The Skills, Competencies, Expertise, and Embedded Knowledge of Nurse Managers, as Leaders, in Long-Term Care

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Abstract
Nurse Managers in long-term care supervise healthcare services for residents who have higher acuity levels and numerous health co-morbidities. There has been minimal research identifying the long-term care Nurse Manager’s skills and competencies and no research on a novice-to-expert scale. The purpose of this qualitative, phenomenological study was to define the Nurse Manager’s leadership skills, competencies, expertise, and embedded knowledge. Nineteen Nurse Managers, with a minimum of five years long-term care management experience, and their respective Directors of Nursing, completed the Nurse Manager Inventory Tool (NMIT) which was based on a 5-point Likert noviceto-expert scale. Interview questions were developed based on the survey results and the Nurse Managers were interviewed. The Nurse Managers rated their clinical skills at the proficient level. They rated their financial and strategic management skills at the novice and advanced beginner level respectively. All other categories, including leadership reflective practice, diversity, Human Resource leadership, relationship management, performance improvement, problem solving, information technology, and Human Resource management, were rated at a competent level. Themes that emerged included the Nurse Manager’s visibility on the unit, trial and error learning, aloneness, peer support, and their primary focus toward supporting the resident during their final journey. It is recommended that long-term care administration support Nurse Manager leadership development, educational advancement, and networking opportunities.

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The Skills, Competencies, Expertise, and Embedded Knowledge of Nurse Managers, as Leaders, in Long-Term Care

By

Kathleen Hodgson Dever

Submitted in partial fulfillment of the requirements for the degree Ed.D. in Executive Leadership

Supervised by

Dr. Michael Wischnowski, Chair

and

Dr. Karyl Mammano, Committee Member

Ralph C. Wilson, Jr. School of Education
St. John Fisher College

August 2010
Dedication

There are many individuals whom I must thank for providing support during this journey.

Viola and Charles Hodgson, I know that you have been with me every day providing my spiritual support to persevere. You instilled the importance of education, gave me the opportunity, and expected only the best. Thank you for your love and support, I only wish you were here to share in “my best.”

Patricia Saffian and Barbara Whitlow, who provided words of encouragement that only “Big Sisters” can do, you patiently waited for my e-mails and sporadic phone calls since I never seemed to have enough time. Thank you for listening when I just didn’t think I could continue. I treasured our “sister’s week-end” as a time to escape the intensity, “sisters were together in one family site, now renewing our friendships is a blessed delight” (Saffian, 2008, p. 51). I am pleased to say that I am now ready for renewed sister’s friendship time.

Janet Englert, Janette McGimsey, Judy and Rick Whelehan, you are my dearest friends who were always supportive even when I was frantically overloaded. You listened at the right times. Thank you for not forsaking me. I look forward to re-energizing our friendships.

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David, Carinne, Meghan, Daniel, and Connor, words can’t express how proud I am to be your mother; and Tyler, to be your grandmother. I love each of you with all that I have. Dave, your creativity and artistic talent helped me to envision things from a much wider perspective, to be open to the opportunities. Thank you. Meghan, your daily support and insights taught me “you can do this.” I really needed your words of encouragement. Thank you. Danny, you always seemed to call at the right times to provide words of support that were so helpful. Thank you. Connor, you simply told me to “do it,” thus helping me to believe it could be done. Thank you. Tyler, your life enthusiasm gave me moments of joy, providing a brief respite. Thank you. Carinne, I know you are with us every day. We miss you. All of you have been my sources of inspiration. You are with me in everything that I do. I hope that my achievement will encourage you to reach for the stars, no matter your age. Nothing is impossible if you really want it. We have moved through this journey together and you were so patient when I could not be. Thank you for being there for each other while I was absent and for being there for me as I needed it. I will treasure our family time and your love even more.
Biographical Sketch

Kathleen Hodgson Dever is currently an Assistant Professor at the Wegmans School of Nursing at St. John Fisher College. Ms. Dever attended Marquette University from 1967-1971 and graduated with a Bachelor of Science Nursing in 1971. She attended St. John Fisher College from 1989 – 1993 and graduated with a Master of Science Nursing Administration in 1993.

She came to St. John Fisher College in the summer of 2008 and began doctoral studies in the Ed.D. Program in Executive Leadership. Ms. Dever pursued her research in defining the skills, competencies, expertise, and embedded knowledge of nurse managers, as leaders, in long-term care under the direction of Dr. Michael Wischnowski and received the Ed.D. degree in 2010.
Abstract

Nurse Managers in long-term care supervise healthcare services for residents who have higher acuity levels and numerous health co-morbidities. There has been minimal research identifying the long-term care Nurse Manager’s skills and competencies and no research on a novice-to-expert scale. The purpose of this qualitative, phenomenological study was to define the Nurse Manager’s leadership skills, competencies, expertise, and embedded knowledge. Nineteen Nurse Managers, with a minimum of five years long-term care management experience, and their respective Directors of Nursing, completed the Nurse Manager Inventory Tool (NMIT) which was based on a 5-point Likert novice-to-expert scale. Interview questions were developed based on the survey results and the Nurse Managers were interviewed. The Nurse Managers rated their clinical skills at the proficient level. They rated their financial and strategic management skills at the novice and advanced beginner level respectively. All other categories, including leadership reflective practice, diversity, Human Resource leadership, relationship management, performance improvement, problem solving, information technology, and Human Resource management, were rated at a competent level. Themes that emerged included the Nurse Manager’s visibility on the unit, trial and error learning, aloneness, peer support, and their primary focus toward supporting the resident during their final journey. It is recommended that long-term care administration support Nurse Manager leadership development, educational advancement, and networking opportunities.
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Chapter 1: Introduction

Statement of the Problem

According to the U. S. Census Bureau (2000), the American population is aging at a rate faster than previously experienced, with data showing individuals over 85 years as the highest percentage increase of all age groups. This increase is projected to continue through 2030 (U.S. Census Bureau). Due to this increase in the number of elderly, there will be a corresponding increase in elderly healthcare frailty needs in this population. Elder frailty includes, “chronic diseases, acute episodes of disease, functional disability, and the need for support in daily life to meet basic human needs” (Young, 2003, p.2).

Long-term care facilities (commonly referred as nursing homes) provide elderly care and must respond to this increased level of health care need in sub-acute, rehabilitation, and dementia units in addition to the standard long-term care units.

The American Nurses Association stated in the “long-term care arena … nursing has a particular leadership role in working through others to promote optimal clinical outcomes, functional ability, and quality of life” (Young, 2003, p.9). This increased demand requires additional staff availability, training, recruitment and retention efforts, and a focus on cultural diversities and leadership competencies (Young, 2003). In long-term care, the Nurse Manager (NM) is a Registered Nurse (RN) who is responsible for the daily unit operations, including resident care and safety, resident and family satisfaction, operations, budgets, staffing schedules, staff and resident management, leadership and at times the provision of direct care. Due to the resident’s increased
needs, the NM’s role in long-term care is critical for the provision of competent aging services. Previous research primarily focused on the Director of Nurses (DONs), as the nurse leader in long-term care organizations, but there was minimal research that defined the Nurse Manager (NM) role as a leader.

According to Gonyea (2005), in the 1980’s, the terms “young old” and “oldest old” defined aging. Gonyea stated that researchers identified “the young old” (65 years to 74 years), “the middle old” (75 years to 84 years), and “the oldest old” (85 years and older) as the newest aging trend (p. 158). The significance of this aging trend was that as Americans age; they required more dependence on the health care system. Burbank, Dowling-Castronovo, Crowther, and Capezuti (2006) stated, “older adults represent the core business of health care, comprising 25% of ambulatory care visits, 48% of hospital patient days, and 85% nursing home residents” (p. 91). In 2006, there were 270.6 residents per 1000 general population over the age of 85 in U.S. nursing homes (Center Disease Control, 2007, p.371). In addition, the nursing home care that the “oldest-old” needed in advanced age was more complex due to higher levels of frailty, numerous health conditions and the need for highly specialized treatments (Harvath, Swafford, Smith, Miller, Volpin, Sexson, et al., 2008).

**Aging Population**

According to the U.S. Census Bureau (2000), there were 35.0 million individuals over the age of 65; 18.4 million were between the ages of 65 – 74 years (old), 12.4 million between ages 75 – 84 years (middle old) and 4.2 million over the age of 85 years (oldest old) (see Figure 1). In 2000, there were a little over 50,000 centenarians (over 100 years). It is projected that in 2020, there will be 135,000 centenarians and in 2050,
the number could surpass 600,000 (see Figure 2). As a reflection of the baby boomers entering the first stage of “old” age, it is projected that in 2030, approximately one in five U.S. residents will be 65 years or older. In 2050, this population will total 88.5 million, double the total for 2008. By 2050, the “oldest old” will triple to 19 million (2008).

*Figure 1.1. U.S. Census Bureau Projections: Aging in millions according to age, 1990-2050.*

*Figure 1.2. U.S. Census Bureau Population Projections: Number of Centenarians, 2000-2050.*
**RN Turnover**

Due to the increased frailty and higher acuity levels, residents in long-term care facilities required more intensive nursing support. Nurse staffing levels were not sufficient to provide the level of care, in turn, contributing to the high RN turnover. Turnover rates for Staff RN and Director of Nursing (DON) levels were significant at 50% (AHCA, 2002). Turnover, recruitment and retention issues were major impacts within long-term care facilities. Collier and Harrington stated, “Inadequate staffing levels and a workforce characterized by high turnover rates are crucial factors that influence the quality of resident care” (2008). With the increased number of “oldest-old” living in long-term care facilities, there was a concern that there will not be substantial nursing staff and trained NMs to support the care needs. Nurse Managers as leaders are essential to the patient care planning process, effective resident clinical care, health paraprofessional staff management, organizational support, and quality outcomes (Dellefield, 2008).

Nursing turnover, recruitment and retention issues will only further impact the provision of health care services for the aging population in the long-term care environment. The future of nursing is in jeopardy and this is most critical within long-term care since individuals who are living longer need increased nursing support. The status of the nursing shortage, the nursing recruitment and turnover issues, and the resulting impact upon the care provided in long-term care facilities will only exacerbate the health care issues facing the elderly. Nurse leadership is critical to the success of the services provided.

The recruitment of nursing staff further impacts long-term care staffing levels.
According to the American Health Care Association (AHCA) survey, greater than 60% of the long-term care facilities stated it was more difficult in 2002, than the previous year, to recruit RN’s (AHCA, 2002; Collier & Harrington, 2008; USGAO, 2001; Wilson, 2005). Nationally, turnover costs approximately $4.0 billion/year (Collier & Harrington). Turnover and retention issues created an environment, in which the NM must constantly re-train staff, revise schedules, and re-organize care to maintain work flow. Castle, Engberg and Men (2007) reviewed turnover statistics in relation to long-term quality measures from 2,840 nursing homes and determined that “high staff turnover is associated with worse quality (p. 659).” Since RN’s provided the primary leadership responsibility for the resident care in long-term care, the need for support of the NM was critical to the overall quality of care.

*Nursing Shortage*

The United States now faces a critical nursing shortage, and it is anticipated to reach between 340,000 and 1,000,000 RN full-time equivalents (FTEs) by 2020 (The Forum of State Nursing Workforce Centers, 2009). More than one million RNs will be needed between 2006 and 2016 to fill newly created RN positions as well as to fill vacant positions resulting from retirements and other departures from the profession (The Center for Health Workforce Studies, 2009). According to the United States General Accounting Office report (USGAO, 2001), the nursing shortage was a result of several recruitment and retention issues including (a) the aging of the nursing workforce, (b) work dissatisfaction, (c) the decrease in the number of replacement nurses, (d) lower nursing school enrollment figures at all educational levels, (e) work pressures, and (f) lower wages.
It is estimated that as the population ages, the age of the nursing workforce will also increase. Nurses, age 20-54 in ratio to the population age 85 and older, will decline from 16.1 in 2000 to 8.5 in 2030, and further, 5.7 in 2040. GAO concluded, “by 2010, approximately 40 percent of the workforce will likely be older than 50” (2001, p.12). The nursing shortage is already a major concern for the increased future health care needs of the elderly. With the aging of the nurse workforce, the shortage becomes even more critical. Unruh and Fottler (2005) projected that the supply of RN’s will not match the demands of the aging population by the year 2020. In fact, “the demand per U.S. resident grows 18% from 2000 to 2020 and supply falls 11%, leaving a shortage of 29% by 2020 (Unruh & Fottler, 2005, p.174). To slow this trend, it is necessary to identify the “educational roadblocks and negative employment conditions” (Unruh & Fottler, p.181); reasons that nurses do not want to stay in the healthcare field, especially in long-term care.

According to Dellefield, “providing effective and safe quality care in nursing homes required clinically and interpersonally competent nurses in both supervisory and management roles” (2008, p.198). Dellefield identified best practice interventions within long-term care facilities to include nurse management training, aide job enrichment programs to improve retention issues, aide workplace support and consistency of aide assignments (2008). Jennings, Scalzi, Rodgers and Keane (2007) completed a literature review to define the competencies for both leadership and management. In the top ten categories, leadership and management shared the following competencies: interpersonal skills, personal qualities, thinking skills, management skills, communication, business skills, health care knowledge and initiating change. The competencies unique to
management were human resources management and information management. The competencies unique to leadership were setting the vision, developing people, independent thinking and being a representative to the group (Jennings et al., 2007).

Management practices supported the relationship between supervisors and staff. These practices included considerate listening, positive reinforcement, trust and respect, role-modeling, helping, professionalism, a positive attitude, teamwork and advocating for staff (Dellefield, 2008; Hall, McGilton, Krejci, Pringle, Johnston, Fairley, et al., 2005). Collier (2008) completed a synthesis of the literature comparing staff turnover, staffing patterns and quality of care in long-term care facilities. The literature supported the fact that the higher the staff turnover in an organization, the more impact there was on the quality of the health care provided. Collier concluded that the increased number of RNs working at the long-term care facility will reduce the overall nurse turnover and increase the resident care quality. Collier reasoned that if there were not enough Nurse Managers, than the clinical supervision was at risk, leading to poor clinical outcomes.

Theoretical Rationale

Expertise. Researchers began the study of expertise in the 1980’s. Johnson (1988) identified the schemata for an expert to include excellent decision-making, knowledgeable, strategic and organized, problem solvers, and more in control of their domain. Glaser (1996) stated that in the process of skills acquisition, “pattern-based retrieval reflects the acquisition of well-organized and integrated knowledge that provides a structure for representation that goes beyond surface features” (p. 305). Self-regulation was important to support the expert process so the person became more automatic in responses to continue to reach a higher level of performance. Ericsson and Charness
(1994) identified the importance of working memory for skills acquisition and the need for an expert to master all knowledge levels for a particular domain. Deliberative practice provided “optimal opportunities for learning and skill acquisition” (p. 739). Experts practiced and had a higher level of performance than novices. Ericsson, Prietula, and Cokely (2007) described an expert as achieving that level after ten years of deliberate practice, which required effort to “improving the skills you already have and extending the reach and range of your skills” (p. 119) to move to a higher level of excellence. It required a minimum of ten years or 10,000 hours of deliberative practice to become an expert (Ericsson, Prietula, & Cokely; Ericsson & Ward, 2007).

**Novice-to-expert.** It was generally understood that there were five levels of skills acquisition; novice, advanced beginner, competent, proficient, and expert. Dreyfus and Dreyfus (1986) studied the knowledge and skills expertise of airplane pilots and chess players in order to explain the process of their skills development. At the same time, Benner (2001) interviewed critical care nurses about their experiences as they gained expertise in their specific clinical knowledge areas. Within her studies, Benner realized that Dreyfus’s novice-to-expert model corresponded to her research and used this framework to explain the levels of nursing knowledge and skills acquisition. Lord and Hall (2005) summarized the novice-to-expert model from a leadership development perspective but only identified three basic levels; novice, intermediate and expert.

**Dreyfus’s model of skills acquisition.** Hubert and Stuart Dreyfus were concerned with the scientific and technical aspects of computerization or artificial intelligence (Dreyfus & Dreyfus, 1986). They investigated the process of knowledge and skills acquisition in reasoning professions, such as chess players. Hubert Dreyfus was
influenced by the philosopher, Martin Heidegger’s teachings that individuals needed to
discover the basic way of the world instead of knowledge and facts, (Dreyfus & Dreyfus, 1986, 2004; Moe, 2004). Dreyfus and Dreyfus stated, “As human beings acquire a skill through instruction and experience, they do not appear to leap suddenly from rule-guided ‘knowing that’ to experienced-based ‘know-how’” (1986, p.19). “Knowing that” was logical, deliberate and guided by rules. “Knowing how” was a result of practice and learning and was experience-based. People moved through the skills acquisition process from a “knowing that” to a “knowing how” (Dreyfus, 2004a, 2004b; Dreyfus & Dreyfus, 1986, 2004).

*Dreyfus’s fives stages of skills acquisition.* To facilitate skills acquisition, people moved through five stages of skills acquisition: novice, advanced beginner, competent, proficient and expert. Each stage included learning a higher level of skills, abilities, and processing. An important point was that not everyone achieved the same level of expertise as they progressed through these levels. Therefore, skills acquisition was very individualized (Daley, 1999; Dreyfus, 2004a, 2004b; Dreyfus & Dreyfus, 1986, 2004).

Rules, regulations, and directions governed the novice who functioned through specific guidelines and recognizable tasks. The novice was detached emotionally and there was minimal flexibility and divergence from the rules. The novice functioned “without benefit of experience” (Dreyfus & Dreyfus, 2004, p. 251). Since the novice responded just to the facts of the situation, there was no judgment in the decision-making process (Benner, 1996; Dreyfus, 2004a, 2004b; Dreyfus & Dreyfus, 1986, 2004).

The advanced beginner had more situational experience but still remained insecure in skills acquisition. It was important to continue to acquire more experience at
this level; however, the insecurity from inexperience forced the individual to continue following the rules. An individual saw similarities of experience in comparison to prior events and situations (Dreyfus & Dreyfus, 1986). The advanced beginner recognized these new situational experiences as a means to add to the knowledge base; utilizing minimal judgment.

The competent individual acquired more experience in a hierarchical, step-by-step approach of decision making. At this level, the person used plans and was in the process of developing a point of view. There was an increased responsibility and an increased involvement in the decision making process. This was a conscious deliberate for decision-making (Benner, 1996; Dreyfus, 2004a, 2004b; Dreyfus & Dreyfus, 1986, 2004). At this stage, there were emotional responses due to the engagement in the planning process and the need to be responsible for decisions (Benner; Dreyfus, 2004b; Dreyfus & Dreyfus, 1986, 2004).

At the proficiency level, experience was used in decision-making so there was increased automaticity and utilization of both positive and negative experiences. Further, decisions may not be explainable, thus more abstract. In addition, there was movement toward goals, but no definition for the path on how to achieve those goals. Similarities were defined and the person was more intuitive and holistic in the acquirement of skills and knowledge. Essentially at this level, there was more emotional engagement and goal-orientation (Benner, 1996; Dreyfus, 2004a, 2004b; Dreyfus & Dreyfus, 1986, 2004).

At the expertise level, the individual achieved full intuition and vision, demonstrating qualities such as involvement, understanding, knowing, and trusting. At this level, decision-making occurred from experience. Decision-making patterns were
stored in memory, enabling these memories to be triggered in an emergency situation. Further, there was also a critical reflection to the response to these situations; by the expert viewing knowledge and decisions as a whole versus individual parts. Consequently, there was increased fluidity since rules were not explicitly followed and the individual did not need to deliberate in the decision-making process. The expert knew the goals and was able to define the path to the goal (Benner, 1996; Dreyfus, 2004a, 2004b; Dreyfus & Dreyfus, 1986, 2004).

**Benner’s novice to expert.** At the same time that Hubert and Stuart Dreyfus identified their model, Benner was researching the transitions that a nurse would experience while acquiring skills in the clinical critical care area. Through a phenomenological approach, Benner observed nurses and obtained individual narratives that chronicled their movement through knowledge and skills acquisition as they became expert nurses. Benner realized that the Dreyfus model of novice-to-expert provided the framework for her research and an understanding of the process that nurses navigate through, in order to gain additional knowledge, expertise and experience for decision-making (Benner, 1996).

Benner researched the acquisition of knowledge and skills in clinical practice through the observations and interviews of critical care nurses at several hospitals. She also affirmed Heidegger’s concept of knowledge that is “knowing that” and theoretical knowledge that is “knowing how” (Benner, 2001, p. 2). She identified five levels of experiential learning skills acquisition that improved nursing practice over time. With each stage of development, Benner found that nurses continually acquired more clinical skills which served as critical building blocks for future decision-making. This enabled
the nurse to eventually move to an expert level of intuitiveness due to the acquisitions of various skills and experiences.

In accordance with Dreyfus and Dreyfus (1986, 2004), Benner (1992) also identified the same five levels of clinical nurse practice skills acquisition: novice, advanced beginner, competent, proficient and expert. Through these stages, the nurse progressed from a follow-the-rules detachment to experienced emotional involvement (Benner, 1992, 1996, 2001; Benner, Tanner & Chesla, 1992). As stated by Benner (2001), “we have learned less about the knowledge embedded in actual nursing practice- i.e. that knowledge that accrues over time in the practice of an applied discipline” (p. 1). For this reason, there was not a complete understanding of how the nurse moved from the novice-to-expert level except for experience.

The student nurse had the basic patient care technical skills and was considered at the novice level of skills acquisition. Upon graduation, the nurse was an advanced beginner and began the steps to further knowledge and skills through experience. As the nurse continued to gain more experience and skills, the nurse moved through the levels of competent, proficient and expert. Thus, the Benner model of novice to expert provided “new ways to view nursing practice so that we do not continue to limit the description of such practice to a simplified, linear, problem-solving process” (Benner, 2001, p. xxvi). Through time and experience, the nurse accumulated problem-solving techniques and on-the-job knowledge and skills acquisition.

According to Benner (1992, 1996, 2001, 2004; Benner, Tanner & Chesla, 1996), the novice was rule-oriented since rules provided the direction for patient care. Due to the lack of experience and competence, the novice remained inflexible, did not

The advanced beginner needed a mentor to guide the new experiences. At this level, the nurse was still not able to make individual decisions. There continued to be a reliance on textbook descriptions since the nurse did not have the ability to recognize subtleties of change. The advanced beginner did recognize the knowledge base of peers and began to establish a trust in those peers. The advanced beginner identified the need to accomplish multi-tasks but was not able to differentiate the importance of tasks, nor define the process of task accomplishment (Benner, 1992, 1996, 2001, 2004; Benner, Tanner & Chesla, 1996).

The competent nurse had at least one to two years of experience, thus, due to this experience; an increased level of skill acquisition existed. Despite the increased experience, there was still inflexibility and difficulty with multi-tasking due to the necessity of planning in order to limit unexpected outcomes. At this level, there were tremendous highs and lows in nurse performance (Benner, 1992, 1996, 2001, 2004; Benner, Tanner & Chesla, 1996). It was necessary for the nurse to have both an emotional attachment and involvement in the patient care as well. There was a risk at this level of burnout if the nurse was not able to accept both the successes and failures of learning (Benner, 1984; Dreyfus, 2004a).

The proficient nurse was more holistic in the care that was provided and in the decision making process. Benner considered the proficient level as the transitioning stage for the nurse due to the knowledge synthesis that takes place prior to the expert
level (Benner, 1992, 1996, 2001, 2004; Benner, Tanner & Chesla, 1996). During this time, the nurse was more involved and active with decision-making and interpretations, as well as using “maxims (tried and tested leadership principles), abstract reasoning and inductive processes to guide practice” (Shirey, 2007, p.168). Differentiation of nursing practice occurred at this stage since the nurse, in the process of knowledge acquisition, also expressed an emotional response to clinical occurrences. (Benner, 1992, 1996, 2001, 2004; Benner, Tanner & Chesla, 1996).

At the expert level, the nurse did not rely on rules or guidelines to make decisions, but on intuition that had been developed through the years of acquired experiences and skills. According to Benner (2004), there was an integration of understanding between current and past experiences that allowed the nurse to experience this intuitive behavior. Benner declared that the expert developed “the capacity to fluidly respond to the situation, even as the situation changes and the relevance of the actions taken change” (p. 198). In addition, Daley stated that experts are able to affect their learning through “concept integration and self-initiated strategies” (1999, p. 134). Moreover, the expert nurse had a skilled “know how” that was based on experiential learning and an intuitive clinical decision-making approach (Benner, 2001, 2004). Benner (2004) stated, “Expert practice, by its very nature, is of local, specific knowledge; know-how; and technical and scientific knowledge” (p. 197). This expertise generally occurred at five years of focused experience, although not all nurses were considered experts by virtue of their years of experience. Expertise was developed through dedicated, focused practice.

According to Patel, Vemla, Kaufman, Magder, and Sheldon (1996), nurses responded to a critical situation based on prior experiences; both quickly and without
thought. Experts used forward thinking based on pattern recognition and viewing the entirety. The novice tended to respond slower due to the increased memory usage. Anderson (1987) stated that the expert only uses memory to evaluate the past occurrences for present need and make adjustments while learning. Anderson, Fincham, and Douglass (1997) researched skills acquisition and stated that “knowledge transitions from a declarative form (encoding of examples) to a procedural form (productions rules)” (p. 932). Skills acquisition was a process of strengthening and assimilating rules, storing declarative knowledge in working memory, and problem-solving procedures (Anderson; Anderson et al.).

Lord and Hall novice-to-expert leadership development. There was minimal research to understand the effectiveness of the novice-to-expert model in leadership development. According to Lord and Hall (2005), leadership development was an acquisition of skills along an expert continuum from novice to intermediate to expert. The leader transitioned on a learning continuum starting from the basics of leadership behaviors to the assimilation of leader-follower sensitivities. Lord and Hall used the novice-to-expert model to explain the development of leadership skills from a learning theory framework. These levels involved the development of a combination of the social, cognitive and behavioral skills that the leader acquired over time. Each leader developed these skills individually; in accordance with their motivation and self-identify. Lord and Hall stated “at each skill level, the emphasis is on qualitatively different knowledge and information processing capabilities” (p. 591). As the leader learned the levels of knowledge and information processing, there was the capacity to pull from “internal resources such as identities, values, and a mental representations of subordinates and
situations” (Lord & Hall, p. 592). Leadership development occurred over an extended period of time as there were changes in the knowledge base, skills, behavior, and social connections. A leader moved from an inner, personal focus to “collective orientations as their expertise develops” (Lord & Hall, p. 592). The focus changed from a self-concern to a collective concern for followers and the organization.

According to Lord and Hall (2005), the novice level of leadership development included the process of skills acquisition and individual identity. The developing leader was focused on experiential problem solving. At this level, there was a concern to have the appearance of being a leader and additionally, to acquire an individual identity or self-view of leadership. Greater focus was on the working memory, to acquire the skills and knowledge of leadership behavior. Lord and Hall identified this level as a focus on the acquisition of “surface structure skills,” which were the observable leader skills (p. 592).

At the intermediate level of leadership development, the leader continued to gain knowledge and problem solving skills and was also beginning to develop connections that match skills to decision making demands. By acquiring more knowledge, there was less involvement of the working memory, as knowledge replaced the need to search for processes; leading to increased efficiency and self-regulation processes. The leader was moving from the internal self-identity to an increased concern for others, such as followers or the organization. Consequently, at this level, the leader was better able to monitor their self-performance and efficiencies (Lord & Hall, 2005).

As the leader moved through the expert level that was approximately five years of leadership experience, there was more of a connection between knowledge and
principles; skills became a part of the leader’s identity. Since this was a higher level of knowledge and skills acquisition, the working memory was not involved in the decision making process, which allowed the leader to deal with increased complexities. Knowledge was not a surface structure skill, but was now a principle that guided decision making and “deeper ways of organizing knowledge” (Lord & Hall, 2005, p. 595). Self-regulation and an increase in self-identities led to a positive self-concept (Lord & Hall). The leader was now focused more on the follower’s needs and less on their own needs, enabling critical collaborating opportunities. The organization of skills enabled “higher level systems that guide behavior, knowledge, and social perceptions” (Lord & Hall, p. 592).

Sullivan, Bretschneider and McCausland (2003) analyzed the novice and expert NM’s satisfying and challenging issues within a health system’s continuum of care in order to create a leadership development program. This research did not include the long-term care level of care but did provide a basic understanding of nurse leader needs. According to the nurses surveyed, the leadership role was most satisfying when there was autonomy, flexibility, situational power and control, influence, peer support, and ability to create positive outcomes. The top challenging components included staffing issues, lack of supportive resources, conflict management, recruitment and retention, and “middle-management syndrome.” Leadership development provided a framework to support the NMs through educational training, in-services, and support as the novice manager acquired the leadership concepts (Sullivan et al.).

Day, Harrison, and Halpin theory of leader development. The novice-to-expert research provided an understanding for the development of an expert. From a theoretical
perspective, there was no theory to explain the process of leader development; only
theories to identify leader traits, behaviors and competencies (Day, Harrison, & Halpin,
2009). Day et al. stated that, “what is missing is a strong theoretical foundation for
understanding, predicting, and accelerating leader development” (p. 172). Since the
research lacked a theory of leadership development, Day et al. (2009) proposed a theory
that provided structure for a leader’s growth over time from more observable skills to
deeper levels that are reached as a leader moves forward. This theory included 13
propositions (see Appendix A) that identified three levels; the acquisition of skills,
identity development and self-regulation, and adult development.

According to Day et al., “Effective acceleration of leader development should
focus more on the interior processes of adult development, identity development, and
self-regulation, and less on the exterior level of observable competencies” (2009, p. xiii).
Despite the emphasis on the deeper levels, the authors stated that the research should
begin with the most visible developmental level. Day et al. stated, “If the research results
ultimately suggest that leadership cannot be adequately conceptualized in expert
performance terms, then the deeper explanations that we propose for this
conceptualization really do not matter” (p. 243).

Further, Day et al. contend that, “theorizing about leader development is a …
process that is complex, multifaceted, nonlinear, and highly subject to differences among
individuals and across environments” (2009, p. 259). The most observable leader
development level was the competence and expertise acquired through skills acquisition;
and “very little research in the leadership literature has empirically investigated exactly
how leaders learn from experience” (p. 191).
The first level of leader development included skills acquisition on a novice-to-expert continuum. At the novice level, there was increased cognitive working memory activity due to the acquisition and assimilation of new knowledge and skills for future situations and challenges. Thus, the leader moved from simple tasks and procedures to more complex ones while acquiring a knowledge base. Declarative knowledge was the acquisition of these skills or the “what” of performance.

