# 2013 Hospital Survey Results

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North Dakota Center for Nursing

A unified voice for nursing excellence.

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# Executive Summary

## Background

In the July/August 2009 *Health Affairs*, Dr. Peter Buerhaus and coauthors found that despite the current easing of the nursing shortage due to the recession, the U.S. nursing shortage is projected to grow to 260,000 registered nurses by 2025. A shortage of this magnitude would be twice as large as any nursing shortage experienced in this country since the mid-1960s. The researchers point to a rapidly aging workforce as a primary contributor to the projected shortage.

The original North Dakota Nursing Needs Study was recommended by the North Dakota Century Code Nurse Practices Act 43-12.1-08.2 in which the North Dakota Board of Nursing was directed to address issues of supply and demand including recruitment, retention and utilization of nurses. The North Dakota Board of Nursing then contracted with Dr. Patricia Moulton at the University of North Dakota School of Medicine and Health Sciences to conduct the 10 year North Dakota Nursing Needs Study. Today, the study format has changed and is under the direction of the North Dakota Center for Nursing. Some of the same information is gathered to continue the work of the initial studies, however additional questions related to the work of the North Dakota Center for Nursing specific to the work environment, leadership and the utilization of advanced practice nurses were included in the 2013 study.

## Hospital Survey Results

This report includes the results from the hospital survey, which was sent to all hospitals in North Dakota. A total of 48 surveys were sent. Of these there were 23 organizational responses, 17 percent represented four urban facilities and 83 percent of the responses came from nineteen rural facilities. These surveys provided a comprehensive picture of the nature of nursing employment and potential shortages throughout the state and to enable comparisons to be drawn between health care facilities, rural and urban areas and North Dakota and national data.

- **Recruitment Issues**

  It was the most difficult to recruit RNs followed by LPNs however the length of time to fill vacancies continues to trend downward since 2005 from 17 weeks to 6 week in both 2010 and 2013. Rural areas still take longer to fill positions especially in the RN and LPN categories.

- **Salary and Benefit Issues**
  All salaries, starting and average wage have continued to increase since 2004. LPNs and APRNs in rural hospitals currently have higher starting wages than their urban counterparts. For average salary, unlicensed staff and NPs have the highest average wage.

- **Staffing**
  The statewide vacancy rate for LPNs was 3% (same for urban and rural) which is down from 5% in 2010.The statewide vacancy rate for RNs was even lower at 1% which is down from 6% in 2010. The statewide turnover rate for LPNs is 14%; this is down from

16% in the previous study in 2010. The statewide turnover rate for RNs is up to 18% in 2013 from 16% in 2010.

- **Utilization of APRNs in ND**
  Nurse Practitioners were most likely to be a recognized voting member of the medical staff, bill under their own NPI number and to have admitting privileges. Other Certified RNs were most likely to be billed incident to a physician NPI number.

- **Workplace Environment**
  While most of the hospital facilities are aware of the ANCC Magnet Program, few are involved with the process or intend to be. Most of the hospitals are unaware of the Pathways to Excellence Program although several are interested. The urban hospitals already have many of the workplace policies in place to apply for the program. Many rural hospitals were unaware of the CAH Quality Network DON Mentoring program. Hospitals were mixed on their interest in a statewide CNO residency program.

# North Dakota Center for Nursing Hospital Survey Introduction

## Background

Health personnel shortages can negatively impact health care quality, through reduced heath care access, increased stress on providers, and use of under-qualified personnel. Also shortages can contribute to higher costs by raising compensation levels to attract and retain personnel and by increasing the use of overtime pay and expensive temporary personnel. Workforce strategies, while a problem for the entire healthcare system, are likely to be most severe for rural regional and medically underserved areas.

The downturn in the U.S. economy has led to an easing of nursing shortages in some parts of the country. Though the nursing workforce is showing signs of stabilizing, workforce analysts caution nurse educators, policymakers, employers and other stakeholders from calling this the end of the nursing shortage. Released in July 2010, in a joint statement, the Tri-Council for Nursing acknowledged the temporary easing of the shortage, but raised concerns about slowing the production of RNs given the projected demand for nursing services, especially in light of healthcare reform. https://www.aacn.nche.edu/Education/pdf/Tricouncilsupplu.pdf.

In an article published in the Journal of Health Affairs (Auerbach, Butterhaus & Staiger, 2009), a study confirmed the nursing shortage is not over and to this point the authors suggest we consider the following:

- Considerable uncertainty persists about whether or not interest in nursing will continue to grow in the future.
- The aging of the population is likely to increase demand for RNs at a greater rate than in the past.
- Full implementation of the Affordable Care Act and expanding roles for nurses in primary care will likely increase demand for RNs and result in future shortages.
- Ongoing bottlenecks in nursing education (i.e. faculty shortages, insufficient clinical training sites) could narrow the future pipeline of nurses below optimal levels.

Nurses comprise the largest group of healthcare providers in the United States. Patient safety and quality issues as well as access to healthcare are directly related to the availability of skilled and competent nursing staff in adequate numbers.

The original North Dakota Nursing Needs Study was recommended by the North Dakota Century Code Nurse Practices Act 43-12.1-08.2 in which the North Dakota Board of Nursing was directed to address issues of supply and demand including recruitment, retention and utilization of nurses. The North Dakota Board of Nursing then contracted with Dr. Patricia Moulton at the University of North Dakota School of Medicine and Health Sciences to conduct the 10 year North Dakota Nursing Needs Study. Today, the study format has changed and is under the direction of the North Dakota Center for Nursing. Some of the same information is gathered to continue the work of the initial studies, however additional questions related to the work of the North Dakota Center for Nursing specific to the work environment, leadership and the utilization of advanced practice nurses were included in the 2013 study.

## Hospital Survey Results

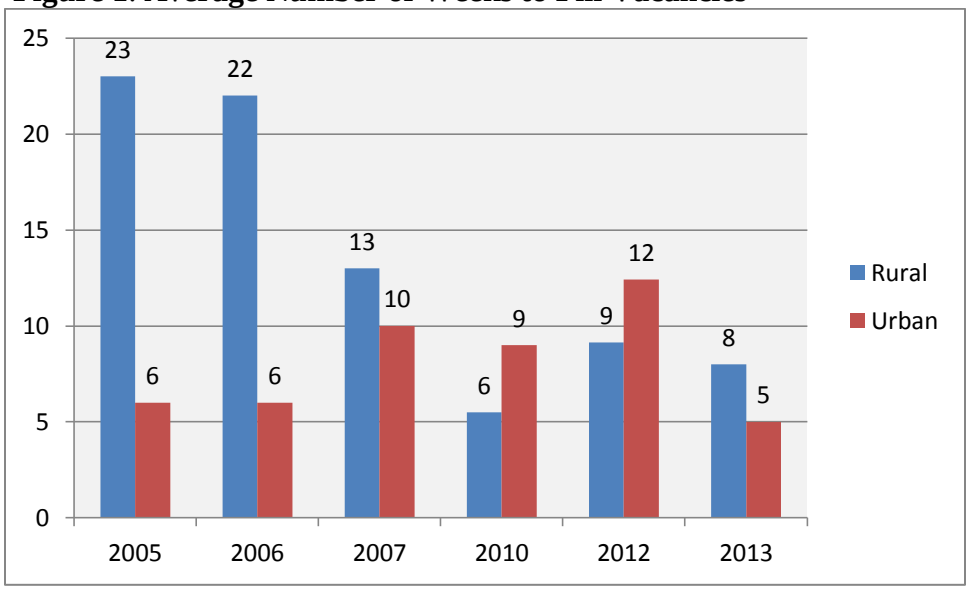
Surveys were sent to all North Dakota hospitals (48) in the spring of 2013. Of the 23 organization responses, 17 percent represented four urban facilities and 83 percent of the responses came from nineteen rural facilities.

Data was divided into urban/rural categories with the four major cities in North Dakota as the definition of urban. All other hospitals were considered rural for purposes of this study. These results are also compared with facility survey results from 2004, 2005, 2006, 2007, 2010, 2012 and 2013.

