
Chief Nursing Officer Retention and Turnover: A Crisis Brewing? Results of a National Survey

Cheryl B. Jones, PhD, RN, FAAN, associate professor, University of North Carolina at Chapel Hill School of Nursing, Chapel Hill, North Carolina; Donna S. Havens, PhD, RN, FAAN, professor, University of North Carolina at Chapel Hill School of Nursing; and Pamela A. Thompson, RN, FAAN, chief executive officer, American Organization of Nurse Executives, Washington, DC

EXECUTIVE SUMMARY

Anecdotal evidence suggests growing concerns about chief nursing officer (CNO) dissatisfaction, intent to leave, and turnover. However, little evidence documents the magnitude of the problem or whether CNO turnover requires direct action. This article reports the results from the first phase of a three-phase study examining CNO turnover and retention in U.S. hospitals. CNOs were invited to complete an online survey to gather data about their experiences with turnover and to identify CNO retention issues. Our sample includes responses from 622 CNOs employed in hospitals and healthcare systems across the United States.

Approximately 38 percent of the respondents reported having left a CNO position—13 percent within two years before the survey and 25 percent within five years before the survey. Of these, approximately one-quarter had been asked to resign, had been terminated, or had lost their jobs involuntarily. When asked about the context of their departure, a high percentage reported leaving their position to pursue another CNO position (50 percent) or for career advancement (30 percent); approximately 26 percent reported leaving because of conflicts with the chief executive officer. Of great concern is the finding that approximately 62 percent of respondents anticipate making a job change in less than five years, slightly more than one-quarter for retirement.

Respondents clearly indicated that CNO turnover is a problem that requires attention. The knowledge gained from this study can be used by healthcare leaders to develop strategies and policies aimed at recruiting and retaining CNOs and easing the transition for CNOs and others in the organization when CNO turnover does occur.

For more information on the concepts in this article, please contact Dr. Jones at cabjones@email.unc.edu.

The chief nursing officer (CNO) represents and advocates for nursing at the most senior level in hospitals and health systems and is responsible for understanding the capability and capacity of the nursing department (American Organization for Nurse Executives [AONE] 2005; Clifford 1998; Freund 1985; Kippenbrock 1995; Kippenbrock and May 1994; VHA, Inc. 2005). Unfortunately, anecdotal evidence suggests that many persons who fill this critical role are dissatisfied and intend to leave their positions. When an organization experiences CNO turnover, the workload of the executive and nursing leadership teams is undoubtedly affected, and even if the CNO is quickly replaced, relationship development must begin anew—between the CNO and the executive leadership team and between the CNO and nurse managers and staff nurses.

Very little recent research has been conducted to understand the nuances of CNO turnover. We have limited knowledge of why CNO turnover occurs, or what could be done to prevent CNO turnover. Kippenbrock (1995) reported the top two reasons for CNO turnover as lack of power (more than 50 percent) and conflicts with the chief executive officer (CEO) (45 percent). In a more recent study by the VHA (2005), the top factors contributing to CNO turnover were work-life balance (70 percent), CEO conflicts/financial issues (62 percent), physician conflicts (54 percent), staff nurse turnover (53 percent), and dissatisfaction with their current position (49 percent).

However, these studies do not provide current statistics on CNO turnover

or information that is needed to quell CNO turnover and promote retention. These issues served as the impetus for this study, which was conducted to explore the current CNO role, as perceived by current, interim, or past CNOs in U.S. hospitals, and to describe the experiences of current, interim, or past CNOs regarding recruitment, retention, and turnover issues. To achieve these goals, we used a confidential, online survey that was completed by current, interim/acting, and past CNOs to glean information about the CNO role, experiences with voluntary and involuntary turnover, and related CNO retention issues. Healthcare leaders can use the knowledge gained from this study to address the serious concerns associated with CNO turnover and develop strategies and policies aimed at recruiting and retaining CNOs as well as to ease the transition for CNOs and others in the organization when CNO turnover does occur.

METHODS

A three-phase study was conducted to examine CNO turnover and retention in U.S. hospitals. The first phase, reported in this article, included a confidential online survey of current, interim/acting, and past CNOs. This survey, developed by the research team and pilot-tested by a group of experts, asked participants about the CNO role, current or prior experiences with turnover, the organizations where CNOs work, career intentions, support available and needed for CNOs who experience voluntary turnover (i.e., turnover based on personal desires) and involuntary turnover (i.e., terminated or asked to resign), and

related CNO turnover and retention issues. The survey was developed from the literature (Bleich 1998; Freund 1985; Freund 1987; Kippenbrock and May 1994; Kippenbrock 1995) and from the researchers' knowledge of turnover and retention in general and CNO turnover in particular. Before initiating the survey, current and past AONE board members reviewed the survey and provided useful feedback to the study team about the content and formatting.