As the novice leader moved through the next level of skills acquisition, there was less cognitive usage and greater automaticity of skills. The leader learned the procedural skills or the “how” of leader development for increased understanding. There was a need to connect the declarative skills to the procedural skill level to further a more automatic response. This more complex level of leader development provided guidance to actions. Practice and experience were critical at these levels. According to Day et al. (2009), the novice level included both the declarative and procedural knowledge of skills acquisition which was the foundation for leader competencies.

As the leader gained experience, the leader’s declarative and procedural knowledge base developed into strategic and adaptive competencies. This was a level for gaining experience and an understanding of concepts. The leader acquired additional strategies to work through different types of situations. At this level, there was less cognitive usage and working memory so that responses became more automatic.

During the acquisition of adaptive competencies, the leader used schematic knowledge to function within new situations, moving from a rules and regulations approach to management of unusual and novel experiences. Self-efficacy was vital, as discussed by Bandura, the: “beliefs about one’s capabilities to situations produce
designated levels of performance that exercise influence over events that affect one’s life” (as cited in Day et al., 2009, p. 302). Self-efficacy was a belief in the abilities to perform and complete skills, moreover, it provided the motivation for the leader to move to an automatic response of skill development. According to Day et al., the application of self-efficacy was “more predictive of early skills acquisition success” (p. 202). The leader’s ability, competence, and self-awareness, impacted how quickly the leader skills were learned. Strategic and adaptive competencies were considered to be an intermediate level of leader development.

As the leader moved longitudinally from novice to expert, progressive movement occurred from the working memory of rules and regulations, to self-awareness and experienced understanding. Further, there was a principle-based, deeper understanding of problems and decision-making. Expertise was experience-based and assumed a practice over an extended timeframe that included “years of intentional practice” (Day et al., 2009, p. 186). This research supported a minimum of ten years, or 10,000 hours of deliberative practice prior to an individual being considered at the expert level in the specific domain (Day et al.). Expertise involved intentional practice, automaticity of routine actions, and the development of cognitive experiential connections. Day et al. concluded, an “expert leader is someone who not only has sophisticated reasoning skills as well as complex knowledge structures, but also a repertoire of observable skills and competencies that is both broad and deep” (p. 130).

Self-regulation was a critical component for the leader to successfully move to an expert level since the “greater the self-regulatory strength, the better equipped a leader is to deliberately practice furthering expertise development” (Day et al., 2009, p. 208).
Over time, an expert leader gained further understanding of their abilities in order to set direction based on experiences yet be adaptive in novel situations. Additionally, the expert leader was goal-oriented, motivated, self-aware, competent, and able to generalize prior experiences to new situations with minimal cognitive involvement. As stated by Day et al., “Leaders develop as they move to more complex ways of knowing” (p. 210). Day et al. contended that the expert leader experienced an embedded knowledge that was not easily identified or explained but formed the “knowing how” of leader practice. Every expert leader reflected on the leader process to preserve useful skills and learn new competencies.

At the next level of this theory, the authors referred to the “identifying spirals” of identity formation and self-regulation that allowed the leader to experience challenges to further define the leader expertise. The leader developed an identity that was goal specific and self-regulation provided the support to self-monitor behavior. Self-regulation included five “spirals”: self-regulatory strength, goal orientation, self-efficacy, self-awareness, and implementation intentions. Through self-regulatory strength the leader focused on attention and persistence. Goal orientation included setting both learning and performance goals. Self-efficacy determined the leader’s belief in their ability to lead, adapt to new situations, and handle change. As Day et al. declared, self-efficacy “is related to increasing performance” (2009, p. 196). Finally, implementation intentions supported the leader in a reflection improving the automaticity of responses.

Assessment, challenge, and support were three influential factors that impacted the leader’s ability to learn and the quality of their experiences. A leader obtained information on strengths and weaknesses through 360 degree assessment that is
supervisor and staff feedback. Challenges supported the leader’s ability to acquire new skills. Support from others for decision-making impacted the leader’s ability to learn from experience.

At the center of this theory was the concept of adult development; Selection, Optimization, and Compensation (SOC theory). The authors chose adult development to parallel leader development that focused the leader toward a goal-oriented path. Adult development moved along a continuum addressing changes in cognition and physical functioning. Leader development also moved along a continuum, addressing the progression of skills acquisition, experience, and goal setting. Both development processes were multi-functional, non-linear; with an approach from the development of expertise. Freund & Baltes first introduced the SOC theory in 1998 to explain the process of successful aging. Selection involved the identification and adaptation of goals. Optimization involved the usage of resources to optimize the goals. Compensation described the alternative means and methods for goal maintenance and preservation (Day et al., 2009).

Through adult and leader development, the individual sought experiences, and over time, it became necessary to discard certain skills that were no longer necessary. These skills were replaced with more complex skills so the leader could move to a more mastered level. During this process, useful skills that were not lost were integrated into the leadership competencies. The leader integrated the deeper levels of experiential goals acquisition and refinement with the superficial skills acquisition and competencies. Self-identity and self-regulatory involvement supported this process.
Significance of the Study

The Dreyfus Novice to Expert Model provided a technological approach to skills acquisition. Benner used this model to explain the acquisition of skills and knowledge from a nursing clinical perspective. Lord and Hall introduced a model for novice-to-expert leadership development that borrowed from learning theory and cognitive science. Day et al. identified a leadership development model that moved beyond the leader’s traits; identifying leader skills acquisition for behaviors, knowledge, and social identity from a central to external focus. All of these models identified novice-to-expert levels for specific domains; however, the literature was lacking a model that specifically explained novice-to-expert nursing leadership development within the long-term care environment.

Day et al. (2009) stated that, “very little research in the leadership literature has empirically investigated exactly how leaders learn from experience” (p. 191). The theory of leader development provided a framework to support this research at the most observable level of expertise. Even though there was research that identified the DON traits and behaviors as a leader, there were few studies that identified the role of the NM in long-term care. There had been extensive research for novice-to-expert nurse expertise within acute care settings, but there was no research for the NM in long-term care from a novice-to-expert perspective (P. Benner, personal communication, February 10, 2009). With the aging of the population and the impact that this aging will have on healthcare and the long-term care environment, the NM leader expertise must be understood to provide support for aging services in the future. An understanding of the NM’s leadership skills acquisition from the novice-to-expert framework will further the body of
knowledge for not only leader development but also NM expertise in long-term care.

The significance of this study lies within a qualitative approach, identifying the NM lived novice-to-expert experiences that define their skills, competencies, expertise, and embedded knowledge as leaders in long-term care. This study will provide research support for Day et al.’s proposed theory of leader development from a nursing perspective and add to the body of nursing knowledge.

**Statement of Purpose**

The purpose of this study was to identify and describe, through a qualitative analysis, the NM leader role in long-term care. The identification of skills acquisition, knowledge competencies, and expertise of the Nurse Managers, as leaders in long-term care, will add to the nursing, clinical, and leadership knowledge.

RN leadership was a critical component of the resident care in long-term care. Cook and Leathard identified five attributes of an effective clinical leader in health care: (1) creativity, “new ways of working;” (2) highlighting, “new ways of doing things;” (3) influencing, “meaningful information;” (4) respecting, “perceptual ability;” and (5) supporting through change (2004, p.438). These leadership attributes, along with understanding, knowledge, values and strong beliefs, provided a transformational leadership approach within long-term care facilities (Cook & Leathard). Often in long-term care, “learning about leadership is undertaken once a person has been designated as a clinical leader, rather than in preparation for the position” (p. 440). Additionally, Wilson noted that a nurse who was good in a clinical setting was placed in a management role, usually without the benefit of leadership training (2005). There was a need to further define, describe and develop the leadership role and skills in long-term care.
Long-term care organizations experience high staff turnover due to client acuity levels, organizational ineffectiveness, and communication issues, as well as workload issues. Quality of care suffered when turnover was high. According to McAlearney and Butler (2008), leadership development programs improved the workforce quality and efficiencies, reduced turnover, and focused leaders on strategic priorities.

**The Research Question**

The following research question will be the focus of this study:

How do expert Nurse Managers, as leaders in long-term care, define and describe their lived experiences to develop their expert leader skills, competencies, expertise, and embedded knowledge?

**Conclusion**

The Aging of America is a reality. Since the baby boomers are entering the “old” stage of aging, they will have a voice in the level of care that is provided in all health care settings, especially long-term care. Currently, the elderly are being classified as “old” to the “oldest-old,” based on their age, and further, are demanding a higher quality of health care services. The long-term care organizations that provide care to primarily the “oldest-old” must provide quality care and outcomes that not just meet, but exceed the resident’s expectations. Issues in long-term care that may impact those outcomes include staffing changes due to vacancy and turnover; recruitment and retention issues; and a lack of nursing leadership to guide the resident care. The nursing leadership deficit is based on minimal educational requirements and nurses who are advanced to leadership positions without the pre-requisite management training.
Resident acuity levels are at a high rate in long term care. The RN leadership is expected to not only provide care to an ill population, but also to tend to the staff dissatisfaction and management responsibilities. The level of staff dissatisfaction is high due to staff turnover, and as a result, resident care is compromised. It is critical to identify the nurse leader skills, competencies, and expertise that will lead to positive resident outcomes and staff satisfaction. Day et al. stated, “Competent leaders not only are knowledgeable about leadership, but they also can enact a well-established set of varied leadership competencies, demonstrate sophisticated levels of behavioral, cognitive, and emotional self-regulation, and engage in high-level moral reasoning and ethical conduct” (2009, p. 234). These competencies would be the basis for NM novice-to-expert leadership development.
Chapter 2: Review of the Literature

Introduction and Purpose

Long-term care organizations, commonly referred to as nursing homes, provide skilled nursing care primarily to an elderly population to support their need for assistance with activities of daily living. Federal legislation that defined the provision of nursing in long-term care created a highly regulated environment. Despite these regulations, the difficulty for the professional staff is the provision of resident care for those who are at a higher acuity level than in previous years. Facing a higher acuity level, in conjunction with the regulatory compliance requirements, creates an environment with tremendous challenges. The Nurse Manager (NM), who is the staff leader on individual care units, is responsible for the management of resident care, staff issues and concerns, quality assurance, family involvement, and regulatory compliance. There has been minimal research to define and describe the Nurse Manager’s role within the long-term care environment. Further, little research exists on their role as a leader in these environments and their development of essential leadership skills, competencies, expertise, and embedded knowledge.

Recent leadership research focused on the traits and behaviors of leaders, their interaction within an organizational hierarchy and also their relationship with the follower. The research identified the characteristics of a leader; but did not describe how the leader moved through the process to develop leadership expertise. Researchers studied the process of skills acquisition for many years, with a focus on the development

Day et al. (2009) identified a leader’s embedded knowledge and the leadership principles that govern their practice. For the leader to develop to an expert level, it was necessary to change one’s own leadership beliefs and move to a “more complex perspective of how things are interrelated” (Day et al., p. 210). These authors developed a new theory of leader development and defined the need for quantifiable research to test this theory. In their research, they found it necessary to focus on leader development rather than leader performance. Day et al. presented five propositions for expertise and expert performance and further, suggested that if the research does not support the hypothesis for expertise development, then additional research would not be warranted to support the theory.

According to Day et al. (2009), there was a need to identify the difference between management and leadership development due to the frequent interchangeability of the concepts. Management development focused on task orientation for “proven solutions to known problems, which gives it mainly a training orientation” (Day et al., p. 582). Day et al. also stated that, “a leadership development approach is oriented toward building capacity in anticipation of unforeseen challenges (i.e. development)” (p.582). In alignment with their research, they provided an explanation of leader versus leadership development. Leader development was defined as individualized, with a focus on personal power, knowledge and trustworthiness. Skills included: self-awareness, self-confidence, emotional awareness and an accurate self-image. Different from leader development, leadership development was relational, with a focus on commitments,
mutual respect and trust. Skills included: social awareness, empathy, political awareness and service orientation.

Current research identified management or supervisory responsibilities and outcomes, but did not look at Nurse Managers as leaders, and their impact on resident service delivery, quality of care, or employee and resident satisfaction. The intent of this literature review was to acquire an understanding of the NM as a leader in long-term care and to understand their role within a framework of expert leader development; which was achieved by focusing on the key terms of nurse leadership, nurse management and long-term care. Due to the lack of leadership research in long-term care, this literature review was expanded to include nurse leadership and acute care. The main leadership and management topics included: long-term care, leader educational levels, staffing and turnover, leadership and management, leader development, leadership development, leadership competencies and excellence. Additionally, Day et al.’s (2009) model of leader development provided an expert framework to situate the research. The research question that situated this review was:

How do expert Nurse Managers, as leaders in long-term care, define and describe their lived experiences to develop their leader skills, competencies, expertise, and embedded knowledge?

*Topic Analysis*

*The long-term care environment.* Residents in long-term care are living longer and have higher acuity levels, resulting in greater needs. Due to these increased needs, the NM’s role became critical to the provision of quality and competent aging services. In this setting, the NM was responsible for the daily unit operations, including: resident-
care oversight, operational issues, staffing schedules, staff and resident management, leadership, and the provision of direct care. According to Scott-Cawiezell et al., “Research suggests the current nursing home environment is one of mistrust and skepticism. General apprehension among staff, residents, and administrators is a prevalent behavior supported in nursing home research over the past decade” (2005, p. 372). Essentially, turnover and retention issues created an environment in which the NM must constantly re-train staff, revise schedules, and re-organize care functions; all to maintain work flow and accountability for quality and safety factors.

The Nursing Home Reform Act of 1987 mandated specific nurse staffing ratios in long-term care, which must be followed to receive Medicare and/or Medicaid reimbursement. The requirements were that the Director of Nursing (DON) must be a Registered Nurse (RN), that the facility employ another RN to work a minimum of eight hours per day (this could be the DON in a small organization); and also employ Licensed Practical Nurses (LPN) to be available 24 hours per day (Harrington, Kovner, Mezey, Kayser-Jones, Burger, Mohler, Burke, & Zimmerman, 2000; Harrington, 2005; Tilly, Black, Ormond, & Harvell, 2003; U.S. Department of Health & Human Services, 2003). According to a literature review completed by Tilly et al., most states required a minimum staffing ratio; however they found there was no specific reason to set this ratio other than the presumption that staffing ratios supported quality of care. Additionally, an expert panel conference, conducted by the John A. Harford Institute for Geriatric Nursing further proposed that the minimum long-term care staffing standards should include a full-time RN with a bachelor’s degree as the DON, a part-time RN Assistant DON, and a full time RN nursing supervisor to be employed around the clock (Harrington et al.).
Moreover, this panel recommended that “increases in the education level and training of nursing staff are also strongly recommended as a step to improving quality of care and reducing turnover rates in nursing homes” (Harrington et al., p. 14). Since the government paid for approximately 61% of long-term care service via Medicare and Medicaid, the prospect that the legislation would support the costs of this suggested staffing ratio or leadership preparation was unlikely.

*RN Manager educational level.* According to Bourboniere and Strumpf (2008), 75% of the RN staff in long-term care settings held an Associate or Diploma degree as their educational level. Similarly, the DON’s educational level was also an Associate or Diploma degree (Aroian, Potsdaughter & Wyszynki, 2000; Bourboniere & Strumpf, 2008; Byers, 2001; Harvath, Swafford, Smith, Miller, Volpin, Sexson, White & Young, 2008). The Associate degree level was clinical–based and may not completely prepare the manager to provide the leadership support that was vital for the level of care that was needed in long-term care facilities. Wilson (2005) identified that RN’s who further supported their education through advanced degrees or certifications may have greater satisfaction in the workplace. Further supporting this idea were Bourbonnieres and Strumpf who suggested continuing education programs that focus on geriatric certifications; enhancing the nurse’s clinical knowledge. However, it was questionable whether continuing educational opportunities would provide the knowledge base that NMs needed to provide leadership.

Luggen (1997) randomly surveyed 100 DONs who were members of the National Association of Directors of Nursing (50 surveys) and the National Gerontological Nursing Associations (50 surveys). Receiving a return rate of 74%, it was found that
greater than 50% of DONs worked 11 or more years in management, with 47% having worked more than 21 years. In addition, these nurses were asked to rate nursing administration leadership skills on a six-point Likert scale. In a descending order, they ranked the following skills as such, communication, long-term-care knowledge, planning ability, organizational skills, and negotiation skills, with power ranked lastly.

In addition, Luggen (1997) summarized a 1995 National Association of Directors of Nursing Administration survey (n = 461) that identified the educational level of nurse leaders: 35% Diploma degree, 22% Associate degree, 29% Bachelor of Science degree, 14% Master degree, and 2% Doctorate degree. Even though the survey was focused on the DON leadership level, the researchers identified the need for additional education to prepare NMs for their responsibilities.

Aroian et al. (2000) mailed 945 surveys to DONs in New England with a return rate of 247 (26%) to assess their educational level, roles and responsibilities in long-term care. Results indicated the following educational backgrounds: 29% Diploma degree, 18.7% Associates degree, 31.3% Bachelors degree, and 21.1% with a Masters degree. The authors stated that the role of the DON was becoming more complex with the increased resident acuity. The DON may not have the educational preparation or management experience to support the higher acuity responsibilities. In turn, it was suggested that the combination of education and practice would provide quality health care (Aroian et al.).

For dissertation research, Foote (2003) studied self-perceived leadership styles and levels of education for DONs in long-term care within five southern states. A demographic survey and the Self-leadership Style/Perceptions of Self survey, as
developed by Hersey & Blanchard (1978, 2000) were mailed to 200 DON’s. Forty-nine (24.5%) were returned, but only 35 could be used for the study due to missing information. The survey consisted of 12 questions, with each question having a potential of four answers to identify leader styles: directing, coaching, supporting, and delegating. The author analyzed both the primary and secondary self-reported styles. Of the 35 responses received, results showed 33 respondents chose the primary style of coaching (p = .05), with the secondary style supported by 28.6%. The educational level of the respondents included: 51% Associate degree, 7% Diploma degree, 28.6% Bachelor degree, and 5.7% Master’s degree; indicating 71% held less than a Bachelor’s degree.

The literature supported a higher level of education for the DONs to maintain the quality of resident care, but did not conclude the required educational level for the Nurse Manager. If the DON educational level supported quality of resident care, than a higher education level for the Nurse Managers may also positively impact the provision of resident quality care.

*Long-term care staffing concerns.* RN leadership was a critical component for the welfare of residents in long-term care. Often in long-term care, “learning about leadership is undertaken once a person has been designated as a clinical leader, rather than in preparation for the position” (Cook & Leathard, 2004, p.440). Wilson (2005) indicated that a nurse who was good in a clinical setting was placed in a management role, without the benefit of leadership training. There was both a need to further define the leadership role in long-term care and to provide educational support to develop the leadership skills (Cook and Leathard; Wilson). Leadership competencies and pro-active leadership training must be identified to enhance the recruitment strategies and reduce the
Retention issues.

Turnover, recruitment, and retention issues were major impacts within long-term care facilities. “Inadequate staffing levels and a workforce characterized by high turnover rates are crucial factors that influence the quality of resident care” (Collier & Harrington, 2008). With the increased number of “oldest-old” living in long-term care facilities, there was a concern that there will be insubstantial nursing staff and trained NMs to support the increased care demands. Flood (2002) stated that care plans that met the elder’s physical, mental and spiritual needs would support successful aging and wellness promotion. NMs and leaders were essential to: the patient care planning process, resident clinical care, health paraprofessional staff management, organizational support, and quality outcomes (Dellefield, 2008).

The American Health Care Association (AHCA, 2002, 2008) conducted a national survey of nurse-vacancy and turnover rates in long-term care. The nursing staff included DONs, Administrative and Staff RNs, and Staff Licensed Practical Nurses (LPNs). Nationally, there were approximately 44,000 vacant nursing positions in long-term care; with 26.0% at LPN and 14.5% at the RN level. Administrative RNs only had a vacancy rate of 8%, with 5% for Directors of Nurses (DON).

According to AHCA (2002, 2008), the turnover rates for Staff RN, LPN and DON levels were significant at 50%. In addition, the Administrative RN vacancy rate in 2002 was 8.1%, versus 10.4% in 2007. Essentially, Administrative RN turnover from 2002 to 2007 decreased from 35.5% to 28.7%. Even though the decrease in turnover was positive, the recruitment of nursing staff continued to further complicate long-term care staffing levels. According to the AHCA survey, greater than 60% of the facilities stated
it was more difficult in 2002 than the prior year, to recruit both RN and LPN levels (AHCA). Further, Collier & Harrington (2008) added that nationally; turnover costs approximately $4.0 billion per year.

Similar to the AHCA, Anderson, Corazzini and McDaniel’s (2004) research focused on staff turnover issues in long-term care organizations as well. These researchers proposed that a reward climate in the organization will lead to lower turnover, versus a laissez-faire climate. Anderson et al. also proposed that communication, openness, accuracy, and timeliness will lower the turnover rates in nursing homes. Lastly, they hypothesized that communication within a reward climate will reduce turnover. The authors randomly surveyed 380 Texas nursing homes with a response rate of 164 (43%), including, 3,449 employees, which consisted of the Administrator, DON, RN, and direct caregiver levels. The DON’s educational level was primarily less than a Bachelor’s degree (67.5%). The independent variables included facility characteristics (environmental change), administrative characteristics (DON tenure), resource allocations (nurse hours per resident day and clinical resources), and communication perceptions (openness, accuracy, and timeliness). Results indicated that RN turnover was significantly related to facility and administrative characteristics and resource allocation. The results of a regression analysis showed that the longer length of DON tenure time was significantly related to decreased RN turnover (p = < .01). Additionally, higher environmental change was significantly related to increased RN turnover (p = < .05) and greater resource allocation (nurse hours) was related to lower RN turnover (p = < .001). In conclusion, the authors found that the DON position, appropriate usage of staff resources, facility size and environmental change as critical factors to the stability of the
Tellis-Nyak (2005) reported that the Virginia Health Care Association and MyInnerView, Inc. studied DON turnover in long-term care; determining that the DON provided the stable leadership needed for quality of care. The educational level for 103 DONs, who worked in Virginia long-term care organizations, included approximately 15% with no college degree, 50% with either an Associate or Diploma degree, and 28% with a Bachelor’s degree. Approximately 20% worked in their respective facility for less than one year, with 50% having not attended an educational presentation during the previous two years. Further, greater than 50% did not have membership with a professional organization. The DONs described the frustrations with staff retention, state surveys, the regulatory environment, and increasing administrative needs. Tellis-Nyak indicated that educated DONs tended to leave the position within five years due to frustration. The DONs were not prepared for issues of liability, state surveys, human resource management, budget, and quality improvement. The DON’s satisfaction was dependent on resident, administrator, and family relationships, and their impacts on resident’s lives. Only 38% cited staff relationships as critical to their satisfaction. The author identified the need for training on resident-centered care, leading and managing, dealing with family concerns, managing time, and influencing good clinical practice.

Collier and Harrington (2008) completed a synthesis of the literature regarding staff turnover, staffing patterns, and quality of care in long-term care facilities. The literature supported the fact that the higher the staff turnover in an organization, the greater the impact on the quality of the health care provided. Collier and Harrington concluded that the increased number of RNs working at the long-term care facility would
reduce the overall nurse turnover and increase the resident-care quality. The NM was responsible for the clinical supervision of the CNAs who provided the direct resident care. Collier and Harrington reasoned that a decreased number of NMs would lead to poor clinical outcomes due to leaving the clinical supervision at risk.

In 1996, Parsons, Simmons, Penn, and Furlough (2003) completed a multivariate analysis in Louisiana to identify aide satisfaction and turnover within 70 facilities; 83% for-profit and 17% non-profit. A total of 1,660 nursing assistants received surveys; 550 surveys were returned (33.1%). Most employees were dissatisfied from a management and organizational perspective (46.5% lack of input to decision-making and 45.4% no inclusion in change decisions). The bivariate analysis identified employee and work turnover characteristics and management and organization work issues as significant to turnover ($p = .000$ to $p = .033$). Fairness with hiring, promotions ($r = -.317$), and work schedules ($r = -.312$), were significantly related to turnover ($p = <.000$) as well. Loyalty of management was also significant to turnover ($p = <.000$). Thirty-five work issues were divided into five categories; with supervision ($p = <.000$) and management issues as two of these categories. The authors completed a multivariate analysis to review the effect of specific work issues with overall satisfaction and turnover ($p = .000$). Data showed supervision as significantly related to overall satisfaction ($B = .153$). Further, the authors also stated that increased supervision and management, was significantly related to the reduction in turnover.

Castle (2005) sent a survey to the administrators of 470 long-term care facilities in five states with a response of 419 (85%); looking at the effect of administrative turnover (administrators and DONs) to caregiver turnover in the organization. The
caregivers were sorted into two groups; nurse aide and RN turnover. Independent variables included administrative turnover, resident factors, and organizational factors. Castle hypothesized that higher administrative turnover would have a negative effect on resident care, employee’s commitment, and the organization’s stability. Results indicated that administrative turnover does significantly affect aide turnover, with 10% administrative turnover versus 21% increase in aide turnover ($p = <.05$). In addition, a 10% administrative turnover was also significant with a 30% RN turnover ($p = <.1$). However, even though Castle recognized that the $p$ level is “less stringent” (p. 192), he was not able to define why there was a correlation between the administrator and caregiver turnover. In turn, he surmised that managers “may have a general destabilizing influence on the organization, may influence employee’s commitment to the organization, and may influence resident care and services” (p. 192). This turnover related to dissatisfaction and poor resident care, leading to state deficiencies

*Nurse management and resident outcomes.* Anderson, Issel, and McDaniel (2003) developed hypotheses for the relationship between management and resident outcomes in nursing homes. A cross-sectional correlation field survey was done with DON’s and RN’s in 164 Texas nursing homes. Management practices for communication, decision making, and leadership behaviors were researched. The authors completed a proportional stratified random sample of 380 nursing homes with a response rate of 164 (43%). Secondary data, obtained from cost reports, client assessment reviews, and the Minimum Data Set (resident outcomes) were also reviewed. There were 164 DONs and 36 RNs who responded to the 5-point Likert scale survey. The RNs also responded to issues of relational leadership, which included recognition, considerate
listening, and relationship building. The DONs obtained degrees that were lower than that of a Bachelor’s (62%); holding their positions for an average of 2.70 years (S.D. = 4.14). Results supported each of the hypotheses for significant influence of management practices on resident outcomes. Communication openness (p = <.05), DON years of experience (p = <.05) and DON tenure (p = <.05) in conjunction, were correlated to reduced restraint usage. Relationship-oriented leadership (p = <.01), formalization (rules to predict performance, p = <.01), and DON years of experience (p = <.01) were significant to resident mobility issues. Relationship-oriented leadership (p = <.01) was also significant to decreased resident fractures. The authors suggested that “developing alternative management strategies-ones that increase connections and interaction among people and increase cognitive diversity-are needed” (Anderson et al., p.20).

Another study, done by Sheridan, White, and Fairchild, (1992) also looked at the nursing home management practices for the supervision and leadership of caregivers. The study was inclusive, incorporating both nursing homes that provided good, and also those that had a lower quality of care. Three hypotheses were defined, with one of the three addressing leadership issues. The authors hypothesized that supervisors are positive on all leadership dimensions when working in homes with high quality care. These dimensions included direction, delegation, assertiveness, recognition, reprimand, liaison, and sensitivity.

For this study, a 32-item leadership instrument was developed by Kruse and Stogdill in 1973 and then modified by Sheridan, Vredenbush, & Abelson in 1984; enabling the measurement of organizational commitment, job tension, and co-worker cohesion in 25 nursing homes in Texas and Florida; 13 being for-profit and 12 non-profit
(Sheridan, White, and Fairchild, 1992). Additionally, two of the nursing homes had recently failed state inspections. The survey sample size (n = 530) included staff who described how often leadership was demonstrated by their immediate supervisors. This sample was divided into three groups (1) 26 staff employed in the for-profit nursing home that had failed state inspections, (2) 206 staff employed in for-profit homes with positive state inspections, and (3) 298 staff employed in the non-profit successful homes. Due to the unbalanced comparison, the MANOVA sum of squares with regression methods was used for analysis.

Results indicated that the leadership behavior in successful for-profit nursing homes was significantly different than those in successful non-profit homes (F = 2.03, p = < .05). It was determined that the “supervisor’s reprimand[ed] behaviors were much more frequent in the successful for-profit homes than in the nonprofit homes” (p = < .01) (Sheridan et al., p. 339). The failed nursing homes demonstrated a greater ‘laissez-faire’ policy than the successful non-profit homes (F = 8.33, p = < .01). Moreover, in the failed homes, the human relation dimension mean scores were lower than that in the non-profit successful homes. From a multivariate perspective, leadership behaviors in the failed homes and the successful for-profit and non-profit nursing homes were similar. Sheridan et al. identified “the administration as being inattentive to staff motivation, demonstrating inadequate planning, providing few resources to enhance the quality of resident care, and showing disdain for lower-level care providers” (p. 340).

Other researchers, Kruzich, Clinton, and Kelber (1992), studied the environmental and personal influences on satisfaction of residents in Wisconsin nursing homes. A total of 289 residents were randomly chosen from 77 units in 51 nursing homes; 45% non-
profit and 43% for-profit. Charge nurses (shift responsibility) and DONs were also interviewed and surveyed. The Satisfaction with Nursing Home Scale developed by Kane, Riegler, Bell, Potter, & Koshland in 1982 and the Resident Management Practices Scale developed by Smith & Holland in 1983 were two of the tools that were utilized (Kruzich, Clinton, and Kelber 1992). Two categories of independent variables researched included, resident measures (nursing home satisfaction, activities of daily living, social support, and self-reported health); and organizational measures (environmental diversity, facility attractiveness, unit routine, and level of resident involvement in decision-making). Resident satisfaction was correlated to the physical space (p = < .01), DON employment and turnover (p = < .01), unit rigidity (p = < .001), resident involvement in decision making (p = < .05), and caregiver’s perception of charge nurse fairness and competence (p = < .05). Data revealed that the higher the residents daily living activities (ADL), the greater the change in caregiver’s perception of charge nurse fairness and competence (p = < .001). Although this study provided support for the effectiveness of the charge nurse who may have sole shift responsibility, it may provide support for the Nurse Manager role in a management or leader capacity.

