Healthcare organizations are likely to continue to evolve and increase in complexity thus putting pressure on nurses in many roles. This study provided a baseline of the status and condition of the NE position. While neither role conflict nor role ambiguity scores are high, there is some level of role stress in the studied population. In addition, while role conflict scores have had a statistically significant decrease, role ambiguity scores have increased. These changes need to be recognized and further studied. The decrease in role conflict may be related to the ability of nurses to balance different expectations. This ability may stem from a recognition that quality healthcare is the unifying expectation for all levels of healthcare. Recognition of this ultimate goal may improve the ability to balance the different expectations of competing constituencies. The increase in role ambiguity may indicate that while NEs are responsible for additional areas and tasks, they may not consistently have the skills or knowledge necessary to manage these areas.

Stress is necessary for an individual to evolve; however, when there is excessive stress, negative outcomes can result. The study by Scalzi also identified NEs have a variety of methods to deal with role stress. These included identifying problem solving

resources, changing activities when the stress gets high as well as conferring with other NEs to share resources and manage stress. While the current study did not consider strategies for coping with role stress, this important avenue needs to be considered. Nursing education and practice need to work collaboratively to explore at what level stress becomes excessive, what coping strategies can be developed and implemented to avoid extremes of role stress and how nursing education can contribute to educating NEs and current nursing students about new strategies to manage stress in the workplace.

Education has been found to be related to both role conflict and role ambiguity, which indicates there was some component in education that affects these concepts in the NE. Nursing education should explore this relationship further to determine if changes should be made in curriculum content to help prepare those nurses who may ultimately pursue administrative and leadership positions.

Study Limitations

A limitation of this study is that it was restricted to NEs who were members of AONE and did not gather data from those NEs who were not members of the organization. There may be some factors that preclude NEs from joining the organization that may affect role conflict, role ambiguity, job satisfaction, or depression. Those individuals who join professional organizations may place a greater emphasis on identification with or have a greater degree of commitment to the profession. These factors may affect levels of role conflict, role ambiguity, job satisfaction and depression.

Another limitation of this study is that it examines only a limited view of the status of the NE. This research focused on exploring four concepts in relation to the NE population, role conflict, role ambiguity, job satisfaction and depression. However there

are many dimensions of this important nursing leader. Factors in the personality or context of the experience of the NE may draw the individual nurse to and may affect success in, the NE role. Some of these factors may include leadership style, organizational skills, negotiating abilities, and characteristics of relationships with nursing and non nursing peers as well as the quality of nursing and other professional experiences. These dimensions should be considered in future research.

Recommendations for Future Research

The findings of this study and the review of literature suggest the need for future research. This section will discuss those recommendations. The sample of NEs studied is well educated, has a great deal of experience and operates in a complex and evolving environment with moderately low role stress. This indicates a group, which is multidimensional, however this study only provided a limited view of these individuals. A recommendation is made to further explore the many dimensions of the NE. Factors in the personality or context of the experience of the NE may draw the individual nurse to and may affect success in, the NE role. These should be examined.

While this study suggests some relationship between educational level and the four variables, this finding does not have sufficient power to make inferences. A recommendation is made for further research examining this possible relationship as well as research to address the potential roles of nursing education programs, including curricular modifications to help better prepare nurses for future leadership roles such as the NE. Furthermore, this study only considered minimal information related to the highest level of education completed by the participants. Future research efforts should seek to collect more detailed data including identifying the type of degree for those who

completed masters or doctorates in non nursing areas. For example, examining if NEs with master degrees in health care administration or business administration, differ than those with masters or doctorate in clinical areas.

Piko (2006), studied health care staff in Hungary and found that education may provide a “protective factor” against negative job satisfaction. While this relationship was not supported in the current study, it should be noted that the current group studied had a higher level of education than studied by Piko and this protective factor may only be effective at lower levels of education. A recommendation is made to design research to assess whether there is a minimal level of education that provides a “protective factor” and at what level does education become protective.