Approximately 6,000 hospital and health system CNOs were invited by e-mail to participate in the survey; the list of CNO e-mail addresses was obtained through the American Hospital Association. This initial survey announcement was e-mailed to the survey population approximately three days before the online survey was initiated. A follow-up e-mail was sent to the CNO population approximately one week after the survey was initiated to thank those who had participated and remind others that the survey was still available. Similar e-mails were sent two and three weeks after the online survey began to increase the response rate.

The questionnaire was formatted as a web-based survey using Zoomerang, a tool for developing online surveys. In the initial survey announcement, CNOs who were interested in participating were asked to read an informed consent statement that was attached as a rich text file to the e-mail announcement. If, after reading the document, they agreed with the terms of participation, they were directed to point their web browser to the Zoomerang survey. The entire online survey took approximately 20 minutes to complete. All surveys were confiden-

tial, and there was no way to associate individuals with their responses. The survey remained active and available to participants for approximately four weeks (September 28 to October 28, 2005).

RESULTS

Online survey respondents included 634 CNOs employed in hospitals and health systems across the United States. Of those, 622 (98 percent) were employed in a permanent CNO role, and the remaining 12 respondents (2 percent) were in the CNO role on an interim basis. Because of the small number of respondents who were in an interim CNO position, we used only those responses of persons who were in a permanent CNO role. Results are presented on the CNO participants, the organizations where they work, their perceptions of the CNO role, and their experiences with turnover.

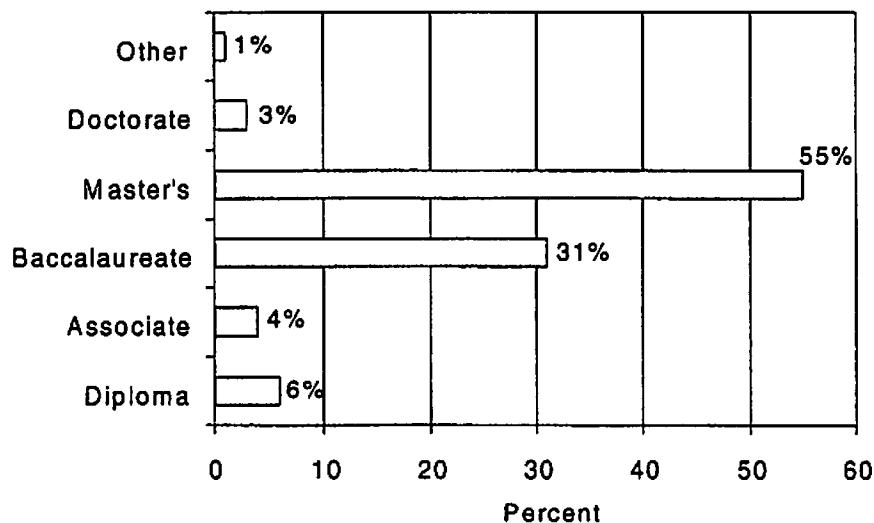
The typical CNO who responded to the survey was a woman (90 percent), was white (96 percent), and was 52 years on average (range = 26 to 70 years) (see Table 1). Figures 1 and 2 illustrate the educational distribution of respondents: approximately 55 percent held a master's in nursing as their highest degree and approximately 29 percent held a master's degree in business or health administration. Table 1 also shows that most of the CNO respondents (62 percent) had been employed in their organization for more than five years, and almost 45 percent had been employed in their organization for more than ten years. A large percentage of CNO respondents (43 percent) had been employed in their current CNO

TABLE 1
Characteristics of CNO Respondents (based on 622 observations, unless otherwise noted)

Variables	Mean (Median)	(%)*	Range	SD
Age (in years)	51.5 (52.0)	—	26-70	6.5
Gender				
Male (n = 60)	—	9.6	—	—
Female (n = 562)	—	90.0	—	—
Race				
White or Caucasian (n = 598)	—	96.0	—	—
African-American or Black (n = 10)	—	1.2	—	—
Hispanic or Latin American (n = 4)	—	0.6	—	—
Asian/Pacific American (n = 6)	—	1.0	—	—
American Indian (n = 2)	—	0.3	—	—
Other (n = 2)	—	0.3	—	—
Years employed in current organization				
< 2 years (n = 112)	—	19.6	—	—
2 to 5 years (n = 124)	—	20.0	—	—
5 to 10 years (n = 108)	—	17.4	—	—
> 10 years (n = 278)	—	44.7	—	—
Years employed in current position				
< 2 years (n = 112)	—	25.2	—	—
2 to 5 years (n = 124)	—	31.4	—	—
5 to 10 years (n = 108)	—	27.3	—	—
> 10 years (n = 278)	—	16.0	—	—
First CNO position				
Yes (n = 375)	—	60.2	—	—
No (n = 247)	—	39.7	—	—
Years of CNO experience	8.9 (7.0)	—	0-36	6.9
Number of CNO positions held (including current)	1.7	—	0-7	1.0
Number of hospitals overseeing as CNO	1.4	—	0-23	1.0