### RECRUITMENT ISSUES

Hospitals were asked how long (number of weeks) on average, it takes to fill a vacant nursing position. Although, it has switched in some years, rural areas currently have a more difficult time filling positions with the length of time decreasing since 2005 (see Figure 1).

**Figure 1**: **Average Number of Weeks to Fill Vacancies**

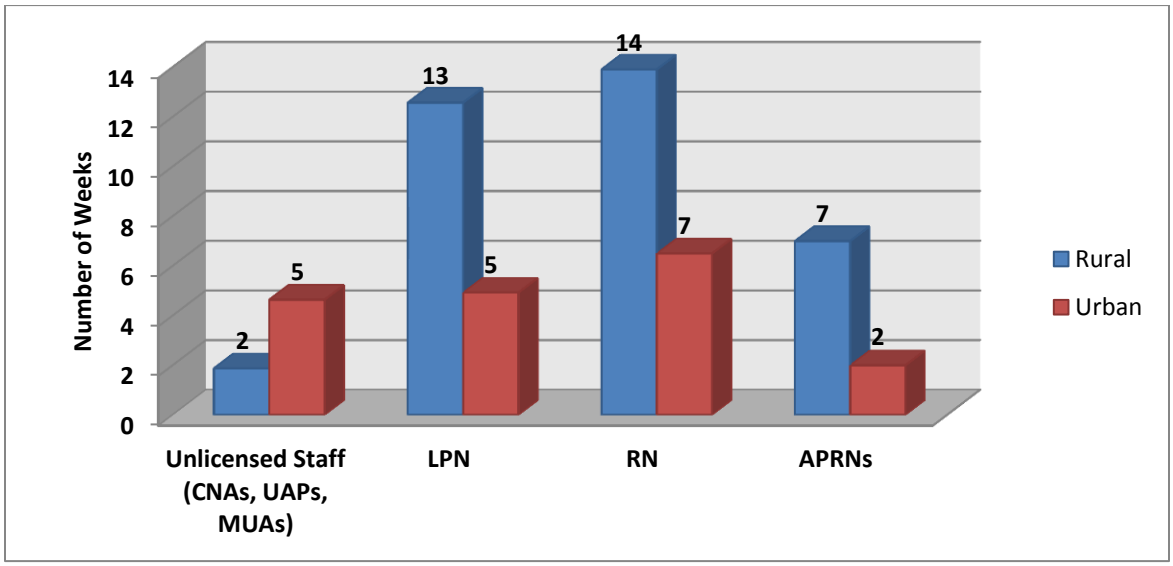



*Biggest Workforce Issue:*

*Replacing retiring employees in rural communities*

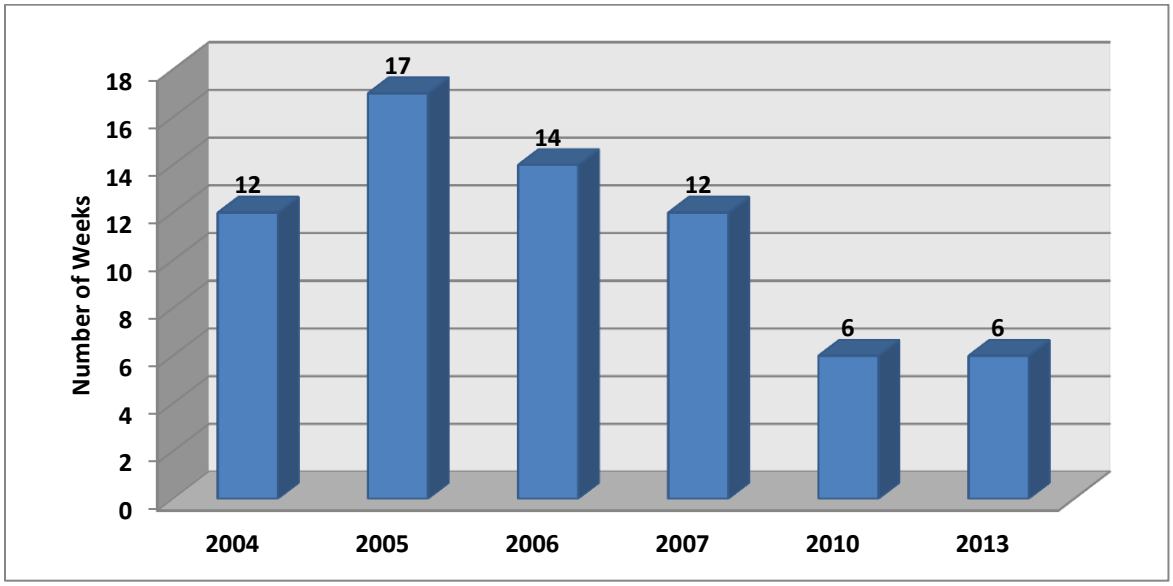
When divided by nurse level, Registered Nurses, followed closely by Licenses Practical Nurses had the greatest number of weeks to fill a nurse vacancy in both rural and urban areas of the state. The least difficult positions to fill are APRNs in urban hospitals and unlicensed staff in rural hospitals (see Figure 2).

**Figure 2**: **Average Number of Weeks to Fill Vacancies by Nurse Level**




The length of time to fill a vacancy (all levels of staffing combined from Figure 1 and 2), has steadily decreased since 2005 (see Figure 3).

**Figure 3: Average Number of Weeks to Fill Vacancies According to Year**



## SALARY AND BENEFITS ISSUES

### Starting Wage

Starting wages are the average hourly wage paid to nurses when they were first hired as new graduates. Starting wage is greater for all categories of urban nurses, except LPNs and Nurse Practitioners (see Table 1).

**Table 1: Average Starting Hourly Wage for Each Nurse Category**

| | Unlicensed Staff | LPN | RN | NP | CRNA | CNS |
|---|---|---|---|---|---|---|
| **Rural** | $ 10.46 (16) | $ 14.81 (15) | $ 21.04 (16) | $ 37.44 (3) | $ 56.12 (3) | $ 29.16 (1) |
| **Urban** | $ 10.48 (2) | $ 14.70 (3) | $ 22.74 (3) | $ 33.80 (1) | $ 65.50 (1) | $ 32.22 (1) |

Note: The number of facilities that responded is included in parenthesis.

The highest starting pay for urban RNs reported was $ 22.87 and rural $ 22.70. The lowest urban starting wage reported was $22.66 and lowest rural reported was $19.50. The highest and lowest starting wages are reported below. There is a lot of variability between rural and urban settings (see Table 2).

**Table 2: Highest and Lowest Average Starting Hourly Wage**

| | Unlicensed Staff | LPN | RN | NP | CRNA | CNS |
|---|---|---|---|---|---|---|
| **Urban Highest** | $ 10.56 | $ 15.39 | $ 22.87 | ---- | --- | --- |
| **Urban Lowest** | $ 10.40 | $ 13.96 | $ 22.66 | _ _ _ | _ _ _ | _ _ _ |
| **Rural Highest** | $ 12.00 | $ 17.00 | $ 22.60 | $ 45.00 | $ 63.00 | --- |
| **Rural Lowest** | $ 8.00 | $ 12.58 | $ 19.50 | $ 29.16 | $ 45.00 | _ _ _ |

Note: When responses were limited to one or not reported, the corresponding cells do not have a wage figure.

