Nursing Leadership in Rural Hospitals: A Competency Needs Assessment

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Abstract

Purpose: Assess competence and competency needs of nursing leadership in rural hospitals located in the Alabama Black Belt Region. Determine the preferred method of continuing education to meet those identified competency needs.

Sample: A purposeful sample of registered nurses currently working in leadership roles identified by the Chief Nursing Officer as nurse manager or nursing directors in a participating rural hospital within the Alabama Black Belt Region.

Method: A pilot study using descriptive statistical analysis to assess competency needs of nursing leadership and preferred method of educational delivery through email survey and Likert-style questions. For purposes of recruitment, Chief Nursing Officers were personally introduced to the purpose and design of the study and asked to distribute the email survey to their staff. Descriptive statistics analysis was used to examine role preparation and experience of nurse managers and mean self-rated competency scores. Bivariate correlations were examined exploring relationships between nurse manager experience, education, and competency.

Findings: Statistically significant at p=0.031, participants with <5 years of experience reported non-proficiency in their knowledge of quality improvement strategies and non-proficiency in their

ability to lead multi-generational work teams as compared to those with > 5 years of experience who reported proficiency, p=0.026.

Conclusions: In an environment where constant change and quality drive organizational success, nurse leaders with < 5 years of experience are not proficient in managing multi-generational work teams or in understanding or managing focused quality improvement strategies to monitor, analyze, and improve the quality of patient care processes to improve the healthcare outcomes in an organization.

Realizing that more than 50% of the current nursing leadership has < 5 years of experience, these findings would suggest that leading and managing, striving for clinical excellence in a diverse workforce would be difficult if not impossible to achieve.

Keywords: Rural Hospital, Competency, Leadership, Needs Assessment, Nurse Manager

Nursing Leadership in Rural Hospitals: A Competency Needs Assessment

Rural hospitals are the cornerstone of economic development in rural communities. They not only provide access to healthcare contributing to the wellness and quality of life for local residents, but they also support the overall strength of the community's economy. The value of a local hospital cannot be underestimated, yet 87% of Alabama rural hospitals are operating in the red, and many others are marginal with razor thin operating margins (Alabama Hospital Association, n.d.; Graves et al., 2021). Nursing leadership is strategically and uniquely positioned to have a significant impact on controlling the quality and cost of healthcare while meeting operational demands and thin margins.

In rural health care settings, the current nursing shortage is compounded by the maldistribution of incoming health care professionals, which disproportionately affect remote

communities as graduating nurses choose to work in urban areas (Johansen et al., 2018; Rural Health Information Hub [RHIhub], n.d.a). Rural communities are especially affected by the provider gap, as 63% of primary health shortages currently exist in rural communities (RHIhub, n.d.a.). In rural hospitals where providers are limited nurses play a significant role in the delivery of health care. They must be able to think critically to assist a diverse patient population representing all ages and all complaints. However, there are unique challenges to rural nursing, among them; professional isolation, lack of professional development and continuing education opportunities, that add additional burdens to the recruitment and retention of highly qualified nurses (Johansen et al., 2018; Jones et al., 2019; Smith et al., 2020; Spero et al., 2014).

The purpose of this pilot study was to assess the competency needs of nursing leadership in rural hospitals located in the Alabama Black Belt Region. A secondary aim was to understand the most effective means of delivering continuing education material designed to support them in their role as nurse leaders. Findings from this study will be used to guide future research projects on a broader scale aimed at identifying leadership competency needs and the most effective means of providing Continuing Education Units (CEUs) designed to meet them. Research findings from the broader study will inform the development and delivery of continue education and professional development opportunities designed to address identified nurse leader competency needs.

Background

The definition of urban and rural areas, according the Economic Research Service of the U.S. Department of Agriculture [USDA, ERS] (n.d.) are multi-dimensional concepts whose definitions are sometimes based on population size and at others, geographic location. Researchers and policymakers alike are required to choose the most appropriate definition for their work. The Federal Office of Rural Health Policy uses Rural-urban Commuting Area Code [RUCA]

methodology to determine rural eligibility for their programs. The RUCA methodology uses population data from the census bureau and geographic location, and commuting distance to determine rurality. The RHIhub has taken a similar stance using a combination of geographic distance and population size to define rural as open country and settlements with fewer than 2,500 residents (n.d.b.). For the purposes of this pilot study rural was defined based on population size, geographic location, and distance.