It is understood that stress at some level is required for an individual to grow and to master past skills and cultivate new skills. However excessive stress becomes counterproductive and can result in negative outcomes. Future areas for research include exploring at what level does role stress allow for growth and development and at what point does the stress become excessive? Furthermore the data indicate that despite a complex role, the NE are able to manage role stress as evidenced by moderately low levels of role conflict and role ambiguity. Similarly, anecdotal information also identifies the ability to balance competing expectations is necessary early in the education of all nurses. Even novice nurses in initial clinical experiences encounter competing expectations from instructors, patients, nursing and other clinical staff. Therefore, a recommendation is made to use a qualitative approach in designing a study that explores strategies for coping with role stress along with a determination of which strategies are most effective. A recommendation is also made to study how nursing students develop

skills to balance competing sets of expectations among various constituencies. As nursing develops an understanding of how these skills are developed and which coping strategies are most effective, curricular modifications can be considered to ensure these skills are provided early and appropriately.

Carver (2008) found differences among generations of nursing faculty in level of organizational commitment. While this study did not find differences among age and the dependent variables it was not designed to examine differences based on generations. A recommendation is made to explore the relationship among Generational Differences and Role Conflict and Ambiguity.

As nursing looks to resolve the nursing shortage, it is important to develop strategies to maintain those currently in profession. This study identified that of those not planning on remaining in their current position for the next two years, 46% were leaving because of dissatisfaction and over 16% because of retirement. Future research should explore specific reasons for NEs not planning on remaining in their current positions including, factors that may affect the decision to possibly postpone retirement.

Summary

This study provided a brief exploration into the status of the NE and addressed an important role for nursing education in support of NEs, both now and in the future. The review of literature revealed several studies exploring role stress, including role conflict and role ambiguity in nurses in a variety of areas, but very little regarding nurse executives. In fact the only study identified concerning this population, was completed nearly 20 years ago. This study identified the average NE is experiencing only moderate levels of role conflict and role ambiguity. It also revealed that while levels of role

conflict are decreasing, levels of role ambiguity are increasing. The study identified high levels of satisfaction and low depression scores. This all seems to fare well for the nurse executive. However, this study while beginning the exploration of these important leaders who “oversee the only product of health care organizations – patient care delivery” (Ballein Search Partners, 2003), is only a first step in the process. Suggestions for further research into the NE have been provided. Information from future studies will contribute to the evolution of nursing education directed at leadership roles.

APPENDIX A

COMMUNICATION WITH PARTICIPANTS AND DATA COLLECTION INSTRUMENTS

May 10, 2008

Dear Nurse Executive,

Please allow me to introduce myself. My name is Theresa Tarrant. I am a graduate student pursuing a doctorate degree in nursing, with an emphasis on education, at the University of Nevada Las Vegas. My dissertation is exploring the presence of role conflict, role ambiguity, as well as job satisfaction levels in the nurse executive. As a member of AONE, I would like to request a few minutes of your time to complete the attached survey. By doing so, it will enable you to participate in this research. Your participation is strictly voluntary.

As a former nurse executive, I know that there are many demands on your time. It is easy to see that with your participation, you will be adding one unnecessary task. I am estimating that completing this survey should take no longer than 10-15 minutes and hope you will agree to take part in this research. To make your participation most convenient for you, I have included a copy of the survey and a self-addressed stamped envelope for you to return the survey. If it is easier, you may also complete the survey via SurveyMonkey.com at the following URL

http://www.surveymonkey.com/s.aspx?sm=eC5_2fSsapG33KNT8Qy12ztA_3d_3d

Please remember that your participation is voluntary and you may elect not to answer any questions that may make you feel uncomfortable. Every attempt will be made to maintain confidentiality. Please do not make any additional marks on the survey to ensure anonymity. You will notice that I am not collecting any names of the nurse executives or the organizations in which they are employed.

All statistical analysis will be made in summary format (no specific individual or facility will be identified). If you are interested in the results, please contact me at timteriemi@yahoo.com and I will be happy to forward a copy of the abstracts of the completed study to you.

Thank you in advance for your time and participation. Your contribution to this study is greatly appreciated. If you have any questions please do not hesitate to contact me at 702-639-7733.

Sincerely,

Theresa Tarrant, RN, MS
Graduate Student
University of Nevada Las Vegas

NURSE EXECUTIVE SURVEY

Demographics

Please answer the following questions about yourself.

These questions are for statistical purposes only and are optional.

Thank you for your assistance. Your participation is greatly appreciated.