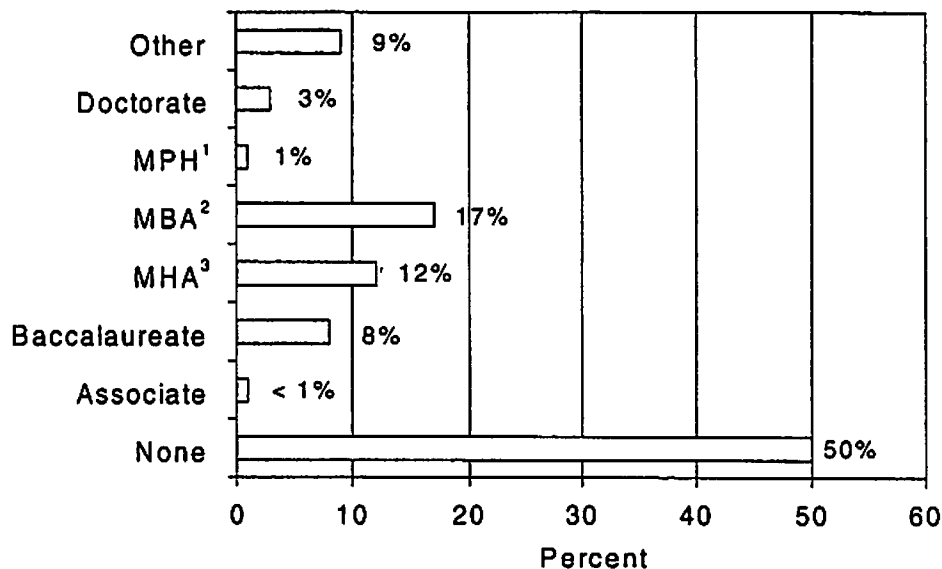
*Percentages may not total to 100 because of rounding.

FIGURE 1
CNO Respondents* Highest Nursing Degree



*n=622

FIGURE 2
CNO Respondents* Highest Degree in Another Field



*n=622

¹ Master in Public Health; ² Master in Business Administration; ³ Master in Health Administration

position for more than five years, and the largest percentage (31 percent) had been employed in their current position for two to five years. Interestingly, the majority of CNO respondents (60 percent) were employed in their first CNO position. The typical CNO respondent had approximately nine years of experience in the CNO role and, on average, reported having held approximately 1.7 CNO positions, including their current position. On average, the CNOs who responded to this survey were responsible for nursing and related services at 1.4 hospitals.

Table 2 presents information on the organizations where the respondents were employed. The majority (48 percent) of CNO respondents reported being employed in a community hospital, and the largest block of CNOs was overseeing services in the East North Central (21 percent), South Atlantic (17 percent), and West North Central (15 percent) regions. The majority (54 percent) of CNOs also worked in non-governmental, not-for-profit organizations. CNOs reported that, on average, the organizations where they worked maintained 271 licensed beds, and, on average, 221 of those beds were staffed and available for use. The organizations employed an average of 412 registered nurse (RN) full-time equivalents (FTEs) for ratios of 1.4 RN FTEs to licensed beds and 1.8 RN FTEs to staffed beds.

Approximately 16 percent of CNOs reported that the nursing staff at their organization was organized for collective bargaining. Roughly 10 percent of CNOs reported that their facility was Magnet-designated; CNOs at almost 12 percent of the remaining facilities

reported that their organization had Magnet applications under review.¹

CNO Relationships and Other Aspects of the Role

Several questions were included to gather more information about the specific relationships the CNO maintained in the organization. Responses to these items, displayed in Table 3, were solicited to obtain contextual information believed to be important for understanding the complexity of the CNO role and CNO turnover.

We first asked CNOs about key relationships with groups and/or individuals in their organization. These relationships were viewed as critical in determining CNO tenure and providing support in their role. A majority (78 percent) of CNOs reported very good or excellent relationships with staff nurses in their organization, and an even greater percentage of CNOs (94 percent) reported very good or excellent relationships with nurse managers and directors.

To gain insight into opportunities that CNOs might have for face-to-face interactions with staff and patients in the clinical setting, we asked CNOs about the frequency with which they made rounds to patient care areas. A clear majority of CNOs (approximately 74 percent) reported making rounds daily or weekly. When examined more closely, about one-third of CNOs reported making rounds daily. Very few CNO respondents (approximately 2 percent) reported that they never made rounds to patient care areas.