*Biggest Workforce Issue:*

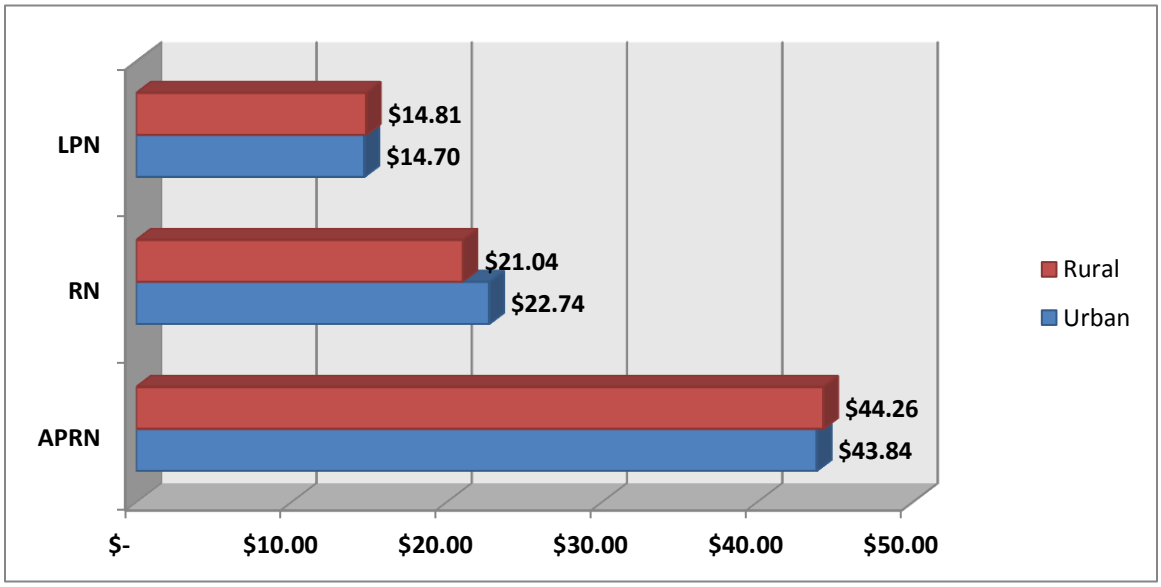
*Getting workers to locate to Western ND*

*Biggest Workforce Issue:*

*Finding employees that are planning for long term employment*

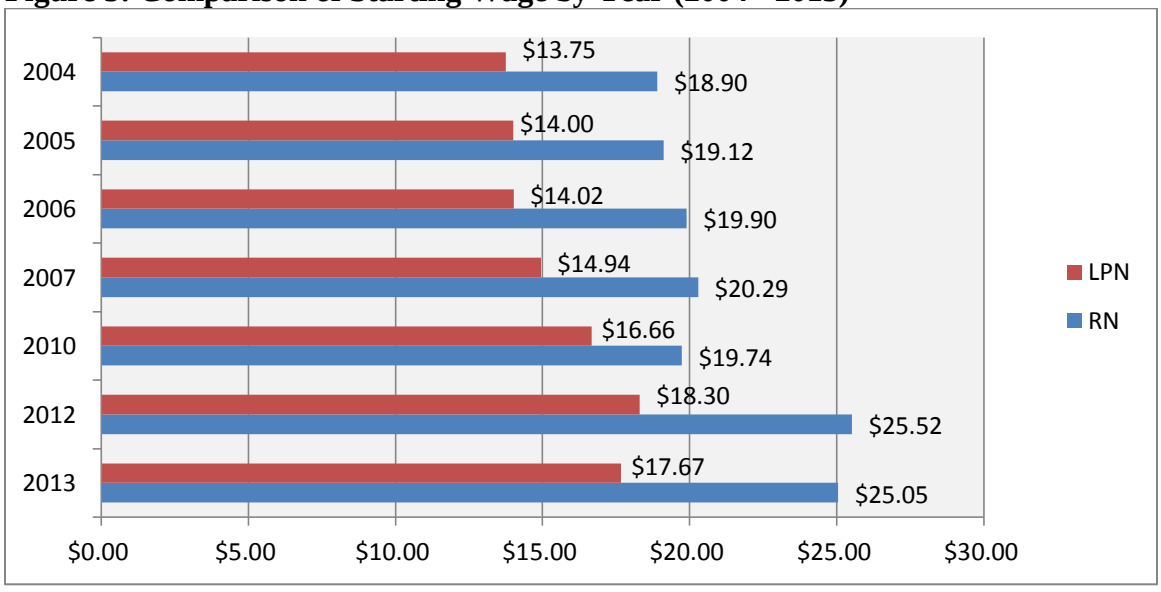
LPNs and APRNs in rural hospitals have a higher starting wage than their urban counterparts (see Figure 4).

**Figure 4: Starting Hourly Wage by Rural/Urban identification**




Across the last nine years, starting wages have increased for LPNs and RNs (see Figure 5).

**Figure 5: Comparison of Starting Wage by Year (2004 - 2013)**



### Average Wage

Average wages reflects the average hourly wage paid for all nurses. Rural unlicensed staff and NPs have a higher average wage when compared to their counterparts in the urban setting (see Table 3).

**Table 3: Average Hourly Wage for Each Nurse Category**

| | Unlicensed Staff | LPN | RN | NP | CRNA | CNS |
|---|---|---|---|---|---|---|
| **Rural** | $ 12.14 (16) | $ 17.67 (15) | $ 24.73 (15) | $ 43.51 (3) | $ 70.00 (2) | --- |
| **Urban** | $ 11.92 (2) | $ 17.67 (3) | $ 26.78 (3) | $ 43.26 (1) | $ 70.69 (1) | $ 35.50 (1) |

Note. The number of facilities that responded is included in parenthesis.

There is a large amount of variation between urban and rural in specific nurse categories. Variation in average wage could be the result of retention or having long term employment (long term employees at top of wage scale) as well as recruitment (see Table 4).

**Table 4: Highest and Lowest Wage**

| | Unlicensed Staff | LPN | RN | NP | CRNA | CNS |
|---|---|---|---|---|---|---|
| **Urban Highest** | $ 12.58 | $ 19.03 | $ 27.85 | $ 43.26 | $ 79.69 | $ 35.50 |
| **Urban Lowest** | $ 11.58 | $ 16.50 | $ 26.00 | _ _ _ | _ _ _ | _ _ _ |
| **Rural Highest** | $ 15.00 | $ 20.75 | $ 27.50 | $ 45.00 | $ 95.00 | _ _ _ |
| **Rural Lowest** | $ 9.05 | $ 15.05 | $ 21.96 | $ 41.02 | $ 45.00 | _ _ _ |

*Biggest Workforce Issue:*

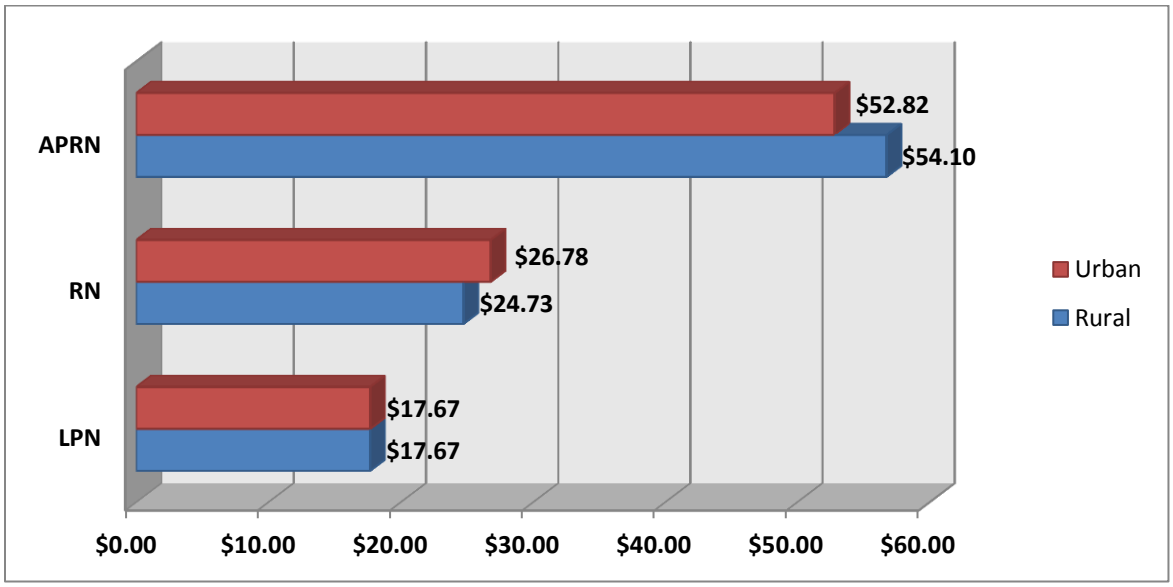
*Getting a group of people to work together to be very efficient*