1. What is your gender? ☐ Male ☐ Female

2. Please indicate which best represents your age?

☐ Under 25

☐ 25-34

☐ 35-44

☐ 45-54

☐ 55-64

☐ 65 or older

3. What is your highest level of education?

☐ No degree

☐ Diploma

☐ Associate Degree

☐ Bachelor Degree – Nursing

☐ Bachelor Degree – Non Nursing

☐ Masters – Nursing

☐ Masters – Non Nursing

☐ Doctorate– Nursing

☐ Doctorate– Non Nursing

4. Are you currently working on a degree or enrolled in an educational program?

☐ Yes

☐ No

5. Indicate the number of years of experience in nursing?

☐ < 2 years

☐ 2-5 years

☐ 6-10 years

☐ 11-15 years

☐ 16-20 years

☐ 21-25 years

☐ >25 years

☐ Not currently employed

6. Indicate the number of years of experience in management position?

☐ < 2 years

☐ 2-5 years

☐ 6-10 years

☐ 11-15 years

☐ 16-20 years

☐ 21-25 years

☐ >25 years

☐ Not currently employed

7. Number of years in current position?

☐ < 2 years

☐ 2-5 years

☐ 6-10 years

☐ 11-15 years

☐ 16-20 years

☐ 21-25 years

☐ >25 years

☐ Not currently employed

8. Which most closely resembles your title for your current position?

<input type="checkbox"/> Chief, Nursing Service	<input type="checkbox"/> Vice President Patient Services
<input type="checkbox"/> Director of Nursing	<input type="checkbox"/> Other Please Specify: _____
<input type="checkbox"/> Vice President Nursing	<input type="checkbox"/> Not currently employed

9. Indicate which best describe your organization (check all that apply)

<input type="checkbox"/> Private	<input type="checkbox"/> For profit
<input type="checkbox"/> Public	<input type="checkbox"/> Not for profit
<input type="checkbox"/> Government	<input type="checkbox"/> Not currently employed
<input type="checkbox"/> Teaching	
<input type="checkbox"/> Non teaching	

10. Indicate which of the following best describe the type of facility in which you are employed?

<input type="checkbox"/> Inpatient Acute Care	<input type="checkbox"/> In patient Mental Health
<input type="checkbox"/> Ambulatory Surgery	<input type="checkbox"/> Other Please Specify: _____
<input type="checkbox"/> Rehabilitation	<input type="checkbox"/> Not currently employed
<input type="checkbox"/> Long Term Care	

11. Which of the following indicates the number of full-time employees supervised?

<input type="checkbox"/> 20 or less	<input type="checkbox"/> 101-200
<input type="checkbox"/> 21-100	<input type="checkbox"/> >200
	<input type="checkbox"/> Not currently employed

12. Which of the following best described the geographic location in the United States of your current facility?

<input type="checkbox"/> Northeast	<input type="checkbox"/> Northwest
<input type="checkbox"/> Midatlantic	<input type="checkbox"/> Southwest
<input type="checkbox"/> Midwest	<input type="checkbox"/> South
<input type="checkbox"/> Southeast	<input type="checkbox"/> Not currently employed

13 Which of the following best describes the area in which your healthcare facility is located?

<input type="checkbox"/> Urban
<input type="checkbox"/> Suburban
<input type="checkbox"/> Rural/Frontier
<input type="checkbox"/> Not currently employed

14. Do you plan on remaining in your current position for the next two years?

<input type="checkbox"/> Yes
<input type="checkbox"/> No
<input type="checkbox"/> Not currently employed

15. If you answered no to question #14, please indicate why?

16. What is the first letter of your mothers' maiden name?

_____A	_____E	_____I	_____M	_____Q	_____U	_____X
_____B	_____F	_____J	_____N	_____R	_____V	_____Y
_____C	_____G	_____K	_____O	_____S	_____W	_____Z
_____D	_____H	_____L	_____P	_____T		

17. Please indicate the last two numbers of your social security number?

Job Satisfaction Index

To what extent are you satisfied or dissatisfied with the following aspects of your nurse executive position. Choose the number that best applies to each statement by placing a checkmark or X to the right of the number which best applies to your level of satisfaction. 1= Highly Dissatisfied and 5 = Highly Satisfied

18. How satisfied are you with the nature of the work you perform?

1 _____	2 _____	3 _____	4 _____	5 _____
Highly	Dissatisfied	Neither Satisfied	Satisfied	Highly
Dissatisfied		nor Dissatisfied		Satisfied

19. How satisfied are you with the person who supervises you – your organizational superior?

1 _____	2 _____	3 _____	4 _____	5 _____
Highly	Dissatisfied	Neither Satisfied	Satisfied	Highly
Dissatisfied		nor Dissatisfied		Satisfied

20. How satisfied are you with your relations with others in the organization with whom you work- your coworkers or peers?