Management and leadership in long-term care. In the Nurse Manager position, the day-to-day management responsibilities can overshadow the potential for leadership; consequently, the Nurse Manager can become burdened with the daily management activities, not focusing on leadership. Jennings, Scalzi, Rodgers and Keane (2007) reviewed the literature from 2000–2004 to define the nursing competencies for both management and leadership. One hundred and forty articles were reviewed, revealing the following competencies that were shared via leadership and management: interpersonal,
thinking, management, and business skills; and also personal qualities, such as communication, health care knowledge, and initiating change. Further, the competencies unique to leadership were: setting a vision, developing people, independent thinking and being a representative to the group. Vision and staff development were ranked high for leadership, indifferently, management articles addressed vision and staff development lower. However, human resource issues and business skills were ranked high in management and lower in leadership. The competencies that were identified for leadership and not management were independent thinking and being a model for the group. Those competencies only identified in management were evidence-based practice, epidemiology, and economics. This literature review was not focused within the long-term care environment, but it demonstrated that there was a difference between the nursing leadership and management responsibilities.

According to Hall, McGilton, Drejci, Pringle, Johnston, Fairley and Brown (2005), research existed on the connections between leadership and outcomes in acute care settings, but little identified the RN supervisor’s effectiveness in long-term care. Hall et al. recognized the “paucity of research on ways to improve the nursing management practices in these facilities” (p. 181); via conducting focus groups, as a qualitative design, to explore the supervisory behaviors and relationships for NMs in long-term care. A stratified sample of 12 long-term care facilities, 6 for-profit and 6 non-profit, in Ontario, Canada, was randomly selected from a list of interested facilities. Twelve focus groups were conducted in six of the homes, with a total of 30 supervisors; 12 at RN level and 26 as support staff as the participants. The groups were led by a long-term care nurse consultant with expertise in focus groups. In a three stage process, the researchers
transcribed and analyzed the focus group data in order to recognize similar themes. The leadership themes that emerged included communication and role modeling behaviors, such as listening, praise, recognition, positive reinforcement, respect, trust and helping behaviors. Supervisors and managers discussed teamwork, teaching support, and finding supportive time for others. Challenges that were identified included the scope and complexity of the management role; demonstrating the need for further research to be done within the role of NM as leaders in long-term care organizations.

Byers (2001) researched the importance of knowledge, skills and attributes for leaders in long-term care in their daily practice. Compiled in a secondary report from a previous research study of health care executives; a convenience sample of 175 nursing and non-nursing leaders in Florida, in long-term care settings: nursing homes and assisted living facilities, was collected. A leadership survey of 14 categories was used to identify demographics and the perceived knowledge, skills and attributes of nurse leaders on a 5 point Likert scale. The reliability and validity of the tool was previously established in the larger study. A total of 23.4% of the respondents held an Associate degree and 37.4% with Bachelors. Descriptive statistics and a paired t test determined the perceptions of knowledge, skills, and attributes for the DON and administrator roles. Data showed clinical knowledge rated high within the nursing leadership role. In an independent t test, nurse leaders ranked their knowledge, skills, and attributes as important for their roles. The research supports the fact that even in long-term care, as in acute care; there is a need for the leader development of knowledge, skills and attributes. Byer’s contended that for senior nursing-level management, the basic education preparation must be a Bachelor’s degree in order for nurse leaders to have the knowledge base to identify resident needs
and develop quality resident outcomes.

Similar to Byer (2001), Anonson (2002) also compiled a study in long-term care to identify the traits and qualities of exceptional nurse leaders; via an open-ended interview process with six staff RNs. At the start of the process, the author requested that staff reflect on a nurse leader with whom they recognized displayed exemplary qualities of leadership in the work environment. Anonson stated that the identified nurse leaders showed various years of nursing experience. Some of the leader’s recognized qualities included (a) uninfluenced by negative thoughts, (b) future-oriented, (c) efficient, (d) knowledgeable, (e) passionate, (f) honest, (g) self-esteem, (h) communication, (i) decision makers, (j) understanding, and (k) visionary. In addition, the RNs identified traits of an excellent leader included listening skills, empathy, and a calm demeanor.

According to Purcell (1999), there were three important characteristics of nurse leaders: (1) communication and interpersonal skills, (2) nursing knowledge and skills, (3) and ability for flexibility and change. Further, essential leader traits include empathy, honesty, confidence, flexibility, fairness, respect and open mindedness. Purcell sent 241 surveys to Nurse Managers in long-term care; receiving a 30% response rate; with 94% of the respondents at the Diploma level and the remaining 6% holding a Bachelor’s degree. In the survey, The NMs were asked to define their role in long-term care and their competency for the specific responsibilities. Data revealed the top three roles as: working with families (81.7%), staff motivation (64.8%), and conflict resolution (56.3%). The NM’s self-reported competencies included ratings of 86%, 38%, and 40.8% respectively. In addition, coaching and delegation followed in significance, with 64% manager competence within both areas. Further, there was a noteworthy relationship
between the total skills score and self-reported competency score (p = < .000). In conclusion, Purcell reported that with increased skill, the NMs reported increased competency.

A mixed methods research study completed by Olson and Zwygart-Stauffacher (2008), also reviewed DONs position in long-term care; via sending out a survey to DONs in long-term care organizations in Minnesota and Wisconsin. The researchers received a 460 (56%) response rate; with approximately 60% of the respondents’ educational level at either an Associate or Diploma level. Results showed three qualitative themes: a desire to be more family-oriented, obtain an enhanced leadership role, and gain further human resources skills. The DON’s expressed “frustration with regulations that were perceived as limiting advancing care quality and constraining in their jobs” (p.12). In addition, it was found that the length of DON tenure improved overall satisfaction, with it being at approximately six years. The increased DON tenure also supported quality of care services as well. In summarization, the researchers stated that the leadership roles within the long-term care environment must be further researched as the regulatory issues, increased resident care needs, and quality care requirements are continuously re-defined.

Further, Fleming and Kayser-Jones (2008) completed an ethnographic study which also looked at DON leadership in long-term care, via a compiling interview and observational data collection methods. In addition, purposive and snowballing methods were used to identify DONs with a minimum of one year DON experience. The authors identified ten DONs from four for-profit nursing homes and conducted their research over a six month timeframe. Six of the DONs had a minimum of a Bachelor’s degree
(one had Master’s in Public Administration), three an Associate’s degree (one had a Master’s in Public Administration and one a Bachelor of Arts degree) and further, one held a Diploma degree. The mean number of years working in a nursing home was 12.6 (SD 9.6); and years as a DON was 4.90 (SD 4.35); with the mean number of years as an RN at 20.8 (SD 8.12). Interviews were transcribed and observational field notes were documented; themes were determined through analysis of the data. The author documented Administration responses to state surveys; often the DON position was replaced, or there was a loss of DON empowerment. The authors stated that,” The focus on passing the annual survey set the tone for how DON leadership was enacted and valued by others,” (p. 23). DONs who replaced successful DONs had a better transition to the new role due to a mentorship focus. Moreover, the relationship between the facility administrator and DON was important for effectiveness and quality of care.

Fleming and Kayser-Jones indicated that the constraint on an autonomous DON leadership in long-term care may restrict the changes that were needed for long-term success.

Leadership effectiveness. Harvath et al. (2008) completed a literature review to define long-term care nursing leadership effectiveness. Although this summary could not provide the evidence to support the effectiveness of leadership training, the authors fully supported the need for leadership training in the long-term care settings. These authors’ hypothesized that the organization’s support of leadership training improved the quality and will “stabilize the workforce” (p. 195). Further stated, leadership training should include “interpersonal skills, clinical skills, organization skills, and management skills” (p. 195). Harvath et al. also contended that on-going mentoring for sustainability was
critical to this training.

Further research on leadership effectiveness was looked at by Swagerty, Lee, and Smith (2005) who completed a qualitative case study on 17 residents, 77 staff members, and nine managers in three Mid-western nursing homes through observation, semi-structured interviews and resident record audits. The purpose was to identify and describe organizations through a review of the phenomena that influenced the care in nursing homes. Findings included shared values and teamwork; the DON and licensed staff helped with patient care. The DON was described as a helper with patient care, but at other times, a paper person. However, it was the DON who created the ‘teamwork’ environment. It was the responsibility of the leaders to identify factors that fragment or promote resident care; which was further contended by Swagerty et al. who stated “that effective leadership is the key to change” (p. 48). Additionally, they declared that leaders “can develop strategies to strengthen integrating contextual factors and modify fragmenting factors by drawing on the literature, borrowing from successful colleagues, and empowering staff who want to make improvements” (p. 48).

From a staff retention perspective, many long-term care nursing studies determined that retention issues were due to wages, hours, and staffing conditions (Bowers, Esmond, & Jacobson, 2003; Parsons, Simmons, Penn & Furgough, 2003). Several researchers hypothesized that the lack of leadership skills was a factor in staff retention; yet minimal studies had been completed to look at this factor (Bourbonniere & Strumpf, 2008; Harvath et al., 2008; Wilson, 2005). Studies had been done to equate leadership effectiveness with job satisfaction, turnover, and stress within acute care settings, but minimal research was available in long-term care (Hall et al., 2005).
Harvath et al. concluded in a literature review, that the “evidence on the effectiveness of leadership enhancement programs in nursing homes is relatively weak” (p.195). Wilson also stated that management development programs must be considered for the retention of nurses in the long-term care setting and research needs to focus on evaluating the effectiveness of these programs.

According to Young (2003), the American Nurses Association stated, in the “long-term care arena…nursing has a particular leadership role in working through others to promote optimal clinical outcomes, functional ability, and quality of life” (p. 9). Young concluded that this increased demand required additional staff availability, training, recruitment and retention efforts, and a focal point on cultural diversities and leadership competencies.

Aligning with Young’s (2003) research, Dellefield (2008, Jan/March) completed seven one-hour focus groups which included 3 – 13 participants in each group; identifying the staff experiences for their specific supervisors/managers in two Veteran’s Administration (VA) nursing homes. From the two VA homes, forty staff members volunteered to participate in the focus groups; including certified nursing assistants, LPNs and RNs. The positive management behaviors recognized included supervisory clinical competence, a listening approach, and demonstrating clear responsibilities within their supervisory role. Negative behaviors included lack of respect and employee recognition, and disrespectful behaviors. Nursing supervisors and managers were expected to be clinically competent and acknowledge employee individuality and ideals. Employees significantly valued the manager’s competence and experience.

According to Dellefield, “Providing effective and safe quality care in nursing
homes requires clinically and interpersonally competent nurses in both supervisory and management roles” (2008, p. 198). This research identified best practice interventions within long-term care facilities, including Nurse Manager training, certified nursing assistant (CNA) job enrichment programs to improve retention issues, CNA workplace support, and consistency of CNA assignments. The data showed that management practices supported the relationship between supervisors and staff. These practices comprised considerate listening, positive reinforcement, trust and respect, role-modeling, helping, professionalism, positive attitude, teamwork and advocating (Dellefield; Hall et al., 2005).

Additionally, Sullivan, Bretschneider, and McCausland (2003) identified leadership development needs from the NM’s perspective through qualitative grounded theory research in a study that consisted of twenty-one focus groups; 8–12 per group; of Chief Nursing Officers, Nurse Administrators, and Nurse Managers (n= 94); participants were from various healthcare areas, such as home care, but none from long-term care. Grounded theory analysis identified three theme levels that included verbatim quotes to theoretical constructs. According to the data, NMs described satisfaction in the workplace as (a) having autonomy, (b) flexibility, (c) control over patient intervention for positive outcomes, (d) staff mentoring, (e) situational power and control, (f) ability to influence and change practice, and (g) creativity in program development. It was found the most challenging issues were staffing, lack of systems support, limited control over work environment, conflict management, and reduced supportive resources. Additionally, experienced NM’s developmental needs included conflict resolution, recruitment and retention, regulatory compliance, and a balance between their personal
and work discourses. Inexperienced NM needs included communication, organization, budget, conflict, and staffing. Essentially, this study supported a further need for leader development at both the novice and expert level.

**Leadership and communication.** Scott-Cawiezell, Schenkman, Moore, Vojir, Connolly, Pratt and Palmer (2004) completed a cross-sectional survey to identify the relationship between communication, leadership, and work environment in a nursing home setting. The authors used Shortell’s Organization and Management Survey developed by Shortell, Rousseau, & Gillies in 1991; modifying it to fit the nursing home rehabilitation setting (Scott-Cawiezell et al.). This 5-point Likert scale survey was sent to fifteen long-term care facilities in four states; receiving a total response of 995 staff that included: 15% RNs, 15% LPNs, 36% Certified Nursing Assistants (CNAs), and 22% other clinicians. A thematic qualitative analysis was completed for the open-ended questions that addressed the facility strengths and weaknesses for each rehabilitation care organization. The quantitative analysis included the communication sub-sets of openness, accuracy, timeliness, satisfaction, and understanding. Leadership sub-sets consisted of high standards, clear expectations, initiative encouragement, and support. For communication and leadership, the MANOVA results showed statistically significant (p=.0001) differences between the diverse roles. Univariate ANOVA for communication indicated differences between the roles of RN and LPN for openness (p = < .01), accuracy (p = < .05), satisfaction (p = < .01), and timeliness (p = < .05). Additionally, for the leadership results, ANOVA indicated differences between the RN and LPN, CNA roles for clear expectations (p = < .01), initiative (p = < .01), and also supportive (p = < .01) categories. Further, role strengths were resident care, teamwork, communication,
experience, and dedication; different from the weaknesses that included communication, staffing, resources, and leadership. From this study, it was clear that the different roles within the rehabilitation units of these long-term care facilities needed to improve the staff satisfaction with a focus on communication; through the aspects of accuracy, openness, and timeliness. In addition, leadership improvement to include staff initiative or input, and also leader-staff connectedness would further lead to better communication and resident quality of care.

*Nurse leadership in an acute setting.* Since there was minimal research that examined leadership in long-term care, it was appropriate to review the relevant literature for nursing leadership in an acute setting, with the intention to determine similarities of findings between the different levels of nursing care. An evidence synthesis was completed by Pearson, Laschinger, Porritt, Jordan, Tucker and Long (2007), which reviewed the development of nursing leadership in a healthy work environment outside of long-term care. The authors reviewed 44 articles that were primarily descriptive and relationship-oriented; leading them to discover that different leadership styles created a positive work environment. During their methodology, Pearson et al. found that 36 quantitative articles addressed empowerment, leadership styles, and leadership behaviors as leadership attributes. Leadership characteristics that were associated with job satisfaction were leadership, consideration, initiating structure, coordination of opportunity, challenging the process, and inspiring a shared vision. All qualitative articles reviewed were categorized; equaling a total of 42 findings, thus 17 categories. Finally, eight themes emerged; collaboration, education, emotional intelligence, positive organizational climate, knowledge, professional growth, positive leadership attributes,
and supportive environments. Pearson et al. identified that a healthy work environment was important and several leadership attributes, as previously identified, were needed to support that healthy work environment. The researchers found that participatory leadership lowered staff turnover; thus, transformational, transactional, consultative and participatory leadership styles were correlated to high quality patient care.

O’Neil, Morjikian and Cherner (2008) conducted a telephone survey of 27 healthcare leaders from the in-patient, local and state public health agencies; determining the need for nursing leadership development. In addition, a survey instrument for 54 chief nursing leaders was completed to find out if these leaders had a different concept for leader developmental need. In addition, these authors also identified 100 leadership developmental programs; focusing in on 42 of them, to assess the needs of nursing leaders at three levels: executive, mid-level and frontline. Further, leadership skills within four domains were evaluated: purpose, personal, people and process. Data showed the primary leadership challenges at the executive and mid-level as similar, which included budgeting and workforce (recruitment, retention, and aging workforce). Additionally, leadership development at the mid-level was also a challenge. Results also indicated nurse leaders viewing their skills as ‘building blocks’ (upon each other), increased level of responsibility, and further showing concern with the visionary process. The following leadership competencies identified were; (a) building effective teams, (b) translating vision into strategy, (c) communicating vision and strategy internally, (d) managing conflict, and (e) managing focus on the patient and customer (O’Neil et al.).

Further research was done by the Robert Wood Johnson Foundation Executive Nurse Fellows program, which identified five core competencies that were “essential for
successful leadership in the health care system” (O’Neil & Morjikian, 2003, p. 174). These competencies were (1) self-knowledge, (2) interpersonal and communication effectiveness, (3) risk taking and creativity, (4) inspiring, and (5) leading change. According to O’Neil and Morjikian, it was necessary to “use different styles of leadership to motivate and inspire others” (p. 178).

According to Shirey (2007), the American Organization of Nurse Executives (AONE) released a listing of competencies for nurse executives. The five key competencies included: communication, healthcare knowledge, leadership, professionalism, and business skills. Shirey stated that, “Excellent nursing leadership is central to the model” (p. 167). The organization promoted a leadership self-evaluation which was based on the Benner novice-to-expert model of expert continuum. Further, she contended that, “Benner’s novice-to-expert research had significant application in the nursing leadership context” (p. 167). This leadership model had only been proposed for the acute care clinical settings, but could easily be transferable to the nurse leader in long-term care. According to the AONE, the following components supported excellent leadership: (1) identify one’s core values, (2) create a vision and engage others in the vision, (3) build alliances and channels of collaboration, (4) be a change agent and advocate for innovation, (5) build community and create joy in the workplace, (6) invest in the growth and development of people, (7) lead with passion, (8) determination, (9) sense of discovery and commitment to self discipline, (10) hire the right people, (11) share power and decision making, (12) ensure accountability, and (13) result as a covenant of good stewardship. The AONE argued that there was a need to study expert competency in nursing leadership (Shirey).
Byers (2000) completed a convenience sample descriptive survey of 1,714 senior nursing and non-nursing leaders in Florida. Through the development of a healthcare leadership survey and the tool’s content validity review by four content experts, Byers looked at the knowledge, skills and attributes needed for nurse and non-nurse executives. The reliability for the Likert-scaled instrument was determined through Cronbach’s alpha and item analysis. The response rate for this survey was 269 (16%) and a paired t test compared the responses to the knowledge, skills, and attributes that were necessary for nurse leadership roles. The MANOVA test showed little statistical significance between work setting and leadership (F = 0.524, p = 0.975). However, the test did show a significant relationship between the categories of leadership role (p = 0.0005) and work setting (p = 0.000). Results also indicated that the characteristics ranked highest for nurse executives were clinical knowledge, human management skills, trustworthiness, humor, communication, quality management, and decision making. Even though this study was primarily in an acute setting, the author indicated that the results could be transferable to other settings (Byers).

Upenieks (2003) looked at nurse leaders’ perceptions on the value they place on their role in the acute in-patient setting. Sixteen nurse leaders from four acute health care settings (Two Magnet and Two Non-Magnet) were interviewed. At Magnet hospitals, the promotion of nursing expertise through professional standards and nurse-based outcomes led to job satisfaction and a positive organizational commitment. The majority of leaders at the Magnet hospitals held a Master’s degree; at the non-Magnet hospitals, a Bachelor’s degree. Interviews were transcribed and content analysis was completed to identify themes and trends. The results showed that the nurse leader with “formal and informal
power, access to information, resources and given the opportunity to grow” (p. 149) will be most effective. Leadership attributes recognized were: visibility, responsiveness, passion for nursing, business savvy, building of trust and partnership, responsiveness, open communication, and credibility. Additionally, necessary leadership health care traits included honesty, influence, vision, knowledge, and clarity of thought and action.

Cook (1999) stated that improving healthcare must include making significant strides in nursing leadership. He completed a literature review for the United Kingdom (UK), United States of America (USA), and Australia; defining a nurse leader as ‘directly involved in providing clinical care that continuously improves care and influences others” (p. 306). Cook reviewed 447 articles for leadership and nursing; the majority was qualitative in design, with a few representing experimental. The UK nurse leadership theme was skills and leader abilities; primarily transactional leadership. The USA nurse leadership themes that were derived from 350 articles included transformational or connective oriented, such as collaborative, contributory, mentoring, persuasive, and interactive. Most of the information was anecdotal and opinionated. The six Australia articles defined the renaissance in nursing leadership or the influence of nursing on health care policy. Cook conducted five semi-structured interviews in the UK to look at the nurses’ responses for effective leadership and improved care. The most effective leadership responses were empowerment of others, being visionary, gaining trust and confidence, balancing workload, focusing on the external, and being a problem solver. He identified a model of leadership that included experience, understanding, and the leader’s beliefs and values. Future implication holds that a leader must understand oneself, assess evidence, form solutions, and evaluate effectiveness; to improve care.
Novice-to-expert skills acquisition. Skills acquisition had been studied for many years. To review, Dreyfus and Dreyfus (1986) questioned the concept of a reasoning computer and decided to research the process of human skills acquisition for chess players. Through a phenomenological approach, they observed chess players acquiring skills while moving from a point of little to no prior knowledge to one of greater schematic knowledge. Their model, which is “developmental, based on situated performance and experiential learning,” (Benner, 2004, p. 188) identified five levels of skills acquisition from a novice-to-expert perspective, identifying “qualitatively different perceptions of his task and/or mode of decision-making as his skill improves” (Dreyfus & Dreyfus, p. 19). Hubert Dreyfus described the steps from novice-to-expert as a movement from the “knowing that” to “knowing how” (Dreyfus & Dreyfus; Moe, 2004). “Knowing that” signified the step-by-step process of rules to learn a basic skill, yet “knowing how” is deeper and intuitive.

Acute care nursing novice-to-expert. Daley (1999) conducted interviews and obtained narratives from ten novice, and also ten expert nurses, to identify their specific learning processes. The nurses were identified in accords to their level of expertise, which was shown by the narrative accounts that they provided; not by their years of nursing experience or evaluation reports by their prior supervisor(s). These narratives were analyzed in regards to the abstract principles or concrete experiences incorporated; viewing clinical situations as a whole or partial experience; and whether the nurse was detached or involved in the work environment. The results supported the fact that novice and expert learners have different learning styles; whereas novice learning involves the need for validation as learners’ acquire knowledge and expert learning involves self-
As Dreyfus identified a technical approach to skills acquisition meanwhile Benner also supported the five levels of skills acquisition in nursing (Benner, 1992, 1996, 2001, 2004; Benner, Tanner, & Chesla, 1992, 1996). Her interview and narrative research, which was conducted primarily in intensive care units and hospital medical-surgical units, was focused on the process that nurses followed as they gained knowledge and expertise in a clinical setting. In 1992, Benner interviewed 67 nurses; 51 nurse clinicians; 11 new graduate nurses; and 5 senior nursing students in six hospitals; relating their clinical experiences in an interpretive approach. She also sampled 130 nurses (98% with Bachelor degrees) in groups over a period of six years from intensive care units at eight hospitals and an additional 75 nurses from various clinical areas. Based on her research, she identified five levels of skills clinical acquisition as the nurse progresses from a detached observer to a fully engaged, holistic-oriented, nurse; from a novice-to-expert. The advanced beginner has worked up to 6 months; the intermediate, at least two years; and the expert, at least five years (Benner, Tanner, & Chesla, 1992). The authors stated, “Each level of practice is characterized by advances in clinical knowledge and a resultant shift in the clinician’s grasp of the clinical world” (Benner, Tanner, & Chesla, p. 27).

Benner’s model of skills acquisition provided a clinical perspective of the novice-to-expert model. Within this model, there was a focus on the “articulation of knowledge embedded in expert practice in nursing” (Benner, 2004, p. 188). Benner summarized this embedded knowledge as the expert nurse would “describe clinical situations where his or her interventions made a difference” (Benner, 1992, p. 406). Benner and Wrubel (1982) defined the embedded knowledge as “the systematic study of what is learned from
experience” (p. 17) and in skilled performance. Clinical knowledge and “know how,” gained from the practice of nursing and experiential learning, was embedded in nursing practice and patient outcomes (Benner & Wrubel; Benner, Hooper-Kyriakidis & Stannard, 1999; Benner). In addition, Carper (1978) defined the patterns of knowing in nursing as “the kinds of knowing that provide the discipline with its particular perspectives and significance” (p. 21). As stated by Polanyi, “Sources of embeddedness concern the tacit nature of human knowledge related to skills, techniques, know-how and routines that cannot be easily articulated” (as cited in Nicholson & Sahay, 2004, p. 322).

In the research for her dissertation, Haag-Heitman (2006, 2008) identified the personal and environmental influences that impacted the development of expert performance in nursing. The influences that were researched included risk taking, deliberate practice (focused, goal-oriented), mentor involvement, and external rewards. The sample consisted of 10 nurses who were identified as experts by their respective hospital systems; one system in Wisconsin and the other in Iowa. The author had three separate contacts with each expert; demographic surveys, interviews, and a focus group to confirm the interview results. Two data collection instruments developed by the author were used: the Expert Nursing Practice Questionnaire (ENPQ) and the interview survey Development of Expert Performance in Nursing (DEPN). Eight of the 10 nurses had a Bachelor’s degree, one a Diploma degree, and another with a Master’s in Nursing degree. Seven had greater than 20 years experience, one had 10–20 years, and two others had five to ten years. This experience level for expertise was supported by the research literature (Benner, 1992; Haag-Heitman, 2006, 2008). From the interview, the deliberate practice themes included lifelong and self-directed focus, positive and engaged
demeanor, and choosing diverse work tasks. The risk–taking themes included self-confidence and innovation. Social mentor themes included the influence of the first manager and also childhood influences. The managers were described as (a) encouraging; (b) dedicated; (c) passionate; (d) self-directed; (e) motivated; (f) responsible; (g) sharing; (h) challenging; (i) confident; and (j) supporting. External reward themes included intrinsic motivation and supervisor and peer recognition.

Gershenson, Moravich, Sellman, & Somerville (2004) identified the issues of a nurse when transitioning from an expert nurse to novice NM; suggesting that novice-to-expert mentoring must be supportive in both the clinical setting and new managerial function. According to Nedd, Galindo-Ciocon, and Belgrave (2006), “mentoring is the mechanism of providing support by using more experienced and knowledgeable staff (mentor) with lesser experienced and knowledgeable staff (learner) for the purpose of advancing the learner’s development” (p. 21). The authors developed a mentoring program and an evaluation tool based on Benner’s Novice-to-Expert framework. Ten nurses completed the tool to rate their level of expertise and were matched accordingly with expert nurses for a six month long mentorship. At the end of the six months, there was an improvement in scores for those nurses who were mentored in the intervention group.

Leadership development. Avolio, Walumbwa & Weber (2009) completed a literature review of the current nursing leadership theories, with particular focus on future directions. They summarized a more holistic, positive leadership style, with an impact on ultimate outcomes, and a focus on the causal relationship to those outcomes. In addition, these researchers indicated that “the field of leadership has done surprisingly little to
focus its energies on what contributes to or detracts from genuine leadership development” (p. 442). Moreover, Avolio (2005) stated, “Leadership development, like leadership itself, is a process that is embedded in a context that is changing and emerging all of the time” (p. 169). Yet, leadership development was also based on the perceptions of others toward your leadership style and your trustworthiness (Avolio).

Burke and Collins (2005) proposed a leadership decision making framework on how to transfer skills, beginning with a knowledge base on how to do something. As described, the individual worked through leadership scenarios as the responses became more automatic. Declarative knowledge involved structures, included the working memory facts, and was strategic. Procedural knowledge involved knowing how to do something in a tactical manner and over time, this became automatic. In a conducted study, Burke & Collins interviewed 18 managers acting in leadership roles about conflict resolution in the workplace. The managers were from various business organizations outside of health care. The authors found in their research “a combination of both tactical and strategic approaches was cited by half of the managers” (p. 981). Thus, concluding that it was beneficial to focus on the declarative model for long-term goals; and the procedural model for short term goals.

The development of leadership skills, as described by Mumford, Marks, Connelly, Zaccaro, and Reiter-Palmon (2000) was a four stage process that began at the novice level. The leader, as a novice, lacked an understanding of the work environment, or the conceptual indicators, thus, must be supervised. At the next level, the leader began to “integrate ‘real-world’ experience into base concepts” (p. 90). Through an organizational process, the leader began to handle leadership problems and developed evaluation
standards. As the leader gained more experience, the knowledge skills acquired became more principle-based, and the leader became a better problem solver. Finally, the leader gained wisdom, and attained “complex organizational skills and mental models” (p. 91); an increased awareness of complex solutions. Further, the authors stated that this skills acquisition process may take more than 20 years to move from a simplistic, technical approach to one that includes creative problem-solving and integrative knowledge (Mumford et al.).

In addition, Mumford et al. (2000) conducted a study of Army officers at various stages of leadership who only had leadership experience in the Army. The first group of 1,160 was new leaders who had not been within the actual leadership role. The second group of 410 officers consisted of senior captains and majors with leadership experience, but not battalion experience. The final group of 220 officers consisted of colonels with battalion experience. The groups completed standardized tests to measure their leadership skills and also responded to skill set case scenarios. Additionally, they reported objective accomplishments and “best performance examples” (p. 95) from the last year. The officers were also asked to define developmental influences for skills acquisition in order for the researchers to categorize the responses. The mean differences of recognized leadership skill changes were analyzed through a series of ANOVA’s. Chi-square analysis was completed to demonstrate the difference between knowledge and skills, both from lower to upper levels. Results indicated the means showing an increase in problem solving skills for mid-level (M = -.69) to senior officers (M = -.91). Essentially, the findings from these studies demonstrated that knowledge complexity, and expertise and skills, increased from one grade level to the next. Implication findings
revealed that leaders must acquire basic skills first, and follow with gaining problem-solving strategies later in the process of leader development. Moreover, additional expertise supported the creative thinking skills process that promoted a positive leader development and organizational involvement.

Long-term care organizations experienced high staff turnover due to client acuity levels, organizational ineffectiveness, communication concerns, work load issues, and staff educational backgrounds. Quality of care suffered when turnover was high. According to McAlearney and Butler (2008), leadership development programs improved the workforce quality, efficiencies, turnover, and also focused leaders on strategic priorities. The identification of the skills, competencies, expertise, and embedded knowledge of nurse leaders was the first step in this process. Sullivan, Bretschneider and McCausland (2003) analyzed both the satisfying and challenging issues of the novice and expert Nurse Manager within a health system’s continuum of care in order to create a leadership development program. Sullivan et al.’s research did not include the long-term care level of care, but did provide a basic understanding of nurse leader needs.