*Biggest Workforce Issue:*

*Meeting needs of underserved populations*

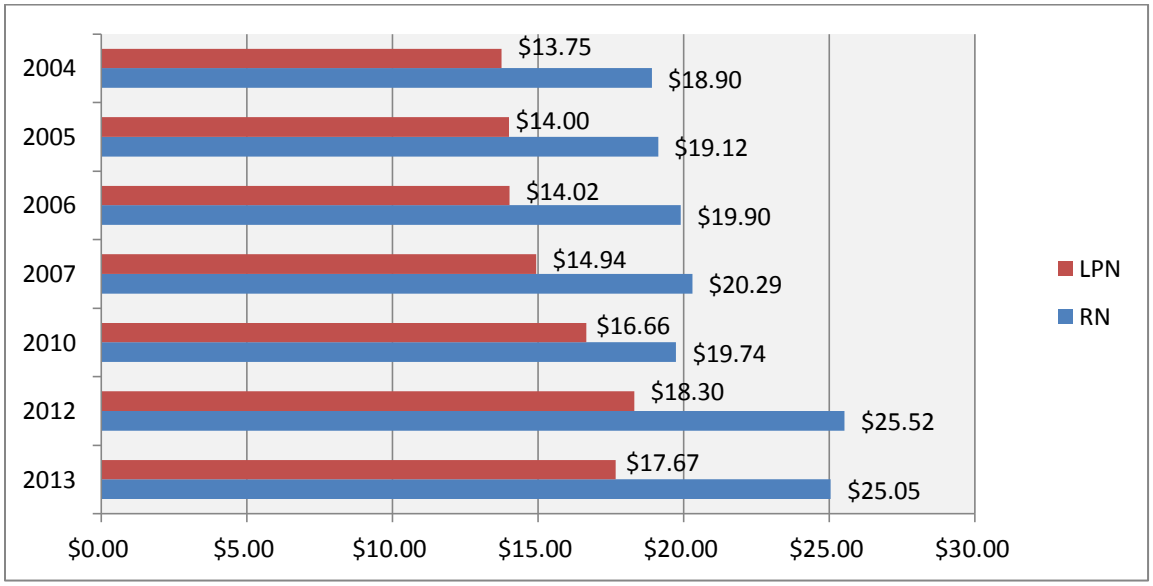
Rural APRNs have a greater average wage as compared to their counterparts (see Figure 6).

**Figure 6: Average Hourly Wage by Rural/Urban identification**




When comparing the average wage over the course of nine years, the compensation for nurses has steadily risen (see Figure 7).

**Figure 7: Comparison of Average Wage by Year (2004 - 2013)**



## STAFFING ISSUES

### Vacancy Rates

Vacancy rates for each facility type, and each nurse category, are defined as the average number of vacant FTE (full-time equivalent) positions divided by the total vacant FTEs + total filled FTEs X 100 (Reinier, Palumbo, McIntosh, Rambur, Kolodinsky, Hurowitz and Ashikaga 2005). According to economists, a full workforce in most industries exists when vacancy rates do not exceed five to six percent (Prescott, 2000). A shortage is considered to be present at a sustained vacancy rate above this level.

The highest vacancy rates were for APRNs especially in rural hospitals. (See Table 5) Referring back to Table 1, Nurse Practitioners started at a higher wage in rural settings compared to urban settings.

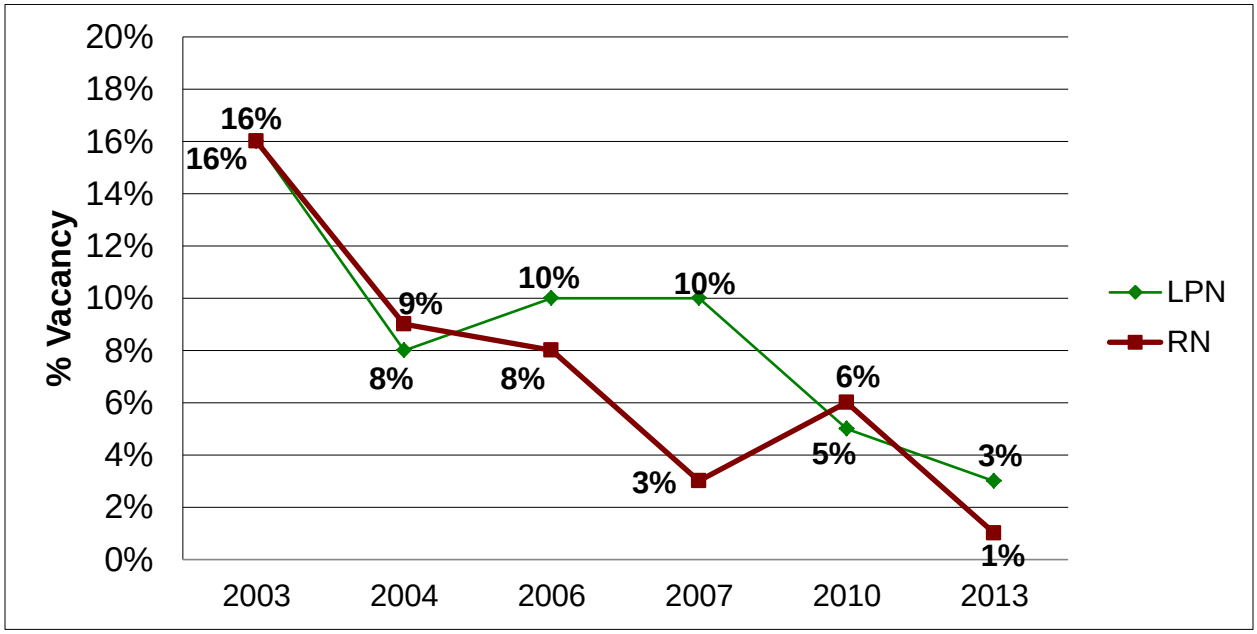
**Table 5: Vacancy Rate by Facility Type**

| | Unlicensed Staff | LPN | RN | APRN |
|---|---|---|---|---|
| **Rural** | <1% (9) | 3% (5) | 1% (11) | 11% (7) |
| **Urban** | 5% (2) | 3% (2) | 2% (3) | 2% (4) |

Note. Parenthesis indicates the frequency of complete survey responses included in calculation of vacancy rates.

The statewide vacancy rate for both LPNs and RNs has continued to decline (see Figure 8). Nationally, RN and LPN vacancy rates in hospitals are about 3 percent (AHA, 2002**).**

**Figure 8: Statewide Vacancy Rates by Year (2003-2013)**



**Turnover Rates**

Turnover rates indicate the stability of the workforce for a particular position. Turnover is defined as the number of individuals leaving in a particular time period divided by the total number of individuals during that period, expressed as a percentage. (Reinier, et al., 2005)

The national hospital average turnover rate is 15.0%. Bedside RN turnover trends slightly below hospital turnover. The national average turnover rate for bedside RNs is 14.2%. (2009 National Healthcare & RN Retention Report).

