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Nursing Leadership: Championing Quality and Patient Safety in the Boardroom

Executive Summary

- ▶ **Objective:** Identify the extent to which hospital boards of trustees, CEOs, and CNOs are engaged in quality and safety at the leadership and governance level and how CNOs can support board engagement in quality and safety.
- ▶ **Background:** Although research is emerging, still relatively little is known about the impact and interface of hospital boards of trustees, CEOs, and nursing executives related to improving quality and patient safety.
- ▶ **Methods:** 73 telephone interviews were conducted with hospital board chairs, CEOs, and CNOs from a convenience sample of 63 U.S. hospitals. The interviews (22 of which were with CNOs) lasted 30 to 45 minutes and were supplemented by a focus group of five nursing executives.
- ▶ **Results:** There are significant differences in the perceptions of CNOs versus those of board chairs and CEOs. CNOs reported a greater familiarity of landmark reports on quality and patient safety than board chairs. CEOs and board chairs gave substantially higher ratings to integration of quality planning. Boards have limited comprehension of salient nursing quality issues.
- ▶ **Conclusion:** CNOs have a critical role as boardroom champions of patient safety and quality improvement.

DRAMATIC CHANGE MUST TAKE place before all consumers will be able to consistently receive health care of the quality and safety they deserve. To achieve that change requires those who lead and govern health care organizations to reframe, rethink, and redesign how health care is delivered so that it is safe, effective, efficient, patient-centered, timely, and equitable.

The science of how boards of trustees and senior health care leaders play this changing and necessary role is in its infancy. However, it is clear that senior leaders and chief nursing officers (CNOs) are main

actors in this journey of health care transformation. Nursing leaders must provide a drive for improvement within an organization through their operational and clinical expertise as well as supply executive colleagues and boards of trustees with a vision of optimal care.

CNOs in all health care settings face multiple challenges in the boardroom environment, but especially so in enhancing board members' understanding of nursing quality of care and patient safety. CNOs define nursing quality of care across the organization, design nursing quality initiatives that improve

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patient outcomes, and report on measures of nursing quality at the governing level (the board of trustees or directors). However, CNOs are often constrained by board members' limited understanding of quality care and patient safety in general, and even more limited comprehension of measuring nursing quality of care and patient safety (Joshi & Hines, 2006). Such a situation, while challenging, also opens doors for CNOs to influence board members' grasp of nursing quality and patient safety measures.

There is a knowledge gap among hospital governing leaders about quality health care and, in particular, about nursing quality—a serious impediment to effective hospital governance in the quest to improve patient safety and quality of care (Joshi & Hines, 2006). In 2004, the National Quality Forum (NQF) issued a “call to responsibility” for members of hospital governing boards that included recommendations on how board members can support quality improvement efforts. Yet, although information abounds on issues of board leadership and quality health care, it is still unclear exactly how boards of trustees respond to this mandate for quality and to what extent boards engage in national and organizational quality initiatives (Joshi & Hines, 2006). How are quality improvement and patient safety perceived and comprehended by hospital governing boards? What role do boards assume in quality improvement and patient safety? Moreover, what do they understand about nursing quality initiatives; about the quality initiatives of the largest professional group caring for hospital patients?

In recent interviews with hospital CEOs, board chairs, and CNOs, it became apparent that there are differences in perception among the three groups regarding board members' comprehension of quality of care and patient safety issues as well as the extent to which board members engage in quality initiatives. CNOs perceive that board members

have more limited comprehension of, and engagement in, quality and patient safety concerns than hospital CEOs and board chairs (Joshi, 2005). One concludes that, at the governing level, there are most likely gaps in knowledge about quality and patient safety as well as different expectations and values about board involvement. Yet, in light of facts revealing that increased patient mortality and complications occur due to health system errors, the campaign to improve patient safety and quality of care is intense across the health care industry, mandating the active participation of all involved. Board members are not exempt; rather they have been challenged to more active participation (NQF, 2004). CNOs are well positioned to help close the knowledge gaps about quality patient care and patient safety in the boardroom, supporting board members as they meet their legal and ethical responsibilities related to quality improvement and patient safety.

The purpose of this article is twofold: (a) compare the perspectives of nurse executives, CEOs, and board chairs about board members' understanding of and engagement in hospital quality and patient safety initiatives based on a 2005 study of hospital leaders (Joshi, 2005); and (b) recommend strategies that CNOs might consider to improve board members' understanding of, and engagement in, activities that improve the quality of nursing care and patient safety.