Further, the American Organization of Nurse Executives (AONE) identified five competencies, serving as a model for the nurse executive: (a) communication and relationship management, (b) knowledge of the healthcare environment, (c) leadership, (d) professionalism, and (e) business skills and principles (Shirey, 2007). As stated, “Excellent nursing leadership is central to the model” (p. 167). Shirey contended that the research was lacking to understand “the relationship between nurse executive expert practice, associated decision making, and effective leadership behaviors” (p. 169). This expert model of the AONE provided a framework to also understand and evaluate nurse
leadership in long-term care as nurse leader development. The strength of the leader development model was that it provided a foundation for skills and knowledge acquisition, as well as an understanding of the decision-making process. Through an understanding of the NM’s lived expert experiences; this research will inform the long-term care nurse leaders for the provision of resident care quality, positive role-modeling, and leadership expertise.

Conclusion

Leader Development was a critical and necessary element for quality improvement and effectiveness in any organization. This was even more evident within the long-term care organizational environment due to the issues of nursing staff retention and turnover being pervasive and potentially detrimental to elder care. The NM in long-term care had the overwhelming primary responsibility for the care of the oldest-old in our society; those living longer with higher acuity care needs. In addition, the NM was responsible for staff supervision, staff scheduling, and general unit management and leadership. Previous nursing research had been primarily focused on the acute levels of care, such as hospitals, and much research was available for the RN leader within these organizations. There was also a vast amount of leader and leadership development research outside of the health care realm.

Minimal research had been conducted within long-term care organizations and most of that previous research identified the leadership behaviors for the DON position. There was a gap within the research to understand the leadership skills and competencies for the NM in long-term care. In addition, the expert nursing skills had been researched at the acute, hospital level of care, but had not been conducted within long-term care. No
research had been conducted to define the expertise of the NM in long-term care based on the novice-to-expert framework.

A qualitative semi-structured interview process was completed at five long-term care facilities located in New York State. To triangulate the data, the identified NMs completed a self-assessment and their respective DONs/Assistant Director of Nurses (ADONs) completed a supervisory evaluation using the same Nurse Manager Inventory Tool (NMIT). These evaluations provided comparison data of the novice-to-expert leader’s competencies and supported the development of interview questions which were conducted after the NMIT analysis. Then the interviews further defined the NM skills and competencies in a long-term care setting. The methodology for this qualitative research is presented in the next chapter.
Chapter 3: Research Design Methodology

Introduction

Various research studies supported a minimum of ten years of dedicated, continuous service in a particular field to define expertise (Ericsson & Charness, 1994). Expertise in a specific clinical area of nursing had been defined as a minimum of five years of continuous service (Benner, 2001; Benner, Tanner, & Chesla, 1992, 1996). There had been several research studies identifying Registered Nurse (RN) expertise within the acute care hospital environment, but minimal research had been completed within long-term care (nursing home) organizations. There was no research to evaluate the Nurse Manager (NM) in long-term care, as an experienced leader from a novice-to-expert level. The NM was instrumental for the quality of long-term resident care and resident, family, and employee satisfaction. Since this was such a pivotal position, it was critical to understand how the NM, as a leader, defined and described their lived experience in this role.

Day et al. (2009) proposed a leader development theory that identified the most observable declarative (what) and procedural (how) traits of skills acquisition. As the leader moved through the developmental process; both strategic and adaptive competencies were learned, thus, increasing the automaticity of responses. Self regulation, awareness, and efficacy were critical aspects for leader competence and movement toward expertise. Expert leaders have an embedded knowledge that defined the “knowing” of practice and allowed the automaticity of actions. This research study
used a qualitative research methodology to learn more about NM’s lived experiences as expert leaders in long-term care. This phenomenological research study asked the following question:

How do expert Nurse Managers, as leaders in long-term care, define and describe their lived experiences to develop their expert skills, competencies, expertise, and embedded knowledge?

**Methodology**

Qualitative research answers questions in the participant’s field, in a natural setting, so the researcher can grasp as much valid, reliable, and meaningful information of each participant. The researcher’s goal is to understand the issue holistically; through the view of the participant (Creswell, 2007, 2009). Phenomenological, qualitative research focuses on the “lived experiences of a concept or a phenomenon…describing what all participants have in common as they experience a phenomenon” (Creswell, 2007, p. 58). Phenomenology focuses on the essences of shared participant experiences. These experiences are the participant’s perception of their world, “embodied” in their own context (Morse & Richards, 2002). Van Manen declared: “Phenomenology practices an almost meditative, yet highly reflective attentiveness to the concreteness of the ordinary things of our world” (2002, para. 2). It is critical in a phenomenological study that the researcher be focused on the participant’s vision of the essence of the phenomenological experience (Creswell, 2007).

Additionally, in a qualitative design, the researcher collects “data in the field at the site where participants experience the issues or problem under study” (Creswell, 2009, p. 175). Multiple forms of data collection are used so that the researcher is able to
learn “the meaning that the participants hold about the problem or issue” (Creswell, 2009, p. 175). In a qualitative design, an inductive approach is used for analysis and “what becomes important to analyze emerges from the data itself” (Maykut & Moorehouse, 1994, p. 127). For this reason, a qualitative phenomenological approach was used in this study. Since NM leadership in long-term care had not been researched, a qualitative phenomenological approach supported an ability to present the manager’s lived experiences in their role.

**Research Design**

This research study used an exploratory descriptive qualitative design to identify the skills, competencies, expertise, and embedded knowledge of expert NMs, as leaders who work in long-term care organizations. These NMs were identified by the Director of Nursing (DON) or Human Resource Department (HR) as having greater than five years NM experiences either at the current or previous organizations. The phenomenon of study included the components of skills acquisition, development of leadership competencies, and the embedded knowledge of the Nurse Manager along a continuum of novice to expert. The study used several methods, including a demographic survey, Nurse Manager Inventory Tool (NMIT) (see Appendix M), semi-structured interviews, and field notes. The NMs completed a demographic survey identifying dates and the history of health care employment, formal health care education, and leadership seminars (see Appendix G). The NM completed the NMIT as a self-assessment, as well as the Director of Nursing (DON) or Assistant Director of Nursing (ADON), which served as their supervisor evaluation. This tool provided an assessment of the NM skills based on a novice, competent, and expert rating scale.
The triangulated qualitative design provided several perspectives to understand the skills and competencies of the expert NM. Creswell (2007) stated that triangulation of the data is achieved through various “sources, methods, and investigators to establish credibility,” (p. 204) in order to support the trustworthiness of the research. In addition, the “multiple strategies” of triangulation “build a coherent justification for themes. If themes were established based on converging several sources of data or perspectives from participants, then this process can be claimed as adding to the validity of the study” (Creswell, 2009, p. 191). Through triangulation, the intent of the research study is further supported via the data that resulted from this investigative study.

Research Context

Setting. The setting for this study occurred in a city in New York State with an approximate population of 200,000 (American Fact Finder, 2005 - 2007). As of 2006, the median household income was $49,200; a decrease of 12% from 2000 (ACT Rochester, 2009). Five long-term care organizations, which are located in this same city, agreed to participate in this research study. These five organizations have worked together collaboratively for more than ten years on shared efforts such as grants, management contracts, and rehabilitation programs. Each organization is non-profit, separately owned and operated, and includes continuums of care. These organizations have high standards of quality, are considered premier long-term care facilities, and have strong community ties.

Elder services. Elder care services in these organizations were provided as a continuum of care; enabling residents to move through each system from full independence to the highest level of long-term care, as their health care needs increase
overtime. Residential services included independent apartments and patio homes, adult care facilities, rehabilitation, long-term care, dementia, and hospice care units. Health care services in the adult and long-term care settings were regulated by the New York State Department of Health and Medicare/Medicaid guidelines. The number of long-term care beds ranged from 183 to 591, with reimbursement including Medicare, Medicaid, other insurances, and private pay.

*Staff levels.* The facility bed size and numbers of nursing employees (full and part-time) per classification at each organization are shown in Table 3.1. Nurse Managers are not included in the RN total, with per-diem staff not included in the total employee count.

**Table 3.1**

*Number of Beds and Employees per Classification at Long-term Care Organization*

<table>
<thead>
<tr>
<th>Items</th>
<th>LTC Facilities</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>1</td>
</tr>
<tr>
<td>Bed Size</td>
<td>183</td>
</tr>
<tr>
<td>CNA(FT/PT)</td>
<td>88</td>
</tr>
<tr>
<td>LPN(FT/PT)</td>
<td>40</td>
</tr>
<tr>
<td>RN(FT/PT)</td>
<td>20</td>
</tr>
<tr>
<td>NM (FT)</td>
<td>5</td>
</tr>
</tbody>
</table>

*Research Participants*

A purposive sample was used for this study. The research participants included identified Nurse Managers with five or more years of experience in the NM position. Based on this experience, these NMs would be considered experts in their field at five years from a nursing perspective and ten years from a non-nursing perspective. This
experience included both the current and previous positions. The DON or HR in each organization identified the NMs. There was a total of 45 NMs working in the five organizations, with 28 being identified as having greater than five years of experience as a NM. At the time of the interviews, all NMs with five or more year’s nurse management experience were considered for this research study. The criteria for inclusion included; (a) a minimum of five years of Nurse Manager experience, (b) experience as NM at current or previous positions (c) ability to complete self-evaluation within a month, and (d) ability to be individually interviewed within two months. Twenty-two Nurse Managers agreed to complete the NMIT survey, with twenty having agreed to the interview.

*Research study permission.* The researcher contacted the Chief Executive Officers (CEOs) of each long-term care organization to obtain permission for the research study in each facility. CEO consent was provided through e-mail and the researcher was told to contact the DON of each organization. The researcher contacted each DON by e-mail or phone to provide a preliminary explanation of the research design and purpose; and followed up with a letter of explanation at a later date (see Appendix B). Two organizations requested copies of all of the research documents; one requested that the information be sent to the Medical Director to review, and the other for an ad hoc review committee. Since there was no resident contact, all organizations approved the research design in each of their respective facilities.

The researcher contacted each DON to set an on-site informational meeting to further discuss the research study and NM qualification criteria. At this meeting, the research study purpose was explained, the process to identify expert NMs was discussed,
and the consent forms were presented and signed (see Appendix C). All DON’s agreed to identify qualified Nurse Managers and to participate in the study. The DON’s were given a folder for each qualified nurse manager, which included the Nurse Manager Inventory Tool (NMIT) with instructions (see Appendix D) and also summary definitions for novice, competent, and expert levels (see Appendix E). The researcher provided an explanation for completion of the NMIT and a discussion of the novice-to-expert model, including the reason for the usage of this model in the research, and the timeframe for the survey completion. Each DON signed the informed consent form and agreed to participate by identifying qualified NMs and completing the NMIT for each participant. Each DON received an envelope in which to place all of the surveys and scheduled times were set for the researcher to pick-up the completed surveys.

The DONs clarified the research information with their HR and then verified which NMs fit the qualifications, based on a minimum of five years experience. The participants, who met the criteria, were identified and contacted by their DON to determine their interest in the research study. Once the NMs agreed to participate, the DON scheduled a meeting for the researcher to meet with the nurse managers. One DON had already identified qualified NMs and they participated in the initial DON meeting. The remaining DON’s scheduled a separate meeting for the researcher and qualified NMs.

Nurse Manager contact. Once the DONs identified the qualified NMs, a meeting was set to explain the purpose of the research study and the reasoning behind their selection. A folder was given to each NM, which included an introductory letter (see Appendix F), informed consent form with a brief study summary (see Appendix C),
demographic sheet (see Appendix G), copy of the NMIT (see Appendix M), summary of the terms novice, competent, and expert (see Appendix E), and, and a self-addressed stamped envelope to return the surveys. The researcher explained how to complete the demographic and the NMIT surveys and the completion timeframe. In addition, the researcher discussed the interview process; that it would be audio-taped and would be one hour in length. Confidentiality of all participant involvement and data was explained as well. Further, the researcher also discussed how the transcriptions would be sent to each participant for review prior to data analysis, for clarification of responses.

During this process, the NMs were given an opportunity to review the information; time was given to ask the researcher questions. Most NMs signed the consent form at this meeting, with a few who chose to leave with the information for further review. All NMs who participated in this research signed an informed consent. Additionally, all NMs provided e-mail contact information for the researcher’s purposes. In addition, the researcher also confirmed the protection of confidentiality and indicated that the College IRB provided permission for the study to be conducted. The NMs received a self-addressed stamped envelope for both the demographic survey and the NMIT survey; with a three week time-frame to complete and return to the researcher. The NMs and DONs agreed to complete the surveys in three weeks; at which time the interviews were scheduled.

Once the surveys and demographic information were sent to the researcher and the data was entered into SPSS for analysis, then the interview questions were developed (see Appendix H). The researcher contacted each NM via e-mail to schedule a convenient interview time. Due to the NMs time constraints, the interviews were 30
minutes to one hour in length and conducted at their respective work sites; either in the NM’s office, a private room on the unit, or a private room which was separate from the employee’s unit, with a three week timeframe provided. All interviews were conducted with solely the researcher and the NM, in consideration of privacy and confidentiality. Further, all of the interviews were audio-taped, transcribed by an outside transcriptionist, then a copy was e-mailed to each NM to review for accuracy. The NM’s requests for transcript changes were made and additional questions were answered. Nineteen NMs agreed to the qualitative analysis of their interviews.

There were 45 NMs working in the five long-term care facilities and the DONs purposively identified 28 who qualified for the research study based on the criteria. The DONs completed 27 NMIT surveys; however, only twenty-two NMs completed the demographic and NMIT surveys. The completed data was entered into SPSS. Following, the researcher e-mailed each NM who completed the survey and gained twenty respondents who agreed to be interviewed. Table 3.2 identifies the NMIT surveys completed by both the DONs and NMs and the interviews conducted.

*Instruments Used in Data Collection*

*Demographic survey.* The researcher developed the demographic survey that the Nurse Managers completed. Each NM received a copy of the demographic survey at one of the scheduled meetings at each organization. The requested data included identification information: name, facility, type of unit, employment history, including dates as a CNA, LPN, RN, and NM, formal education level, and year of graduation (see Appendix G). This survey took approximately 10 minutes to complete.
Table 3.2

*NMIT Surveys Completed and Nurse Managers Interviewed*

<table>
<thead>
<tr>
<th>Items</th>
<th>LTC Facilities</th>
<th>NMs</th>
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<td>2</td>
</tr>
<tr>
<td>NM Total</td>
<td>5</td>
<td>5</td>
</tr>
<tr>
<td>NM Met Criteria</td>
<td>3</td>
<td>3</td>
</tr>
<tr>
<td>DON Surveys</td>
<td>3</td>
<td>3</td>
</tr>
<tr>
<td>NM Surveys</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>NM Interviews</td>
<td>2</td>
<td>3</td>
</tr>
</tbody>
</table>

*The Nurse Manager Inventory Tool (NMIT).* The American Organization of Nurse Executives (AONE), American Association of Critical-Care Nurses (AACN), and the Association of Peri-Operative Registered Nurses (AORN) created an alliance in 2002 and developed the Nurse Manager Learning Domain Framework (NMLDF); consisting of three competency domains that would support the success of nurse managers. The first domain, *The Science: Managing the Business,* included (a) financial management, (b) human resource management, (c) performance improvement, (d) technology, (e) strategic management, and (f) clinical practice knowledge. The second domain, *The Art: Leading the People,* included (a) human resource leadership skills, (b) relationship management, (c) diversity, and (d) shared decision making. The third domain, *The Leader Within: Creating the Leader in Yourself,* included (a) personal and professional accountability, (b) career planning, (c) personal journey disciplines, and (d) optimizing the leader within. The Nurse Manager Leadership Partnership (NMLP) was created in 2006 as a partnership between the AACN and AONE.
The NMIT was developed from the learning domain framework and “captures the skills and behaviors that are envisioned for the successful nurse manager” (Nurse Manager Inventory Tool, 2006, p. 1). It can be used as a Nurse Manager Self-assessment tool and a supervisory evaluation for various health care settings. The NMIT survey was a 5-point Likert Scale with three identified ratings. These three ratings were based on the novice-to-expert continuum (1) novice experience/skill, (2) competent experience/skill, and (3) expert practice, based on Benner’s novice to expert model. Benner identified these levels: (a) novice, (b) advanced beginner, (c) competent, (d) proficient, and (e) expert. The NMs and supervisors were instructed to mark anywhere along the five point scale. If a response was placed in the middle of the two levels, it was scored to the next highest rating if beyond the mid-point, and scored lower, if below the mid-point. For this research, the NMs were provided a definition of terms for novice, competent, and expert (see Appendix E). NMs at the novice level were rule-oriented, somewhat inflexible, and capable of learning basic management skills. At the competent level these NMs showed an increased level of management skills acquisition, but inflexibility continued to exist, especially with new experiences, and there was some difficulty in multi-tasking. Lastly, NMs who were at the expert level showed increased confidence, involvement, active decision-making, and flexibility with new situations; and further, interpreted situations using tried and tested management and leadership principles, abstract reasoning and holistic processes in which to guide practice.

This tool was primarily used in the acute care settings. According to Thompson, the AONE Chief Executive Officer, validation of the tool’s competence was achieved through a previous analysis of the AONE Nurse Manager certification examination which
correlated to the inventory tool (P. A. Thompson, personal communication, July 20, 2009). Thompson also stated that there was no indication that this tool had previously been used in the long-term care setting and granted permission through e-mail to use the tool in this research study.

Most surveys were received within one month. If a survey was not returned, the researcher made a maximum of two additional contacts with the participant, either via e-mail or phone. If the participant did not respond, it was understood that the NM did not want to continue with the research study. The DONs completed the NMIT tool for 27 of the qualified NMs. The NMIT surveys that did not match to a completed NM survey were disregarded from the data analysis. The NM and DON survey tool data was inputted into the SPSS for descriptive and means statistical analysis. The results of this analysis were used to develop the interview questions.

A comparative analysis of the means for the NMs and DONs responses was conducted through an Independent Samples t-test analysis (see Appendix J). An Independent-samples t-test that “compares the means of two samples…which are independent of each other” (Cronk, 2006, p. 58) was analyzed; the results were used to develop the interview questions. The NM and DON survey responses were analyzed according to the NMIT categories. The independent variables included (a) clinical skills, (b) leadership reflective practice, (c) diversity, (d) HR leadership, (e) relationship management, (f) performance improvement, (g) problem solving, (h) information technology, (i) HR management, (j) strategic management, and (k) financial management. The dependent variables were the NM and the DON/ADON groups (see Appendix J). Based on the NM and supervisor t-tests results, there was no evidence that
the two populations differed in mean levels and the results of the Independent Samples t-test were used to develop the interview questions (see Appendix K).

**Feasibility of interview questions.** Prior to the NM interviews, the researcher conducted two phone call interviews with NMs in other organizations to determine the feasibility of the interview questions. One NM was in staff development for a long-term care facility and the other was a NM in an acute care setting. Each NM responded easily and appropriately to the questions asked. No changes were made to the interview questions.

**Interviews.** Twenty interviews were scheduled over three weeks at the Nurse Manager’s offices in the long-term care facilities. Interview questions were developed from the analysis of the NM and DON/ADON responses on the NMIT. These questions were open-ended, regarding the NM’s skills, competencies, and expertise in their management role. Additionally, three questions were added for the Nurse Managers to reflect upon, concerning the future of leadership development in long-term care, recommended changes, and defining the long-term versus acute care NM skill set (see Appendix H).

At the beginning of each interview, the researcher presented the NM with a copy of the summary descriptions for the novice, competent, and expert levels to review before answering the questions (see Appendix E). Each NM was reminded that the interview would be audio-taped, and that these tapes would be transcribed by an outside transcriptionist who signed a confidentiality statement. It was also emphasized that confidentiality would be maintained throughout the interview and analysis process. The NM was able to not follow through with the interview or refrain from completing it at
any time without consequence. At the end of the interview, the researcher presented a $10 gift card to each Nurse Manager for their participation.

NMIT category headings were used as interview questions, with the exception of the foundational thinking skills category, which asked decision making and problem solving skills. Additionally, the shared decision-making category was eliminated in the interview due to shared governance as an undefined nursing responsibility in the long-term care environment. Lastly, personal and professional accountability, career planning, and personal journey categories were also not included in the interview process since the research question’s focus was on NM skills and competencies.

Field notes. At the completion of each interview, signified by the turning off of the audio tape, some of the NMs continued to share information about their management role in long-term care. The researcher obtained verbal permission to document these statements and included them in the data analysis.

Procedures Used in Data Collection

Confidentiality. The NMs were asked to sign an informed consent statement prior to each interview. This statement provided the specific measures to protect the confidentiality of each participant in the interview and evaluation process. Confidentiality was maintained during the audio-taped interview by not using personal identifiers during the interview process. The transcriptionist also signed a confidentiality agreement before receiving the transcriptions. Confidentiality was also maintained through the analysis of the self-assessment and supervisor evaluation by using classification codes for the manager and supervisor surveys. The researcher solely accessed the individual names in order to link the codes between the manager’s self-
assessment survey and supervisor’s survey. The NM and the DON/ADON did not receive any identifying information from these inventory tools, and further, the data was not shared between the participants.

Confidentiality of interview data, transcripts, audio-tapes, and any supporting documentation will be maintained in a locked, secure area in the researcher’s possession for a minimum of three years upon the conclusion of the dissertation process.

Institutional Review Board. Prior to the start of the research study, permission from the Institutional Review Board (IRB) was obtained through the college to ensure confidentiality, informed consent, and the safety of all participants. Permission was also obtained from each long-term care organization as required by their individual review processes. Further, confidentiality was maintained during the interviews. Each participant signed an informed consent form that provided research study information and provided a copy for their own records.

Data Analysis

Several methods of data analysis were utilized during this research study. The researcher used descriptive statistics to summarize the demographic surveys. For the NMIT survey results, an Independent-Samples t-test was completed, with the results being used to develop the interview questions. The NM and DON survey responses were analyzed according to defined categories from the NMIT survey tool as identified in the Independent Samples t-Test Group Statistics results (see Appendix J). The independent variables included (a) clinical skills, (b) leadership reflective practice, (c) diversity, (d) HR leadership, (e) relationship management, (f) performance improvement, (g) problem solving, (h) technology, (i) HR management, (j) strategic management, and (k) financial
management. The dependent variables were the Nurse Manager group and the DON/ADON group. A comparison of means for each category is provided through the Independent Samples t-test. (see Appendix K).

The Independent-Samples t-test compared the mean scores of the NMs in different categories to the mean scores of the DON responses in the same categories. Overall, no significant differences were found between the means in each category. In addition, the NMs and the supervisors assessed the manager skills and competencies at a similar level. Based on the NM and supervisor t-test results, which indicated no evidence that the two populations differed in mean levels for each category, the outcomes of the Independent-Sample t-tests were used to develop the interview questions. The results from each category of the Independent Samples t-test are summarized in chapter four.

The transcriptions were organized and identified by the labeling used in the audio-tape. They were initially reviewed to obtain a sense of the data and to begin the process of understanding the meaning of each manager’s responses. Initial codes were placed in the margins identifying initial codes that pertain to NM skills, competencies, and expertise. Maykut and Morehouse (1994) stated, the “units of meaning are identified by carefully reading through transcripts, field notes and documents” (p. 128). At the second data review, the researcher and another coder reviewed all of the responses from a sample of the transcripts, enabling them to identify and obtain agreement on the initial codes and also find new ones. Once the initial codes were identified, each coder separately reviewed additional transcripts and continued this process until reaching a 90% intercoder agreement. According to Creswell (2007), this intercoder agreement provided “an external check on the highly interpretive coding process” (p. 210).
Morse and Richard (2002) identified three types of qualitative coding: descriptive, topic, and analytic. All transcripts were downloaded to Atlas Ti, a qualitative software program, which was used to highlight and categorize the codes that were identified via the intercoder agreement. The interviewees’ transcriptions were read additional times with descriptive and topic notations noted in the margins, in hard copy form, in order to “highlight ‘significant statements,’ sentences, or quotes that provide an understanding of how the participants experienced the phenomenon” (Creswell, 2007, p. 61). These notations and highlights were also added to the Atlas Ti data software. In addition, topics were identified and grouped according to similarities in the established codes and new codes were identified when necessary. Moreover, data was reviewed based on the NMIT interview questions categories and similarity of codes within those categories was identified.

Additionally, the audio-taped transcriptions were further reviewed, identifying “descriptive wording,” (Roberts, 2004, p. 143) which correlated to the research question. Notations on the audio-tape were added to the data as well. Next, the researcher further analyzed the texts, topics, and codes to identify concepts and themes pertinent to the research question and description of the essence of the phenomenon for the NM’s skills, competencies, and expertise. Triangulation of the data through NM interviews, NMIT self-evaluations, and NMIT supervisor evaluations provided additional trustworthiness of the findings for the identified codes and themes (Roberts).

Field notes were taken at the end of the audio-taped interview to document observations, impressions, and reflections from the interview process (Morse & Richard, 2002). These field notes were also used in the data analysis and coded with previously
determined codes.

Summary

Qualitative research in acute care hospitals was conducted to understand the roles of novice-to-expert clinical nurses. Minimal research had been completed to understand the expertise of nurses within the long-term care environment. Most of the research within long-term care had focused on the role of the DONs or administrators. Further research was critical to the understanding of the role of the NM who was responsible for daily unit operations and quality of care. This qualitative phenomenological research study focused on the skills, competencies, expertise, and embedded knowledge of NMs as leaders in long-term care who were considered experts by the definition of greater than five years of NM experience.

This research study occurred at five New York State long-term care organizations that were all nonprofit continuums of care. Demographic data was obtained to identify each nurse’s education level and years of NM experience. Each NM completed the NMIT as a self-assessment, as well as the DON, utilizing it as a supervisor evaluation. This tool included response categories of novice, competent, and expert which correlated to the research question. Analysis of the data included a statistical analysis of the means for the NM and supervisor surveys. Interviews were conducted with NMs who had a minimum of five years NM experience. The researcher reviewed these transcribed interviews and field notes for identified codes and themes. The significance of the results of this analysis is discussed in the following chapter.
Chapter 4: Results

Introduction

The research question for this study was, “How do Nurse Managers, as leaders in long-term care, define and describe their lived experiences to develop their expert leader skills, competencies, expertise, and embedded knowledge?” To answer this research question Nurse Managers (NM) and Directors of Nursing (DON)/Assistant Directors of Nursing (ADON) completed the Nurse Manager Inventory Tool (NMIT) survey and NMs were interviewed after the surveys were completed. According to the survey results, NMs reported themselves at the proficient level (level 4) only in one area: clinical skills. They described themselves as competent in these areas: leadership reflective practice, diversity, human resources leadership, relationship management, performance improvement, problem solving, information technology, and human resources management. They placed themselves at the advanced beginner level (just above a novice) for strategic planning and at a mid-novice stage for financial management.

The NMIT survey and interview results, along with NM demographic information are summarized, starting with the proficient (near-expert) and ending with the novice scores. The quantitative NM and DON results, including the means, standard deviations, standard error of the means, and Levene’s Test for the equality of variances are presented. Corresponding qualitative interview themes are provided for each category. During the interviews, the NMs identified several themes that crossed categories; visibility on the unit, trial and error learning, lack of RN availability (aloneness), peer
support, intuition, and final journey. A summary of these themes are also presented.

**Demographics**

Initially, 28 out of 45 female nurse managers (62%) met the criteria for inclusion in the research study which included; (a) minimum of five years of NM experience, (b) experience as NM at current or previous positions (c) ability to complete self-evaluation within a month, and (d) ability to be individually interviewed within two months.

Twenty-two (79%) agreed to participate in the research; completing the NMIT (see Appendix M) and demographic surveys (see Appendix G). The DONs/ADONs (96%) completed 27 NMIT surveys but only twenty-two of these surveys were matched with the NM surveys. Twenty (71%) NMs agreed to a follow-up interview. Nineteen (68%) NMs agreed to participate in the qualitative analysis of their interviews. Reasons given by those NMs who decided not to participate in the study included lack of time, concern with providing the information, and change of employment status.

Several NMs had previous Certified Nursing Assistant (CNA) (26%) or Licensed Practical Nurse (LPN) (16%) experience. Some NMs started as a CNA then were educated as an LPN (21%) before obtaining their Registered Nurse (RN) license. RNs can graduate from any of three educational levels; a hospital-based three year Diploma Degree, a two year Associate’s Degree (AAS) or a four year Bachelor of Science Nursing Degree (BSN). Each degree provides the requisite nursing education for a graduate to take the RN licensure examination to practice as an RN in the state of licensure. Of the 19 responders who participated in the NMIT survey and the interview, three (16%) had a Diploma Degree, nine (47%) had an Associate’s Degree, seven (37%) had a Bachelor’s Degree. Four NMs (21%) obtained their RN license first then completed a BSN. Three
(14%) NMs had a non-nursing Bachelor’s Degree and two (9%) had a non-nursing Master’s Degree. One was pursuing a Masters in Advanced Practice Nursing (APN).

Clinical Skills

When asked about clinical skills, the NMs very quickly responded that expertise in these skills was necessary due to the increased resident acuity levels, the lack of unit RNs, and lack of daily physician/Nurse Practitioner (NP) presence. The NMs had to be confident with their clinical skills in order to accurately manage resident care on the unit including knowing when to contact the physician/NP. With technological advances, the NM had to balance both clinical and technological skills and for some NMs this was very difficult. Several managers emphasized that due to the lack of RN availability and support, they relied on LPNs to provide resident and staff updates. Most of the NMs described a “do it all” approach for unit clinical management and a sense of “aloneness” for clinical decision-making. Previous acute and long-term care (LTC) experience played an important role in the development of their expertise.

Quantitative analysis. The independent samples t-test for clinical skills indicated that the means for both the NM and DON/ADON responses was equivalent to the proficient level (Table 4.2). Seven of the supervisors rated the NM at an expert level but only three of the NMs rated themselves as experts. Four NMs rated themselves at a novice to advanced beginner level, despite many years of LTC experience while their supervisors rated them at competent or proficient level. One NM indicated that numerous technological and clinical advancements required learning new clinical and managerial tasks every day; thus supporting a sense of always being at a novice level.