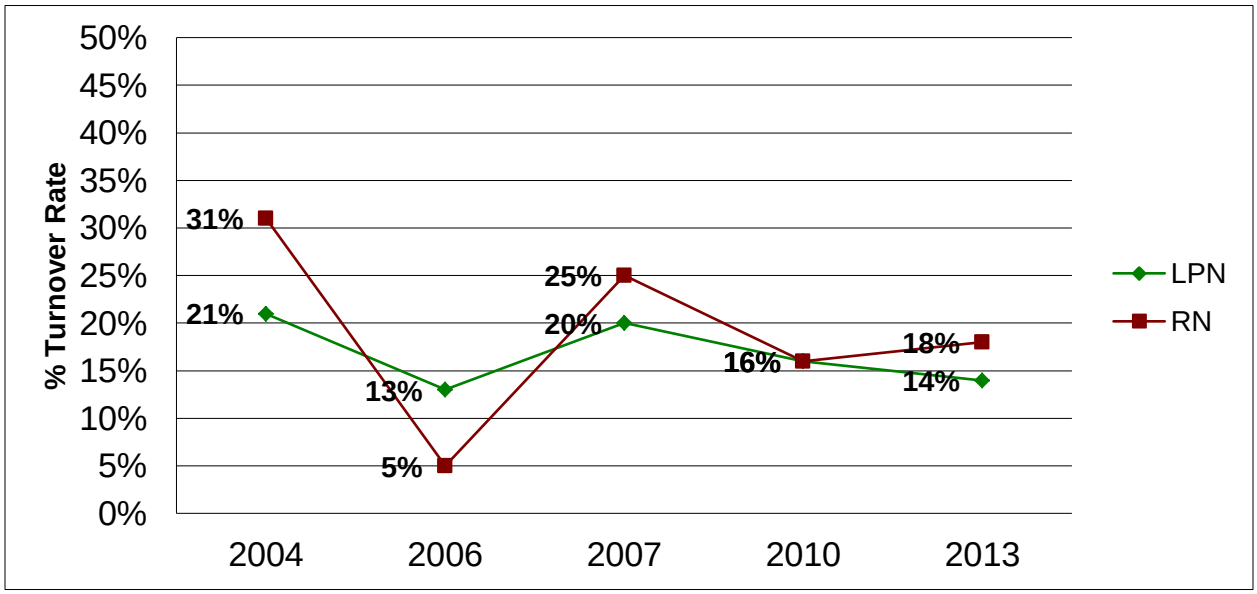
The statewide turnover rate is VERY high for urban unlicensed staff. Rural nurse turnover rates are higher than urban rates (see Table 6).

**Table 6: Turnover Rate by Rurality**

| | Unlicensed Staff | LPN | RN | APRN |
|---|---|---|---|---|
| **Rural** | 14% | 16% | 19% | 18% |
| **Urban** | 63% | 11% | 16% | 3% |

The statewide turnover rate for RNs in 2013 is 18%, which is slightly up from the last survey result. LPN turnover is slightly lower. This is something to watch since wages had increased significantly between 2010 and 2013 on average (see Figure 9).

**Figure 9: Statewide Turnover Rates by Year (2003-2013)**




**UTILIZATION OF ADVANCED PRACTICE NURSES IN NORTH DAKOTA**

The Center for Nursing is in the process of gathering information related to utilization of Advanced Practice Nurses in North Dakota to inform the development of a policy brief. Five specific questions were asked as part of the 2013 Hospital Survey (see Table 7). Nurse Practitioners were most likely to be a recognized voting member of the medical staff, bill under their own NPI number and to have admitting privileges. Other Certified RNs were most likely to be billed incident to a physician NPI number.

**Table 7: Utilization of Advanced Practice Nurses in North Dakota**

| | CRNA | Nurse Practitioner | Midwife | Other Certified RN |
|---|---|---|---|---|
| **Always bill under APRN NPI Number** | 20% | 60% | | 20% |
| **Always bill incident to a physician NPI Number** | 25% | 25% | 8% | 42% |
| **Are recognized as a voting member on the medical staff** | 13% | 75% | 12% | -- |
| **Hospital bylaws allow APRNs admitting privileges** | -- | 90% | 10% | -- |

Note: Those cells without figures had no response.

# Workplace Environment

The North Dakota Center for Nursing is interested in examining the workplace environment, including the participation in identified programs such as the ANCC Magnet Hospital Program and a similar program available to smaller rural hospitals called Pathways to Excellence. Survey questions also enquired about the Critical Access Hospital DON mentorship program and about the interest in a CNO residency program. The ND Center for Nursing plan to utilize this information to design targeted programs over the next couple of years as a part of workplace planning efforts.

### ANCC Magnet Status

Magnet status is an award given by the American Nurses' Credentialing Center (ANCC), an affiliate of the American Nurses Association, to hospitals that satisfy a set of criteria designed to measure the strength and quality of their nursing. A Magnet hospital is stated to be one where nursing delivers excellent patient outcomes, where nurses have a high level of job satisfaction, and where there is a low staff nurse turnover rate and appropriate grievance resolution. Magnet status is also said to indicate nursing involvement in data collection and decision-making in patient care delivery. Magnet hospitals are expected to have open communication between nurses and other members of the health care team, and an appropriate personnel mix to attain the best patient outcomes and staff work environment. Sanford Bismarck is currently the only hospital with ANCC Magnet Status in North Dakota.

Hospitals were asked about their interest in the ANCC Magnet program. Most hospitals are not thinking or planning to apply for Magnet Status (see Figure 10). Hospitals also provided comments including that the requirements are not practical for rural Critical Access Hospitals (see Table 8).

**Figure 10: Hospital Status for the ANCC Magnet Program**

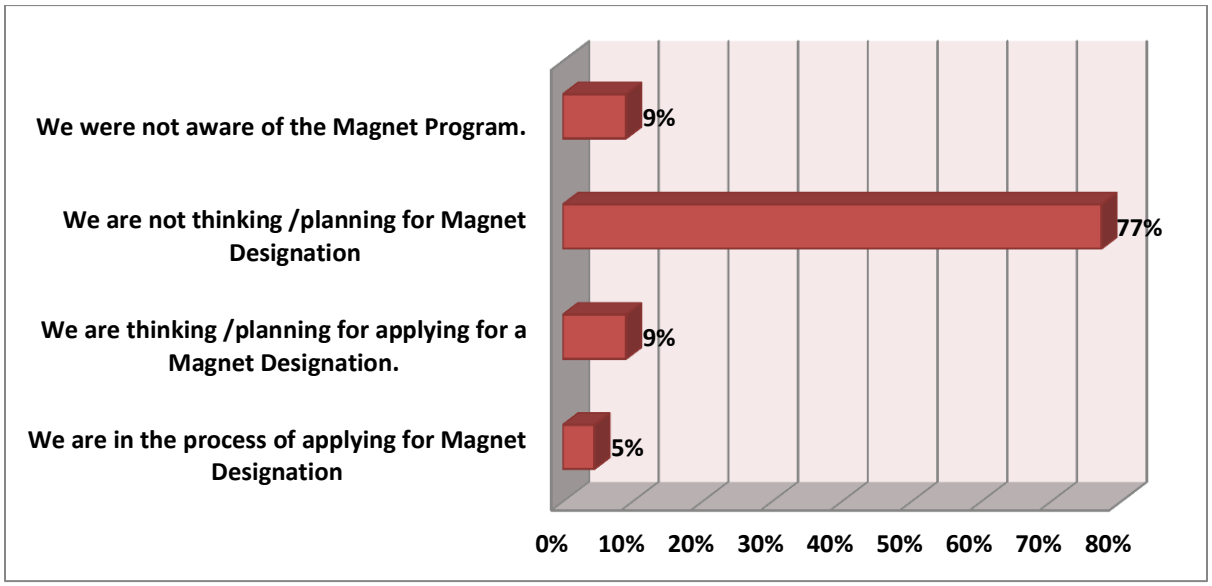



**Table 8: Comments about the Magnet Recognition Program**

| | |
|---|---|
| **1.** | We are initiating components but not interested in magnet. |
| **2.** | We are not thinking of becoming a magnet hospital. |
| **3.** | We are currently involved in the Studer Program to help us with our path to excellence. That is the basis for many of the answers I gave. We are currently working on many processes/initiatives and I don't know that we are ready for or would want to take on Magnet Designation at this time. |
| **4.** | We are not thinking/planning for Magnet Designation. |
| **5.** | Very time consuming for leaders. In rural areas we wear multiple hats so it's difficult to implement. |
| **6.** | The new standards were released this past week. Sneak peak only which we will use to apply. We have been working toward this the past 2 years. |
| **7.** | Not practical for CAH. |

## ANCC PATHWAYS TO EXCELLENCE

"The Pathway to Excellence program recognizes the essential elements of an ideal nursing practice environment," said Ellen Swartwout, RN, MSN, NEA-BC, director of Pathway to Excellence for ANCC, "The focus is on the workplace, balanced lifestyle, whether there is a collaborative atmosphere, positive nurse job satisfaction and retention, and that nurses feel their contributions are valued." The Pathways program originated from the Texas Nurse Friendly Hospital program which was designed as an alternative to the Magnet program for rural hospitals. Nationally, some hospitals participate in both Magnet Program and Pathways to Excellence Program.