Overwhelmingly (87 percent), CNOs reported very good or excellent

TABLE 2
Characteristics of the Organizations Where CNO Respondents Worked

Variables	Mean (Median)	(%)*	Range	SD
Type of hospital				
Community (n = 302)	—	48.6	—	—
Rural (n = 127)	—	20.4	—	—
Academic health center (n = 62)	—	10.0	—	—
Corporate system (n = 57)	—	9.1	—	—
Other (n = 74)	—	11.9	—	—
Location of hospitals where CNOs worked**				
New England (n = 28)	—	4.4	—	—
Middle Atlantic (n = 55)	—	8.7	—	—
East North Central (n = 131)	—	20.7	—	—
West North Central (n = 95)	—	15.0	—	—
South Atlantic (n = 107)	—	16.9	—	—
East South Central (n = 30)	—	4.7	—	—
West South Central (n = 73)	—	11.5	—	—
Mountain (n = 53)	—	8.4	—	—
Pacific (n = 62)	—	9.8	—	—
Hospital ownership				
Government, nonfederal (n = 67)	—	10.8	—	—
Nongovernmental, not-for-profit, church affiliated (n = 99)	—	15.9	—	—
Nongovernmental, not-for-profit (n = 336)	—	54.0	—	—
Investor owned, for-profit (n = 94)	—	15.1	—	—
Government, federal (n = 9)	—	1.4	—	—
Other (n = 7)	—	1.1	—	—
Number of licensed beds (n = 621)	271 (186)	—	0 [†] - 4,548	324.4
Number of staffed beds	220.9 (150)	—	0 [†] - 4,548	303.2
Nurses organized for collective bargaining				
(n = 622)	—	15.9	—	—
Magnet-designated (n = 622)	—	9.6	—	—
Magnet application under review (n = 562)	—	11.7	—	—

*Percentages may not total to 100 because of rounding.

**Numbers exceed 622 because some CNOs had role responsibilities across multiple states.

†The facilities reported as having 0 beds were in non-acute care facilities.

TABLE 3
Key CNO Respondent Relationships Within the Organizations Where They Worked

Variables	Mean (Median)	(%)	Range	SD
Relationships with staff nurses (n = 622)*	4 (4)	—	3–5	0.7
Excellent (n = 131)	—	21.1	—	—
Very good (n = 352)	—	56.6	—	—
Good (n = 139)	—	22.3	—	—
Relationships with nurse managers and directors (n = 622)*	4.5 (5)	—	3–5	0.6
Excellent (n = 355)	—	57.0	—	—
Very good (n = 232)	—	37.3	—	—
Good (n = 35)	—	5.6	—	—
Frequency of making rounds on patient care units (n = 622)				
Daily (n = 212)	—	34.1	—	—
Weekly (n = 250)	—	40.2	—	—
Every other week (n = 60)	—	9.6	—	—
Once per month (n = 60)	—	9.6	—	—
Less than once per month (n = 30)	—	4.8	—	—
Does not make rounds (n = 10)	—	1.6	—	—
Relationships with members of the senior leadership team (n = 622)*	4.3 (4)	—	1–5	0.8
Excellent (n = 305)	—	49.0	—	—
Very good (n = 235)	—	37.8	—	—
Good (n = 72)	—	11.6	—	—
Poor (n = 9)	—	1.4	—	—
Very poor (n = 1)	—	0.2	—	—
Relationship with CEO (n = 622)*	4.2 (5)	—	1–5	1.0
Excellent (n = 324)	—	52.1	—	—
Very good (n = 167)	—	26.8	—	—
Good (n = 95)	—	15.2	—	—
Poor (n = 26)	—	4.2	—	—
Very poor (n = 10)	—	1.6	—	—
Primary reporting relationship (n = 622)				
CEO (n = 476)	—	76.5	—	—
Chief operating officer (n = 118)	—	19.0	—	—
Board (n = 1)	—	0.2	—	—
Other (n = 27)	—	4.3	—	—

CHIEF NURSING OFFICER RETENTION AND TURNOVER

Time CEO had been in position (n = 622)				
< 2 years (n = 152)	—	24.4	—	—
2 to 5 years (n = 161)	—	25.9	—	—
5 to 10 years (n = 136)	—	21.9	—	—
> 10 years (n = 173)	—	27.8	—	—
Number of CEOs employed in organization during past ten years				
	2.3 (2)	—	1-10	1.4
CNO regularly attends board meetings (n = 534)				
	—	84.2	—	—
CNO reports to the board (n = 515)				
Monthly (n = 221)	—	35.5	—	—
Quarterly (n = 134)	—	21.5	—	—
Annually (n = 61)	—	9.8	—	—
Different schedule (n = 99)	—	15.9	—	—

*This rating was based on a scale ranging from 1 to 5, with 5 representing an excellent relationship and 1 representing a very poor relationship.

relationships with senior organizational leaders, and 49 percent of CNOs reported excellent relationships with senior organizational leaders. When asked specifically about their relationship with the CEO, a clear majority (approximately 79 percent) of CNOs reported very good or excellent relationships with their CEO, and more than half of the respondents reported excellent relationships with senior leadership. Only a very small percentage of CNOs reported poor or very poor relationships with the senior leadership team (less than 2 percent) or their CEO (approximately 7 percent).