1 _____	2 _____	3 _____	4 _____	5 _____
Highly	Dissatisfied	Neither Satisfied	Satisfied	Highly
Dissatisfied		nor Dissatisfied		Satisfied

21. How satisfied are you with the pay you receive for your job?

1 _____	2 _____	3 _____	4 _____	5 _____
Highly	Dissatisfied	Neither Satisfied	Satisfied	Highly
Dissatisfied		nor Dissatisfied		Satisfied

22. How satisfied are you with the opportunities, which exist in this organization for advancement or promotion?

1 _____	2 _____	3 _____	4 _____	5 _____
Highly	Dissatisfied	Neither Satisfied	Satisfied	Highly
Dissatisfied		nor Dissatisfied		Satisfied

23. With all things considered, how satisfied are you with your current situation?

1 _____	2 _____	3 _____	4 _____	5 _____
Highly	Dissatisfied	Neither Satisfied	Satisfied	Highly
Dissatisfied		nor Dissatisfied		Satisfied

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Role Conflict and Ambiguity Scale

To what extent do you agree or disagree with the following aspects of your current position. Choose the number that best applies to each statement by placing a checkmark or X to the right of the number which best applies to your level of agreement.

1 = strongly disagree and 7 = strongly agree

24. My authority matches the responsibilities assigned to me.

1 _____	2 _____	3 _____	4 _____	5 _____	6 _____	7 _____
Strongly	Disagree	Somewhat	Neither Agree	Somewhat	Agree	Strongly
Disagree		Disagree	Nor Disagree	Agree		Agree

25. I do not know what is expected of me.

1 _____	2 _____	3 _____	4 _____	5 _____	6 _____	7 _____
Strongly	Disagree	Somewhat	Neither Agree	Somewhat	Agree	Strongly
Disagree		Disagree	Nor Disagree	Agree		Agree

26. My responsibilities are clearly defined.

1 _____	2 _____	3 _____	4 _____	5 _____	6 _____	7 _____
Strongly	Disagree	Somewhat	Neither Agree	Somewhat	Agree	Strongly
Disagree		Disagree	Nor Disagree	Agree		Agree

27. I feel certain about how much authority I have.

1 _____	2 _____	3 _____	4 _____	5 _____	6 _____	7 _____
Strongly	Disagree	Somewhat	Neither Agree	Somewhat	Agree	Strongly
Disagree		Disagree	Nor Disagree	Agree		Agree

28. I know what my responsibilities are.

1 _____	2 _____	3 _____	4 _____	5 _____	6 _____	7 _____
Strongly	Disagree	Somewhat	Neither Agree	Somewhat	Agree	Strongly
Disagree		Disagree	Nor Disagree	Agree		Agree

29. I have clear, planned goal objectives for my job.

1 _____	2 _____	3 _____	4 _____	5 _____	6 _____	7 _____
Strongly	Disagree	Somewhat	Neither Agree	Somewhat	Agree	Strongly
Disagree		Disagree	Nor Disagree	Agree		Agree

30. The planned goals and objectives are not clear.

1 _____	2 _____	3 _____	4 _____	5 _____	6 _____	7 _____
Strongly	Disagree	Somewhat	Neither Agree	Somewhat	Agree	Strongly
Disagree		Disagree	Nor Disagree	Agree		Agree

31. I do not know how I will be evaluated for a raise or a promotion.

1 _____	2 _____	3 _____	4 _____	5 _____	6 _____	7 _____
Strongly Disagree	Disagree	Somewhat Disagree	Neither Agree Nor Disagree	Somewhat Agree	Agree	Strongly Agree

32. I know what is expected of me.

1 _____	2 _____	3 _____	4 _____	5 _____	6 _____	7 _____
Strongly Disagree	Disagree	Somewhat Disagree	Neither Agree Nor Disagree	Somewhat Agree	Agree	Strongly Agree

33. Explanations are clear of what has to be done.

1 _____	2 _____	3 _____	4 _____	5 _____	6 _____	7 _____
Strongly Disagree	Disagree	Somewhat Disagree	Neither Agree Nor Disagree	Somewhat Agree	Agree	Strongly Agree