Based on the survey results, 29% of the respondents were thinking /planning for participation in the ANCC Pathway to Excellence Program. However, a large number (41%) were unaware of the program existence. Comments included that this would be an excellent process for rural areas (see Table 9).

**Figure 11: Hospital Status for the ANCC Pathway to Excellence Program**

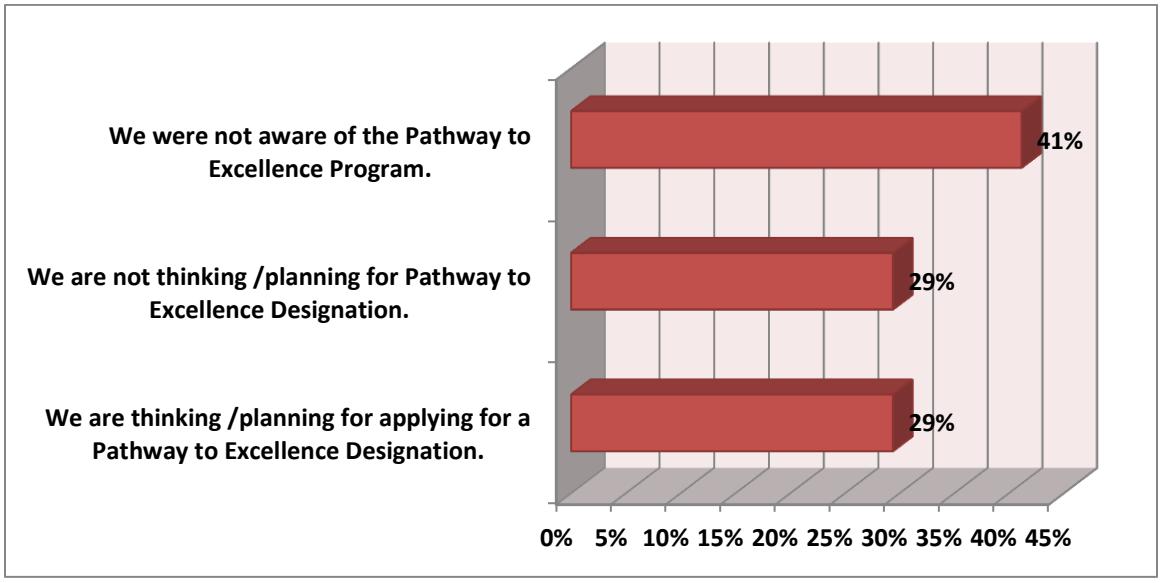



**Table 9: Comments about the Pathway to Excellence Program**

| | |
|---|---|
| 1. | We are not thinking/planning for Pathway to Excellence designation. |
| 2. | As I mentioned earlier – we are in the Studer program as our Destination to Excellence and would probably not want to take on another excellence initiative right now. |
| 3. | We were not aware of the Pathway to Excellence Program. |
| 4. | We like this for rural areas. |
| 5. | We are very interested in this process. |

The 2013 Hospital Survey asked a series of questions for nursing leadership to consider regarding the role of nursing in their facilities. These questions were derived from the Pathways to Excellence Program pre-assessment survey and were slightly modified. The survey question results are in percentages of those answering yes to the specific question by rural and urban hospitals (see Table 10).

One hundred percent of urban hospitals indicated that they currently meet 35 of the 42 criteria indicating that as a group, these hospitals already have needed policies in place to apply for the Pathways to Excellence program. The criteria that the fewest urban hospitals had implemented included #4 a policy indicating that overtime in not mandatory except in the event of a disaster (25%) and #28 is there is evidence of of recognition awarded by an external entity to the organization (50%).

In contrast, 100% of rural hospitals met 7 of the 42 criteria. The criteria that the fewest hospitals had implemented included #2 a shared governance structure that includes LPNs (38.9%), #4 a policy indicating that overtime in not mandatory except in the event of a disaster (21.1%), #14 preceptors individualize the orientation of a nurse using actual needs assessment data and adjustment of staffing (36.8%), #16 a process to prepare preceptors for their role (21.1%), a mentoring program in place that helps nurses at all levels develop professionally (22.2%), #26 evidence of monetary or nonmonetary retention incentives received by direct care nurses (31.6%), #27 nurse recognition for achieving quality outcomes or benchmarks (36.8%) and #28 recognition awarded by an extenral entity to the organization (31.6%).

**Table 10: Pathways to Excellence Program Assessment Questions**

| | | Rural | Urban |
|---|---|---|---|
| 1 | Are staff nurses involved in decision-making and all phases of projects that affect nursing including quality processes? | 100.0% | 100.0% |
| 2 | Is there evidence that a shared governance structure is in place that demonstrates shared decision-making including shared governance, nursing councils or nursing representation at facility meetings for LPNs? | 38.9% | 75.0% |
| 3 | Is there evidence that a shared governance structure is in place that demonstrates shared decision-making including shared governance nursing councils or nursing representation at facility meetings for RNs? | 52.6% | 75.0% |
| 4 | Is there a policy indicating that overtime is not mandatory for nursing staff except in the event of a disaster? | 21.1% | 25.0% |
| 5 | Do nurses use new knowledge and evidence-based findings to develop and implement initiatives that improve nursing practice? | 94.7% | 100.0% |
| 6 | Is there substantive input by direct care nurses into daily and long- range staffing decisions including the hiring of new nursing staff? | 57.9% | 100.0% |
| 7 | Are protective security measures in place for patients and staff? | 94.7% | 100.0% |

| | | | |
|---|---|---|---|
| **8** | Are prevention measures in place to decrease injury illness and accidents? | 94.7% | 100.0% |
| **9** | Are nurses engaged in the decision–making process regarding safety strategies and product evaluation? | 100.0% | 100.0% |
| **10** | Are employee support structures in place for reporting and addressing safety related event at work? | 100.0% | 100.0% |
| **11** | Are there systems in place that ensures nurses can report without negative consequences and concerns they may have about patient care and professional practice? | 94.7% | 100.0% |
| **12** | Are there educational offerings provided to nurses about how to address patient care and professional practice concerns excluding orientation? | 84.2% | 100.0% |
| **13** | Does the organization monitor patient care and professional practice concerns for trends? | 78.9% | 100.0% |
| **14** | Is there evidence of how preceptors individualize the orientation of a nurse using actual needs assessment data and is staffing adjusted to accommodate these needs? | 36.8% | 100.0% |
| **15** | Are nurses evaluated and given feedback throughout the orientation process? | 84.2% | 100.0% |
| **16** | Is there a process that prepares preceptors for their role? | 21.1% | 75.0% |
| **17** | If nurses are assigned to an area other than their primary area is there a process that identifies how nurses are deemed competent to work in variable practice settings? | 68.8% | 100.0% |
| **18** | Does the CNO have a bachelor's degree or higher in *nursing* (i.e. BSN, MSN, DNSc)? | 63.2% | 100.0% |
| **19** | Is the CNO visible and accessible to nurses at all levels? | 100.0% | 100.0% |
| **20** | Is the CNO an effective advocate for direct care nurses and their patients? | 100.0% | 100.0% |
| **21** | Is there an established performance evaluation process in place for the CNO that is based on predetermined outcomes measures? | 61.1% | 100.0% |
| **22** | Is there evidence of a comprehensive staff development program in place that nurses use to enhance their knowledge, skills and provides advancement opportunities? | 63.2% | 100.0% |
| **23** | Does the direct care nurse have input into the selection of educational offerings provided? | 63.2% | 100.0% |
| **24** | Is there a mentoring program in place that helps nurses at all levels develop professionally? | 22.2% | 100.0% |
| **25** | Does the organization evaluate compensation packages in the marketplace to ensure nurses are compensated fairly, equitably and competitively? | 84.2% | 100.0% |
| **26** | Is there evidence of monetary or nonmonetary retention incentives received by direct care nurses? | 31.6% | 100.0% |
| **27** | Is there evidence of how nurses are recognized for achieving quality outcomes or benchmarks? | 36.8% | 75.0% |