Issues of Quality Within Hospital Leadership

A recent study of hospital leadership found that the level of knowledge about landmark Institute of Medicine (IOM) quality reports was remarkably low among hospital CEOs and hospital board chairs; conversely both groups were well attuned to public reporting of quality information (Joshi & Hines, 2006). An as-yet unreported part of that study specifically addressed nursing quality issues where the aims were to determine hospital CEO, board

chair, and CNO perceptions of (a) hospital board member knowledge about and engagement in quality initiatives and (b) critical nursing quality issues.

Methodology

Data collection occurred during structured telephone interviews with hospital CNOs, CEOs, and board chairs and a single face-to-face focus group with CNOs. A description of the full methodology is available in an earlier publication of related findings (Joshi & Hines, 2006).

Sample. A total of 73 interviews with hospital leaders (CEOs, CNOs, and board chairs) were conducted. The leaders represented 63 hospitals from across the United States, ranging in size from 20 to 935 beds (median less than 250 beds). The type of facilities ranged from a single, free-standing hospital to an 11-hospital health system. The interview instrument was developed and refined in consultation with nurse and hospital leader experts.

Data collection. Data were collected during individual interviews of all hospital leaders and a focus group of CNOs as follows:

- Telephone interviews of 22 hospital CNOs.
- Telephone interviews of 29 hospital CEOs.
- Telephone interviews of 22 hospital board chairs.
- A single focus group discussion with five CNOs.

The interview questions focused on two major areas: (a) the important issues boards face in improving quality care and patient safety and (b) nursing quality of care. To determine the general issues surrounding boards' performance related to quality, the CNOs, CEOs, and board chairs were asked to rate, on a scale of 1 to 10 (1 representing low and 10 representing high), their perspectives on:

- The extent of the board's engagement in quality.
- Leaders' satisfaction with the pace of improvement.
- The extent to which the board adds value in quality initiatives.

Table 1.
Comparison of CNO, CEO, and Board Chair Perceptions of Quality

Response ratings on a 1 to 10 scale	How familiar are you with the 2 IOM reports <i>To Err is Human</i> and <i>Crossing the Quality Chasm</i> ?*	How familiar do you think the board chair is with the 2 IOM reports <i>To Err is Human</i> and <i>Crossing the Quality Chasm</i> ?	How familiar do you think ALL board members are with the 2 IOM reports <i>To Err is Human</i> and <i>Crossing the Quality Chasm</i> ?	How well do you feel you understand the data being publicly reported?	How many board members have an expertise in quality?#	How satisfied are you that the quality data the board reviews are the right measures for a comprehensive assessment of the organization's real quality performance?
Board Chair Average (n = 22)	6.0	N/A	5.0	8.7	9.5	7.5
CEO Average (n = 29)	7.6	4.8	4.1	8.5	5.5	6.4
CNO Average (n = 22)	7.9	4.9	4.3	9.0	4.4	7.0
Response ratings on a 1 to 10 scale	How well does the hospital culture foster interdisciplinary collaboration on quality and safety improvement? >>	How well do you think the organizational quality planning is integrated with the overall strategic planning? ^^	How satisfied are you that the board adds value through its' efforts in quality?//	How satisfied are you with how your hospital is progressing in improving quality?*	How engaged is the board in quality?*	
Board Chair Average (n = 22)	7.8	8.7	7.9	8.4	8.0	
CEO Average (n = 29)	7.3	7.6	7.7	7.2	7.6	
CNO Average (n = 22)	7.0	7.0	7.0	6.8	6.4	

* Difference between CNO average and Board average, $p < 0.01$
 # Difference between CNO average and Board average, $p < 0.05$
 >> Difference between CNO average and Board average, $p < 0.12$
 ^^ Difference between CNO average and Board average, $p < 0.04$
 // Difference between CNO average and Board average, $p < 0.07$

- Leaders' understanding of the right measures for real quality assessment.
- The extent of institutional culture in fostering interdisciplinary collaboration.

Findings

Important issues facing boards in quality improvement. The responses among the three groups to the five general issues of board involvement in quality and patient safety showed both similarities and striking differences between CNOs' perceptions and those of CEOs and

board chairs. The responses of CEOs and board chairs were similar to those of CNOs on questions concerning hospital culture as fostering interdisciplinary collaboration and the quality data reviewed by the board.