At a 95% confidence level, the Levene’s test for equality of variances for clinical
skills was not significant (p = .090) and equal variances of the means was assumed (Table 4.3). There was no difference in the mean levels between the NM and the DON/ADON groups for this category.

Table 4.2

Clinical Skills Independent Samples t-test NM and DON Group Statistics

<table>
<thead>
<tr>
<th>Group</th>
<th>N</th>
<th>Mean</th>
<th>Std. Deviation</th>
<th>Std. Error Mean</th>
</tr>
</thead>
<tbody>
<tr>
<td>NM</td>
<td>21</td>
<td>3.57</td>
<td>1.0757</td>
<td>.2347</td>
</tr>
<tr>
<td>DON/ADON</td>
<td>20</td>
<td>4.10</td>
<td>.8522</td>
<td>.1906</td>
</tr>
</tbody>
</table>

Qualitative analysis. During the interview, several themes emerged when the NMs discussed their clinical involvement in long-term care. These themes supported the NM/DON means scores at a proficient level and included aloneness, increased acuity levels, intuition/gut feeling, trial and error, laddering, peer support, constant learning, training, and resident priority. In the following section, a summary for the clinical themes is provided along with supporting NM comments.

Table 4.3

Clinical Skills: Independent Samples Levene’s Test for Equality of Variances

<table>
<thead>
<tr>
<th>Levene's Test for Equality of Variances</th>
<th>t-test for Equality of Means</th>
</tr>
</thead>
<tbody>
<tr>
<td>Equal Variances</td>
<td>F</td>
</tr>
<tr>
<td>Assumed (A) or Not Assumed (NA)</td>
<td>M</td>
</tr>
<tr>
<td>Clinical Skills</td>
<td>1.518</td>
</tr>
<tr>
<td>NA</td>
<td>-1.748</td>
</tr>
</tbody>
</table>
From a clinical perspective, the pressure on the NMs was very intense since many of them were the only RN for the unit, responsible for all resident care outcomes and the coordination of clinical care. This theme of *aloneness* was pervasive throughout the interviews, that the managers were generally the only decision-maker, to complete the assessments, and to carry the responsibility for resident care, family involvement, and staff support. Twelve out of 19 NMs were the only RN on the unit and six had 1 RN to assist them. “You are it” was the description by one manager. As the only RN was a tremendous responsibility and this manager described it as, “simply by virtue of their license they are responsible.” Since there are not enough RNs in this healthcare setting, most managers were supported by Licensed Practical Nurses (LPNs) to complete nursing tasks. Yet this NM summarized the LPN limitation as being “task oriented, [they] do not have the assessment skills.” This adds to the manager’s sense of *aloneness* and “the Nurse Manager realizes that she is responsible for the care of all the residents on the unit, knowing that the LPN’s are at different levels of expertise.”

Adding to this sense of *aloneness* in clinical decision making, the providers, such as Physicians or Nurse Practitioners, were not routinely accessible on the unit. For this reason, the NMs had to be comfortable with their clinical decision making process. In other words,” they have to know when the situation has escalated to a point where somebody needs to be called.” One participant acknowledged that “you have to become an expert because you don’t have your medical right there; I mean you have to make clinical judgments and use critical thinking even to decide to call them.” Another explained, “first thing in the morning you do rounds, you find out what your problems are … communicate to medical … acute needs… I have to do all that.” Clinical assessments
and subsequent decisions must be made quickly and the RN made that assessment and relayed accurate information to the provider. As a nurse stated,” the physicians here trust our judgment and rely on what we see and report to them. I guess we’re just pretty darn good.”

Resident acuity levels in long-term care were increasing and residents definitely had more co-morbidity and consequently more clinical needs. As stated by this participant, “the residents are coming in with more challenging diagnosis, illnesses, equipment, procedures.” And another indicated that, the acuity level of residents “has changed in the last four or five years…we’re getting more clinically complex people and we send people in and out of the hospital more frequently.” With higher acuity levels, the presence of the NM was even more critical for quality resident outcomes.

The NMs also spoke about the theme of having a gut feeling, or an intuition, that they sensed when something was wrong with the resident. This gut feeling was an embedded knowledge, a “knowing how” that they must make a quick decision to impact resident care. Identified as the most useful skill in long-term care, an experienced NM defined the “gut feeling … it’s from head to toe and just getting to know the person, get a feel for them … if there’s a problem … just by looking at someone … you have to be in the gray area … to really know everything.” In addition, she stated, “it’s like intuition … just by looking … into their eyes, just their facial expressions you just know something isn’t quite right.” Clearly, more years of clinical experience were instrumental to develop this gut feeling as stated by this NM, “you get more expertise the longer you’re a nurse.”

Learning through trial and error was a frequent theme across several categories. In the clinical category, the NMs indicated that they often learned by making mistakes.
*Trial and error* was sometimes the only way to learn those assessment skills as this Nurse Manager stated that “you have to make those judgment calls and you have to rely on yourself and others around you and your clinical skills” and learning “from the school of hard knocks” to gain experience.

Interestingly, the “many years of experience” as an RN was not the only way that these Nurse Managers learned. The NMs described the theme of *laddering* as previously having other LTC staff positions that helped them to understand staff and unit expectations. This *laddering* experience supported their clinical expertise as stated by this manager, “going up in the ranks…the majority of us just didn’t start out as a Nurse Manager … a lot of us were CNA’s, LPN’s, and RN’s.” And another NM summarized that, “We’ve done all the hands-on.” This provided the NMs a more comprehensive approach to the unit responsibilities.

In these long-term care facilities, there was not a defined NM orientation or *training* program. This interviewee described that, “you don’t get a lot of *training*…you just kind of learn by doing” and “when you come in at that level as a Nurse Manager…you get just the bare minimum basic general orientation… but there’s no formal classes.” Since there were limited RN’s in long-term care settings, those who were successful clinically as a staff RN were approached for management positions. One manager described this approach as you were “such a great staff nurse, we have an opening why don’t you take the job” and further stated that she had “never been shown the organizational skills that you need to have to be a manager.” So managers primarily learned by *trial and error* and *peer support*. During the orientation process, one manager re-called those first days as a manager, “I did follow her [*peer nurse manager*] for a
couple of days and I took her ideas and some that I had of my own and put together some things.” Another manager described peer support as, “We always ask each other, we always help each other in different aspects of difficult situations.”

Even though there may not be formal management training, the Nurse Managers emphasized that in their position it was critical to develop confidence through a constant state of learning. This statement from an interviewee summarized this learning state, “one of the things I always love about nursing is every day I’m learning something new.” This was supported by another participant, “I can’t direct staff to do things if I can’t do it myself, and so I have to have the experience of doing it.” In most facilities, staff education supported training on technology, new clinical techniques, resident care, policies and procedures and they did encourage in-services and continuing education.

In every interview, there was always an emphasis on resident priority and the NM responsibility for resident care. One manager, who had acute care experience, was asked if she would be bored transitioning into long-term care and her response was, “I said no because there comes a point in your life that as I call it getting back to the residents.” And another NM very simply stated, “We’re all here for one purpose and that’s to take care of the patient.” Since the resident priority was so clearly stated, NMs needed to depend heavily on their clinical knowledge, skills and assessment expertise. As stated by this NM, it was critical “to be confident with what I’m doing to be able to manage and to be the leader of the unit.”

To summarize the clinical category, the NMs and DONs/ADONs rated their clinical skills at the highest level for all categories; the proficient level of expertise. It was clear that the Nurse Managers were most comfortable with their clinical skills and
often were advanced into the manager role based on their clinical expertise. Even though the NMs stated that expert clinical skills were necessary in their position, they did not rate themselves as experts. They felt that being an expert would not allow room for additional learning and growth. During the interviews, several themes emerged in the interviews including *aloneness, increased acuity levels, intuition/gut feeling, trial and error, laddering, peer support, constant learning, training, and resident priority*. As the manager’s were most comfortable with their clinical skills, the proficient level of expertise supported them through other leadership and management practices. The next section provides a summary of both the quantitative and qualitative results for leadership reflective practice; the NMs scored at a competent level.

*Leadership Reflective Practice – Constant State of Learning*

The NMIT defined leadership reflective practice as a “set of guidelines/tenants that can be used as a tool to guide personal reflection of an individual’s leadership behaviors (NMIT, 2006, p. 8). Nine sub-sets defined this category. A sampling of the sub-sets include the quest for knowing, keeping commitments, holding the truth, holding multiple perspectives without judgment, and discovery of potential. For the interview, leadership reflective practice was defined as the constant state of learning and constant self-improvement. The NMs identified the importance of constantly improving their leadership practice and remaining open to new learning opportunities. Further, they felt a sense of being comfortable with decisions due to their individual skills and competencies. It was necessary to be positive about one’s accomplishments and to be self-promoting since supervisory feedback was not always provided.

*Quantitative analysis*. The leadership reflective practice independent sample t-
test indicated that the means for both the NM and the DON/ADON responses was equivalent to the competent level (Table 4.4). Both the NMs and the DONs/ADONs collectively scored the sub-set of holding the truth (integrity) and discovery of potential at the proficient level (level 4). Five NMs individually scored integrity at the expert level while eight DONs/ADONs scored this sub-category at expert. Four NMs individually scored discovery of potential at an expert level. For the sub-sets diversity and holding multiple perspectives without judgment, the NMs scored at a proficient level (level 4) while the supervisors rated at the competent level (level 3). These results were not significant between the groups and there was no difference in the mean levels for discovery of potential (p = .140) and holding multiple perspectives (p = .197). At a 95% confidence level, the category leadership reflective practice Levene’s test for equality of variances was not significant (p = .598) and the equal variances of the means was assumed (Table 4.5). There was no difference in the mean levels between the NM and the DON/ADON groups for this category.

Qualitative analysis. The qualitative analysis of leadership reflective practice supported the competent level of expertise. Several themes were identified during the interviews including constant learning, trial and error, tough job, and training needs. These themes will be discussed in this section.

Most NMS identified that it was absolutely necessary to be reflective about their leadership and to set-up opportunities for constant learning. In this environment, resident acuity levels constantly changed but resident care could be routine. One NM cited, “you need to learn because everything is changing” yet another manager stated, “we do have certain things we do every day so if you don’t switch it up and you know kind of recharge
yourself the resident is going to get the end result of that.”

Table 4.4

**Leadership Reflective Practice Independent Samples t-test NM and DON Group Statistics**

<table>
<thead>
<tr>
<th>Group</th>
<th>N</th>
<th>Mean</th>
<th>Std. Deviation</th>
<th>Std. Error Mean</th>
</tr>
</thead>
<tbody>
<tr>
<td>NM</td>
<td>21</td>
<td>3.4836</td>
<td>.75857</td>
<td>.16553</td>
</tr>
<tr>
<td>DON/ADON</td>
<td>20</td>
<td>3.3472</td>
<td>.88382</td>
<td>.19763</td>
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</tbody>
</table>

Table 4.5

**Leadership Reflective Practice: Independent Samples Levene’s Test for Equality of Variances**

<table>
<thead>
<tr>
<th>Reflective Practice</th>
<th>Equal Variances</th>
<th>t-test for Equality of Means 95% Confidence Interval of the Difference</th>
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</thead>
<tbody>
<tr>
<td></td>
<td>Assumed (A) or Not Assumed (NA)</td>
<td>F</td>
</tr>
<tr>
<td>Reflective Practice</td>
<td>A</td>
<td>.029</td>
</tr>
<tr>
<td>NA</td>
<td>.529</td>
<td>37.484</td>
</tr>
</tbody>
</table>

If the acuity levels changed and there was increased family involvement, staff concerns, and regulatory oversight, then managers must constantly “be proactive and you have to want to learn constantly, that only makes it better. You can’t have the same style as you had twenty years ago; it’s not going to work.” Part of self-reflection included the NM’s ability to define their competence in the role as confirmed by one manager, “We have to be competent, as a leader you can’t be working here if you don’t know what you’re doing.” And another NM stated, “I think that you have to learn in the role to have self-worth and to be comfortable with your decisions and to feel competent.”
Trial and error, without the benefit of an orientation, was identified as the way that most NMs learned about their role, how to deal with families, resident priorities, and staffing needs. As this participant indicated, “You have to educate yourself as a manager, if you want to be an effective manager.” Another NM reflected on the trial and error learning process, “a lot of times things that are new you don’t get a lot of training for, you just kind of learn by doing … I had seven years of learning on my own.” The process of trial and error was explained by one of the managers, “If it’s going to be something that’s creating discomfort because I did it this way, and I was very uncomfortable because I didn’t like the results that I got, I’m going to do something different.” Trial and error was a common way for the NMs to learn their responsibilities.

In addition to learning through trial and error, the job itself was considered a tough job due to the overwhelming resident and staff needs; it was difficult and very complicated. Over and over, the NMs identified the tough job status as explained by this Nurse Manager, “I think the job is more challenging now, there’s more problems now. Families are more educated and question more.” Another interviewee stated, “It is a very demanding job … because you always have to expect the unexpected. There are emotional things that happen with staff, with residents, with family members.” Besides being described as tough, this NM also stated that it felt like an emotional beating, “You get beat up constantly. If it’s not staff or administration, or a resident, or a family member … who’s angry and where does that anger get directed … it gets directed a lot at the Nurse Manager.” Despite these negativities, most NMs expressed how much they “love the job” since they developed long-term resident and family relationships.

The lack of the Nurse Manager’s orientation was very evident. Without an
appropriate orientation and training, “You’re expected to be able to jump in and do all of these different roles, all of these different things.” This NM learned her role as, “I started by learning the basics, I asked a lot of stupid questions, did a lot of research, I mean basically I trained myself.” Another way to state this was “you just kind of learn by doing.”

In summary, Nurse Managers and their supervisors scored at a competent level for reflective leadership practices. The interview themes that were identified supported the competent level and those themes included constant learning, trial and error, tough job, and the need for training. Some participants recognized that long-term care was not always perceived as the place for an RN to work as stated by this manager, “People have always had the opinion that gerontology was a lesser field … we are really good at what we do and we’re here because we want to be here, not because there’s no other place that would hire us.” Even though the NMs did not necessarily feel that their role was well-perceived, they identified that their main priority was always resident care. Reflecting upon that priority, this Nurse Manager stated “looking at patient outcomes and what did we do good, what did we do that we could improve upon … how can we make this work better …we were constantly relooking at that, and to see … how can we get this better?”

In the next section, the quantitative and qualitative analysis for the diversity category is presented. Nurse Managers and supervisors scored at a competent level in the diversity category.

Diversity

Diversity is defined in the NMIT as cultural competence, social justice, and generational differences. In the interview, diversity was specifically defined as the ability
to work fairly with differences in staff or residents based on race, gender, religion, sexual orientation and generations. Nurse Managers stated clearly that everyone had a right to be respected regardless of differences and that it was necessary to accept people as having different points of view. As a NM, it was imperative to keep an open-mind and not be judgmental. Most importantly, the focus of care was the resident and that each person had worth. It was the Nurse Manager’s responsibility to help staff identify that worth and communicate that to others. Many Nurse Managers were comfortable with diversity due to personal upbringings, values, and their own experience from *trial and error*.

*Quantitative analysis.* The diversity independent sample t-test indicated that the means for both the Nurse Manager and the DON/ADON responses was equivalent to the competent level (Table 4.6). The NMs rated themselves higher for cultural competence, social justice, and generational diversity than the supervisor’s ratings. Three NMs individually rated themselves at an expert level for social justice; two rated expert for cultural competence and generational diversity. For social justice, which is the maintenance of an environment of fairness, the Nurse Managers collectively rated themselves at the proficient level (level 4) and the DON/ADON rated at a competent level (level 3) but the difference in means was not significant (p = .075). At a 95% confidence level, the Levene’s test for equality of variances for the diversity category was not significant (p = .134) and the equal variances of the means was assumed (Table 4.7). There was no difference in the mean levels between the NM and the DON/ADON groups for this category.
Table 4.6

**Diversity Independent Samples t-test NM and DON Group Statistics**

<table>
<thead>
<tr>
<th>Group</th>
<th>N</th>
<th>Mean</th>
<th>Std. Deviation</th>
<th>Std. Error Mean</th>
</tr>
</thead>
<tbody>
<tr>
<td>NM</td>
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<td>.88581</td>
<td>.19330</td>
</tr>
<tr>
<td>DON/ADON</td>
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<td>3.0167</td>
<td>1.09478</td>
<td>.24480</td>
</tr>
</tbody>
</table>

Table 4.7

**Diversity: Independent Samples Levene’s Test for Equality of Variances**

<table>
<thead>
<tr>
<th>Equal Variances</th>
<th>F</th>
<th>Sig.</th>
<th>t</th>
<th>df</th>
<th>Sig. (2-tailed)</th>
<th>M</th>
<th>SE</th>
<th>95% Confidence Interval of the Difference</th>
</tr>
</thead>
<tbody>
<tr>
<td>Assumed (A)</td>
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<td></td>
<td></td>
<td></td>
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<td>Lower</td>
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<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Upper</td>
</tr>
<tr>
<td>Diversity</td>
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<td>.742</td>
<td>1.532</td>
<td>39</td>
<td>.134</td>
<td>.47540</td>
<td>.31029</td>
<td>-.15223 - 1.10302</td>
</tr>
<tr>
<td>NA</td>
<td>1.524</td>
<td>36.573</td>
<td>.136</td>
<td>.47540</td>
<td>.31192</td>
<td>-.15685</td>
<td>1.10765</td>
<td></td>
</tr>
</tbody>
</table>

**Qualitative analysis.** During the interview, the NMs identified several themes to support a competent rating in the diversity category. These themes included job expectation, resident priority, staff diversity, communication, open door policy, personal values, and training. During the interview, their skills and competencies presented at a higher than competent level because they had a certain assuredness working with residents and staff. They were most concerned with the need to communicate resident and staff diversity concerns, so everyone was aware. And daily, they identified the issues of generational diversity, that is, employees in their late teens were working with elders who were centenarians. As stated by this NM, long-term care had “an extremely diverse
populous, whether it be residents or employees, and they are all very culturally different and you have to be able to understand that.” There was a comfort level managing the diversity of both residents and staff; it was a job expectation. This participant defined the Nurse Manager’s diversity role as, “You have to learn how to adapt yourself in the different cultural diversity … we have to be respectful of all of them, allow them to express their thoughts and opinions and accept them.

As a part of their role, a primary responsibility was to oversee that the resident needs were being met and that they communicated those needs to the staff. Resident priority was critical for this interviewee, “Sometimes thinking these are somebody’s loved ones, their mother, their father, and their grandmother … our job is to provide what’s best.” Another NM summarized the individuality of diversity, “You have to look at what they bring to the table from life experience and from culture. I really feel that every resident has reasons why they may be the way they are.” Understanding that resident priority was central to the care yet at times difficult to accomplish, this NM succinctly stated that, “We have to honor the resident request, we have to do that and sometimes it can be very difficult to get that point across.”

Not only resident priority but also staff diversity was paramount for the Nurse Managers. Employees were from backgrounds and lifestyles very different from the residents. This was summarized by one NM as “there’s a different level of how they live from day to day… just their home situations, their beliefs and their values are different … if you understand it or try to understand it then you have a better connection with them.” And making that connection was very important, to know and understand the staff lifestyles. One participant offered a way to learn about staff, “working with the different
cultures that you’re not familiar with and sitting down and talking with them when they get together … listening to them talk and asking questions and just spending time with them.” By spending time with staff, the NMs understood more about their personal lives and what they could bring to resident priority.

As a critical component to understanding the resident and staff diversity needs, most NMs identified that excellent communication, between the NM, staff, and residents, was necessary for success. Many NMs used an open door policy for communication which was time-consuming but also very effective as stated by this participant, “They don’t understand each other’s ways, but I try to keep the unit open and freely talking about things.” Even with good communication and an open door policy, identifying and educating about diversity issues remained a continuous responsibility, “It can be hard for people to work with people that are different from them, and that’s something that continually needs to be taught, encouraged and tolerated.”

Most Nurse Managers agreed that their experience supported leading in a diverse environment as this participant summarized, “You have to know those differences. You take the knowledge base and then you add on the experience.” In addition to work and personal experiences, personal values were also supportive to the NM role as expressed by this NM describing the impact of her upbringing,

I think it comes from my own upbringing, not so much what I learned in nursing school, but what I value about life and I just feel that everybody has the right…to have respect and be treated as an individual…I treat everybody the same.

And sometimes a NM’s personal negative experiences helped them to support resident
and staff diversity, “My upbringing … and knowing when I’m mistreated, that feeling that I would never inflict on someone else.”

Nurse Managers had mixed responses regarding training support. One NM stated, “Training no, not a lot…Just experience, you learn from one instance to another what worked and hasn’t worked.” But another felt supported by training in her facility, “Staff education does do a very good job with diversity training, and classes, and inservices.” Whether training was provided, self-education remained an important responsibility, “You have to educate yourself on diversity. You have to educate yourself on culture.”

In summary, the NMs rated the diversity category at a competent level. They managed diversity issues on a daily basis, using communication, their experience and personal values, and an open door policy to increase an understanding of the differences for both residents and staff. Nurse Managers had the responsibility to not only understand diversity’s impact but also to remain educated and open to the challenges of resident and staff diversity. In the next section, Human Resource leadership skills are presented from both a quantitative and qualitative perspective. The NMs rated themselves as competent in the Human Resource leadership category.

**Human Resources Leadership – Coaching/Mentoring, Staff Development**

The Human Resources Leadership category included performance management, staff development, coaching, and mentoring. When asked, the Nurse Managers responded quickly that on a daily basis it was an expectation to coach and mentor staff. Most NMs were comfortable with the coaching and mentoring process; learning from experience, trial and error, and supervisory or administrative support. Some reported a
discomfort with coaching and mentoring due to a personal impatience, lack of time or comfort level but all NMs did participate to some degree. It was important for the NM to set expectations or to develop the “gold standard” for resident care and staff interactions, to be certain that everyone was doing what they should be doing. As expected, most managers spoke favorably about the outcomes of coaching and mentoring but were somewhat uncomfortable with the disciplinary process.

Quantitative analysis. The Human Resource leadership independent sample t-test indicated that the means for both the NM and the DON/ADON responses was equivalent to the competent level (Table 4.8). Collectively, the supervisors rated the managers slightly lower on all sub-categories of performance management, staff development, coaching and mentoring. Only one NM individually rated herself at an expert level for three of the sub-categories. The reason for this could be that the supervisors were not completely aware of the level of coaching, mentoring, and disciplining that the Nurse Managers accomplished on a daily basis and were only contacted if the manager has a problem that could not be resolved. From the statistical analysis of the sub-sets in this category, the sub-set of mentoring was significant (p=.037) and that there was a difference in the means for NM and DON/ADON. This could be the result of an interpretation of the NMIT definition for mentoring or the fact that the DON/ADON was not aware of the NM mentoring involvement. At a 95% confidence level for the entire category of Human Resource leadership, the Levene’s test for equality of variances was not significant (p = .109) and equal variances of the means was assumed (Table 4.9). There was no difference in the mean levels between the NM and the DON/ADON groups for this category.
Table 4.8

**Human Resource Leadership Independent Samples t-test NM and DON Group Statistics**

<table>
<thead>
<tr>
<th>Group</th>
<th>N</th>
<th>Mean</th>
<th>Std. Deviation</th>
<th>Std. Error Mean</th>
</tr>
</thead>
<tbody>
<tr>
<td>NM</td>
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<td>3.3905</td>
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<td>.16874</td>
</tr>
<tr>
<td>DON/ADON</td>
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<td>.86639</td>
<td>.19373</td>
</tr>
</tbody>
</table>

Table 4.9

**Human Resources Leadership: Independent Samples Levene’s Test for Equality of Variances**

<table>
<thead>
<tr>
<th>Levene's Test for Equality of Variances</th>
<th>t-test for Equality of Means</th>
<th>95% Confidence Interval of the Difference</th>
</tr>
</thead>
<tbody>
<tr>
<td>Equal Variances</td>
<td>F</td>
<td>Sig.</td>
</tr>
<tr>
<td>Assumed (A) or Not Assumed (NA)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>HR Leadership</td>
<td>A</td>
<td>.093</td>
</tr>
<tr>
<td>NA</td>
<td>1.637</td>
<td>37.991</td>
</tr>
</tbody>
</table>

**Qualitative analysis.** When interviewed, the Nurse Managers identified themes that supported the rating of competent in HR leadership. These themes included *visibility on the unit, coaching, role modeling, and peer support.* Coaching and mentoring were used interchangeably to define the provision of staff instruction or teaching on a regular basis. Coaching was identified as one of the most important nurse manager roles.

Being available to staff on a daily basis and being *visible on the unit* to identify resident or staff needs was identified as part of the coaching process. One NM described the role as, “You coach, mentor, every day, you teach, supervise, you assist them, you
work with them.” And this was confirmed by this NM, “I still feel that it’s my responsibility…to make sure that the team is following and doing what they’re supposed to be doing.” Generally, coaching was truly an enjoyable part of their job as summarized by this Nurse Manager’s sentiment, “I love to teach, I love to coach, I love to watch somebody just blossom and take off … look at weaknesses and strengths.” Interestingly, this NM accepted coaching as a job requirement but also identified the theme of aloneness, “I think a big huge part of what a Nurse Manager’s job is coaching her staff, and again, I think it’s just because there is nobody else so you do it.”

Role modeling provided a way for the NMs to remain involved in the clinical aspects of resident care, to be certain that the care was provided appropriately, and to actually demonstrate expectations for care. As one participant indicated, “you have to be able to do everything that they do out on the unit…so you could best educate and mentor them.” Another NM’s perspective provided a glimpse for the role model commitment; identifying Nurse Manager expectations,

If you have somebody that needs to learn a new skill you teach it to them. I would rather take the time and do it myself and know that I showed them how to do it. They know how to do it, they know how to do it correctly and they’ve already shown me.

Role modeling helped the Nurse Managers set the expectations and provided opportunities for staff learning and growth. This NM described the importance of role modeling for staff growth,

I look for people to grow and to me it’s if you don’t teach people to grow, you don’t teach people to think, and if you don’t teach people to think you have the
same CNA that you started out with a year ago.

Not everyone was comfortable with the coaching role and formal training was generally not provided. A participant clearly stated that, “I mentor and I coach staff but I’m really not comfortable” with the process and another indicated that “I have to slow down and be more understanding of that because I do have trouble with the mentoring.” When a NM was not comfortable with a job responsibility such as coaching, they sought peer support. As one Nurse Manager, who recognized the critical support of a NM with more experience, stated, “We have a couple Nurse Managers in the building that have been here for 30 years and one of them I just adore and if I have questions or concerns … I’m on her doorstep.” Another NM reiterated the importance of peer support, “People do all different things based on what they were taught or what works for them. So I do go to them when I’m really stuck on something.” Some interviewees had extensive Nurse Manager experience and were considered the peer support for new NMs. As one experienced NM expressed, “I often get calls from other people on other units looking for advice and consult” or another stated, “even where I used to work, I was a peer because I was like the one with the most experience…a little bit of support that you don’t get at this level…you have to create it.” Clearly, peer support was the means for the NMs to obtain support in their coaching responsibilities.

To summarize, the Nurse Managers identified several themes when interviewed about HR leadership. These themes were visibility on the unit, coaching, role modeling, and peer support. From the NM perspective, coaching was very important for the provision of quality resident care and for the establishment of Nurse Manager unit expectations. As stated by this participant, “one of the biggest parts of my job is
education, it’s got to be ongoing; something is brought to your attention, you have to stop and you have to educate.” Training in coaching was usually not provided but the NMs learned through experience and peer support. And the NMs did learn to guide their staff as summarized by this NM, “You try to teach as much as you can along the way, but a lot of it is guidance, ongoing guidance and teaching as a nurse manager.”

In the next category, the Nurse Managers rated their relationship management skills, such as communication and conflict management, at a competent level. The quantitative and qualitative analysis for the relationship management category will be provided.

*Relationship Management – Communication Skills, Conflict Management*

There were nine sub-sets for the relationship management category in the NMIT survey. For the interviews, the focus was primarily on communication skills and conflict management. All Nurse Managers agreed that communication was an essential skill, required an open dialogue, and was a job requirement to maintain relationships between residents, staff, and family members. But it was very difficult for the NMs to achieve a comfort level with conflict management since they learned through trial and error; experience and maturity being critical for success.

*Quantitative analysis.* The relationship management independent sample t-test indicated that the means for both the NM and the DON/ADON responses was equivalent to the competent level (Table 4.10). The NMs rated themselves slightly higher for communication, conflict management, and negotiation but the difference in means for these sub-sets was not at a significant level. Individually, two NMs scored at an expert level for the sub-categories, such as communication, emotion IQ, self-awareness, team
dynamics, and collaborative practice. At a 95% confidence level, the Levene’s test for equality of variances for the category relationship management was not significant (p = .461) and equal variances of the means was assumed (Table 4.11). There was no difference in the mean levels between the NM and the DON/ADON groups for this category.

Table 4.10

<table>
<thead>
<tr>
<th>Group</th>
<th>N</th>
<th>Mean</th>
<th>Std. Deviation</th>
<th>Std. Error Mean</th>
</tr>
</thead>
<tbody>
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<td>NM</td>
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<td>3.3122</td>
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<td>.19285</td>
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<tr>
<td>DON/ADON</td>
<td>20</td>
<td>3.0889</td>
<td>1.03267</td>
<td>.23091</td>
</tr>
</tbody>
</table>

Qualitative analysis. In relationship management, the NMs scored at a competent level and communication was considered an important component for this category. Several themes emerged from the interviews, including relationship development, visibility on unit, expectations, listening skills, trial and error, and peer support. These themes will be further discussed in this section.
Communication skills threaded through all daily activities and were important for resident outcomes, family relationships, and staff success. And the Nurse Managers who agreed that “Communication is A-number one” knew that it supported positive relationship development on the unit. In addition, the NMs understood that “you have to create those relationships.” As stated by this NM, “We have to be able to communicate with the staff, because if you can’t communicate with them and you can’t bring yourself to their level wherever they are it’s not going to happen.” Interestingly, the NM’s ability to communicate with everyone was also tied to their visibility on the unit and the need to be available as much as possible. As this NM stated, “We all joke at the end of the day how our chest hurts and we have no breath left and it’s because we’re talking all day to everyone on every level and every discipline.”