| | | | |
|---|---|---|---|
| **28** | Is there evidence of recognition awarded by an external entity to the organization in which nursing was highlighted by the external entity? | 31.6% | 50.0% |
| **29** | Are flexible staffing options provided for direct care nurses? | 89.5% | 100.0% |
| **30** | Is there evidence of how the input of direct care nurses impact routine schedules? | 68.4% | 100.0% |
| **31** | Are there programs and policies in place that reflect a commitment to a balanced lifestyle for employees? | 57.9% | 100.0% |
| **32** | Does the organization promote and encourage self-care for nurses on the job? | 68.4% | 75.0% |
| **33** | Are there education sessions that address how to facilitate communication or collaboration among employees? | 52.6% | 100.0% |
| **34** | Are there non-retaliatory protections established for reporting and addressing disrespectful conduct abuse or violent? Are established procedures utilized to constructively manage interdisciplinary conflict? | 78.9% | 100.0% |
| **35** | Is there evidence that employees know how to access the non-retaliatory system in place for reporting disrespectful conduct? | 77.8% | 100.0% |
| **36** | Is there a performance evaluation process in place for the nurse manager that is based on annual predetermined goals? | 61.1% | 100.0% |
| **37** | Is the nurse manager an effective advocate for direct care nurses and their patients? | 100.0% | 100.0% |
| **38** | Are nurse managers visible and accessible to the direct care nurses and other nursing staff? | 100.0% | 100.0% |
| **39** | Is there evidence the organization implements quality initiatives based on internal or external benchmarks? | 94.7% | 100.0% |
| **40** | Are direct care nurses provided multiple opportunities for participating in and learning about quality initiatives? | 78.9% | 100.0% |
| **41** | Is there evidence that nurse representation on an interdisciplinary quality team influenced a quality initiative? | 57.9% | 100.0% |
| **42** | Are research findings or evidence based practices systematically evaluated and implemented to improve patient care? | 68.4% | 100.0% |

*Biggest Workforce Issue:*

*Recruiting, training and retaining qualified and talented employees*

## North Dakota Critical Access Hospital Quality Network Director of Nursing Mentorship Program

Hospitals were queried regarding their awareness of the Critical Access Hospital Quality Network DON mentorship program. Only 11 rural hospitals responded to this question. Many of the hospitals were unaware of this program (see Figure 12). Rural hospitals also provided comments (see Table 11).

**Figure 12: Rural Hospital Awareness of the ND Critical Access Hospital (CAH Quality Network DON Mentorship Program**

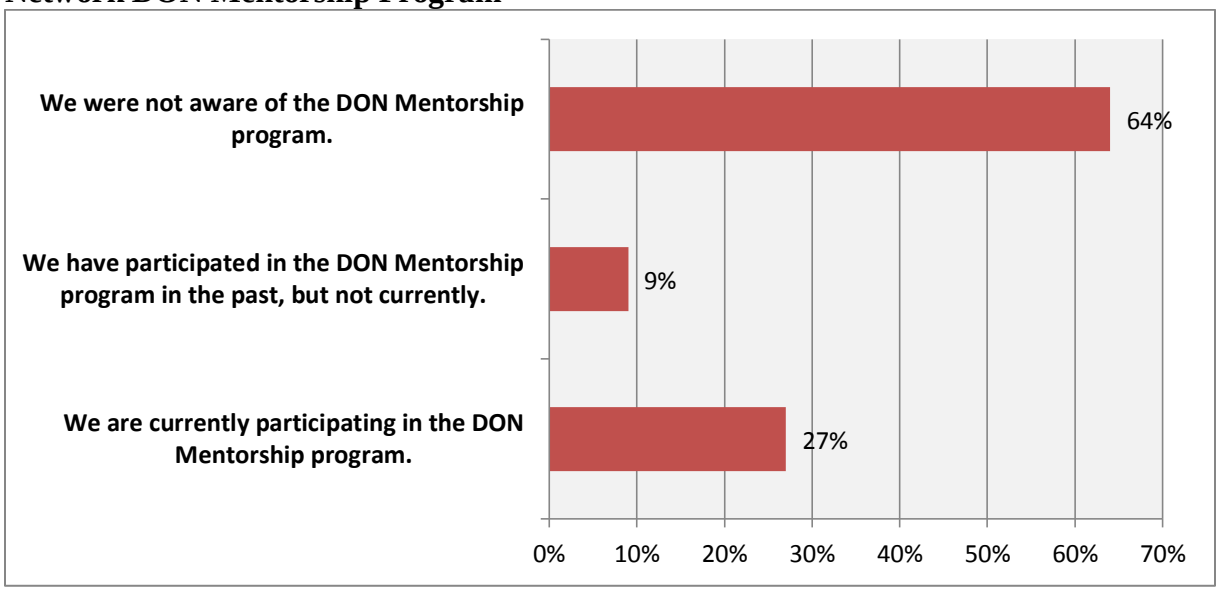



**Table 11: Comments about the CAH DON Mentorship Program**

| | |
|---|---|
| 1 | Aware of, have not used. Could be beneficial. |
| 2 | We are currently involved with the DON mentorship program. |
| 3 | We are aware and have signed on with the CAH Quality DON Mentorship program – however, we have not been active in it. |
| 4 | We were not aware of the DON Mentorship program. |
| 5 | None of above. We are aware, but no time to participate. |
| 6 | We are not a CAH. |
| 7 | We are managed by Sanford Health and our DON and ADON attend leadership meetings at Sanford with other CAH CON on the Sanford Network. This has been very helpful Also, we have Sanford Nurses who are available to us whenever we have questions or need help with info/policies & etc. |
| 8 | The CAH Quality Network has made great strides in support of nursing leadership in the state. |
| 9 | We are aware of it. We have not used it this far. |

**Chief Nurse Executive Skill Set and Interest in CNO Residency Program**

Hospitals were asked several open ended questions regarding the skills needed for CNOs and whether they were interested in a CNO residency program. The concept for this program originated from the North Dakota Action Coalition, although this group has moved to another leadership development framework.

Hospitals identified the need for multiple skill sets to function successfully as a CNO. The most frequent response was communication skills (see Table 12).

**Table 12: What skill sets are needed to function successfully as a CNO?**

| | |
|---|---|
| **1** | Multi-tasked, Goal Oriented, Knowledgeable in managing employees. Ability to see the whole picture, creative in finding solutions to problems. |
| **2** | Thick skin! Good Understanding of conditions of participation/rules/regulation. |
| **3** | Flexibility, working side by side, listening managing multiple projects. |
| **4** | Knowledge of the day to day workings of the unit he/she manages, Knowledge of the state and federal regulations, Problem solving abilities, Delegation, People skills, Knowledge of Quality measures and ability to determine action plans to improve, Organizational skills, Professionalism, Patience, Listening skills. |
| **5** | An extensive nursing background and positive effective leadership skills. |
| **6** | Communication, conflict management, finance, emotional intelligence. |
| **7** | Communication Skills. |
| **8** | Communication, facilitation, evidenced based practice implementation. |
| **9** | The skills sets required would include an in depth understanding of the clinical area and an understanding of what to expect in particular situations. |
| **10** | People skills are critical. That is something that can't be learned. Also, it is difficult to find that combination in conjunction with knowledge of regulations and wanting the responsibility of this position. Very high turnover rate. |
| **11** | Communication. |
| **12** | Patience, Good Listening skills, Precise in public & private reprimand. |
| **13** | Evaluating and ensuring staff competency with the ability to provide education regarding deficits, Quickly evaluating staffing needs for various populations and ensuring adequate staffing while being fiscally responsible, Oversee department budget to ensure needs are met while meeting financial goals, Ability to work with other department managers to coordinate treatment, Strong knowledge of JC and CMS requirements and ability to evaluate, Knowledge of evidence-based practices to ensure policy is reflecting best practice, Communication skills to ensure that staffs are familiar with changes, plans, and policies, Time management to effectively prioritize responsibilities, Promote growth and professional development of subordinate staff, Team-building to effectively utilize staff, Ability to manage patient grievances and strive toward satisfaction. |