Differences occurred in the perceptions of CNOs versus those of board chairs and CEOs in the other categories. Compared with CNOs, CEOs and board chairs gave substantially higher ratings with regard to the integration of quality planning with overall strategic planning, satisfaction with the

board adding value through its quality efforts, the number of quality experts on the board, satisfaction with the hospital's progress in quality improvement, and level of board engagement in quality. Table 1 displays the differences among the perspectives of the three groups and any statistical differences among them.

Figure 1 displays a graph of the perceptual differences on specific measures of board engagement in quality between CNOs and the CEO/board chair group.

The CNOs' responses suggest-

Figure 1.
Comparison: CNO and Board/CEO Perspectives on Board Engagement in Quality



ed that they perceive board members to have only moderate engagement in quality initiatives due to (a) limited or incomplete knowledge about quality and patient safety issues, (b) limited time available for participating in or contributing to health care quality initiatives, and (c) a lack of quality “champions” at the board level.

The research findings suggest two important themes with boards and quality. First, there are major differences in the perceptions of key quality and safety issues between hospital leaders and those who govern hospitals. Numerous organizational management doctrines and philosophies emphasize the need for alignment between leadership and governance for organizational success, but these differences in perception scores highlight gaps between the two instead. Second, CNOs and CEOs have a tremendous opportunity to dramatically improve board engagement in quality, which is a vital lever to the transformation of health care. This opportunity is a call to action for CNOs to embrace this challenge and serve as leaders in this transformation.

Governance perceptions of nursing quality issues. CNO, CEO, and board chair perceptions of nursing quality issues addressed the following categories:

- Nurse leader knowledge about quality.

- Nursing quality measures reported at the board level.
- Opportunities for improving nursing quality of care and patient safety.

Nurse leader knowledge about quality. Nurse executives feel fairly well versed in knowledge about quality improvement and perceive that the board is significantly less knowledgeable (Joshi, 2005). The CNOs generally were familiar with the two IOM reports, *To Err is Human* (2000) and *Crossing the Quality Chasm* (2001). On a 1 to 10 scale of familiarity, the CNO average was 7.9. Comparatively, CNOs’ perceptions of the board chairs’ familiarity with the IOM reports averaged 4.9, with the familiarity of all board members rated lower at 4.3. However, all three groups had a strong grasp of publicly reported data. On a scale of 1 to 10, CEOs averaged 8.5, board chairs averaged 8.7, and CNOs averaged 9.0 (Joshi & Hines, 2006).

Board review of nursing quality measures. The hospital board chairs, CEOs, and CNOs all reported that they generally monitor two types of nursing quality measures: (a) measures of organizational performance as related to nurse staffing concerns (nurse-to-patient ratios, staffing hours of care/nursing time-to-patient ratios, vacancy rates, turnover/retention, employee satisfaction, and travel nurse

usage); and (b) measures addressing nursing clinical information, such as incidence of pressure ulcers, adverse events, patient safety, pain, and falls (Joshi, 2005).

Staffing concerns are the most frequent measure of nursing quality reported at the board level. Board chairs and CEOs were particularly sensitive to the effect of the aging nursing workforce on staffing, training, recruiting, and work design. Yet, while these were the most frequently reported measures, CNOs, board chairs, and CEOs did not have a firm understanding of the time nurses spend in direct patient care. Just half of the CNOs responded to the question, and only 27% of the board chairs and CEOs did so. Of those who responded, the average for nurse time spent in direct patient care was 63%, reported similarly in all three groups (Joshi, 2005).

Mentioned by only one CNO interviewee, nursing-sensitive clinical quality measures received minimal attention. Board discussion of nursing quality issues (staff related) was generally reported to occur on a monthly or quarterly basis. One CNO reported that nursing measures were reported annually, and two CNOs reported that nursing quality was never addressed at board meetings. Few of the CNOs, CEOs, and board chairs responded that issues are discussed more fre-

quently, such as at every meeting. Interesting to note is that quality and patient safety measures for nurses — the largest group of caregivers in hospitals — are not consistently addressed during all hospital board meetings.

Opportunities for improvement. CNOs, CEOs, and board chairs identified similar opportunities for improvement. Members in all three groups indicated that leadership, human resource initiatives, and staffing present the greatest nursing quality improvement opportunities.