34. My boss makes it clear how he will evaluate my performance.

1 _____	2 _____	3 _____	4 _____	5 _____	6 _____	7 _____
Strongly Disagree	Disagree	Somewhat Disagree	Neither Agree Nor Disagree	Somewhat Agree	Agree	Strongly Agree

35. I often get myself involved in situation in which there are conflicting requirements.

1 _____	2 _____	3 _____	4 _____	5 _____	6 _____	7 _____
Strongly Disagree	Disagree	Somewhat Disagree	Neither Agree Nor Disagree	Somewhat Agree	Agree	Strongly Agree

36. There are unreasonable pressures for better performance

1 _____	2 _____	3 _____	4 _____	5 _____	6 _____	7 _____
Strongly Disagree	Disagree	Somewhat Disagree	Neither Agree Nor Disagree	Somewhat Agree	Agree	Strongly Agree

37. I am often asked to do things that are against my better judgment

1 _____	2 _____	3 _____	4 _____	5 _____	6 _____	7 _____
Strongly Disagree	Disagree	Somewhat Disagree	Neither Agree Nor Disagree	Somewhat Agree	Agree	Strongly Agree

38. I receive an assignment without adequate resources and materials to execute it.

1 _____	2 _____	3 _____	4 _____	5 _____	6 _____	7 _____
Strongly Disagree	Disagree	Somewhat Disagree	Neither Agree Nor Disagree	Somewhat Agree	Agree	Strongly Agree

39. I have to buck a rule or policy to carry out an assignment

1 _____	2 _____	3 _____	4 _____	5 _____	6 _____	7 _____
Strongly	Disagree	Somewhat	Neither Agree	Somewhat	Agree	Strongly
Disagree		Disagree	Nor Disagree	Agree		Agree

40. I receive incompatible requests from two or more people.

1 _____	2 _____	3 _____	4 _____	5 _____	6 _____	7 _____
Strongly	Disagree	Somewhat	Neither Agree	Somewhat	Agree	Strongly
Disagree		Disagree	Nor Disagree	Agree		Agree

41. I have to do things that should be done differently under different conditions.

1 _____	2 _____	3 _____	4 _____	5 _____	6 _____	7 _____
Strongly	Disagree	Somewhat	Neither Agree	Somewhat	Agree	Strongly
Disagree		Disagree	Nor Disagree	Agree		Agree

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**For the next 20 questions think about how you felt and behaved over the past week.
Choose the appropriate response.**

42. I was bothered by things that do not usually bother me

- ☐ Rare or none of the time (<1 day)
- ☐ Some or a little of the time (1-2 days)
- ☐ Occasionally or a moderate amount of the time (3-4 days)
- ☐ Most or all of the time (5-7 days)

43. I did not feel like eating: my appetite was poor.

- ☐ Rare or none of the time (<1 day)
- ☐ Some or a little of the time (1-2 days)
- ☐ Occasionally or a moderate amount of the time (3-4 days)
- ☐ Most or all of the time (5-7 days)

44. I felt that I could not shake off the blues with the help of my family or friends

- ☐ Rare or none of the time (<1 day)
- ☐ Some or a little of the time (1-2 days)
- ☐ Occasionally or a moderate amount of the time (3-4 days)
- ☐ Most or all of the time (5-7 days)

45. I felt that I was just as good as other people

- ☐ Rare or none of the time (<1 day)
- ☐ Some or a little of the time (1-2 days)
- ☐ Occasionally or a moderate amount of the time (3-4 days)
- ☐ Most or all of the time (5-7 days)

46. I had trouble keeping my mind on what I was doing

- ☐ Rare or none of the time (<1 day)
- ☐ Some or a little of the time (1-2 days)
- ☐ Occasionally or a moderate amount of the time (3-4 days)
- ☐ Most or all of the time (5-7 days)

47. I felt depressed

- ☐ Rare or none of the time (<1 day)
- ☐ Some or a little of the time (1-2 days)
- ☐ Occasionally or a moderate amount of the time (3-4 days)
- ☐ Most or all of the time (5-7 days)

48. I felt everything was an effort

- ☐ Rare or none of the time (<1 day)
- ☐ Some or a little of the time (1-2 days)
- ☐ Occasionally or a moderate amount of the time (3-4 days)
- ☐ Most or all of the time (5-7 days)

49. I felt hopeful about the future

- _____ Rare or none of the time (<1 day)
- _____ Some or a little of the time (1-2 days)
- _____ Occasionally or a moderate amount of the time (3-4 days)
- _____ Most or all of the time (5-7 days)