CNOs were also asked about their primary reporting relationship. The vast majority of CNOs (77 percent) reported to the CEO or president. Those respondents who selected an "other" reporting relationship identified such arrangements as a dual reporting relationship with the CEO and chief operating officer

(COO), chief of medical staff, or some other organizational administrator. Because of the close and important working relationship between the CNO and CEO, additional information was sought from CNOs about their organizational CEO. Almost half of the CNOs reported that their CEO had served in this capacity for less than five years, while approximately one-quarter of CNOs reported that their CEO had served in the role for more than ten years. CNOs also reported that an average of 2.3 CEOs led their organization during the past ten years.

Given that today's CNO serves at a high level within a healthcare organization and maintains a high profile both inside and outside the organization, we specifically asked CNOs about their interactions with the board of directors. The vast majority of CNOs reported regular attendance at board meetings (84 percent) and regular reporting to the

board (83 percent). The greatest percentage of CNOs (36 percent) reported to the board on a monthly basis. The CNOs were given a list of topics from which they could select as many as were relevant to describe the content on which they reported to the board. The content on which they reported most frequently pertained to status of nursing services (97 percent); patient safety/quality of care (78 percent); and a variety of other topics (37 percent), such as patient satisfaction, new service development and programs, and the nursing strategic plan.

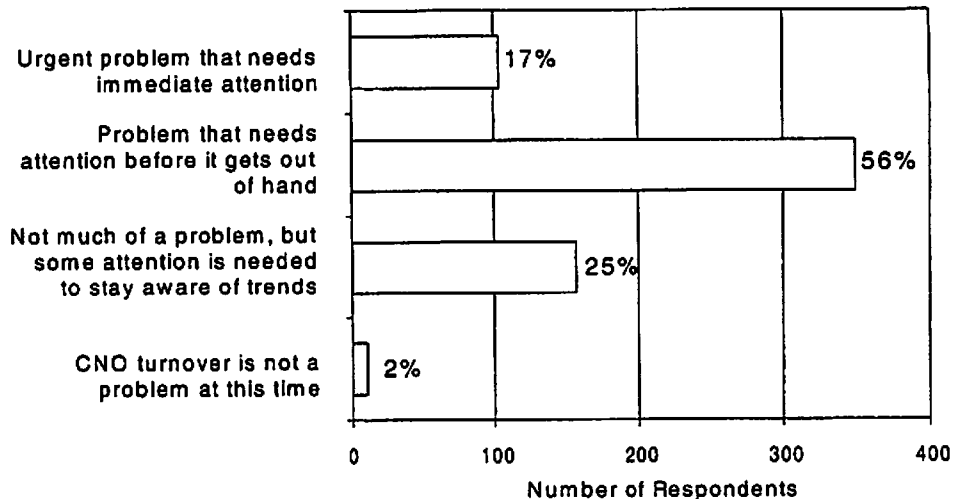
CNO Turnover

To get an overall sense of CNO turnover today, we asked CNOs to first think about their interactions with other CNOs and professional colleagues and then characterize current CNO turnover. A characterization of their responses is shown in Figure 3. The majority of

respondents (73 percent) expressed real concerns about the "slippery slope" of CNO turnover. Specifically, 17 percent of respondents reported that CNO turnover is an urgent problem in need of immediate attention, and 56 percent reported that CNO turnover is a problem that needs attention before it gets out of hand. About 25 percent of respondents reported that CNO turnover is not much of a problem, but some attention was needed, or that CNO turnover was not a problem (2 percent).

The history of CNO turnover in organizations may also provide some insight into the turnover behaviors of current CNOs. That is, if several CNOs had been employed but left the organization, it may indicate common problems for CNOs at the specific organization. Although we did not ask specifically about the reasons for prior CNO departures, we might anticipate that these reasons could range from

FIGURE 3
Characterization of CNO Turnover



personal issues to problems with nursing services to conflict with the board or external environment. CNO respondents reported that, on average, two previous CNOs had been employed at their organization during the past ten years (range = 0 to 11 prior CNOs in the past ten years).