| | |
|---|---|
| 14 | Communication skills, data analysis, organizational development, leadership of individual groups, marketing and public relations for nurses, financial skills, strategic planning skills, project planning, human resources. |
| 15 | Good communication skills, Background positive for evidence based practice. |
| 16 | Knowledge of the day to day workings of the unit he/she manages, knowledge of the state and federal regulations, problem solving abilities, delegation, people skills, professionalism, patience, listening skills. |
| 17 | Leadership, organization, knowledge, flexibility, responsible, motivator, up to date with current practice and regulations. Good communication skills. |

When hospitals were asked about their interest in participating and supporting a CNO residency program, the results were mixed. Eleven hospitals indicated that they were not interested, unsure, did not have the time, had low turnover or limited resources. Seven hospitals indicated interest in the program (see Table 13).

**Table 13: Would your hospital participate and support a CNO Residency program?**

| | |
|---|---|
| 1 | Depends on what is all entailed in this program. We are a small hospital with limited resources. |
| 2 | Probably Not. |
| 3 | Unsure, already work as center of 5 hospitals. |
| 4 | Not Sure. |
| 5 | I am new in my position as Risk Manager and Quality Coordinator and am sharing many of the DON responsibilities with my Nurse Managers. It is a new system and we are working out the "kinks" right now. I feel my Nurse Managers would benefit from the CNO Residency Program as a participant but right now I don't think we are in the position to be the mentor/instructor. |
| 6 | No. |
| 7 | Yes. |
| 8 | No, unfortunately no time. |
| 9 | Not sure. |
| 10 | Yes. |
| 11 | No. |
| 12 | Yes. |
| 13 | Possibly. |
| 14 | No. |
| 15 | Unsure. |
| 16 | Absolutely. |
| 17 | Yes. |
| 18 | We have had limited turnover. |
| 19 | Yes, at least interested in how this would be set up and the follow through |
| 20 | Time commitment would need to be defined. |

## SURVEY CONCLUSIONS AND POLICY IMPLICATIONS

Hospital facilities indicated that they spent less time recruiting nurses than the previous years. According to economists, vacancy rates above five to six percent are indicative of a shortage. Vacancy rates decreased this year for RNs to 1% compared to 6% in 2010. LPN vacancy rates are also lower than 2010, 3% in 2013 compared to 5% in 2010. Reasons for the decrease in vacancy rates could be attributed to several factors;

- the state of the ND economy and the influx of nurses into our thriving state for employment
- the retention of nurses who may have planned retirement yet choose to remain working
- the change of entry into practice

Turnover rates, which are used to determine the amount of staffing fluctuation that is occurring in health care facilities, were at 16% for both hospital RNs and LPNs in 2010. The turnover rate increased slightly to 18% for RNs and decreased slightly to 14% for LPNs in hospitals. The highest turnover rate was for urban Unlicensed staff.

Salaries have continued to increase, with some rural nurses receiving higher wages than their urban counterparts. This could be a recruitment strategy to help bring nurses to hard-to-recruit areas. Although data indicate an increase in both starting and average wages of the both LPN and RN staff for hospitals, the turnover rate for RNs has still risen since 2010 according to the 2013 study results. Unfortunately, this is the same group that takes the longest to fill the vacancy (14 week average, or 3.5 months). Hospitals may want to examine their nursing compensation in conjunction with their vacancy rates.

Survey respondents utilizing Advanced Practice Nurses billed Nurse Practitioners 3 to 1 under their own (National Provider Identification) NPI number however CRNAs were billed split equally between the CRNA NPI number and that of the physician (3 to 3). Other certified RNs were more frequently billing under the physician than their own NPI. Future work is indicated in increasing utilization of all types of APRNs including as voting members and on bylaw committees.

There were vast differences in the workplace environment between rural and urban hospitals utilizing Pathways to Excellence assessment criteria. Few hospitals were aware of the Pathways to Excellence program and expressed a desire to learn more about the program.

## HOSPITAL SURVEY METHOD

This project was designed to assess nursing workforce demand and the characteristics of potential shortages in North Dakota hospitals. To better understand current nursing workforce a survey was sent to the Chief Nurse Executive/Director of Nursing and Human Resource Director of the hospitals in North Dakota.

This survey was developed to provide a comprehensive picture of the nature of nursing employment and potential shortages throughout the state and to enable comparisons to be drawn between hospital facilities, rural and urban areas in North Dakota and national data. Survey questions were derived from the National Nursing Workforce Minimum Dataset. Questions were modified to be appropriate for hospital surveys only. Additional questions were developed or obtained from ANCC (American Nurses Credentialing Center) to identify workplace environmental characteristics in North Dakota.

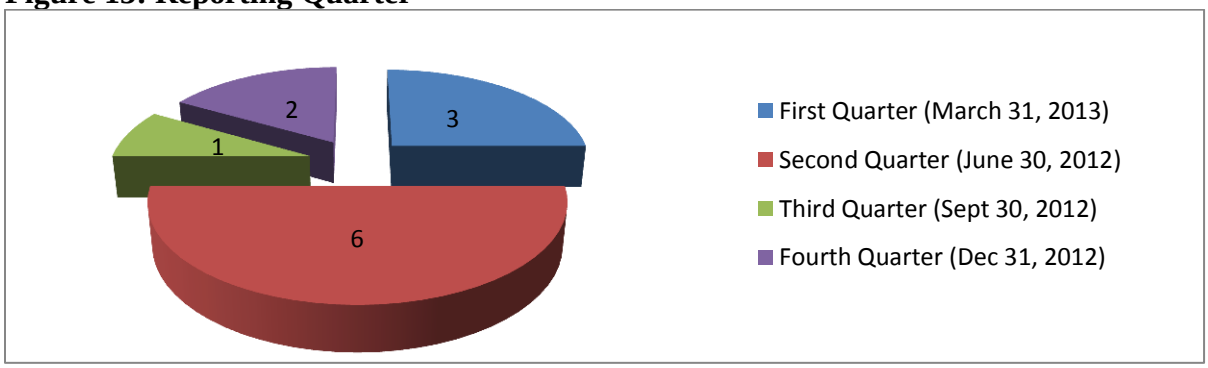
Mailing lists for all facilities were derived from the 2013 North Dakota Medical Services Directory. Following the Dillman method (2009), participants first a letter and the survey with a postage-paid envelope. The survey was accompanied by a cover letter outlining the purpose of the study. The surveys were sent in April/May and respondents were asked to return the survey within two weeks. Those participants that had not returned their survey within one month were sent another copy and given two weeks to respond. Finally copies were sent via email if necessary after personal follow up emails and phone calls.

The actual responses were given for each facility and for each level of nurses in the facility. These values were used to calculate the vacancy and turnover rates according to facility location.

- Total percentages were obtained by computing the average of all data points and rounding the results rather than by averaging percentages across the rural—urban continuum.
- If the response contained a range of numbers, the response was converted to a median number (example: the range 2-4 was reported as 3)
- The results utilize the 4 largest metropolitan communities for urban; Minot, Grand Forks, Bismarck and Fargo. All other communities in North Dakota fell into the rural definition.

Hospitals were asked which reporting quarter they were deriving their data from. The greatest number who responded to this question were reporting June 30, 2012 data (see Figure 13).

**Figure 13: Reporting Quarter**



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