Rural hospitals serve remote and rural areas of the state where individuals living in these rural communities must travel long distances, upwards of 45 minutes one way, to gain access to health care. Rural communities typically center around farming and agriculture and rely on the local hospital as the cornerstone of economic support and development in the community. They are often the single largest employer in the community and the wages generated through employment and support services to the hospital underpin local economies (Alabama Hospital Association, n.d.; Graves et al., 2021; Health Resources and Service Administration [HRSA], n.d.). Rural hospitals not only provide access to health care contributing to the overall health and wellbeing of local residents, they also enrich community living and the quality of life for those living in rural areas.

Since 2013, thirteen Alabama hospitals have closed their doors; seven of which were rural. These closures have had significant economic ramifications and loss of access to health care for our rural residents (Alabama Hospital Association, n.d.; RHIhub, n.d.a) According to a recent study by the Chartis Group, a health care analytics research firm, twelve of Alabama's 45 rural hospitals are considered most vulnerable to closure while 50% overall are currently considered at high financial risk (RHIhub, n.d.a.). The value of a local hospital cannot be underestimated, yet

the financial outlook is dire without intervention (Alabama Hospital Association, n.d.; Graves et al. 2021; RHIhub, n.d.a., n.d.b.).

Rural hospitals and rural healthcare have unique challenges. According to the literature, Rural populations have a disproportionate share of the elderly, uninsured and patients with major health challenges (Alabama Hospital Association, n.d.; Graves et al., 2021; RHIhub, n.d.a). They are more likely to have higher morbidity and mortality rates than those of their urban counterparts. Healthcare in rural populations is often covered by programs such as Medicaid and Medicare and while the average Alabama hospital might have half of its patients covered by Medicare and Medicaid, the rate can be as high as 90% for rural hospitals (Alabama Hospital Association, n.d.). But to the rural resident, preventive care is not a priority, the state of their health is determined by their ability to work and function independently (Long et al., 1989). To compound the health disparities noted in the literature regarding rural populations the geographical distance and lack of internet connectivity create unique challenges for nurses and provider as well (RHIhub, n.d.b.).

Rural nurses play an integral role in providing healthcare for rural communities. In fact, it is estimated that at least half the healthcare providers in rural areas are registered nurses. They may be the first and only point of contact for rural healthcare consumers (Alabama Hospital Association, n.d.; RHIhub, n.d.b.). Many nurses who have chosen to live and practice in rural settings are life-long residents of the community returning to work in the community after graduation (Bushy & Leipert, 2005). Small communities have close ties where everyone knows everyone, and everyone's business. Trust and acceptance are built on longstanding relationships. Nurses who were born and raised in the community will have inroads into and understanding of the community that someone relocating or commuting to the area will not. *Outsiders* are not trusted

and have a difficult time inserting themselves into the community. It takes time to develop those relationships (Bushy & Leipert, 2005).

Rural nurses work in smaller healthcare facilities with limited resources and without the benefit of specialty services and specialists. They are expert generalist who must be able to think critically and assist patients of all ages, with all types of complaints in an unpredictable environment (Jones et al., 2019; RHIhub, n.d.b.; Smith et al., 2020). According to Pavloff et al. (2017), the unique practice environment of rural nurses and the expectations of the role necessitate a highly specialized generalist nurse who has expertise and integrated competencies in a comprehensive and broad fashion. Further, the literature states that the diversity and complexity of rural nursing dictates specialized education to support the on-going competencies of these nurses so that they are able to maintain the high level of care they provide (Jones et al., 2019; Paré et al., 2017; Pavloff et al., 2017; Smith et al., 2020). But in rural, oftentimes geographically remote areas, the resources for professional support are lacking.

Current literature has highlighted the need to support rural nurses by providing adequate professional development opportunities that address competency, competency development and safety for rural nurses. The mechanism for significant impact has not been identified and warrants further investigation.

Methodology

This was a pilot study that used descriptive statistical analysis to determine the efficacy of a larger scale study designed to assess the leadership competency needs and preferred method of continuing education to best meet those needs for nurse leaders in rural hospitals located in the Alabama Black Belt region.