CNOs' Prior Turnover Experiences

CNOs were asked about their prior turnover experiences, including voluntary and involuntary turnover. Voluntary turnover was defined as originating from

an individual CNO's personal choice or decision to leave an organization; involuntary turnover was defined as turnover that is imposed by the organization, such as being let go or being asked to resign from their position. The CNO responses are shown in Table 4. Of the 622 CNO respondents, approximately 40 percent (n = 247) indicated that they had left a CNO position at some point during their careers. Approximately 13 percent of the sample had left a position in the past two years, and 25 percent of the sample had left a position in the

TABLE 4
CNO Turnover (n = 622, unless otherwise indicated)

Variables	N	(%)*
Never experienced turnover	375	60.3
CNOs who had experienced job turnover	247	39.7
Experienced turnover within the past 2 years	81	13.0
Experienced turnover within the past 2-5 years	77	12.4
Experienced turnover within the past 5-10 years	54	8.7
Experienced turnover in greater than 10 years	35	5.6
Type of turnover (n = 247)		
Turned over voluntarily	189	76.5
Turned over involuntarily	58	23.4
Asked to resign	20	8.1
Terminated	11	4.4
Other reasons	27	10.9
Top reasons for prior turnover (n = 247)**		
Take another CNO position	123	49.8
Pursue promotion/career advancement opportunity	71	28.7
Conflicts with CEO	63	25.5
Job dissatisfaction	51	20.6
Family/personal reasons	50	20.2

* Percentages may not total to 100 because of rounding.

**Numbers and percentages exceed the sample size indicated because respondents could select more than one response.

past five years. Of these CNOs, approximately 77 percent (189) had left a position voluntarily. The remainder had been asked to resign (8 percent); had been terminated (4 percent); or had lost their job because of other reasons (11 percent), such as a merger, downsizing, restructuring and/or position elimination, mutual decision to resign, and/or hospital closure.

To better understand the context of turnover, CNOs were also asked why they had left their position. The top five reasons for leaving a prior CNO position were to take another CNO position (50 percent); to pursue advancement or career development opportunities (29 percent); conflicts with the CEO (26 percent); job dissatisfaction (21 percent); and family/personal reasons (20 percent).

CNO Job Satisfaction

Turnover research in general has consistently shown a relationship between job satisfaction and employee intent

to leave² and, ultimately, leaving a job (Griffeth, Hom, and Gaertner 2000; Hom and Griffeth 1995; Hom, Griffeth, and Sellaro 1984; Maertz and Gampion 1998; Mobley 1982). We thus asked CNOs about satisfaction with their current CNO position; their responses are shown in Figure 4. The vast majority (85 percent) of CNOs were satisfied (48 percent) or very satisfied (37 percent) with their jobs. A much smaller percentage of respondents were dissatisfied (12 percent) or very dissatisfied (3 percent) with their current CNO position.

Intent to Leave

Finally, we asked CNOs about their plans to leave their current positions in the future. A detailed breakdown of their responses is shown in Figure 5. Approximately 61 percent (n = 380) of the CNO respondents reported that they would change jobs in less than five years. Of those who planned to leave in the next five years, the top reasons for leaving (shown in Table 5)

FIGURE 4
CNO Job Satisfaction

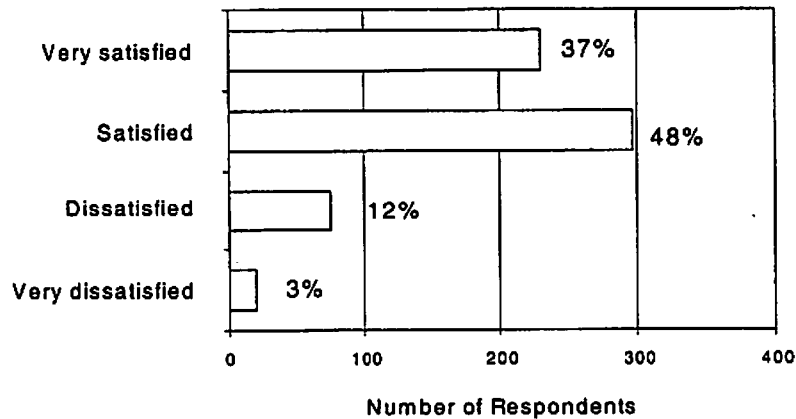
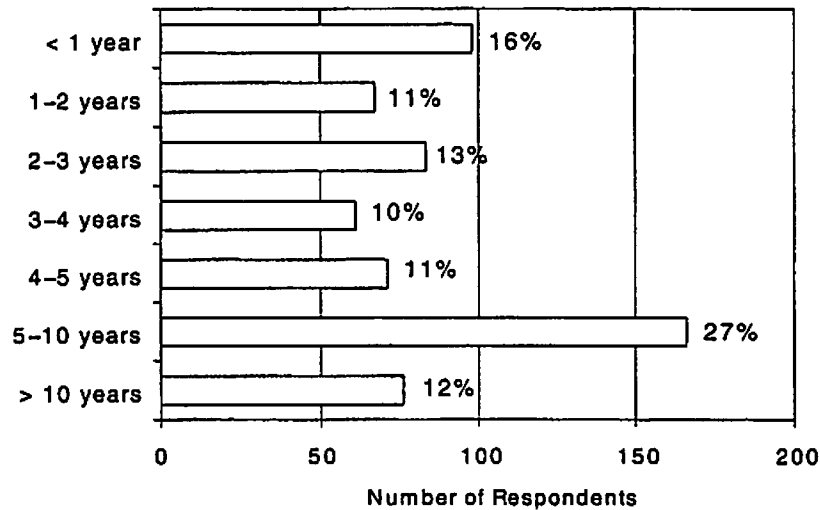


FIGURE 5
CNO Intent to Leave Current Position



included promotion or advancement (29 percent), need for work-life balance (29 percent), retirement (28 percent), another CNO position (21 percent), a COO or CEO position (21 percent), personal/family reasons (18 percent), and lack of power (19 percent).