50. I thought my life has been a failure

- _____ Rare or none of the time (<1 day)
- _____ Some or a little of the time (1-2 days)
- _____ Occasionally or a moderate amount of the time (3-4 days)
- _____ Most or all of the time (5-7 days)

51. I felt fearful

- _____ Rare or none of the time (<1 day)
- _____ Some or a little of the time (1-2 days)
- _____ Occasionally or a moderate amount of the time (3-4 days)
- _____ Most or all of the time (5-7 days)

52. My sleep was restless

- _____ Rare or none of the time (<1 day)
- _____ Some or a little of the time (1-2 days)
- _____ Occasionally or a moderate amount of the time (3-4 days)
- _____ Most or all of the time (5-7 days)

53. I was happy

- _____ Rare or none of the time (<1 day)
- _____ Some or a little of the time (1-2 days)
- _____ Occasionally or a moderate amount of the time (3-4 days)
- _____ Most or all of the time (5-7 days)

54. I talked less than usual

- _____ Rare or none of the time (<1 day)
- _____ Some or a little of the time (1-2 days)
- _____ Occasionally or a moderate amount of the time (3-4 days)
- _____ Most or all of the time (5-7 days)

55. I felt lonely

- _____ Rare or none of the time (<1 day)
- _____ Some or a little of the time (1-2 days)
- _____ Occasionally or a moderate amount of the time (3-4 days)
- _____ Most or all of the time (5-7 days)

56. People were unfriendly

- ☐ Rare or none of the time (<1 day)
- ☐ Some or a little of the time (1-2 days)
- ☐ Occasionally or a moderate amount of the time (3-4 days)
- ☐ Most or all of the time (5-7 days)

57. I enjoyed life

- ☐ Rare or none of the time (<1 day)
- ☐ Some or a little of the time (1-2 days)
- ☐ Occasionally or a moderate amount of the time (3-4 days)
- ☐ Most or all of the time (5-7 days)

58. I had crying spells

- ☐ Rare or none of the time (<1 day)
- ☐ Some or a little of the time (1-2 days)
- ☐ Occasionally or a moderate amount of the time (3-4 days)
- ☐ Most or all of the time (5-7 days)

59. I felt sad.

- ☐ Rare or none of the time (<1 day)
- ☐ Some or a little of the time (1-2 days)
- ☐ Occasionally or a moderate amount of the time (3-4 days)
- ☐ Most or all of the time (5-7 days)

60. I felt that people disliked me

- ☐ Rare or none of the time (<1 day)
- ☐ Some or a little of the time (1-2 days)
- ☐ Occasionally or a moderate amount of the time (3-4 days)
- ☐ Most or all of the time (5-7 days)

61. I could not get "going"

- ☐ Rare or none of the time (<1 day)
- ☐ Some or a little of the time (1-2 days)
- ☐ Occasionally or a moderate amount of the time (3-4 days)
- ☐ Most or all of the time (5-7 days)

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from: The CES-D scale: A self report depression scale for research in general population. By Lenore
Sawyer Radloff in *Applied Psychological Measurement* Volume 1

REMINDER POSTCARD – THREE WEEK

May 31, 2008

Dear Nurse Executive,

This is just a friendly reminder requesting your participation in the Role Conflict, Role Ambiguity and Job Satisfaction Survey. By now, you should have received the initial letter requesting participation about three weeks ago. If you have already completed your survey, please accept my gratitude and disregard this reminder.

If you have not, please consider taking a few minutes of your day to complete the survey at the following website

http://www.surveymonkey.com/s.aspx?sm=eC5_2fSsapG33KNT8Qy12ztA_3d_3d. If you still have the original letter and survey, you may still participate using that method.

I am a graduate student pursuing a doctorate degree in nursing with an emphasis on education at the University of Nevada Las Vegas. My dissertation is exploring the presence of role conflict, role ambiguity, as well as job satisfaction levels in the nurse executive. As a former nurse executive, I know that there are many demands on your time. It is easy to see that with your participation, it will be adding one more unnecessary task. I would appreciate it if you could take a few minutes to complete this survey.

Please note your participation is voluntary and you may elect not to answer any questions that may make you feel uncomfortable. Every attempt will be made to maintain confidentiality. You will notice that I am not collecting any names of the nurse executives or the organizations in which they are employed.

Thank you for consideration of this request.