Study Design

The Nurse Manager Competencies Self-Assessment Inventory Tool developed by the American Organization of Nurse Executives (AONE), American Association of Colleges of Nursing (AACN), and Association of periOperative Registered Nurses (AORN) to assess requisite skills and behaviors of the successful nurse leader were used to examine mean responses from nursing leadership in all three domains of success for nurse leaders: (a) managing the business, (b) leading the people, and (c) creating the leader within yourself (American Organization for Nursing Leadership [AONL], 2015). Two research questions were addressed in the pilot study:

Research Questions

- Using Benner's (1982) novice to expert continuum as a guide to define your perception of competence, how would you assess your leadership competencies as identified in the nurse manager competency self-assessment tool?
- As nurse leaders in a rural hospital, what is the most effective means of receiving continuing education material?

Procedure and Sampling

Purposeful sampling of nursing leadership in rural hospitals located in the Alabama Black Belt Region. With Institutional Review Board approval, the Chief Nursing Officer (CNO) of each hospital was contacted via telephone to schedule a face-to-face appointment. Given the exclusive culture of rural communities, the purpose of the meeting was to develop relationships and improve the likelihood of a positive response rate to the study. The principal investigator (PI) introduced the purpose and intent of the study, described plans to develop free continuing education resources based on the findings of the study, and then requested the CNO's support of the study by electronically distributing the anonymous survey to their nursing leadership team.

With their agreement to distribute the electronic survey the PI forwarded the recruitment email containing a brief description of the study and hyperlink to the informed consent and voluntary anonymous survey. Inclusion criteria for this pilot study included: 1) nurse leader with formal leadership role, 2) currently working in a rural hospital located in the Alabama Black Belt Region. A thank you note was emailed to the CNO within 24 hours of the initial meeting to acknowledge appreciation for their support.

Definitions

Nursing Leadership

All nurses can be considered leaders in their field with or without a formal title or leadership role. Formal titles may vary by specialization, education, or even healthcare system. Nursing leadership roles are determined by the span of control and sphere of accountability and responsibility within the organization. The CNO is typically identified as the nurse executive at the top of the organizational chart. The nurse responsible for all daily and long-term nursing operations. The Director of Nursing (DON) is just below the CNO on the organizational chart and is generally responsible for balancing staff leadership and broader organizational operations. They are typically responsible for a group of nursing departments. Nurse Managers considered front-line managers are just below the DON on the organizational chart and are generally responsible for the daily operations of a single nursing department within the organization. They coordinate staff training and hiring, design schedules, and manage the direct care of patients (Sullivan, 2017).

Small rural hospitals don't have the resources to support multiple layers of formal leadership positions on an organizational chart. Nurses promoted to formal leadership roles are expected to function at all levels of leadership and have comprehensive responsibilities that span the management of the entire organization. Typically, the nurse at the top of the organizational chart

is known as the DON rather than the CNO. For the purposes of this study, nurse leaders identified as having legitimate authority in formal leadership roles were given an opportunity to participate in the survey.

Alabama Black Belt Region

The term *Black Belt* refers to the region's exceptionally fertile rich, black topsoil that stretches from Texas across the southeast through Alabama and up to Virginia. At one time in Alabama history, the area was a thriving prominent and influential financial, political, and agricultural commercial powerhouse for the entire United States. Today, the region is poverty-stricken and economically underdeveloped with the poorest counties in the nation (University of Alabama Center for Economic Development, n.d.; University of West Alabama, n.d.). According to the University of Alabama Center for Economic Development (n.d.), this region is defined by its dire socioeconomic situation. The region was chosen for the pilot study due to the dire socioeconomic and demographic factors plaguing the region and lack of community resources to support rural hospitals in the area. See Figure 1.

Protection of Human Rights

This study received approval from the University of Alabama, Institutional Review Board for non-medical review. All participant rights for anonymity, privacy, and voluntary consent were observed.

Figure 1

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Instrument

Nurse leader competency was assessed using an instrument that was adapted from the American Organization of Nurse Leaders (AONL's) Nurse Manager Self-Assessment Inventory Tool. The electronic survey was developed and tested for research by Warshawsky and Cramer (2019). The tool was designed to assess essential nursing leadership competencies in three domains of competence as identified by the nurse manager domain framework:

- Science: Managing the Business,
- Art: Managing the People, and

- Leader Within: Creating the Leader in Yourself (AONL, 2015).

Benner's (1982) novice to expert competency development model was used to define the levels of competence on the survey. It contained seven demographic questions, twenty-eight competency-based items, and one open ended question to solicit preferences in continuing education formats.