Study Limitations

Online surveys offer certain advantages and disadvantages—something that we were aware of before deciding on this data-collection strategy. The ease and flexibility an online survey offers for participants and the ability to maintain confidentiality and anonymity were

TABLE 5
Top Reasons CNOs Intend to Leave Their Current Position (n = 380)*

	N	(%)**
Pursue promotion/career development opportunity	110	28.9
Lack of balance between personal and professional life	109	28.7
Retirement	106	27.9
Take another CNO position	78	20.5
Take a COO or CEO position	78	20.5
Personal/family reasons	68	17.9
Lack of power in role	71	18.7

* These responses represent only those CNOs who intend to leave their positions.

**Numbers and percentages exceed the sample size indicated because respondents could select more than one response.

primary considerations. Also, the ability to quickly access potentially large numbers of CNOs and staff nurses/nurse managers was critical. For these reasons, we selected an online survey over other methods of data collection. By doing so, we were faced with several limitations. Because the survey was anonymous, participants were not required to log in; thus, we could not track individual respondents and we could not control the number of times that participants responded. We attempted to address this issue by tracking the number of completed responses to the online CNO survey to ensure that the number of responses did not exceed the possible number of responses.

Despite these limitations, this study provides data that offer new insights into CNO recruitment, retention, and turnover issues. Moreover, this study is unique in its use of online survey methods, a strategy that will likely be used more in the future. We believe our study will contribute to a better understanding of how these methods can be used to augment more traditional research methods.

DISCUSSION AND IMPLICATIONS

This article reports the first of a three-phase study to examine CNO turnover. The first phase, reported here, used an electronic CNO survey to solicit feedback from a broad audience of current CNOs and to gather information about current or prior experiences with turnover, career intentions, and related CNO turnover and retention issues. The second and third phases were conducted to complement the first phase. These

phases included a series of qualitative interviews with CNOs and healthcare recruiters to explore turnover and retention issues in greater detail (second phase) and an online survey of staff nurses and nurse managers to gather data on the impact of CNO turnover on the delivery of patient care (third phase).

Several study findings are worthy of further elaboration. A high percentage of CNOs had been employed in their organization (62 percent) and in their current position (43 percent) for more than five years. Regarding their CNO role, respondents reported having very good or excellent relationships with staff nurses (78 percent), nurse managers and directors (94 percent), senior leaders (87 percent), and CEOs (79 percent). These relationships are obviously critical to the role of CNOs in today's healthcare organizations. While positive overall, there is room for improving relationships, particularly between staff nurses and CEOs. Interestingly, the percentage of CNOs who reported good or excellent relationships with staff nurses is very similar to the percentage of CNOs who reported making rounds at least weekly (74 percent). It may be that CNOs use these walking rounds to ask questions, engage frontline staff, discuss pertinent issues, and build relationships with staff nurses and other leaders. These rounds are also in keeping with current patient safety research, which indicates that having management "walk rounds" improves patient safety (Frankel et al. 2003) and nurses' perceptions of the safety climate (Thomas et al. 2005).

Regarding their perceptions of CNO turnover, the majority (73 per-

cent) of respondents reported that CNO turnover was an urgent problem (17 percent) or a concerning problem that required attention (56 percent). In keeping with prior research (Kippenbrock and May 1994), approximately 13 percent of the respondents had left a position in the past two years, 25 percent had left a position in the past five years, and 39 percent had left a position at some time during their career. Of the respondents who had left a position, approximately one-quarter were asked to resign, were terminated, or lost their job involuntarily—a considerably lower percentage than reported by Freund in 1985. When asked about the context of their departure, a high percentage of respondents reported leaving their position to pursue another CNO position (50 percent) or for career advancement (29 percent). Alternatively, approximately 26 percent reported leaving because of a conflict with the CEO, considerably less than the 45 percent reported by Kippenbrock in 1995 and the 62 percent reported by the VHA in 2005.