When asked what one thing would most positively impact the quality of nursing care, CNOs, CEOs, and board chairs had similar responses addressing staffing, work processes, and environment-related improvements. CNOs specifically listed the following, in most frequent order of mention:

1. Staffing-related improvements, such as increasing nurse-to-patient ratios, ensuring adequate staffing, providing more ancillary resources, maintaining hours per patient day and nurse-to-patient ratios in line with national standards, increasing hours of care, finding enough quality staff, hiring more experienced nurses, needing constructive turnover (“nurses come and stay forever – lack new ideas that come with new staff”), changing the experience mix for staffing, and more continuing education.
2. Work process-related improvements, such as less paperwork, fewer interruptions, increasing nurse satisfaction with work environment, ability to perform more clinical specialty-type functions, better collaboration with physician staff, enhanced communication, and multidisciplinary daily rounds.
3. Environment-related improvements, such as linking quality to pay and maximizing regulation.

When asked to describe the most effective thing they have done

to improve nursing retention, CNOs gave the following responses, starting with most frequently mentioned categories (Joshi, 2005):

1. Leadership, such as shared leadership model, CEO support, and Magnet® status or program.
2. Human resource initiatives, such as improved orientation program, mentoring program, clinical ladder, continuing education unit support, student nursing program, scholarships, and internships.
3. Staffing, such as increased staffing for improved nurse-to-patient ratio and creating a better balance of the right type of nurses required for the care environment.
4. Pay, such as increased salaries, off-shift differential pay, and monetary link to education advancement.
4. Work environment, such as transforming the work environment of nursing and removing non-nursing work.
5. Work schedule, such as no mandatory overtime and flexible scheduling.

In summary, this sample of hospital CNOs perceived that they have a good grasp of quality improvement mandates across the industry and the public reporting of data. Improving safety, the quality of care, and patient outcomes has historically been a part of nursing professional values (McBride, 2006). The CNOs also perceive that hospital board members, in comparison, have more limited comprehension of and engagement in these same issues. Lack of knowledge about nursing clinical measures is a second gap that exists in the boardroom, compounding board members’ knowledge gaps regarding quality in general. Specific to nursing, these samples of CNOs, CEOs, and board chairs review quality measures of nursing care only from an organizational perspective (staff-related issues such as turnover and salaries). Indeed, staff-related issues are crit-

ical measures of nursing quality to monitor and report. A solid evidence base links nurse staffing ratios to patient safety and quality care (Hinshaw, 2004). However, staffing ratios alone do not provide a comprehensive base for measuring nursing performance related to patient safety and quality of care. Clinical measures of nursing performance must also be considered on a regular basis given that the clinical setting is the primary site where nurses deliver care. Nursing clinical performance measures are as critical to monitor and report as are staffing quality indicators.

CNOs can help close the gaps in boardrooms by reshaping board values and expanding board members’ knowledge about patient safety and quality of care. If hospital leadership and the governing board are not committed as a forceful entity to building a culture of safety and quality improvement, improvements in quality care will be limited and difficult to sustain (Hinshaw, 2004; IOM, 2004).

Discussion: Closing Quality Gaps In Hospital Boardrooms

Closing knowledge gaps and reshaping values about quality and patient safety in the boardroom calls for CNOs to play a key leadership role. First, CNOs are rarely responsible for contributing to or framing board agendas; agendas are usually the purview of the CEO or board chair, dependent on organizational bylaws and protocols. Second, CNOs are not always at the board table. There is substantial evidence that, over the past decade, hospital CNOs have acquired responsibilities beyond nursing to include other patient services and many CNOs have become board members (Hinshaw, 2004; IOM, 2004). However, many hospitals do not consider CNOs as members of the board nor are they consistently invited to attend all board meetings (for example, strategic planning meetings). Lags in adopting inclusive leadership practices occur in

boardrooms as well as within individual hospital organizations, a situation as much the responsibility of the CNO as that of the CEO and the board (Curran, 2006).

Faced with inconsistencies, what can the CNO do to improve board understanding of and active participation in nursing quality and patient safety? CNOs can apply leadership expertise to transform board members' values, beliefs, and behaviors related to patient safety and quality in general, and use their knowledge base to enlighten board members specifically about relevant measures of nursing quality and patient safety (Hinshaw, 2004; IOM, 2004; Reinertsen, 2004).