Theresa Tarrant
Graduate Student
University of Las Vegas Nevada

REMINDER POSTCARD – SIX WEEK

June 14, 2008

Dear Nurse Executive,

This is just a second and final reminder requesting your participation in the Role Conflict, Role Ambiguity and Job Satisfaction Survey. You should have received the initial letter requesting participation about six weeks ago. If you already completed your survey, please accept my gratitude and disregard this reminder.

If you have not, please consider taking a few minutes of your day to complete the survey at the following website

http://www.surveymonkey.com/s.aspx?sm=eC5_2fSsapG33KNT8Qy12ztA_3d_3d. If you still have the original letter and survey, you may still participate using that method.

As a former nurse executive, I know that there are many demands on your time. It is easy to see that with your participation, it will be adding one more unnecessary task. I would appreciate it if you could take a few minutes to complete this survey.

Please note your participation is voluntary and you may elect not to answer any questions that may make you feel uncomfortable. Every attempt will be made to maintain confidentiality. I am not collecting any names of the nurse executives or the organizations in which they are employed.

Thank you for consideration of this request.

Theresa Tarrant
Graduate Student
University of Las Vegas Nevada

APPENDIX B

PERMISSION TO USE COPYRIGHTED TOOLS



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File: Tarrant, Theresa A. (author)

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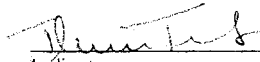
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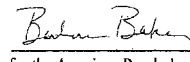
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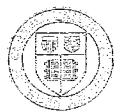
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Please let me know is you need additional information. I appreciate your consideration of this request.

Theresa Tarrant

APPENDIX C

TABLES RELATED TO STUDY SAMPLE

Table C1

What Is Your Gender?

Gender	N	Percent
Male	27	7.1
Female	353	92.9
Total	380	100

Table C2

Indicate Which Best Represents Your Age?

Age	N	Percent
25-34	3	0.8
35-44	40	10.5
45-54	186	48.9
55-64	145	38.2
65 or older	6	1.6
Total	380	100

Table C3

What Is Your Highest Level Of Education?

Degree	N	Percent
Diploma	5	1.3
Associate	2	0.5
Bachelor Nursing	30	7.9
Bachelor Non Nursing	9	2.4
Masters Nursing	273	71.8
Masters Non Nursing	33	8.7
Doctorate Nursing	26	6.8
Doctorate Non Nursing	2	0.5
Total	380	100 %

Table C4

Are You Currently Working On A Degree Or Enrolled In An Educational Program?

	N	Percent
Yes	60	15.8
No	320	84.2
Total	380	100

Table C5

Indicate The Numbers Of Years Of Experience In Nursing?

Number of Years	N	Percent
6-10 years	2	.5
11-15 years	14	3.7
16-20 years	37	9.7
21-25 years	49	12.9
>25 years	278	73.2
Total	380	100

Table C6

Indicate The Numbers Of Years Of Experience In Management?

	N	Percent
<2 years	1	.3
2-5 years	12	3.2
6-10 years	29	7.6
11-15 years	63	16.6
16-20 years	105	27.6
21-25 years	80	21.1
>25 years	90	23.7
Total	380	100

Table C7

Indicate The Numbers Of Years Of Experience In Current Position?

	n	Percent
<2 years	82	21.6
2-5 years	138	36.3
6-10 years	85	22.4
11-15 years	34	8.9
16-20 years	27	7.1
21-25 years	7	1.8
>25 years	7	1.8
Total	380	100

Table C8

Which Most Closely Resembles Your Title For Your Current Position?

	N	Percent
Director of Nursing	107	28.2
Director, Other	19	5.0
Chief Nursing Service	77	20.3
Vice President, Nursing	38	10.0
Vice President, Patient Services	105	27.6
Vice President, SR	7	1.8
Vice President, Other	12	3.2
Administrator	5	1.3
Chief Operating Officer	7	1.8
Chief Executive Officer	3	0.8
Total	380	100

Table C9

Indicate Which Of The Following Best Describe Your Organization

	N	Percent
Private	88	23.2
Public	1	0.3
Government	19	5.0
Teaching	79	20.8
Non Teaching	58	15.3
For Profit	40	10.5
Not For Profit	304	80.0
Total	589	

Note: Participants could choose more than one option

Table C10

Indicate Which Of The Following Best Describes The Type of Facility In Which You Are Employed?