Of great concern is the fact that approximately 61 percent of respondents reported that they anticipate making a job change in less than five years, which reinforces CNO perceptions of the concerning nature of this problem. Slightly more than one-quarter of those CNOs planned to leave their job in the next five years because of retirement. Consistent with findings from the VHA study (2005), this particular finding emphasizes the grave need for succession planning to identify and develop future candidates for this high level of nursing leadership, beginning early in a CNO's tenure. In addition, it points to the need

to adequately socialize and prepare future leaders through educational and professional activities to function successfully in complex healthcare environments and to fill a key role on the senior leadership team.

This study also has the potential to inform policymaking, and particularly the work of AONE to address professional development for nurse executives. Four specific policy issues are highlighted: (1) services needed for the nurse executive who experiences involuntary turnover, (2) support for leadership succession planning, (3) continuing and supplemental educational programs, and (4) the characteristics of the work/practice environment for nursing leadership. Regarding involuntary turnover, nurse executives would benefit from access to legal advice, coaching, and networking with colleagues who share similar experiences. Support for succession planning can be provided through educational offerings that prepare current aspiring nurse leaders and nurse managers to step into future nurse executive roles. Clearly, a need exists for educational programs aimed at increasing financial and relationship management skills. Most importantly, the need is critical to articulate the characteristics of the work/practice environment that will allow the field not only to recruit but also to retain nurses in executive roles. Without immediate attention to the impending crisis of CNO turnover, we face a void in leadership for the largest professional discipline in healthcare. AONE is uniquely positioned to develop the services needed to address these issues that emerged from this research endeavor.

CONCLUSIONS

This study contributes to the field by providing insight into CNO turnover and retention issues, identifying factors that precipitate CNO turnover, and highlighting the magnitude of the issues. In turn, this knowledge can be used to develop strategies to retain CNOs, ease the transition for CNOs who turn over, and support staff and managers employed in organizations where CNO turnover occurs. These actions are critical given the importance of the CNO role in creating environments in which safe, quality care is delivered (AONE 2005; VHA 2000). The knowledge gained through this study helps us to better understand the current CNO role within the context of patient care delivery; thus, the findings highlight the importance of creating environments in which patient care is improved and the quality of work life for CNOs is enhanced. Finally, we learned that the current healthcare environment presents great opportunities for CNOs to shape and sustain quality environments for nursing work and patient care.

Notes

1. Magnet certification is awarded by the American Nurses Credentialing Center (ANCC). This designation recognizes healthcare organizations that are determined to provide excellent nursing services. For additional information, please see the ANCC website at www.nursingworld.org.
2. In our sample, the correlation between CNOs' current reported job satisfaction and their intent to leave was 0.45, $p < .05$.

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PRACTITIONER APPLICATION

Linda J. Knodel, CNABC, CPHQ, FACHE, senior vice president and chief nursing officer, St. Alexius Medical Center, Bismarck, North Dakota

It is true that little, if any, data currently exist relative to chief nursing officer (CNO) turnover. The findings of this study are, therefore, critically important to determine future directions.

In the past ten or so years, the nursing industry has focused on staff nurses and the need to address their current and future needs. Minimal emphasis has been placed on recruitment, retention, and succession planning for CNOs. As a practicing CNO, I fully agree that supporting literature is necessary to uphold anecdotal comments relative to CNO turnover. The data presented in this article provide a comprehensive analysis for our field. The survey respondents are a representative sample of the current healthcare industry in that they accurately stand for rural, community, university, and system-based healthcare facilities. The response rate accounts for approximately 12 percent to 13 percent of all U.S. healthcare organizations.

The findings from this study are affirming: CNOs participate in board activities at a significant level, a practice that is upheld by regulatory agencies. The article also provides testimony that positive relationships among the nursing staff, the executive suite, and the board of directors are key to a healthy work environment. Even though the study reports that a significant number of the CNOs had excellent or very good relationships with the organization's chief executive officer (CEO), it is interesting to note that the turnover rate for CEOs is much higher than the CNO's. Also, the findings indicate that CNOs had greater tenure in their organization compared to the length of time reported for the CEOs. Could these data suggest that the CNO moved within the organization and the CEO did not? These findings suggest that further study is needed.

Approximately 26 percent of current Magnet-designated organizations responded to this survey. It may be valuable to expand the number of Magnet facilities that participate in future studies to evaluate what (if any) strategies have been used to address not only staff recruitment and retention but also CNO and nursing leadership succession planning. Even though 85 percent of CNOs who responded to the survey said they were satisfied with their job, the 62 percent who indicated that they would

change jobs within the next five years represent a call to the healthcare system to take action. Can employers, professional organizations, and higher education play a role in addressing this situation?

This study is merely the tip of the iceberg in addressing CNO retention, turnover, and related issues. The fact that within the next five years the CNO turnover rate is expected to increase exponentially supports the urgency of addressing this national healthcare issue. I strongly recommend that the authors continue this valuable work in the two additional study phases mentioned in this article. I would also like to extend my compliments to the authors for this timely professional information that will be shared beyond the nursing leadership arena and into the broader healthcare executive field.