Being able to set expectations supported good communications. One NM provided a view on this, “I believe in good communication because I tell people you can’t do anything if you don’t know what I expect.” In addition to setting expectations, listening skills were critical for good communication and relationship development. This
participant described the balance that needed to occur between the NM and staff or families, “you need to be sometimes the balance between the staff and families…you need to be able to listen. They trust you to have patience and listen.”

Nurse Managers developed staff relationships by taking the time to understand employee backgrounds, their lifestyles, what they bring to the care team as stated by this NM, “people come to work they have all types of problems … not always just the surface, it’s things that are deeper and I think you just need to sit down and try to see where the person is coming from.” And another NM supported this concern, “it’s pretty tough with some of the aides that you work with … how they live and what they may be dealing with and how to talk with them and get them to understand how things need to be here.” The NM responsibility was to communicate resident outcomes and expectations through good listening skills.

Conflict resolution, which was “a daily occurrence,” was a more difficult part of relationship management. The facility expectation for the NM was “if there’s a conflict with the staff … then you have to be there to be the middle person or assisting how to resolve the conflict.” Most NMs were not comfortable with resolving conflict possibly due to lack of training as indicated by this participant, “I found the hardest when I first started as a Nurse Manager leader, conflict management, even confrontation, speaking with somebody. I still find that very difficult, to this day.”

As in other job responsibilities, many of the Nurse Managers learned communication and conflict resolution through trial and error. They had to make mistakes in order to become more competent. As this interviewee stated, “It’s a trial and error … one approach doesn’t work then you have to resort to one that’s working” and
another NM supported that by stating, “Just over time, maybe doing it the wrong way one time and then saying oh that didn’t work.” Learning communication and conflict resolution through *trial and error* supported, “Putting it into practice” and gaining experience. As this NM stated, “I understand you treat each individual different case by case, but it still goes by experience as well and you’ve been down that road before so you know what to expect.” When trial and error doesn’t work anymore, the NMs will seek out *peer support* as stated by this participant, “I do seek people out. I do talk with my boss, I think that’s the way to do it, and my peers that would be another person I would access or utilize.”

As in other categories, *resident care* was always the priority. Nurse Managers were responsible to not only develop relationships with residents, families, and staff but also communicate to staff they were also “responsible for these people [residents] and I[NM] have to build that relationship with you that I can trust you and you’re going to take good care of them.” This participant summarized the reason that NMs rated this category as competent, “You’re maintaining all your relationships with all the people above you, below you, and beside you … because you do that all the time you have a level of confidence and competency.”

In summary, relationship management, including communication and conflict management, was a daily responsibility yet the NMs only scored at a competent level. During the interview, it was apparent that they learned these skills through *trial and error* without training support and it was also evident that *relationship management* was important to, “treat people the way you would want yourself treated if there was an issue.” *Resident outcomes* were priority as stated by this NM, “I guess I just like to help
people, and by creating a good floor and team I know they’ll be helping the residents the way they should be helped and that gives me satisfaction.” Ultimately, the NM’s focus was to communicate to the staff the importance of resident care and to provide the means for appropriate communication and effective conflict resolution. This NM summarized that, “If you don’t have the skills you don’t run the floor…you should be able to manage staff conflict, you should be able to manage resident/family issue, and how you handle it depends how the floor runs.”

Moving from relationship management, the next category was performance improvement, including safety and quality improvement. The NMs scored this category at competent level and the themes will be presented in the next section.

*Performance Improvement – Patient/Workplace Safety and Quality*

The category of performance improvement included knowledge of performance improvement tools for quality improvement, patient safety, and workplace safety. The long-term care environment was highly regulated by both the state and federal government. Patient and workplace safety were key indicators for the regulatory oversight. For these reasons, the NMs identified that performance improvement was an organizational expectation and their unit responsibility which was facilitated by their visibility on the unit in identifying resident safety issues. The NMs were also responsible for documenting and reviewing incident reports, coaching staff for identification of quality and safety issues. Previous experience, peer support, and supervisory mentoring were instrumental to the Nurse Manager’s success.

*Quantitative analysis.* The performance improvement independent samples t-test indicated that the means for both the Nurse Manager and the DON/ADON responses was
equivalent to the competent level (Table 4.12). The supervisors rated the NMs higher on the following sub-sets: knowledge of performance improvement tools, patient safety, and workplace safety. For performance improvement tools, the Nurse Managers rated themselves as advanced beginner (level 2) and the DON/ADON rated them as competent (level 3). Only one NM individually rated as an expert in the sub-category of patient safety, and interdepartmental communication. Even though the NMs were confident in their skills for resident and workplace safety, they may not have been comfortable with the quality tools measurements. The differences in the means for the sub-sets were not at significant level. At a 95% confidence level for the performance improvement category, the Levene’s test for equality of variances was not significant (p = .420) and equal variances of the means was assumed (Table 4.13). There was no difference in the mean levels between the NM and the DON/ADON groups for this category.

Table 4.12

*Performance Improvement Independent Samples t-test NM and DON Group Statistics*

<table>
<thead>
<tr>
<th>Group</th>
<th>N</th>
<th>Mean</th>
<th>Std. Deviation</th>
<th>Std. Error Mean</th>
</tr>
</thead>
<tbody>
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<tr>
<td>DON/ADON</td>
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</table>
Table 4.13

Performance Improvement: Independent Samples Levene’s Test for Equality of Variances

<table>
<thead>
<tr>
<th>Equal Variances</th>
<th>F</th>
<th>Sig.</th>
<th>t</th>
<th>df</th>
<th>Sig. (2-tailed)</th>
<th>M</th>
<th>SE</th>
<th>95% Confidence Interval of the Difference</th>
</tr>
</thead>
<tbody>
<tr>
<td>Assumed (A) or Not Assumed (NA)</td>
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<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Performance Improvement</td>
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<td>.923</td>
<td>-.816</td>
<td>39</td>
<td>.420</td>
<td>-.18929</td>
<td>.23211</td>
<td>-.65877-.28020</td>
</tr>
<tr>
<td>NA</td>
<td>-.815</td>
<td>38.851</td>
<td>.420</td>
<td>39</td>
<td>-.18929</td>
<td>.23218</td>
<td>-.65896-.28039</td>
<td></td>
</tr>
</tbody>
</table>

Qualitative analysis. Scoring at a competent level for performance improvement, the NMs defined similar themes for this category as previous categories which included expectation, visibility on unit, peer support, trial and error, and coaching. The best way to describe the Nurse Manager’s perspective on performance improvement including patient, workplace safety and quality improvement, was that it was an expectation for the position and “something we deal with every day.” This weighed heavily on the NMs as the expectation became that, “The manager has to be the one that enforces those things that they talk about in general orientation” and another reinforced “the safety on a unit, it falls on the Nurse Manager because she needs to make sure that the residents are safe and the staff is safe.” Yet the NMs had a high comfort level with this expectation, possibly due to their clinical expertise for safety assessments.

Once again, visibility on the unit was very important for the identification of resident, staff, or family issues. According to this NM, through visibility on the unit, safety issues were identified for both the resident and the staff, “when they do have a fall, go in, check the room out, check the environment…and make sure everything is safe, not
for the resident but for the staff as well.” The sense of competency in this category was
evident as expressed by this NM, “I am very competent in making sure that my residents
are safe” and as this NM stated, “making sure the environment is safe.” One NM even
summarized how an empathetic approach supported safety considerations,

Putting your patient first, that’s what you’re here for, so you know, being

empathetic, if this was my mother how would I want my mother to be treated,

so I want her in a safe environment …you want to make sure the patient is safe.

Quality improvement can’t be accomplished alone so it required an

interdisciplinary team effort including peer support. As this NM stated, “talking things

over with your peers, it’s good to be able to have people that you work with that have

more experience.” With peer support, the NMs learned how to handle the documentation

process, such as, “reviewing accidents and incident reports…reinforcing a care

plan…looking at patient satisfaction surveys.” And they learned the process for “doing

an action plan, what’s the problem, what’s my action, who’s responsible for it and what’s

my follow-up to show that it’s all in place.”

Along with peer support, the NMs couldn’t deny the impact of trial and error to

their competence for safety as stated by one Nurse Manager, “it is learning from our

mistakes.” Through trial and error, the NM gained experience, “I’ve had a lot of

experience, a lot of exposure so that I can use past experience.” Coaching was important

for teachable moments to help staff identify safety options, “I’ll say do you think that it

might not work better if we do this and let them think about it and a lot of times they’ll

challenge me and then I’ll say but what if?”

As a summary, performance improvement, including safety, was defined as an
important responsibility and the NMs rated themselves at a competent level. The goal was always for the residents to feel that “this is their home, they’re comfortable, what they need we’re here to give them … for the staff to realize that too, that it isn’t the residents doing what they want it’s what they need to do for the residents” to maintain safety. The assurance of resident and workplace safety and quality resident outcomes were important management skills. Identified themes were expectation, visibility on unit, peer support, trial and error, and coaching. The next category, the NMs also scored competent, was problem solving and decision making.

**Problem Solving – Decision Making**

Nurse Managers identified that another role expectation was that they were the “point person” for unit problem solving which included resident, family, or staff issues and concerns. They identified their responsibility as the “buck stops here” approach and learned how to problem solve generally through experience. Many of the NMs indicated that along with coaching, problem solving occurred on a daily basis as stated by this participant, “that’s what we do every minute of every day, problem solve continually; decision making, you make decisions constantly.”

**Quantitative analysis.** The problem solving independent samples t-test indicated that the means for both the Nurse Manager and the DON/ADON responses were equivalent to the competent level (Table 4.14). The supervisors rated the NMs slightly higher on all sub-sets of this category but the difference of means was not significant. Only two DONs/ADONs scored the NMs at an expert level for decision-making and problem solving skills while the NMs scored a proficient and competent level each. At a 95% confidence level for the problem solving category, the Levene’s test for equality of
variances was not significant (p = .325) and equal variances of the means was assumed (Table 4.15). There was no difference in the mean levels between the NM and the DON/ADON groups for this category.

Table 4.14

**Problem Solving Independent Samples t-test NM and DON Group Statistics**

<table>
<thead>
<tr>
<th>Group</th>
<th>N</th>
<th>Mean</th>
<th>Std. Deviation</th>
<th>Std. Error Mean</th>
</tr>
</thead>
<tbody>
<tr>
<td>NM</td>
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<td>2.8095</td>
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<td>.19296</td>
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<tr>
<td>DON/ADON</td>
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<td>3.0700</td>
<td>.78210</td>
<td>.17488</td>
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</tbody>
</table>

Table 4.15

**Problem Solving: Independent Samples Levene’s Test for Equality of Variances**

<table>
<thead>
<tr>
<th>Equal Variances</th>
<th>F</th>
<th>Sig.</th>
<th>t</th>
<th>df</th>
<th>Sig. (2-tailed)</th>
<th>Difference</th>
<th>SE</th>
<th>95% Confidence Interval of the Difference</th>
</tr>
</thead>
<tbody>
<tr>
<td>Assumed (A) or Not Assumed (NA)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Lower</td>
</tr>
<tr>
<td>Problem Solving</td>
<td>A</td>
<td>.274</td>
<td>-.997</td>
<td>39</td>
<td>.325</td>
<td>-.2604</td>
<td>.26122</td>
<td>-.7883</td>
</tr>
<tr>
<td>NA</td>
<td>-1.000</td>
<td>38.796</td>
<td>.323</td>
<td>.26048</td>
<td>.26042</td>
<td>-.78731</td>
<td>.26636</td>
<td></td>
</tr>
</tbody>
</table>

**Qualitative analysis.** For this category, the NM scored at a competent level and problem solving/decision making was considered a daily expectation. Along with being an expectation, there was a sense of aloneness when making decisions and they learned through trial and error, gathering experience, while maintaining a balancing act. “We pretty much have to make our own decisions … and we’re expected to solve our own problems … we are expected to be self sufficient and solve the problems on our floor.”
One interviewee confirmed that “we’re always making decisions; it seems like that’s where the buck stops, the nurse manager level … it just comes with the territory.” So, problem solving and decision making was an expectation in the role.

Without additional RN support on the unit, the NMs experienced an *aloneness* when making decisions and had to rely on *trial and error* to learn how to make those decisions. One NM described the *aloneness* as, “When you’re the Nurse Manager, it’s you, you address it or it doesn’t get taken care of.” *Trial and error* was often the only way to learn how to problem solve or make decisions. As stated by this manager, “you just learn from your mistakes, you learn from new *experiences*, you learn from other Nurse Managers who’ve had a similar *experience*; if it doesn’t work then you try something else.” And with time they did learn how to make decisions. According to this participant, *experience* “has helped me develop an independent level of making decisions that some of the Nurse Managers newer to the game haven’t had the opportunity to do.”

In addition to *trial and error*, the NMs relied on *peer support* as evidenced by this statement, “you always have people you can refer to for help if you haven’t handled that situation before.” *Peer and administrative support* could be obtained in the weekly Nurse Manager meetings where “we can bring … any kind of problem that we’re having on the unit, we can bring that to the meeting.” Administration was helpful when the NM did not have the answer as stated by this interviewee, “I usually try to handle it myself but as I have said if it’s a real tricky sticky wicket I usually go to the Director of Nursing or Assistant Director to get a little guidance.” And the supervisor would also provide mentoring guidance as indicated by this statement, they “allowed me to go ahead and supported me in my decision process, right or wrong.”
Some NMs identified problem solving as a babysitting job and a balancing act as stated by this NM,

You have to be able to think quickly, be able to problem solve in order to help the staff to deal with the residents and their family members as well. They depend a lot on you; sometimes it’s basically a babysitting job and a balancing act.

Babysitting was further described as “coaching in the moment” and always being on top of things as they occur. The balancing act was defined as the necessity to “have the maturity, the professionalism and to actually be totally objective, get everybody together and hear them out.”

Along with resident and staff problem solving, the NM was also responsible for family issues. As one NM indicated, “We need to give ourselves credit for our skills and tact in working with family members and avoiding … volatile situations with them to phrase things … in a way that the family can understand it.” Another participant explained in “long term care it’s not just the patient, you have the whole family … so you need to make a wise decision to be able to work with family and to help residents.”

Being open and working with families helped the NM to reduce family anxiety and support resident/family satisfaction.

To summarize, Nurse Managers rated the problem solving category at a competent level. Interestingly, they had the confidence for problem solving even though they were usually alone in that decision making. They used trial and error, peer support, and acquired experience to bolster their competencies. This NM summarized it well, “its part of what we have to do every day and so you do become pretty good at problem
solving, trouble shooting and trying to be creative.”

The next category was information technology which included electronic medical records and the unit call-bell systems. Once again, the Nurse Managers rated themselves at a competent level.

*Information Technology*

Each long-term care facilities differed on the extent of electronic medical records (EMR) from one facility having complete EMR including medication administration to another just investigating the options. The Nurse Managers were at various comfort levels with technology based on previous experience and educational support. Some NMs had minimal computer experience and were concerned with learning the technology while others considered themselves to be computer literate. All of the organizations provided information technology support if electronic medical records were used. Some Nurse Managers were concerned that EMRs will eventually remove them from being visible on the unit due to the need to complete computerized documentation in their offices.

*Quantitative analysis.* The information technology independent samples t-test indicated that the means for both the Nurse Manager and the DON/ADON responses was equivalent to the competent level (Table 4.16). The supervisors rated the NMs slightly higher on these category sub-sets: basic computer skills, knowledge of facility medication management systems, ability to integrate technology into patient care processes, and using information systems to support business decisions but the difference in means for these sub-sets was not at a significant level. At a 95% confidence level, the Levene’s test for equality of variances for information technology was not significant (p = .374) and
the equal variances of the means was assumed (Table 4.17). There was no difference in the mean levels between the NM and the DON/ADON groups for this category.

Table 4.16

*Information Technology Independent Samples t-test NM and DON Group Statistic*

<table>
<thead>
<tr>
<th>Group</th>
<th>N</th>
<th>Mean</th>
<th>Std. Deviation</th>
<th>Std. Error Mean</th>
</tr>
</thead>
<tbody>
<tr>
<td>NM</td>
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<td>2.7381</td>
<td>.97549</td>
<td>.21287</td>
</tr>
<tr>
<td>DON/ADON</td>
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<td>3.0500</td>
<td>1.23433</td>
<td>.27600</td>
</tr>
</tbody>
</table>

Table 4.17

*Information Technology: Independent Samples Levene’s Test for Equality of Variances*

<table>
<thead>
<tr>
<th>Equal Variances</th>
<th>F</th>
<th>Sig.</th>
<th>t</th>
<th>df</th>
<th>Sig. (2-tailed)</th>
<th>Difference M</th>
<th>SE</th>
<th>95% Confidence Interval of the Difference</th>
<th>Lower</th>
<th>Upper</th>
</tr>
</thead>
<tbody>
<tr>
<td>Assumed (A)</td>
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<td>.900</td>
<td>39</td>
<td>.374</td>
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<td>.34655</td>
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<td>.38905</td>
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</tr>
<tr>
<td>Not Assumed (NA)</td>
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<td>.377</td>
<td>.3119</td>
<td>.34856</td>
<td>-1.01870</td>
<td>.39489</td>
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<td></td>
<td></td>
</tr>
</tbody>
</table>

Qualitative analysis. The Nurse Manager interviews supported the competent level primarily due to the newness of the information technology systems. Responses varied from lack of technological experience to a technological comfort level due to previous experience. Not all of the long-term care facilities were using EMRs and those that did have EMRs, the usage varied from documentation records to a total system including medication administration. Every facility used an electronic call-bell system that reported the response time for resident lights. Identified category themes included
technological expertise, and time availability.

The Nurse Manager’s technological expertise was important to the success of electronic changes on the unit and in the organization. According to this NM, “Every single Nurse Manager is at a different level … far fewer people are comfortable … There’s a couple of Nurse Managers … the only thing they do on the computer is read their e-mail, they don’t go out onto the internet ever.” Another NM confirmed this lack of technological expertise, “Electronic things boggle my mind, - I don’t actually use one, I have one in my office but I don’t actually use it, I’m computer illiterate.”

For both the call-bell system and the EMRs, the NMs understood the technological impact of having information readily available especially at the start of a day. This participant stated, “I know every morning what exactly has gone on overnight and then you can follow up on any problems.” Another NM commented on the change from chart documentation to the EMR,

When I started everybody had it in their written chart, if you wanted to know what happened over night you pulled each chart out. Now all the progress notes are here. I run a report every morning for the last 24 hours and I can read it it’s so helpful because it’s transparent, you can see exactly what everybody is doing and it’s at the touch of your hand

A major NM concern was time availability to learn the computerized system as stated by this interviewee, “I don’t think many of us have the luxury to practice because you are going from the time you get here until the time you leave.” The NMs knew that the EMRs were necessary but some expressed concern that the computerization focused more on the documentation process and less on the resident. This NM summarized this
focus as,

The shift off the resident to the data input of the computer. It is the focus of the
customer versus the sole individual resident, there is a … different scheme of
doing things, the manager on duty focus, like they do in hotels, versus what we
used to do as more individual to the resident.

And the fear of not being prepared for electronic documentation had an impact on this
nurse who expressed concern that, “I don’t sleep well at night because I’m always in fear
that I’m going to get called somewhere because I’m behind on my computer work or my
paperwork.”

In summary, the NMs rated the information technology category at a competent
level even though Nurse Managers were at various points of technological comfort. One
NM summarized a successful electronic conversion, “It was a lot of work, but we did it
and we’re doing really well and I’m so proud of them because they’re doing such a great
job, on the computer.” The NMs identified their lack of technological expertise and time
availability as issues that needed to be overcome since the EMRs were a reality. The NM
also expressed concerns that the electronic involvement will remove them from a
presence on the unit and force them to their offices to complete paperwork.

For the next section, the NMs rated the category of Human Resources management
at a competent level which included interviewing and hiring.

*Human Resources Management - Interviewing, Hiring, Orientation*

In the NMIT survey, the Human Resources management category included
questions about recruitment, interviewing, the hiring process, and staff orientations.

From an HR perspective, the Nurse Managers were not involved in the initial recruitment
or in the actual hiring process. Facility staff orientation was completed by the staff development department and the NMs were involved with only unit orientation, using staff CNA, LPN or RN as peer orientation support. The NMs discussed that the interview process was a major responsibility in their position in order to identify qualified staff for each unit. In many of the organizations, it was only recently that the Nurse Managers became involved in interview process for their specific unit. Previously, either the Human Resources (HR) department interviewed all applicants or the NMs interviewed for all units. According to most NMs, being able to interview and choose their own staff was beneficial to quality resident care and staff team building. Many of the NMs did not receive formalized interview training but were supported by individual HR, supervisory, or peer instruction. Some NMs used established interview questions while others trusted their “gut feeling” or intuition in the interview process. The Nurse Manager’s experience played a role in the comfort level completing interviews.

Quantitative analysis. The Human Resources management independent samples t-test indicated that the means for both the Nurse Manager and the DON/ADON responses was equivalent to the competent level (Table 4.18). The supervisors rated the NMs slightly higher on hiring policies and implementing unit change based on need but the difference in sub-set means was not at a significant level. No NMs individually scored an expert level for any of the sub-categories. At a 95% confidence level, the Levene’s test for equality of variances for the category Human Resource management was not significant (p = .575) and the equal variances of the means was assumed (Table 4.19). There was no difference in the mean levels between the NM and the DON/ADON groups for this category.
Table 4.18

**Human Resources Management Independent Samples t-test NM and DON Group Statistics**

<table>
<thead>
<tr>
<th>Group</th>
<th>N</th>
<th>Mean</th>
<th>Std. Deviation</th>
<th>Std. Error Mean</th>
</tr>
</thead>
<tbody>
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<td>DON/ADON</td>
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</tbody>
</table>

Table 4.19

**Human Resources Management: Independent Samples Levene’s Test for Equality of Variances**

<table>
<thead>
<tr>
<th>Levene's Test for Equality of Variances</th>
<th>t-test for Equality of Means</th>
<th>95% Confidence Interval of the Difference</th>
</tr>
</thead>
<tbody>
<tr>
<td>Equal Variances</td>
<td>F</td>
<td>Sig.</td>
</tr>
<tr>
<td>Assumed (A) or Not Assumed (NA)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>HR Management</td>
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<td>.388</td>
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<tr>
<td></td>
<td>NA</td>
<td>-.565</td>
</tr>
</tbody>
</table>

Qualitative analysis. Previously, Nurse Managers were not involved in the interview process and due to this lack of experience, the Nurse Managers scored at a competent level. During the interviews, the following themes were identified by most NMs; involvement, competence, intuition, experience, and informal training.

Nurse Managers just recently had an involvement in the staff interview process. At some long-term care facilities, the NMs had to be available and were expected to interview for any nursing unit; a concern expressed by this participant, “I don’t feel that I’m an expert … I don’t always see the full process … it might not be for somebody on
this unit, it may be for somebody hiring for another unit, it’s kind of like a screening process.” For those NMs who interviewed for their particular unit, there was an identified importance to choose your own staff, “You’re not just hiring a body to fill the position, and you want a fit for the team too.” It was expressed by most NMs that they wanted to be involved with the unit interview process in order to determine best fit for their unit and to have a choice in the hiring process.

*Competence* in the interview process was very important to the NMs. As one Nurse Manager explained, they were *competent* with interviews because “that’s part of our job, that’s something we have to be competent in doing and know how to do…that’s part of our job as a manager.” This participant summarized the importance of *intuition* in an interview by stating, “I can just have a feeling if someone is answering me honestly” and another mentioned the “gut feeling…we just go by what we want in a CNA or nurse.” *Intuition* for the NMs was more comfortable since it was an acquired skill that they used in clinical situations.

Past *experiences* and *informal training* supported the interview process but there was not a formal orientation program to learn interview techniques. As stated by one NM, “I think its *experience* again as you go through interviews that you feel more comfortable with them” and another interviewee expressed the lack of formal training, “we haven’t had really any classes in how to do it.” The NMs learned through an *informal training* process as explained by this participant, “one of our ADON’s is an excellent interviewer and when I’ve sat in on group interviews with her I’ve learned.” Regarding staff orientations, the Nurse Managers were responsible for just the unit orientation. As an interviewee stated, “We’ve had experience and exposure and we
actually understand what people need to do the care for residents.”

To summarize the HR management interview category, the Nurse Managers scored at a competent level since they have only recently been involved. They identified the importance of participating in each unit interview and in the final hiring decision for unit staff. As stated by this NM who was very clear about the importance of unit interviewing, “it’s kind of nice to be able to hand pick your team so that you’re all meshing together and you’re not clashing.” Nurse Managers identified the need for more HR educational support especially when first learning interview techniques and hiring policies/procedures but definitely identified the importance of receiving peer and informal administrative support in the learning process.

For the next two categories, the Nurse Managers quantitatively scored below the competent level. For strategic management, they scored at an advanced beginner level and for financial management the mean scores were mid-novice. These findings will be discussed in the next sections.

*Strategic Management*

Strategic management included identification of the facility strategic plan and Nurse Manager responsibilities at the unit level including developing an annual unit strategic plan, identification of unit goals, and development of unit specific projects. Nurse Managers were generally aware of their organization’s strategic plan but were somewhat uncertain what their specific role was in that plan. The NMs did develop unit plans which were then monitored by some administrative oversight.

*Quantitative analysis.* The strategic management independent samples t-test indicated that the means for both the Nurse Manager and the DON/ADON responses was
equivalent to the advanced beginner level (level 2), above a novice but not at the competent level (Table 4.20). The supervisor means were slightly less than the Nurse Manager’s means in project management, business plan and business plan development, development of strategic and operational plans. Supervisors scored the NMs the lowest for business plan development and development of a strategic plan. The highest Nurse Manager mean scores were for project management and persuasion skills. One NM individually scored at an expert level for presentation and persuasion skills, and another scored expert at project management. At a 95% confidence level, the Levene’s test for equality of variances was not significant (p = .909) and the equal variances of the means was assumed (Table 4.21). There was no difference in the mean levels between the NM and the DON/ADON groups for this category.

Table 4.20

*Strategic Management Independent Samples t-test NM and DON Group Statistics*

<table>
<thead>
<tr>
<th>Group</th>
<th>N</th>
<th>Mean</th>
<th>Std. Deviation</th>
<th>Std. Error Mean</th>
</tr>
</thead>
<tbody>
<tr>
<td>NM</td>
<td>21</td>
<td>2.2030</td>
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<td>.20813</td>
</tr>
<tr>
<td>DON/ADON</td>
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<td>2.2348</td>
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</tr>
</tbody>
</table>
### Table 4.21

**Strategic Management: Independent Samples Levene’s Test for Equality of Variances**

<table>
<thead>
<tr>
<th>Equal Variances</th>
<th>F</th>
<th>Sig.</th>
<th>t</th>
<th>df</th>
<th>Sig. (2-tailed)</th>
<th>M</th>
<th>SE</th>
<th>95% Confidence Interval of the Difference</th>
<th>Lower</th>
<th>Upper</th>
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</thead>
<tbody>
<tr>
<td>Assumed (A) or Not Assumed (NA)</td>
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<td></td>
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<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Strategic Management</td>
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<td>.909</td>
<td>-.03178</td>
<td>.27728</td>
<td>-.59262</td>
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</tr>
<tr>
<td>NA</td>
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<td>38.531</td>
<td>.909</td>
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<td>.27617</td>
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<td>.52705</td>
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<td></td>
<td></td>
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</tbody>
</table>

**Qualitative analysis.** An interesting aspect of this interview question was that the Nurse Managers were not certain how to respond, not thinking that they were responsible for any strategic involvement. Themes that were identified included *time, strategy by others, and acute care experience.* Most NMs indicated that they were aware of the organization’s strategic plan but did not have a sense of their involvement to that plan. One participant did not have strategic knowledge, “I was never really exposed to the strategic planning.” Another Nurse Manager stated, “I don’t know as the Nurse Manager feels like she has an awful lot of impact in being able to drive a lot of the change.”

The NMs were very busy every day and focused just on their unit responsibilities as stated by this participant, it is “difficult to be able to look long range because of the fact you’re dealing with day–to-day things.” Another NM agreed, “There’s not a lot of *time* to sit down and really project and plan things like that.” Some NMs, who do have unit goals, may not have the *time* to implement a plan as stated by this interviewee, “things that I have in my head that I want to carry out. I have a hard time getting to that ever because it’s all the day-to-day stuff that I have to take care of.”

Strategic unit planning required administration oversight in some facilities, so
many NMs considered organization strategic planning as a strategy by others. This statement by one Nurse Manager identified this administrative oversight, “There are a lot of things that I need to go through if I want to make some big changes … I always have to report to my Assistant Director of Nursing (ADON).” Yet, at this facility, the Nurse Manager did not need to obtain administration approval and stated, “I’m the manager so I can get an idea I just meet with my staff and we discuss what is realistic, what we can achieve and how we can do this.” Knowledge of the nursing department strategic plans varied at each facility from one NM stating, “I haven’t seen a nursing department one [strategic plan]” to another stating, “we were all asked to come up with … goals for the year for each Nurse Manager and then the nursing department put together goals for the year.”

Nurse Managers, who were comfortable with the strategic process, cited previous acute care strategic experience or continuing education programs as being helpful to their understanding of the strategic planning process. Acute care experiences, such as hospital management, provided support to this NM who stated “we had to do our own business plans for our units … from the strategic plan; I was part of a health system, so as a manager we were involved in the acute care strategic plan.” In the long-term care organizations, there was not as much of a unit less strategic involvement as summarized by this NM, “It doesn’t trickle down to us … these are things that they have decided as that team or group that they would like to see accomplished.”

In summary, strategic management occurred in all of the organizations at the administrative level but the Nurse Manager’s involvement depended on the specific organization. For this reason, the NMs scored at an advanced beginner level for this
category and identified the following themes, *time, strategy by others, and acute care experience*. Some NMs were not comfortable with their role in the organization’s strategic planning process. They were more comfortable with the planning and implementation of unit strategies even though, in some facilities, it was necessary to acquire administrative recognition before implementation. The NMs all agreed that it was difficult to focus on unit strategic management due to the busy workload but it was clear that they identified their unit strategy to “basically keep my residents happy, to be deficiency-free.” Resident clinical satisfaction was once again the primary responsibility. The next category, financial management, scored at an even lower level, mid-novice, due to lack of financial management experience.