The CNO as a transforming leader. Visible leadership and the use of interactive, open communication are leadership and management practices that build strong and positive environments, in the boardroom as well as within the organization. The CNO must be an operational leader and strategic supporter in governance situations, where board members, as representatives of the hospital's owner, oversee the mission, strategy, executive leadership, quality performance, and financial stewardship (Reinertsen, 2004). Transformational leadership occurs when the leader engages others in the pursuit of jointly held goals and values. Such leadership has been described as "elevating" or "inspiring," raising the level of human conduct as well as the aspirations of all involved (a transforming effect) (Burns, 1978; IOM, 2004). However, it is a challenge to transform, inspire, and elevate higher-ranking individuals in an organization. Meeting the challenge requires the exercise of "leading up skills." Maxwell (2005) notes the first "leading up" skill is leading oneself; knowing and managing one's emotions, work, and personal life, not denying any aspect of oneself, but putting others first. For a nursing leader, this translates into being "emotionally intelligent;" focusing on what the

team, in this case the board, needs related to quality and how to meet these needs (Goleman, 2000; Maxwell, 2005).

Hospital boards are in transition, moving from a traditional focus on the financial integrity of the organization to learning how to integrate finances with quality and patient safety improvement initiatives. Board members usually represent different professions and community businesses; they are not experts on quality care issues in general or on nursing quality of care and patient safety. However, board members are responsible for designing long-term organizational strategies and making decisions that affect organizational life and performance; decisions that indirectly but ultimately affect patient safety and health outcomes. The CNO can enhance board members' ability to make decisions by sharing information and framing what they need to hear about nursing quality of care and patient safety.

CNO leadership in the boardroom means influencing board members, thinking long term, placing nursing quality and patient safety in the context of the big picture, and pushing boundaries (Maxwell, 2005; Reinertsen, 2004). Defining the nurse's role in improving patient safety and the quality of nursing care and placing it in the context of the organization are critical boundaries for the CNO. Pushing boundaries related to nursing performance can be a part of the board's journey in determining how it will more actively participate in improving patient safety and quality of care.

CNOs can be most effective as transforming leaders when acting in concert with the CEO and entire leadership team: providing the board with information about quality and patient safety initiatives, emphasizing how nursing quality integrates with organizational management and planning initiatives, and educating the board about measures sensitive to professional nursing practice (see Figure 2).

Improve quality and safety literacy and mastery. With the leadership team, CNOs can ensure the literacy of all board members about quality and patient safety, emphasizing the importance of quality reports such as those from the IOM. These seminal reports, compiled by health care industry experts, have been clarion calls for action as well as providing recommendations for specific remedial initiatives.

Serve as a role model of professional nursing and nursing quality. The CNO can advance board members' comprehension about nursing quality and patient safety by first establishing credibility as an expert source on the subject, and demonstrating expertise during board briefings about nursing quality reports. The CNO can weave evidence-based knowledge and information into the reporting of quantitative data, emphasizing the importance of monitoring such measures and their relevance to overall organizational planning, management, and performance.

Critical to board understanding about quality and patient safety is to grasp the relevance of *nursing-sensitive* measures, perhaps shared through tangible and understandable stories about the importance of nursing care in provider teams and patient centeredness. For instance, the CNO may:

- Specify the value of nurses on the professional health team as teamwork gains significance in improving patient safety and care.
- Demonstrate how nursing quality and patient safety link with financial and operational aspects.
- Develop and use evidence-based nursing-sensitive quality measures that reveal the value of nursing and its impact on quality of care.

CNOs can add insights to board engagement in patient safety and quality improvement by making logical and quantitative links, including financial connections,

Figure 2.
The CNO as Transforming Leader

Improve Quality and Safety Literacy and Mastery
<ul style="list-style-type: none"> <input type="checkbox"/> Work with the leadership team to ensure the literacy of all board members on quality and patient safety, highlighting the importance of landmark quality reports and their impact on the organization. <input type="checkbox"/> Continuously educate regarding quality measures and nursing-sensitive measures as the science of data and measurement evolves.
Serve as a Role Model of Professional Nursing and Nursing Quality
<ul style="list-style-type: none"> <input type="checkbox"/> Establish credibility as the expert source about nursing quality and patient safety. <input type="checkbox"/> Weave evidence-based knowledge and information into the reporting of quantitative data, emphasizing the importance of monitoring such measures and their relevance to overall organizational planning, management, and performance. <input type="checkbox"/> Specify the value of nurses on the professional health team as teamwork gains significance in improving patient safety and care. <input type="checkbox"/> Demonstrate how nursing quality and patient safety link with financial and operational aspects. <input type="checkbox"/> Develop and use evidence-based nursing-sensitive quality measures that reveal the value of nursing and its impact on quality of care.
Build the Evidence Base for Nurse Staffing
<ul style="list-style-type: none"> <input type="checkbox"/> Demonstrate the importance of workflow and design on nurse retention and quality of care. <input type="checkbox"/> Define the importance of the work environment and use of technology on nursing productivity, retention, and quality of care. <input type="checkbox"/> Continue to emphasize the importance of teamwork and the critical nurse role on the team as an effective and efficient model for delivering care.