Participants

The final sample contained responses from 22 nurse leaders from 8 participating rural hospitals in the Alabama Black Belt Region. From the estimated 65-70 formal nurse leaders in this region of the state, this was an estimated 31% response rate. Demographics of the sample group were 93.7% female and 6.3% male; 46.6% held an associate degree while 53.4% held a bachelor's degree. 50% of them indicated that they had been in their leadership role at least 5 years while the other 50% had not. It was interesting to note that not all respondents answered the demographic questions. See Table 1.

Table 1

Characteristics of nurses in leadership roles in rural Alabama hospitals.

Cohort Characteristics, N (%)	**Total* (N = 22)**
Gender	
Female	15 (93.7)
Male	1 (6.3)
Highest educational degree currently held	
Associate	7 (46.6)
Baccalaureate or higher	8 (53.4)
Title and scope of current management or leadership role	
Nurse Manager	12 (75.0)
Director of Nursing	3 (18.8)
Chief Nursing Officer	1 (6.2)
Years in formal leadership Role	
Less than 5 years	8 (50.0)
5 or more years	8 (50.0)
Minimal educational requirement for promotion to management or leadership	
Associate	8 (61.5)

Cohort Characteristics, N (%)	Total* (N = 22)
Baccalaureate or higher	5 (38.5)
Preference for Continuing Education Materials	
Resource Materials	3 (18.8)
Just-in-time video vignettes	4 (25.0)
Informational Brochures	3 (18.7)
Independent Study Mini Courses	4 (25.0)
Face-to-face seminars	2 (12.5)

Results

Fisher's Exact p-value is the preferred method of statistical analysis when working with nominal variables in a small sample size. Fisher's exact p-test for statistical significance is more accurate in small samples because it applies an exact procedure that considers all possibilities when calculating p-values (Kim, 2017).

Research Question One

Assess the competency needs of nursing leadership in rural hospitals. Despite the small sample size in this pilot study, two questions on the survey instrument had statistically significant findings measuring below the threshold of significance, identified as Fisher's Exact p-value, (p-values < .05) indicating that the responses to those questions were significantly associated with leadership experience. Participants who indicated that they had less than 5 years of experience as a nurse leader reported non-proficiency on question 10, Knowledge of quality improvement strategies such as Continuous Quality Improvement, Total Quality Management, Six Sigma, and Balanced Scorecards ($p = .031$); and non-proficiency on question 27, Able to lead multi-generational work teams ($p = .026$). See Table 2.

Table 2

Level of nursing practice proficiency by years of leadership experience

	Leadership Experience	Total (N=22)	Less than 5 years (n=8)	5 or more years (n=8)	**p-value
	Business-related Items*, N (%)				
1	Knowledge of health care economics and application to the delivery of patient care				0.6
	Not Proficient	9.0 (60.0)	5.0 (71.4)	4.0 (50.0)	
	Proficient/Expert	6.0 (40.0)	2.0 (28.6)	4.0 (50.0)	
2	Knowledge of the unit and departmental budgeting processes - both capital and operational				0.12
	Not Proficient	9.0 (60.0)	6.0 (85.7)	3.0 (37.5)	
	Proficient/Expert	6.0 (40.0)	1.0 (14.3)	5.0 (62.5)	
10	Knowledge of quality improvement strategies such Continuous Quality Improvement, Total Quality Management, Six Sigma, and Balanced Scorecards				**0.031**
	Not Proficient	9.0 (64.3)	6.0 (100.0)	3.0 (37.5)	
	Proficient/Expert	5.0 (35.7)	0.0 (0.0)	5.0 (62.5)	
19	Knowledge of basic business skills such as developing a business case and the project planning process				0.2
	Not Proficient	11.0 (78.6)	6.0 (100.0)	5.0 (62.5)	
	Proficient/Expert	3.0 (21.4)	0.0 (0.0)	3.0 (37.5)	
	People skills-related items* N (%)				
6	Knowledge of how to manage performance of employees. This includes performance appraisals, goal setting, motivation, and the disciplinary process				0.3
	Not Proficient	6.0 (42.9)	4.0 (66.7)	2.0 (25.0)	
	Proficient/Expert	8.0 (57.1)	2.0 (33.3)	6.0 (75.0)	
27	Able to lead multi-generational work teams				**0.026**
	Not Proficient	6.0 (42.9)	5.0 (83.3)	1.0 (12.5)	
	Proficient/Expert	8.0 (57.1)	1.0 (16.7)	7.0 (87.5)	
28	Demonstrates knowledge of evidence-based nursing practice needed to lead the clinical services				0.3

Leadership Experience	Total (N=22)	Less than 5 years (n=8)	5 or more years (n=8)	**p-value
Not Proficient	6.0 (42.9)	4.0 (66.7)	2.0 (25.0)	
Proficient/Expert	8.0 (57.1)	2.0 (33.3)	6.0 (75.0)	

*Denotes missing participant responses. **Fisher's Exact p-value, **p-values < .05 considered meaningful**.