	N	Percent
Acute Care Inpatient	307	80.8
Ambulatory Surgery	3	0.8
Rehabilitation	6	1.6
Long Term Care	4	1.1
Inpatient Mental Health	11	2.9
Outpatient Care	7	1.8
Multi-facility Institution	29	7.6
Other	13	3.4
Total	380	100

Table C11

Which Of The Following Indicates The Number Of Full-Time Employees Supervised?

	N	Percent
20 or less	66	17.4
21 – 100	63	16.6
101-200	43	11.3
>200	208	54.6
Total	380	100

Table C12

Which Of The Following Best Describes the Geographic Location, in The United States Of Your Current Facility?

	N	Percent
Northeast	129	33.9
Midatlantic	8	2.1
Southeast	103	27.1
Midwest	55	14.5
Northwest	19	5.0
Southwest	44	11.6
South	19	5.0
West	3	0.8
Total	380	100

Table C13

Which Of The Following Best Describes The Area In Which Your Healthcare Facility Is Located?

	N	Percent
Urban	136	35.8
Suburban	135	35.5
Rural/Frontier	109	28.7
Total	380	100

Table C14

Do You Plan on Remaining In Your Current Position For The Next Two Years?

	N	Percent
Yes	315	82.9
No	65	17.1
Total	380	100

Table C15

If You Answered No To Question #14, Please Indicate Why?

	N	Percent
Dissatisfied	30	46.2
Career Advancement	17	26.2
Retirement	11	16.9
Relocation	7	10.77
Total	65	100

APPENDIX D

TABLES RELATED TO DATA ANALYSIS

Table D1

Reliability of Survey Tools

Instrument	Mean	Variance	Std. Dev	Alpha
Role Conflict	21.26	24.399	4.940	.801
Role Ambiguity	31.99	75.433	8.686	.771
Job Satisfaction Index	24.10	15.276	3.908	.803
CES- Depression Scale	7.40	59.187	7.693	.856

Table D2

Descriptive Statistics of Dependent Variables

Instrument	Mean	Std. Dev	Minimum	Maximum
Role Conflict	3.04	.71	1.00	5.43
Role Ambiguity	2.91	.79	1.00	5.91
Job Satisfaction	4.01	.653	1.00	5.00
CES- Depression Scale	7.42	7.67	0.00	50.00

Table D3

Correlation of Dependent Variable

	Role Conflict	Role Ambiguity	Job Satisfaction	CES Depression Scale
Role Conflict	----	.895	-.490	.453
Role Ambiguity	.895	----	-.544	.464
Job Satisfaction	-.490	-.544	----	-.539
CES- Depression Scale	.453	.464	-.539	----

p < .01

Table D4

Relationship between Age Or Educational Level and Dependent Variables

	Wilks' Lambda	df	<i>p</i>
Age	1.351	16.00	.159
Educational Level	1.652	28.00	< .05

Table D5

Role Conflict Scores Varied Based Upon Effect of Educational Level

Education Level (I)	Educational Level (J)	Mean Difference (I-J)	Std. Error	<i>p</i>
Doctorate Non Nursing	Master's Nursing	1.5474	.49301	< .05
	Master's Non Nursing	1.6797	.50588	< .05
	Doctorate Non Nursing	1.6538	.50976	< .05

Table D6

Role Ambiguity Scores Varied Based Upon Effect of Educational Level

Education Level (I)	Educational Level (J)	Mean Difference (I-J)	Std. Error	<i>p</i>
Doctorate Non Nursing	Bachelor's Non Nursing	1.8787	.61270	< .05
	Master's Non Nursing	1.7410	.57075	.050

Table D7

Comparison Of Those Who Responded Yes (1) When Asked, "Do You Plan On Remaining In Your Current Position For The Next Two Years", To Those Who Responded No (2)

Category	Df	F	<i>p</i>	Post hoc comparison
Role Conflict	128	9.299	<.01	2>1
Role Ambiguity	128	7.215	<.001	2>1
Job Satisfaction	128	16.192	<.001	1>2
Depression	128	4.869	<.05	2>1

Table D8

Comparison of Results of Scalzi Study and Results of Current Study

Dependent Variable	Scalzi Mean	Current Study Mean	T Value	<i>p</i>
Role Conflict	4.00	3.04	8.44	<.001
Role Ambiguity	2.70	2.91	-2.32	<.05
Depression	8.70	7.42	1.44	.152

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