between nursing quality measures and key business goals (Reinertsen, 2004). For example, when reporting on finances related to nurse staffing, CNOs can highlight the relationship to specific quality measures of nursing care and patient safety. Doing so will help board members connect financial information or other quantitative data to organizational initiatives focused on improving care and patient safety — steps in creating a culture within the boardroom for emphasizing improved quality of care and patient safety (Hinshaw, 2004).

CNOs can demonstrate their expertise to board members by creating a more comprehensive framework for measuring the quality of nursing care and patient safety outcomes using evidence-based measures sensitive to nursing performance. One place for the CNO to

start is with the quality measures developed under the leadership of the American Nurses Association (ANA) and the University of Kansas School of Nursing: the National Database of Nursing Quality Indicators (NDNQI). Since 2001, NDNQI has collected data from participating hospitals on structure, process, and patient outcome measures directly related to nursing care. Participating hospitals receive confidential reports and can benchmark their nursing performance against similar institutions. Additionally, NDNQI has provided definitions for nursing-sensitive indicators to the NQF and the Joint Commission on Accreditation of Healthcare Organizations (ANA, 2006). Sharing professional nursing knowledge and evidence can serve as a springboard for board members to engage more actively and rele-

vantly in not only nursing but organizational quality improvement.

Build the evidence base for nurse staffing. As the organizational nursing expert, the CNO is optimally poised to influence and guide board comprehension of and ability to address issues beyond the traditional areas of nurse staff turnover and nurse staffing ratios. Quality measures related to nurse staffing concerns are legitimate and critical indicators of a hospital's ability to provide safe, quality care and they need to be meaningful. The CNO can (a) demonstrate the importance of work flow and work design on nurse retention and quality of care; (b) define the importance of the work environment and use of technology on nursing productivity, retention, and quality of care; and (c) continue to emphasize the importance of teamwork and the critical nurse role on the team as an effective and efficient model for delivering care.

Nurse staffing issues have a rich research base from which the CNO can draw. For example, when reporting on nurse-to-patient ratios, the CNO can cite the research documenting the optimal nurse-to-patient ratios known to result in improved patient safety and nursing quality of care. Or, when reporting on the mix of different types of nursing personnel, the CNO can refer to the concept of “nurse dose” that includes three major components: (a) dose (number of nurses/amount of care); (b) nurse (education, expertise, experience); and (c) host (organizational or patient receptiveness) (Brooten & Youngblut, 2006). In short, the CNO can share the research and evidential basis for maintaining specific nurse-to-patient ratios on a given unit rather than note that a nursing shortage exists. Defining a problem is a CNO responsibility, hopefully accompanied by possible alternative solutions, but enlightening board members as to why the problem needs their attention is a creative step in promoting their ability to make decisions about possible solutions.

Conclusions

Regardless of industry-wide mandates for hospital boards to assume leadership responsibility for improving patient safety and quality of care, it is unclear whether hospital board members have defined their role in improving patient safety or how they engage in quality improvement and patient safety initiatives. Further, board oversight of the quality of nursing care generally is limited to staffing concerns, with minimal attention given to quality indicators sensitive and specific to nursing performance and outcomes. Gaps in boards' comprehension of quality must be reduced. Without the full commitment of all hospital leaders, improvements in quality and patient safety will remain limited and generally nonsustainable.

CNOs have a responsibility to help close gaps in board members' understanding of quality and to be champions of quality care and patient safety. Doing so calls for CNOs to exercise leadership skills and apply strategies for influencing people in the organizational structure above as well as below the nurse leader. Use of self as a role

model and as a knowledgeable expert leverages CNOs' ability to transform board members' values, beliefs, and behaviors related to quality improvement and patient safety, as well as to diminish gaps in their comprehension of and engagement in quality initiatives.

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