Comparing educational preparation of nurse leaders, those with an associate degree versus bachelor's degree, no significant associations were found between educational degree held and business-related or people-skills related questions on the survey. All exceeded ($p \geq .05$) the acceptable threshold of significance as defined by Fisher's Exact p-value, (< .05) to be considered meaningful.

Research Question Two

What is the preferred method of addressing continuing education needs of nurse leaders in a rural organization. Just-in-time video vignettes 27.2% and independent study mini course (webinars) 36.37% were identified as the preferred method of education and continuing education. Face-to-face seminars were the least preferred method of continue education.

Limitations

Limitations of the study are the relatively small sample size as there are only nine rural hospitals located in the Alabama Black Belt Region with one hospital declining to participate leaving eight participating hospitals and approximately 70 potential study participants. The culture of rural communities, particularly with outsider engagement could negatively influence recruitment. To improve recruitment and participation, the PI contacted each of the CNOs via telephone to schedule an appointment. The face-to-face appointment gave the PI an opportunity to share common experiences as nurse leader/manger and rural residence and introduce the purpose of the study.

All participant responses were self-selected based on their personal perceptions of competence related to their nurse manager/leader role. Although this was a small sample size of self-reported competencies, this study does provide insights into nurse manager perceptions of competence related to quality and multi-generational, multi-cultural workforce management. It also highlights the relationship between years of experience and knowledge with perceived competence.

Discussion

This study provides evidence that knowledge of quality improvement strategies and their ability to lead multi-generational work teams; nurses are significantly associated with leadership experience. Nurse leaders with less than five years of experience reported non-proficiency in their knowledge of quality improvement strategies and non-proficiency in their ability to lead multi-generational work teams as compared to those nurse leaders with five or more years of experience who reported being proficient.

While a multigenerational workforce presents diverse challenges in understanding the nuances of communication style, motivation factors, conflict management, or even work expectations, the rewards of harnessing those diverse viewpoints has the potential to reap exponential reward for the organization when faced with challenges (Coulter & Faulkner, 2014). Five generations of nurses working side by side is not uncommon in today's healthcare workforce. Each generation brings its own perspective. Nurse leaders must be skillful at building trusting relationships with the members of their healthcare team. The ability to understand and connect with staff members at any level in their career helps the overall organization navigate constant change and maintain focus on the core values of patient-centered, high quality patient care and performance improvement. It is this sphere of influence that allows leaders to lead with followers

who respect and trust their leader able to exceed every expectation (Graystone, 2019; Sullivan, 2017).

The Centers for Medicare and Medicaid Services, reimbursement models, such as value-based purchasing and pay-for-performance are focused on quality improvement and nursing excellence and are driving the financial landscape of healthcare delivery today (Rome et al., 2016). As a result, the quality and safety of patient care, patient outcomes, and the patient experience along with the associated costs of providing that care are under intense scrutiny. Nursing leadership, particularly in rural hospitals are strategically and uniquely positioned to have a significant impact in controlling the cost of healthcare while ensuring the quality of patient care and meeting operational demands with thin margins. Their ability to maintain continuous quality improvement in an efficient cost-effective manner is the foundation of economic viability and success for the hospital itself (Muller & Karsten, 2012; Schuettner et al., 2015).

Rural hospitals provide medical services to residents in small rural communities who otherwise would not have access to healthcare. They are generally small in size with low patient volumes. The remoteness and size of the hospital can present significant financial challenges. They struggle to achieve economies of scale and don't have the patient volume or revenue from commercial payers in the payer mix to offset lower Medicare reimbursements (RHIhub, n.d.b.).

The success of rural hospitals with limited resources and tight margins depends on quality nursing leadership. Individuals whose knowledge and competence goes beyond the daily business of patient care extending into the relationship and impact of quality metrics, costs, and reimbursement (Rome et al., 2016; Schuettner et al., 2015) and the hospitals financial viability.