**Financial Management**

The financial management category score was mid-novice level and included unit budget creation, budget analysis, budget evaluation, and budget monitoring. Overall, the Nurse Managers were not comfortable working with budget creation, analysis, and budget evaluation due to lack of experience, lack of education, and lack of unit responsibility. They were more comfortable with their involvement in the unit expenses and variance reports since this was a job requirement and they intuitively knew on a day-to-day basis what supplies and equipment were used. Even though some asked for further financial training, in most organizations, they had not received budgetary continuing education.

**Quantitative analysis.** The financial management independent samples t-test indicated that the means for both the Nurse Manager and the DON/ADON responses was equivalent to the novice level, almost to the advanced beginner (level two). The Nurse
Manager group mean was slightly higher than the supervisor group means (Table 4.22). Several Nurse Managers rated themselves at a level three or four (competent) and the supervisor rated only between a level one and two (novice). This may be due to the supervisor not being completely aware of the NM’s previous financial experience. At a 95% confidence level, the Levene’s test for equality of variances for the financial management category was not significant ($p = .515$) and the equal variances of the means was assumed (Table 4.23). There was no difference in the mean levels between the NM and the DON/ADON groups for this category.

*Qualitative analysis.* The interview responses supported the quantitative results that the NMs scored at a mid-novice level. When the Nurse Managers were asked about their role in managing the financial aspects of the unit, most of them stated that unit budget involvement was typically not part of their job. Budgeting was generally done by others in administration. The interview themes included *budget by others, expense variances, visibility on unit, experience, and staffing by others.* One NM stated that her “understanding is that in a lot of long-term care facilities, budgeting is not one of the expectations of a Nurse Manager.” And another participant supported that budgeting expectation, “A Director of Nursing is … the budget keeper and sets the budget … what’s allocated for the whole team.” There was no NM involvement for setting the unit budget.
Table 4.22

Financial Management Independent Samples t-test NM and DON Group Statistics

<table>
<thead>
<tr>
<th>Group</th>
<th>N</th>
<th>Mean</th>
<th>Std. Deviation</th>
<th>Std. Error Mean</th>
</tr>
</thead>
<tbody>
<tr>
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<td>21</td>
<td>1.7688</td>
<td>.94679</td>
<td>.20661</td>
</tr>
<tr>
<td>DON/ADON</td>
<td>20</td>
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<td>.68030</td>
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</tbody>
</table>

Table 4.23

Financial Management: Independent Samples Levene’s Test for Equality of Variances

<table>
<thead>
<tr>
<th>Equal Variances</th>
<th>F</th>
<th>Sig.</th>
<th>t</th>
<th>df</th>
<th>Sig. (2-tailed)</th>
<th>Difference</th>
<th>M</th>
<th>SE</th>
<th>95% Confidence Interval of the Difference</th>
</tr>
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<tbody>
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Even though the Nurse Managers were not involved with the budget development and analysis, there was an expectation that they were responsible to oversee unit expense variances. A NM reported that, “You have to manage the cost, you’re really not developing it, it’s determined for you and then you have to stay within the restrictions.” Another interviewee agreed that, “you’re accountable for your monthly variances whether you’ve been over or under, but yet you don’t have any control over it.” Most Nurse Managers had no understanding of the budget process but their visibility on the unit was important to help explain the expense variances. “The paperwork aspect of actually understanding the numbers, the codes, you know, what does that mean on the
paper versus what I can actually see and tangibly know” explained a participant. The NMs instinctively knew resident and unit usages through their daily rounding and their visibility on the unit. Previous experience in other types of healthcare organizations was instrumental for some NMs who understood the budgetary process. Those managers with previous hospital experience had more familiarity with the budgetary process since in a hospital setting, “it was something that was more or less expected at some level.” Another aspect of the budgetary process was staffing. The staffing budget was not usually controlled by the NM as this participant stated, “We do see the staffing salary budget. We cannot control that in any way, nor do we control how many staff members are assigned to the unit.” According to the NMs, staffing coordination was usually centralized through a staffing coordinator position; staffing was done by others.

Some Nurse Managers stated that more involvement with the unit budgetary process would be helpful for their day-to-day operations but the additional paperwork would remove them from the residents and staff. One NM stated her concern for more budgetary involvement, “It’s more on the paper, it’s more taking charge of your budget … define the role I guess of a manager because I know managers in the hospitals are … paper managers; here I’m thinking it’s moving more towards that.”

In summary, Nurse Managers did not have the experience and expertise for the budgetary process; they were involved with the identification of unit expenses and reporting the variances. For this reason, the interview responses supported the quantitative analysis of mid-novice for financial management and the identified interview themes included budget by others, expense variances, experience, visibility on the unit, and staffing by others. There was a fear for becoming more involved in the unit financial
aspects since that would potentially remove them from the resident and staff contact, yet many were interested in becoming more educated about the budget to improve resident care. There was also a general sense of needing to be more involved in the unit staffing for consistency of care.

The Nurse Managers were asked two additional interview questions about the future of leadership development in long-term care and the difference between long-term and acute care skills. A brief summary of the NM responses are provided in the next section.

Future of Leadership Development in Long-Term Care

This question, even though it was not a part of the NMIT survey, was important to ask because Nurse Managers will play a key role in the future of long-term care, especially with the increased resident acuity levels and resident aging. Clinical management and leadership expertise are critical to the changes that are projected for long-term care. The participants all agreed that the Nurse Manager’s clinical skills will continue to be important for resident outcomes as expressed by this participant, “The Nurse Manager in particular in long-term care has to be at the top of the game. They have to be strong clinically; they have to be strong with their leadership abilities and critical thinking.”

The NMs expressed a sense of optimism about their role for resident outcomes. Coaching staff will continue to be important, “trying to show them what little things they can do to make someone’s life better.” Culture change for person-centered care is a strategic plan in some facilities and one NM stated that, “I think the role of the Nurse Manager will change. I think we’re at a point now we’re trying to decide what will be
the Nurse Manager’s role.” Even though there was some uncertainty for the future role of LTC NMs, there was a commitment to their role and this participant summarized that commitment, “you do it because you enjoy the patients or you love the people. I don’t think you do it for the money.”

Interviewees were clear that there had been and will continue to be an increase in resident acuity which requires more nursing support. As stated by this NM, “certain skills are needed because the residents are coming in with more challenging diagnosis, illnesses, equipment, and procedures.” The higher acuity and heavier workload will continue to place a strain on the Nurse Managers as expressed by this interviewee, I can’t imagine how the young people coming into this are going to handle the load … it’s a lot of responsibility, a lot of stress and it constantly gets heavier. In agreement with the heavy workload this NM stated, “I have a lot of respect for anyone that does what I do. I think they’re the best nurses in the world … I don’t think anybody … has a clue what it takes to do this job every day.”

Long-term care Nurse Managers understood that their future would continue to be resident and staff focused but they were also very clear that new Nurse Managers will need educational support. In the current situation, “a lot of times when you come in at that level as a Nurse Manager, you’re hired, you get just the bare minimum basic general orientation … and then it’s hit and miss, but there are no formal classes.” This manager described how additional support will be positive for leader growth, “I think if we continue to have the support, continue to have the education, continue to…have the confidence of the people, that we can do our job and continue to do it in the future and be there as a leader.”
All NMs indicated that the position was very difficult, that it was a “tough job” and that they were responsible to “do it all” on the units. Their responsibility was far-reaching and included not just the residents, but also staff, families, providers, ancillary personnel, and administration. Quality resident care will always be the priority and as stated by this NM, “to invest in Nurse Managers’ clinical skills...if I didn’t have clinical skills I would be uncomfortable.” Clinical skills will continue to be the core of the management and leadership skills and responsibilities.

*Long-term Care Skill Differences*

When asked about the different skills for Nurse Managers in long-term care and acute care, most agreed that the clinical skill set in LTC was definitely different. This NM made an interesting comment that, “people always used to say when they needed to start winding down their life and kick back a little bit they’d go to long-term care. Well, I never found that it’s laid back.” This manager further added, “My assessment skills actually had to be better than the nurse in acute care. In acute care not only do you have the physicians available, not only do you have a bazillion other nurses around, you also have staff education.” In comparison to the hospital setting, this NM summarized the differences in long-term care,

Here, it’s more dealing with dementias and the day-to-day care … of somebody living with you; you have their whole life and their family problems and their family members. In the hospital, you see people get better and go home; here they’re here for years and years.

In summary, the NMs indicated that the future of nurse management will only become more difficult and burdensome due to the projected increase in resident acuity.
They identified the need for additional management and leadership training. In long-term care, the NM must continue to have excellent clinical, communication, and relationship skills.

Additional Skills for Long-term Care Nurse Managers

In describing their roles, NM identified two additional themes that were critical for quality resident outcomes. These themes were woven through the interview responses, providing a glimpse into the uniqueness that was a part of working in long-term care organizations. The NM visibility on the unit included both resident and staff rounding but in long-term care it included all categories for the NM clinical, management, and leadership presence. The second additional theme mentioned by many of the NM was the resident’s final journey, the last stage of the resident’s life, and the role of the NM in that final stage. A description of these themes is now provided.

Visibility on the unit. The importance of visibility on the unit, as repetitively stated by the NM, was a function of the NM’s ability to coordinate all unit activities and be mindful of the resident and staff needs at any point in time. This NM stressed the importance of having a physical presence on the unit on a daily basis, “They get used to you noticing things and that’s part of your job to notice things and keep people positive.” Visibility on the unit included resident and staff rounding to identify resident issues and concerns and to be available for staff questions and issues. This physical presence was a key component in all clinical, management, and leadership NM functions.

The NM was able to intuitively identify resident changes, complete resident assessments, and remain current with resident problems, that is, the NM’s clinical expertise was vital to the success of this visibility. As stated by this NM, “you keep your
clinical skills up” by being visible. The NM’s ability to inform the provider of any resident changes, possibly alleviating complications or negative resident consequences, was enhanced by the unit presence. One NM stated, “If you don’t visibly look, see, hear, and smell you’re not going to get past the gate because you will miss something.”

In comparison to an acute care setting, an experienced interviewee stated that in long-term care, “they’re hands on way more than what I saw when I was in acute care.” Due to their visibility on the unit and the length of stay for many residents, this participant described that, “long-term care nurses…know their patients inside and out, left and right.” Interestingly, the NMs have acquired an embedded clinical knowledge, a “knowing how,” of being able to intuitively identify resident changes through observation and assessment. This was confirmed by one manager, “I can go into a room of a whole bunch of residents … and I can see the danger areas. I can see who’s at high potential of falls … things that are unsafe that somebody else might walk by.” Another participant indicated, “I can look at them and tell you something is not right” and she additionally stated, “I hadn’t really thought about it before but I don’t miss a lot.”

Visibility was also identified as being powerful in building relationships and trust. This NM defined visibility as, “Making rounds and listening to the staff and listening to families and members, any concern that they have, but just being around on the unit.” There was a defined presence for trusting relationships. Staff coaching and staff communication were also enhanced through this unit presence. As stated by this participant, “I’m always aware and always looking around and curious … I try to teach them that, don’t just walk in the room, give a pill, set a tray down, look, observe, notice things.”
Financially, being available to identify resident and unit expenses helped the NM with variance reports as stated by this participant, “When I’m out and about on the unit I can tell you verbatim who uses liners and continent products, how many pencils we use, how much paper and I can tell by just overlooking if something has changed.” Safety and quality measures were supported by the NM’s visibility as confirmed by this interviewee, “You see it and it’s not safe, it’s not safe for staff, it’s not safe” for the resident.

Most NMs stated that they are fearful for the technological changes that may restrict them to their offices to complete documentation. This manager was clear that visibility was more important than technological advances as stated, “if there’s some way you could alleviate so much time spent on it (EMR) and spend more time … out in the field, out on the floor with the residents, with your staff … hand in hand working together.” And this manager suggested that hiring more RNs to help with documentation would support the manager’s being more visible on the unit,

It would be very beneficial if we had more RN’s to maybe assist or completely take some of our clerical needs or obligations away from us so that we can be out on the unit more, observing more, teaching, spending more time with the residents, families, instead of being pulled in so many different directions.”

Clearly, the NM ‘s visibility on the unit was a critical component to their role as both unit manager and leader, ensuring that quality resident care was provided.

Final journey. This theme resonated throughout the interviews and was a very powerful role for the Nurse Manager. The majority of residents in long-term care, not including the rehabilitation floors, were in the facility due to the need for increased
nursing care. Due to this increased acuity and their increased age, long-term care was
often identified as the final journey for the resident. Resident decline over time would be
expected and the majority of long-term care residents lived-out their days in these
facilities. During the interview, several NMs identified the final journey as a positive
journey in which they were very deeply and willingly involved. By understanding the
concept of the final journey, this NM’s remarks about LTC skills became even more
clear, “compassionate, comfort care, dealing with dementia, seeing dementia, increased
hospice involvement, family dynamics, dealing with condition changes, and comfort
measures.” These are all end-of-life focused clinical skills.

Interestingly, the Nurse Managers accepted their role as participating and
coordinating the final journey and considered it an honor to be a part of this journey with
the residents and their families. For this reason, the NMs placed a great emphasis on
responding to resident needs, answering resident questions, and having a presence for
both the residents and the families. Visibility was also extremely important through this
journey. Resident care, throughout the interview process, remained a priority for Nurse
Managers for the resident’s final journey as summarized by this participant,

It is the most important job that you have, is to get everyone through the process
of, they come here to live, and they’re going to pass away with us, and how do
you do that from beginning to end so that everyone is comfortable.

It was incredible to listen to the positive description for the final journey process
and there was not a better way to understand how this responsibility affected Nurse
Managers than to read their personal statements. As this NM stated, “It’s not just
everybody is here to die. Everybody is here to live and experience complications along
the way that we must try to figure out how to deal with, but it’s a different way of
thinking.” This participant additionally explained that, “long-term care to me that’s their
home…their quality of life. That to me is you want to make their last few years the best
that they can be.” In long-term care, the NM was the force who supported, not just the
resident, but also the family, friends, and staff through this process. The NM was such a
vital element to this relationship as described by this interviewee, “Living the life
anywhere from five years to three days with the residents and their families, and going
along step by step and sharing their feelings and their experiences … and just being part
of their life more than just a hired worker.” And according to this NM, “it’s the end of
the life; you’re going to journey through the final stages where you might not do that in
the other settings. So you connect with families in ways that you wouldn’t necessarily in
other settings.” Finally, this participant added, “you look at more of the whole picture
here…how they were and where they are now and help them get to a place of rest when
the time comes, make the most of their days.”

The concept of providing resident care through the “final journey” was best
explained through the Nurse Managers’ statements. It was powerful to watch the
softening of their facial expressions during the interview and to hear their compassion in
the audio-tapes. This was truly one of the main reasons that they remained in long-term
care despite the long hours and difficult workload. It was their responsibility to support
the resident, the family, and the staff through this process. Their involvement with
comfort care, teaching, clinical assessments, and just being present supported resident
outcomes that did not prolong life but supported the quality of the resident’s life through
their final days. The Nurse Manager was responsible for that quality of life, the quality
of the resident’s final journey.

Conclusion

The Nurse Managers in this research were very eager to tell their story and provided vivid descriptions about their role in long-term care. The NM position was considered a tough job because of the high demands from residents, families, and staff as described by this manager, “this is one of those types of jobs where I think it’s a tough thing to break into and it’s a tough, it’s very difficult to stay in this position.” At times the job was very isolating since there was minimal RN clinical support as stated by this participant, “I’ve found that it’s challenging and its aloneness, I mean the fact that you are so disconnected at times from nurses within other settings.” And the NMs identified the need for additional support as described by this interviewee, “It just needs more support…and not just when something is going wrong.” The NMs frequently defined their role as being responsible to “do it all” as stated by this participant,

It’s a hard job. You have to keep the residents happy, the families happy, you have to keep the staff happy, keep medical department happy, nursing administration happy and the State Health Department happy and when you get all that done you try to have a little happiness for yourself.

Yet, most of the NMs felt a fondness for the role, emphasizing the importance of what they did. As this interviewee stated, “I think sometimes that the position is looked down on, you know, and I think it needs to be pumped up.” Several participants summarized that they knew their role was difficult but they really did like what they did as stated, “It’s a tough job but I like it” and “I do I really enjoy my job,” or “It’s just really hard but it’s very rewarding.” With the increased emphasis on the elders in long-
term care, this NM identified the need for a new perspective to the role that “a Nurse Manager in long-term care is a specialty in its own.” And this NM summarized,

I think all the Nurse Managers that I know truly like what they are doing, feel that we are accomplishing something and we’re making life and the health status of all our folks better because of our jobs, of what we do. I think we do accomplish things for them.

As they defined and described their skills, competencies, expertise, and embedded knowledge to meet resident outcomes, the NMs also expressed their frustrations, their concerns, their feelings of isolation and overwhelming responsibility, the regulatory oversight, and having to do it all on a daily basis. They positively focused on their visibility on the unit, providing support through the final journey, and their clinical strengths that supported all management and leadership responsibilities. Collectively, the Nurse Managers made a point that they had a job to do and that this primary job was to provide for quality resident care no matter what the need. They begged for more administrative support, additional continuing education, mentoring, and recognition. They wanted to do the best that they could in a highly regulated environment. This NM provided an excellent summary for what was most important, “mostly everything I learned, I learned by trial and error, learned from my mistakes, learned from people that I respected … if it’s good for the resident that’s always the bottom line.”
Chapter Five: Discussion

Introduction

The purpose of this research study was to answer the question: How do expert Nurse Managers, as leaders in long-term care, define and describe their lived experiences to develop their expert leader skills, competencies, expertise, and embedded knowledge? Prior research had not been completed to study Nurse Manager leadership development in long-term care (LTC) based upon the novice-to-expert framework. The Nurse Managers (NMs), as a self-assessment, and the Directors of Nursing (DONs), as a supervisory evaluation, completed the Nurse Manager Inventory Tool (NMIT) with a 5-point Likert scale from novice-to-expert. These survey results were used to develop the interview questions through an analysis of the Independent Samples t-test that compared the means of the NM category scores to the means of the DON/ADON category scores. At the core of the NM leadership attributes were their clinical skills; where the clinical mean scores were found to be at a proficient level (level four). Data also showed the NMs and supervisor’s mean scores for the other categories, not including financial and strategic management, at the competent level (level three). Results indicated for financial management; the mean scores at the mid-novice level (level 1); and for strategic management, at the advanced beginner level (level 2).

For the interviews, NMs were chosen based on the criteria of having five or more years of NM experience. A total of nineteen NMs were interviewed, following their completion, the results were coded and analyzed. Additionally, the interview questions
identified each NM’s perception of competency in the following leadership categories: (a) clinical skills, (b) leadership reflective practice, (c) diversity, (d) human resources (HR) leadership, (e) relationship management, (f) performance improvement, (g) problem solving, (h) information technology, (j) HR management, (k) strategic management, and (l) financial management.

During the NM interviews, several identified themes crossed over many of the NMIT categories. A sense of aloneness or being the only nurse support played a role in clinical skills, HR leadership coaching and problem solving. Trial and error learning, which is on-the-job learning, occurred in the categories of diversity, clinical skills, relationship management, problem solving, and leadership reflective practice. Common to HR leadership management, clinical skills, relationship management, performance improvement and financial management was visibility (presence on the unit). Peer support was very important to HR leadership, clinical skills, relationship management, performance improvement and intuition played a role in both HR management and clinical skills. Clearly, in their role, the NMs learned their skills and competencies through trial and error with peer support. Often being the only RN on the unit, they had a sense of aloneness with decision-making and problem solving but relied on their visibility on the unit and their intuition. And the primary importance of their role was resident outcomes, especially in the support of resident and family relationships through the resident’s final journey of their life.

A novice-to-expert model for long-term care Nurse Manager leadership skills and competencies, based on the findings of this research study is represented in Figure 5.1.
Figure 5.1. Novice-to-Expert model for LTC NM leadership.

In this model, each circle represents a level of the novice-to-expert continuum moving from the outside novice circle toward the inner circles of advanced beginner, competent, proficient, and finally expert. In the role of a Nurse Manager, there is a movement from a more generalized, outward-focused, follow-the-rules detachment novice level to a more focused, defined, experienced, intuitive expert level as the NM gained skills, competencies, expertise and embedded knowledge. The inner circle represents the final journey since my research indicated that this was an important Nurse Manager responsibility to support the resident, family, and staff through the end of life process. As the LTC Nurse Managers moved through these novice-to-expert learning levels, the final journey remained their mission and permeated through all that they did. In their quest to fulfill this mission, they perceived their skills to be at various levels of proficiency along the novice-to-expert continuum.

In Chapter One, the novice-to-expert model and theoretical concepts were discussed. In Chapter Two, the literature review paid particular focus on Benner’s
novice-to-expert model, Day et al.’s theory of leadership development, and the skills, competencies, and leadership expertise of NMs in both long-term and acute care environments. Following, in Chapter Three, the triangulated qualitative research study was described. Next, in Chapter Four, the results of the research, including the NMIT survey and NM interviews was summarized. Lastly, in Chapter Five, a discussion of the main findings from this qualitative research study was summarized; following with implications for Administrators, DONs, NMs, and Staff Development. Further, implications for future research were described; finally, a discussion of the limitations of the study.

Novice-to-Expert

Upon completion of the literature review, no research existed on the novice-to-expert model for NM leadership or leadership development in long-term care. Benner’s research on the novice-to-expert framework solely was based on an acute-care clinical perspective; where she identified five levels of expertise; novice, advanced beginner, competent, proficient, and expert. Through these five levels, the nurse progressed from a follow-the-rules detachment to experienced, emotional attachment; occurring generally after five years of focused clinical experience (Benner, 1992, 1996, 2001; Benner, Tanner & Chesla, 1992). In addition, Benner identified embedded knowledge as an intuitive “knowing how” and expert nurses could “describe clinical situations where his or her interventions made a difference” (1992, p. 406). Outside of health care research, Lord and Hall (2005) identified three levels of leadership development that occurred overtime as there were continuous changes in the knowledge base, skills, behavior, and social connections. These levels were novice, intermediate, and expert; where the leader moves
from the process of skills acquisition to problem solving, followed by automaticity of skills and lastly, connections between knowledge and the learned principles.

In the study, nineteen LTC NMs completed the NMIT survey and also answered interview questions based on the novice-to-expert framework. All NM’s had five or greater years NM experience, yet when answering the survey, few NMs responded at an expert level in any category and in some categories no NM responded at an expert level. Collectively, the NMIT Nurse Manager or Director of Nursing mean scores for any category were not at the expert level. The NMs stated that their clinical skills should be at an expert level due to caring for residents at higher acuity levels; however, their mean scores reflected solely being at the proficient level. The majority of the NMs stated that they were uncomfortable rating their skills and competencies at an expert level because there would then be no room for growth or learning, yet this researcher listened to them speaking about clinical issues from an expert perspective. Further, the NMs identified a clinical intuition (gut feeling) that can be equated to embedded knowledge; knowing the resident’s needs through observation and assessment. The NMs cited assessment examples that “made a difference” for the resident’s well-being by identifying resident healthcare changes through a clinical assessment. This was an extension of Benner’s concept for embedded knowledge; a clinical intuition or “know how” when assessing resident needs.

Theory of Leadership Development

This research was based on the leader development theory by Day et al. (2009) that identified the skills acquisition process from a novice-to-expert perspective. Day et al. stated for the first proposition of this theory that “Expert leadership can be
differentiated from novice leadership” (Day et al., p. 176). Daily practice and experience allowed the leader to move from the declarative (rules-based) and procedural (process-based) levels to the strategic (automatic response) and adaptive (new situations) levels. Day et al. declared that “basic level skills combine to form complex and multifaceted leadership competencies” (p. 178). The results of this research study supported the fact that NMs as leaders moved from a rules and procedural-based nursing leadership, toward a leadership reflective of strategic and adaptive responses; based upon some of the identified categories.

From a clinical perspective, the NM within many of the units, did not have additional RN support and was expected to be the clinical decision-makers; leading the NM to be clinically strategic and adaptive to the changes in the environment and the resident acuity levels. They demonstrated self-efficacy, a belief that they can respond correctly to any clinical issues, and self-regulatory strength, an ability to set direction based on experience. According to Day et al., self-efficacy was reflective of the intermediate leadership level (competent) but self-regulation was reflective of an expert level. Yet after greater than five years clinical experience, the NM means scores were only at a proficient level for this category, with no consideration for being clinical experts. Based on survey results, the leadership reflective practice and diversity means scores were competent but above mid-line; NM demonstrated more comfort with automaticity and adaptability in the diversity category. The categories in which the NM mean scores were the competent level, the NM were capable of rules (declarative) and processes (procedural) and displayed some automatic (strategic) responses while adapting to new situations (adaptive). Despite the competent scores, not all NM were adaptive in
every category and often administrative support was needed for decision-making. Considering financial and strategic management, most NMs remained at the rules and procedural-based level, which was equated to Day’s novice and Benner’s novice/advanced beginner levels.

According to Day et al. (2009), leadership development required personal power, knowledge, trustworthiness, and a focus on commitment, mutual respect, empathy, and service orientation. In this study, the NM’s surveys and interviews did not specifically address the leadership development qualities described by Day et al., however, it was evident that the managers did have clinical knowledge due to the clinical means score and the NM discussion about intuition and the “gut feeling” response to clinical issues. In turn, the NM’s lacked knowledge within some categories, in particular strategic and financial management. In the interviews, they presented a focus for commitment and service, resident, family and staff empathy, and also respect, especially for the residents and their peers. In addition, it was revealed they lacked personal power; where they often acted based on administration direction due to the hierarchical organization style.

Discussion of Findings

According to Wilson (2005), in both rural acute and long-term care, nurses who were excellent from a clinical perspective were often placed in a leadership role without the benefit of management education. There was an “expectation that a nurse who does well in clinical nursing will also do well in management, even with no formal training” (p. 137). Most of the LTC Nurse Managers in this study aligned with Wilson’s observation, stating that they began their career in long-term care as clinical coordinators or staff RNs with specific clinical job responsibilities, then were asked to be the unit
Nurse Manager because they were either the only available RN or they were excellent in their clinical role. These NM’s were advanced to a management role without the benefit of formal training or orientation in management. Many NMs indicated that they learned through experience, which included daily trial and error and peer support. Those with more experience eventually became the peer support for newer Managers. The NMs usually sought the support of nursing administration for more difficult problems or issues, on an as-needed-basis.

In addition, not being given the opportunity to participate in a formal manager orientation could also possibly add to work stress. As Wilson (2005) stated in today’s long-term care healthcare environment, the increased stress levels, “coupled with a lack of knowledge and skills in management competencies such as human resources or budget management can be devastating for the new manager and the organization” (p. 138).

Likewise, the NMs in this study considered their financial and strategic management skills at a mid-novice level. For most of the organizations, the budgetary responsibilities only included expense variance reports, not unit budgetary development or analysis. Several NMs lacked the budget and strategic management skills to effectively and efficiently manage the LTC unit. The HR management category responses were at the competent level, but many NMs learned how to effectively manage through trial and error, not from educational support. As a result of this trial and error, the majority of NMs indicated that working in a long-term care setting was a “tough job”; due to the tremendous workload set upon them on a daily basis.

Further, the NMs in this research study indicated in the interviews that they were stressed and extremely busy on a daily basis; not just from a trial and error learning
process, but also from the scope of their crucial supervisory behaviors. Based on the literature, Hall et al. (2005) identified LTC supportive supervisory behaviors as considerate listening, an awareness of staff personal issues, providing positive reinforcement, respect and trust, role-modeling and helping behaviors. These “helping behaviors” (p. 184) allowed the NM to provide the staff support through a visibility on the unit. Dellefield (2008) identified similar behaviors including: considerate listening, positive reinforcement, trust and respect, role-modeling, helping, professionalism, a positive attitude, teamwork, and advocating. In comparison, this research study affirmed these supervisory behaviors, such as; listening or an open door policy, helping through a visibility on the unit, positive role-modeling, and coaching responsibilities; all critical attributes of a NM as a leader. Although advocacy was not addressed explicitly in this study as in Dellefield’s, the managers did show support toward their staff for both personal and work issues while promoting teamwork. The managers did not speak specifically about the effect of a positive attitude, but the majority of interviewees spoke positively in regards to their role in meeting resident needs, as well as being pleased with their job even though challenges existed. The fact that the NMs defined their role as a “tough job,” and further, the implications of the work that must be accomplished on a daily basis; may both overshadow the presentation of a positive attitude.

Positively, Hall et al. (2005) also summarized the importance of “teaching that involved recognizing the strengths and weaknesses of individual staff members and encouraging their growth” (p. 184). In comparison, NMs in this study stated that coaching and teaching staff on a daily basis were necessary, in order to set expectations and foster individual growth; the NMs enjoyed identifying staff weaknesses and helping
them develop strengths to grow in their respective roles. Interestingly, Hall et al. (2005) identified that communication was placed with a lower value on a supervisor’s responsibility. In contrast, the NMs in this study emphasized the importance and critical nature of communication between residents, staff, and families. Communication, trust, and coaching were fostered through the NM’s visibility on the unit and the “helping behaviors” approach.

Supporting the importance of communication and interpersonal skills, Purcell (1999) also identified several more characteristics, such as flexibility, thus ability to adapt to change, and nursing knowledge and skills; as important attributes of long-term care NM. Further, their essential role included motivating and coaching staff, delegating tasks, providing conflict resolution, and also supporting the families that need assistance. In comparison, the NMs in this research also emphasized the importance of resident, staff, and family communication, coaching staff for improvement and assisting families. In contrast to Purcell’s study, the NMs recognized the importance of conflict resolution but were uncomfortable resolving issues; thus requesting support from peers or administration to handle the issue accordingly. Moreover, learning communication and coaching strategies primarily occurred through trial and error, peer support, and some guidance from the administration. It is important to note, delegation questions were not asked in the interviews, but the NMs did discuss having a supportive team. Additionally, on most units, RN tasks could not be delegated without availability of sufficient nursing staff.