The findings from this study will help determine competency needs and support strategies to promote nursing leadership within rural hospitals and help them remain viable in the community.

Additionally, findings from this study will help guide future research projects aimed at developing and providing the support structures and CEUs most needed by rural nurse leaders. Rural hospitals need strong effective leadership to be successful and given the challenges of working in rural environments, opportunities for professional support and development are also a challenge.

Recommendations

Rural nursing theory applies to nurses who work in rural, sparsely populated areas and who face unique challenges not observed by their counterparts in urban areas. These nurses must possess an independent autonomous spirit and have a strong knowledge base to provide quality care to diverse patient populations. The shear nature of the rural environment creates obstacles and barriers to professional development. According to Pavloff et al. (2017) despite the challenges of rural nursing, these professionals must be able to maintain a level of the competency and autonomy to provide quality patient care.

The seminal work of Long and Weinert (1989) outlined the core tenants of the rural nursing theory:

1) rural residents define health in the context of their ability to work, be productive, self-sufficient, and their ability to do usual tasks;

2) rural residents are independent and resist help from others, especially, those seen as outsiders and when necessary, prefer to seek help from their family or neighbors, those seen as *insiders*;

3) rural healthcare providers cannot separate professional and personal roles and have greater role diversity in the clinical setting than their urban counterparts.

It is imperative to understand the culture of the target population and identify potential barriers to success. The resistance and lack of trust that rural residents have for outsiders was an

important concern to strategically address. The CNO of the hospital was identified as a key gatekeeper, someone influential with a prominent and recognized role within the local community (Hennink et al., 2011). The initial meeting with the CNO gave the researcher an opportunity to develop a rapport and establish interest in the project. Consider not only the expense, but the safety and time commitment required to travel and meet with individual CNO's in remote locations. It was also important to establish a measure of reciprocity. While the initial meeting served to introduce the study and build relationships, it was also a recruitment opportunity. In return for their support CNO's will receive an aggregate report of leadership competency needs and free leadership development CEUs. The ability to garner community acceptance was important to the success of the project (Kirchgessner & Keeling, 2014). Given the 31% response rate in this pilot study, the investment was worth the effort. Before leaving the CNO's office, exchange business cards for future contact information. Future studies are recommended to replicate the procedure.

The current survey tool did not have hard stops. Several questions in the survey were skipped by participants. It is worth considering the option of adding rules to critical questions to encourage participant answers to all questions on the survey.

The study also addressed a common evidence-based gap for nursing leadership training. The practice of promoting bedside nurses who excel in interpersonal skill or clinical excellence is common practice in hospitals and is no longer a feasible option in today's chaotic healthcare environment (Rome et al., 2016; Schuettner et al., 2015; Warshawsky and Cramer, 2019). Current nurse leaders recognize the importance of transitional support and training to be successful and embraced the opportunity for continuing education opportunities focused on leadership development.

Evidence from this pilot study suggests that hospitals struggling to meet quality metrics and maintain workforce morale and motivation may need to consider implementation of a comprehensive leadership orientation program for nurses who transition into management positions. With limited resources, networking with institutions of higher education to provide the needed education would be a viable option.

Conclusions

Rural hospitals are the cornerstone of economic development in rural communities. They not only provide access to healthcare contributing to the wellness and quality of life for local residents, but they also support the overall strength of the community's economy. The value of a local community hospital cannot be underestimated, yet 88% of Alabama rural hospitals are operating in the red, and many others are marginal with razor thin operating margins (Alabama Hospital Association, n.d.; Graves et al., 2021; RHIhub, n.d.a.). Nursing leadership is strategically and uniquely positioned to have a significant impact on ensuring the of quality patient care while also controlling the costs of care to meet operational demands with thin margins. Although the sample size was small, the findings from this pilot study were statistically significant supporting the need for a broader assessment of rural nursing leadership. Findings from these studies will inform the development of support strategies and continuing education opportunities designed to meet the identified leadership competency needs of nurse leaders in rural hospitals promoting strong nursing leadership.

In an environment where constant change and quality drive organizational success, nurse leaders with < 5 years of experience are not proficient in managing multi-generational work teams or in understanding or managing focused quality improvement strategies to monitor, analyze, and improve the quality of patient care processes to improve the healthcare outcomes in an

organization. Realizing that more than 50% of the current nursing leadership has < 5 years of experience these findings would suggest that leading and managing, striving for clinical excellence in a diverse workforce would be difficult if not impossible to achieve.

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