Since long-term care research studies were limited, a review of the acute care research provided additional insight to an understanding of the NM skills and
The American Organization of Nurse Executives (AONE) identified five competencies for nurse executives: (1) communication and relationship management, (2) knowledge of the healthcare environment, (3) leadership, (4) professionalism and (5) business skills and principles (Shirey, 2007). In addition, Jennings et al. (2007) defined the competencies of leadership and management in acute care settings as both including: management, and business skills, communication, health care knowledge, setting the vision, developing staff, and independent thinking. For my long-term care research, the NMs were proficient in their clinical skills but identified their business skills at a novice level due to lack of involvement in that competency. Further, their communication, relationship, human resources, information management skills and leadership reflective practices were at a competent level. In most facilities, the NMs did not have the opportunity to be visionary and independent of their administration; additionally, were not always able to find time to develop staff due to regulatory influence, lack of clinical support and the burden of completing all of their daily responsibilities. This was a marked difference between the acute care leadership and management environment.

In an acute care study by Sullivan, Bretschneider, and McCausland (2003), NM leadership satisfaction in the workplace included autonomy, flexibility, ability to direct patient intervention for positive outcomes, staff mentoring, situational power and control, and capability to influence and change practice. As a support to that research, Upenieks (2003) identified nurse leader values as visibility, responsiveness, passion for nursing, business savvy, responsiveness, open communication, and credibility. Additionally, researching nurse executives, Byers (2000) completed a survey ranking their skills as clinical knowledge, human management skills, trustworthiness, humor, communication,
quality management, and decision making. In support of these studies, NM satisfaction in the long-term care environment included positive resident outcomes, staff coaching, long-term resident and family relationships, and genuineness for running the unit especially for clinical skills which ranked the highest. In fact, the NMs had a passion and a great deal of pride for the clinical intuition skills; the “gut feeling” they learned to identify resident needs and for their credibility before residents and their families. Trustworthiness was not specifically discussed in the interviews but could be an assumption through relationship building; shown by NM’s staff and resident responsiveness through the visibility of the unit.

Leadership challenges affect every manager; O’Neil et al. (2008) surveyed healthcare leaders and determined that some leadership challenges included budgeting and workforce (recruitment, retention, and aging workforce) building effective teams, managing conflict, and focusing on the patient, and translating vision into strategy. In contrast, in this research study, administrative oversight limited the NMs ability to influence and change nursing practice. Additionally, the most challenging issues in long-term care were staffing resources and scheduling, lack of organizational resources, limited control over work environment, conflict management which is in alignment with acute care challenges as well. Business savvy was not an expectation for the NMs; creating a disadvantage for unit management.

As most are aware, long-term care facilities provide nursing care for elders who may be living through their final days. In this research, many NMs spoke openly about their responsibility to support resident final days; they considered their role to be critical for the residents, families, and staff during the dying process. During the NM interviews,
this theme of the “final journey” resonated with the managers; that it was their responsibility to maintain an awareness of resident needs and wishes at all times. They spoke openly about this final journey and whether it was a few days or several years, it was the NM who supported everyone involved. Further, the NMs openly identified, whether or not the resident was to live for years to come in the unit, that he/she would experience their final days with the unit staff. When residents were in the facility for several years, the NM and staff developed long-term relationships; different from the acute care environment in which it did not necessarily occur. This further added to the NM’s sense of responsibility and need for credibility. Thus, an empathetic approach was necessary to manage resident and family needs and to coach staff for the highest quality of resident outcomes. The definition for the NM role during the “final journey” was not identified in the literature yet its importance must be recognized within the novice-to-expert framework; it encompasses the competencies of the NM role in long-term care.

The results of my NM research in which identified skills, competencies, expertise, and embedded knowledge of NM leaders in LTC further validated the skill and competency findings from previous acute and long-term care nursing leadership studies. As formerly stated, the LTC NMs were able to score their skills and competencies along a novice-to-expert continuum yet most NMs, who had five years or greater of NM experience, did not respond at an expert level. In fact, the mean scores for most of their skills remained at a competent level, except for the competency of clinical skills which was rated proficient; and also strategic/financial skills which was rated from mid-novice to advanced beginner. As discussed, my research results provided a summary of the LTC NM responsibilities along the novice-to-expert continuum. In the next sections, the
implications of these results for the LTC Administrators, DONs, NMs, and Staff

Education will be presented along with future implications.

**Implications for LTC Administrators**

During the interviews it was evident that the LTC NMs played a critical role in the day-to-day unit operations and served as a primary supporter for resident/family and employee satisfaction. Frequently, the NMs stated that their main focus was high quality resident outcomes. As stated by Upenicks (2003), the nurse leader with “formal and informal power, access to information, resources and given the opportunity to grow” (p. 149) will be most effective in their role. In contrast, the NMs in my research described themselves as often powerless in the organizational hierarchy; as not being included in the organization’s strategic planning. Further mentioned was their lack of budgetary power which primarily consisted of monitoring expenses; frequently they needed administration oversight for unit strategies. Also, the NMs indicated a sense of “aloneness” when making decisions, different than the acute care settings where the presence of an additional RN level is found.

Essentially, Administrators should become aware of the importance of the NM role in support of the organization strategic vision; considering opportunities to enhance NM’s power and access to information and resources that will provide for their growth and development. Nurse Managers need to be more involved in the organization’s strategic planning and provide strategic input, such as being a part of the decision-making process; enabling them to more accurately align their unit strategies to the larger entity. NMs growth and development would be a result of that involvement.

Since most of the NMs in my research were the only RNs in their respective units
thus responsible for all of the unit’s operations, it was continuously mentioned that their role was difficult due to the lack of additional RN support. NMs with RN clinical coordinators (assistants) had more time to coach staff, identify and resolve issues and problems, and also monitor unit operations. It would be advantageous for the Administrator in conjunction with the Director of Nursing to review the number of available RN’s per unit based on budgetary guidelines and regulatory oversight. The organization should at a minimum have an RN manager and an RN clinical care coordinator on each unit to support resident decision-making and quality outcomes. Further noted, additional RNs on the unit would provide the clinical support needed; enabling NMs to focus on teaching and coaching, developing relationships, trust, and advocating for residents and staff.

Additional RN support will also be instrumental in reducing the RN turnover in long-term care. According to Castle, Engberg and Men (2007) “high staff turnover is associated with worse quality (p. 659).” Administrators must be aware that increased nursing turnover compromises resident quality of care since continuity of nursing healthcare services and nursing expertise is lost. Nurse Managers are critical to effective resident care, health paraprofessional staff management, organizational support, and quality outcomes (Dellefield, 2008). It is essential that sufficient RN leadership levels be maintained since nursing support provides positive reinforcement and shared decision-making.

Administrators should consider beginning the process to develop nursing shared governance programs within the long-term care environment through involvement of the Director of Nursing and the Nurse Managers. According to McDowell, Williams, Kautz,
Madden, Heilig, and Thompson (2010) shared governance is an “organizational framework that affords nurse professional autonomy, empowers professional nursing staff and managers to contribute to the decision-making process” (p.33). Nurses should be involved in consensus decision-making at all levels of the organization, providing both clinical and leadership input. By benchmarking acute care shared governance programs, Administrators should begin to recognize the importance of nurse participation in the decision-making; at both the unit and administrative levels. This implication aligns to McDowell et al.’s statement, “Those closest to the point of care understand best what’s needed to provide that care” (p. 37); additionally, the shared governance program benefits included increased resident satisfaction, and nurse retention, “an open relationship with management … and improved professional growth” (p. 37). This would be the first step to further develop the LTC NM’s autonomy, professionalism, and organizational support.

**Implications for DONs**

My research indicated that most of the NMs were previously expert clinical nurses and offered the NM position without the benefit of an orientation or support before for additional education, prior to accepting the job. Also, most of the NMs indicated that, once they were in the position, whether time constraints or lack of opportunity disenables them to attend conferences to further their management/leadership education. The Directors of Nursing (DON) were the executive clinical leaders in the long-term care setting and served instrumental to NM’s leadership development. An implication for DONs was the pivotal role in which they play in assuring RNs chosen for a NM position, to be provided with a formal orientation prior to starting their new leadership role. This formal orientation should be specific to the NM needs and encompass the skills and
competencies identified in the NMIT survey. It should also focus on the NM’s expertise on a novice-to-expert continuum so that each manager is provided with the educational level that addresses their individual needs. At the novice level, the orientation should be more rules-based including the organization’s policies and procedures. At the competent level, the program should focus on the aspect of multi-tasking within the role. Lastly at the expert level, the program should focus on enhancing leadership skills and developing relationship building. In addition to this orientation, DONs should provide continuous mentoring support to enhance the NM’s movement from a novice-to-expert leader. With this educational support, the NMs could more easily gain the requisite knowledge, while moving from the novice (declarative and procedural) to expert level (strategic and adaptive).

According to Bourboniere and Strumpf (2008), 75% of the RN staff in long-term care settings held an Associate or Diploma degree. In this research, 63% of the NMs who participated in both the survey and interview (n=19) held either an Associates or Diploma Degree as well. Additionally, Wilson (2005) identified that RN’s who seek further education as more satisfied in the position, which also aligns to Luggen’s (1997) contention that additional education was foreseen as necessary in preparing nurses for management roles. The NM’s ratings revealed leadership/management skills and competencies at the competent level; even with greater than five years of experience as a NM. Learning through trial and error did not provide the appropriate educational support needed for this level of leadership; consequently the NMs were not completely prepared accordingly for the role.

Additionally, the DONs should review the organization’s educational leadership
opportunities, including both continuing education and outside conference offerings; enabling NMs to continue their individualized leadership training after the initial orientation. DONs can also be instrumental to review the organization’s tuition reimbursement programs that provide monetary support for the NMs to advance their degrees to the BSN and MSN levels. Since the resident acuity levels have increased and the NMs primary focus was resident care through the final journey process, it is critical that the NM’s leadership development have a gerontological focus, potentially with a hospice track. Nursing administration can identify schools of nursing higher education to support the gerontology and hospice tracks, focused on long-term care and leadership development.

In addition to the tuition reimbursement, DONs must also ensure that NMs are granted sufficient time away from work to attend classes and educational conferences, however, during this time, adequate RN unit support must be available while the NM is fulfilling these other opportunities. The additional RN support would ensure the NM’s ability to focus on their leadership development and educational goals.

Anderson et al. (2003) stated that in the long-term care setting “developing alternative management strategies-ones that increase connections and interaction among people and increase cognitive diversity-are needed” (p.20). According to the NMs in my study, the DONs were generally available to assist with immediate critical decision-making or problem solving. As one NM stated, “You need someone that you could look to for support and guidance.” The NMs needed to seek the connections and interactions that the DON’s should be there to provide, which should be available on a regular basis, not just during critical decision-making. Moreover, DONs should develop a Nurse
Manager mentoring program which includes rounding on the Manager’s unit; regular, informal meetings; personal coaching sessions that focus on managerial issues and concerns; and progressive mentoring. This mentoring program should be based on the novice-to-expert model.

For an example, at the novice level, DONs could provide policy and procedure information, round with the NM on a daily basis to troubleshoot and discuss options, and also be available for one to one coaching. As for the competent level, DONs could discuss multi-tasking scenarios and also, set models for the NM. At the expert level, DONs could provide mentoring support for interdisciplinary and networking opportunities. As shown, DONs could be instrumental to the leadership mentoring process, by ensuring that the mentoring is on-going and geared toward the management and leadership competencies and skill levels.

Since the NMs identified the importance of their support through the resident’s final journey process, it is critical that the DONs determine the appropriate educational and managerial support for the Nurse Managers. Currently, home health care hospice programs provide additional medical and nursing support for residents living in long-term care. Nurse Managers could benefit from certification programs offered by the hospice organizations that would provide educational advancements, providing the NM an additional level of expertise.

Implications for Nurse Managers

In my research, the NMs understood the impact of their role in long-term care for resident, family, and staff satisfaction. Through their visibility on the unit, the NMs strongly identified with the successful resident outcomes; however, they were often
frustrated with not having enough time to complete all of their responsibilities on a daily basis. In some of the leadership categories, the NMs scored at a competent level; and shared that if advice was needed, then they would find the DON or a peer for support. It is critical that NMs identify what individual needs exist in leadership development and communicate these to the DON regularly; and request educational opportunities to meet those needs in order to move toward an expert level of competence within their responsibilities. In addition, the NMs emphasized their “aloneness” within the role since it was generally difficult to locate peer support when needed. Based on the data, it was critical for the NMs to develop peer networking opportunities that met on a regular basis to share management and leadership best practices. These networking opportunities should not only be at the individual facility level but also include NMs from other long-term care facilities to identify benchmarking and additional learning opportunities.

The sense of “aloneness” that the NMs often felt could be addressed through nursing networking opportunities and the establishment of monthly interdepartmental and interdisciplinary meetings. At these various opportunities, the NMs would identify the resident, staff, and unit needs so interdisciplinary and interdepartmental approaches could be used to improve resident care through a proactive, collaborative approach. In this way, everyone would approach resident care through a ‘team building’ approach at the unit level.

As previously noted in my study, NMs did not have budgetary and strategic experience. However, they mentioned that it would be beneficial to have greater involvement at these levels. An implication for NMs was to request continuing educational support from the organization’s staff development department, identifying
both financial and strategic needs, and also other needs in educational leadership. As expressed by the NMs, it was important to be proactive for learning requirements, to anticipate that need, and also be visionary or future-oriented. Through these educational requests, the NMs could identify their specific needs, allowing staff education to provide the necessary support on a regular basis.

Finally, an implication for NMs is to develop a way to profile their successful accomplishments in turn, developing an administrative awareness of their job performance. From my research, it was evident that the NMs were responsible for all unit activities; residents, families, and employees. This responsibility crossed from resident admission through the final journey. Despite the lack of educational and orientation support, these NMs learned through trial and error; fulfilling a great amount of duties on a daily basis. These NMs truly loved their job and accepted their responsibilities despite the difficulties faced in the position. There should be an avenue for these NMs to profile their accomplishments in order for administration and others to recognize their expertise; enabling the NMs to be seen as an expert in long-term care leadership and management.

Implications for Staff Education

Harvath et al. (2008) hypothesized that the organization’s support of leadership training would improve the quality and also “stabilize the workforce” (p.195). Dellefield (2008) identified best practice interventions within long-term care facilities to include NM training. Most NMs in this study learned their leadership skills through trial and error or peer support. Consequently, NMs learned their skills on an individual basis without a defined educational program. Even with the vast years of experience that most
NMs held, they rated the majority of management and leadership skills at a competent level. With formalized management and leadership training, these NMs could receive the additional training and support needed to recognize their abilities. Staff education departments can take an active role in developing a novice-to-expert NM leadership program that would identify the management needs at each level of the continuum. This training program would complement the novice-to-expert mentoring that the DON would conduct. This training can focus on the initial novice skill acquisition level and then advance to the strategic and adaptive level of the expert leader; these levels can be based on the competencies identified in the NMIT survey.

**Implications for Future Research**

Due to the resident clinical complexity, resident longevity, and the fact that more elders in the future will need long-term care nursing support, more research should be conducted in long-term care with a focus on the NM level. Current research focused on the DON level; leaving a gap in the literature on the skills and competencies of the LTC NM. There also was a lack of research to understand the novice-to-expert model in long-term care. Additional research should focus on the leadership and management skills, competencies, expertise, and embedded knowledge of the LTC NM from the novice-to-expert perspective. Replication of this study with a larger NM population would provide additional research to define and confirm the NM skills and competencies. Further research should also be done with the use of the NMIT survey to ensure coverage of a larger geographic area; to further look at identifying the LTC Nurse Manager’s novice-to-expert management and leadership skills.

It is also suggested that replication of this research be conducted in long-term care
organizations that implement culture change philosophies of person-centered care, such as the Pioneer Network (www.pioneernetwork.net) and Eden Alternative (www.edenalt.org) programs. These programs are revolutionary in how they provide resident care services within a home-like environment. Resident care focus is the driving force and nursing leadership’s focus may not be similarly aligned as in the traditional care models. Critical to the long-term care future is an understanding of the Nurse Manager’s role and responsibility, including the necessary skills, competencies, expertise, and embedded knowledge. Additionally, research will be necessary to further understand the NM’s role, as a supporter of the resident’s final journey, within an environment that is focused on culture change and person-centered care. Research to understand the NM and hospice program impact would be beneficial to an understanding of person-centered care at the end-of-life.

Nurses who completed a BSN program received leadership and management classroom instruction in addition to clinical foundations. Diploma and Associate degree nurses were primarily clinical-trained without additional leadership training. According to my research, 63% of the NMs who participated in the study were not trained at the BSN level. Further research needs to be completed to correlate the LTC NM’s education level with the level of needed leadership and management experience and expertise in accords to the novice-to-expert continuum. As the acute care environment identified the scope for the Bachelors’ prepared management level, the long-term care environment needs to evaluate the role of education in this leadership position.

Limitations of the Study

There were several limitations in this study. One limitation was the small sample
size of NMs who held greater than five years of leadership experience. Due to the long-term care recruitment and retention issues, the long work hours, difficult workload, and increased resident acuity levels, many NMs refrained from remaining in their positions. In the five long-term care facilities, there were 45 NMs and only 28 identifying as having greater than five years of NM experience. Due to the NM’s time constraints, only 19 interviews were summarized for this study. In turn, additional surveys and interview responses would support the identification of skills, competencies, and expertise for the novice-to-expert levels.

Another limitation was that the research was conducted in only five long-term care organizations located in one city. The results could be more generalizable if NMs from additional long-term care facilities were surveyed and interviewed, including organizations that were not aligned, located in other states, and for-profit. This would provide more comparison results and possibly identify additional leadership development skills and competencies.

A final limitation for this study was the inability to fully connect theory to practice due to the minimal nursing research available on Nurse Manager’s leadership based on the novice-to-expert framework in long-term care. Current research studies focused primarily on acute-care or non-healthcare settings, and those that did look at long-term care were mainly about the DON position. Long-term care provided a different nurse hierarchical and decision-making environment; additionally, fewer RNs were available than in the acute care setting. This impacted the NM leadership, including the extent of the NM responsibilities and level of empowerment.
Conclusion

This study summarized the nurse leadership and management skills, competencies, expertise, and embedded knowledge of NMs in five long-term care facilities. A quantitative NMIT survey was completed by the NMs to define their competencies on a novice-to-expert scale. The results of the survey were used to develop the interview questions. Twenty-two NMs completed the survey with twenty further participating in the interview process; nineteen interviewees agreed to the research analysis. The LTC NMs who agreed to participate in this research did not receive formal orientation or education for their leadership role. The NMs indicated that their knowledge base was acquired through a trial and error approach and via seeking support from the DON or fellow peers when confronted with difficult situations. Their focus was the day-to-day unit management; consequently being unable to seek out additional leadership development activities. The NMs lacked the personal power and the self-governance that was generally found in the acute care setting.

According to Shirey (2009), the American Organization of Nurse Executives (AONE) released a listing of competencies for the nurse executive model. The five key competencies include communication, healthcare knowledge, leadership, professionalism and business skills. Shirey stated that “Excellent nursing leadership is central to the model” (p.167). The nursing leadership that the NMs provided in these five long-term care organizations falls along the continuum of novice-to-expert. One of the tips that AONE identified for excellent leadership was to lead with passion. The passion that these managers showed for their residents, families, and staff was clearly palpable. Further, the passion they portrayed for their role was indicative of their understanding for
the criticalness of being resident-focused. The NM’s visibility on their units, having a presence for both residents and staff, in conjunction with utilizing their clinical expertise were imperative attributes in supporting the NM’s leadership competencies. Maintaining a focus toward residents and the final journey process, and further, continually directing staff and family toward that focal point was essential in supporting the NM’s leadership competency. Leadership provided support toward the unit vision and the final journey may be that unit vision.
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Appendix A

Day, Harrison, and Halpin Propositions for Developing the Expert Leader

1. Expert leadership can be differentiated from novice leadership.
2. The development of leadership expertise occurs as a result of identity changes that take place throughout the lifespan, but particularly in adulthood.
3. Basic level skills combine to form complex and multifaceted leadership competencies.
4. The development of expert leadership follows a longitudinal trajectory that parallels the development of expertise in other domains.
5. Intentional practice in leadership is needed to reach a level of expert leader performance.
6. Leadership competence is formed through spirals of leader identity formation and change in the context of learning and development through leadership experience.
7. Individual differences between leaders influence the rate and direction of the spirals of identity development and leader development.
   7a. Self-regulatory strength accelerates the ongoing learning and development of leaders.
   7b. Learning goal orientations facilitate development of leader expertise through the use of self-regulations strategies.
   7c. A leader’s generalized self-efficacy will positively relate to leader development and learning.
7d. Self-awareness will facilitate the development of leader learning and expertise.
7e. Forming implementation intentions regarding initiating leadership practice and persisting through distractions will facilitate leader development.
8. Leader development is ongoing throughout the adult lifespan and is shaped by experience as well as through adult development and age-related maturation processes.
9. Maintaining an active and healthy lifestyle and building self-regulatory resources may facilitate health and well-being into late adulthood and contribute to lifelong development.
10. Individuals engage in selection, optimization, and compensation (SOC) processes in maximizing developmental gains and minimizing losses associated with developing as a leader.
11. The development of complex, multifaceted leadership competencies is supported by a web of adult development that is dynamic and nonlinear in nature.
12. Moral reasoning and reflective judgment (i.e., epistemic cognition) develop concomitant with positive identity-development spirals.
13. Wisdom involves the alignment of morality and moral reasoning (virtue), identity and self-regulations (self) and reflective judgment (knowledge and thinking).
Appendix B

Introductory Letter to Director of Nurses in Long-term Care Organization

Date

DON Name
Facility Name
Address

Dear DON:

I am a doctoral candidate at St. John Fisher College Ed.D. Executive Leadership program and plan to conduct a research study in your organization about nurse manager skills, competencies, and expertise. I have obtained permission from (CEO name) to conduct this research. In addition, the Institutional Review Board (IRB) for St. John Fisher College has reviewed and approved this research study.

I need to identify nurse managers who have at a minimum five years nurse manager experience. The criteria include the following:

1. Greater than five years nurse manager experience.
2. Experience as a nurse manager at current position or immediate previous position
3. Ability to complete self-evaluation nurse manager inventory tool within next three months.
4. Ability to be individually interviewed within next three months.

The nurse managers will (a) complete a demographic survey, (b) complete a self-assessment Nurse Manager Inventory Tool within four weeks of agreement, and (c)
participate in a 1:1 interview with researcher. This interview can occur at work or off-site and will take approximately one hour to complete. The researcher will audio-tape the interview and the tapes will be transcribed by an outside company.

The manager’s immediate supervisor (either ADON or DON) will complete the Nurse Manager Inventory Tool from a supervisory perspective. The self-evaluation and the supervisor’s evaluation tools will never be shared with either person. The researcher will use this information for comparative purposes, for development of interview questions, and to determine nurse manager skills and competency levels. Confidentiality will be maintained at all times.

I would like to set a meeting with you to further discuss the research study. You can contact me at the e-mail address listed below. I appreciate your assistance in this study. Your interest and cooperation will support an understanding of the nurse manager role in long-term care.

Thank you for your consideration of my request.

Sincerely,

Kathleen Hodgson Dever MS, RN
St. John Fisher College Executive Leadership Program
Contact Information Provided
Appendix C

St. John Fisher College Informed Consent Form

**Title of study**: Skills, Competencies, Expertise, and Embedded Knowledge of Nurse Managers, as Leaders, in Long-Term Care

**Name of Researcher**: Kathleen Hodgson Dever, MS, RN

**Faculty Supervisor**: Dr. Michael Wischnowski – Contact Information Provided

**Purpose of study**: The nurse manager is responsible for long-term care daily unit operations, including resident care and safety, resident and family satisfaction, operations, budgets, staffing schedules, management and leadership needs and at times the provision of direct care due to under-staffing. Current nurse management and leadership research is focused on acute hospital care. Minimal research has been conducted within long-term care. There is a need to understand the long-term care nurse manager’s leadership skills, competencies, and expertise. The purpose of this study is to identify and describe the NM role in long-term care through demographic data, survey, and interviews.

**Approval of study**: This study has been reviewed and approved by the St. John Fisher College Institutional Review Board (IRB).

**Place of study**: Five local long-term care organizations

**Length of participation**: Two weeks timeframe to complete survey – 1 to 1.5 hour interview – additional time to review personal transcribed interview for correctness

**Risks and benefits**: The expected risks and benefits of participation in this study are explained: There are no identified risks or benefits for participation in this study.

**Method for protecting confidentiality/privacy**: Confidentiality will be maintained during the interviews and no identifiers will be used during the interview process. Confidentiality will be
maintained in the self-evaluation and supervisor evaluation by coding the responder’s names. No information will be shared. Confidentiality statements will be signed by the transcription company. Interview data, transcripts, tapes, and any supporting documentation will be maintained in a locked, secure area in the researcher’s possession for a minimum of three years from the conclusion of the dissertation process.

**Your rights:** As a research participant, you have the right to:

1. Have the purpose of the study, and the expected risks and benefits fully explained to you before you choose to participate.
2. Withdraw from participation at any time without penalty.
3. Refuse to answer a particular question without penalty.
4. Be informed of appropriate alternative procedures or courses of treatment, if any, that might be advantageous to you.
5. Be informed of the results of the study.

I have read the above, received a copy of this form, and I agree to participate in the above-named study.

Name (Participant) ___________________________  Date ___________________________
Signature ___________________________________

Name (Investigator) ___________________________  Date ___________________________
Signature ___________________________________

If you have any further questions regarding this study, please contact the researcher listed above. If you experience emotional or physical discomfort due to participation in this study, please contact the Office of Academic Affairs at 385-8034 or the Wellness Center at 385-8280 for appropriate referrals.
Appendix D

NMLP Nurse Manager Inventory Tool Instructions

Thank you for your support to complete the Nurse Manager Inventory Tool. This tool provides a self-assessment of the nurse manager’s skills in the leadership role based on a novice, competent, exert scale. An explanation of the rating levels is provided in your information packet. Please follow these summarized ratings when determining your level for each category.

The inventory tool should take approximately thirty minutes to complete. On page one, section III, the explanation to meet with your supervisor is crossed out. As a part of this research, it is not necessary to meet with your supervisor. All research information remains confidential and is only for the use of the researcher. All responses are coded for research purposes.

Once you have completed the survey, please include your name on the last page. You may also provide additional comments in the space provided but this is not required. Return the survey in the postage-paid envelope that was provided for your use. It is critical that this tool be completed within four weeks of receipt.

For any questions or concerns, contact me through e-mail at (contact information provided) or my cell phone. I appreciate your assistance in the completion of this survey that supports the long-term care nurse manager research.

Kathleen Hodgson Dever MS, RN, St. John Fisher College Executive Leadership Program
Appendix E

Nurse Manager Inventory Tool (NMIT): Novice, Competent, and Expert Definitions

The Nurse Manager Leadership Partnership (NMLP) was formed in 2006 to promote the critical importance of the nurse manager, as a leader, in the ever-changing healthcare environment. The nurse manager directly impacts the quality of resident care and resident/family satisfaction. The NMLP identified the skills and competencies that are necessary for a nurse manager to successfully complete his/her responsibilities today and to provide the health care leadership that will be necessary in the future. The nurse manager uses the tool to review and rate himself/herself in each of the content areas, along a continuum from minimal skill/experience to expert. As a participant in this research study, please complete this tool by rating your skills in each area according to the following guidelines of novice, competent, and expert. All information will remain confidential.

**Novice:** At this level, the nurse manager is learning basic management skills. The novice is rules-oriented and somewhat inflexible. The novice is guided by the organization policies and procedures. The lack of experience and competence leads to ineffective decision-making. The novice nurse manager needs a mentor to provide guidance and begins to establish a trust in peer relationships. The novice needs help to differentiate the importance of tasks and is not able to multi-task effectively.

**Competent:** There is an increased level of management skill acquisition. Despite the
increased experience, there is still some inflexibility especially with new experiences. There is some difficulty with multi-tasking at times. Planning is still necessary to limit unexpected outcomes but the nurse manager is more aware of resident and family responses to certain situations. The competent nurse manager is more confident with routine management tasks and tries to control and limit unexpected occurrences.

**Expert:** The expert nurse manager is confident, more involved, active with decision-making, and more flexible with new situations. The manager interprets situations using tried and tested management and leadership principles, abstract reasoning and holistic processes to guide practice. At this stage, the manager builds relationships. The expert nurse manager does not only rely on rules or guidelines to make decisions but on intuition which has been developed through the years of acquired experiences and skills and anticipates the unexpected. The expert nurse has a skilled “know how” that is based on experiential learning and an intuitive decision-making approach.
Appendix F
Introductory Letter to Identified Nurse Manager

Date
Nurse Manager Name
Facility Name
Address
Dear NM:

I am a doctoral candidate at St. John Fisher College Ed.D. Executive Leadership program and plan to conduct a research study in your organization about nurse manager skills, competencies, and expertise. You have been recommended by the nursing department to participate in my research study due to the number of years that you have practiced as a nurse manager. In addition, the Institutional Review Board (IRB) for St. John Fisher College has reviewed and approved this research study.

The criteria include the following:

1. Greater than five years nurse manager experience.
2. Experience as a nurse manager at current position or immediate previous position
3. Ability to complete self-evaluation nurse manager inventory tool within next two weeks.
4. Ability to be individually interviewed within next three months.

As a participant, you will (a) complete a demographic survey, (b) complete the Nurse Manager Inventory Tool within one month of agreement, and (c) participate in a 1:1 interview with researcher. This interview can occur at work or off-site and will take approximately one hour to complete. The researcher will audio-tape the interview and
the tapes will be transcribed by an outside company.

Your immediate supervisor (either ADON or DON) will also complete the Nurse Manager Inventory Tool from a supervisory perspective. The self-assessment and the supervisor’s evaluation tools will never be shared with either person. The researcher will use this information for comparative purposes, for development of interview questions, and to determine nurse manager skills and competency levels based on novice to expert. Confidentiality will be maintained at all times. Interview data, transcripts, tapes, and any supporting documentation will be maintained in a locked, secure area in the researcher’s possession for a minimum of three years from the conclusion of the dissertation process. This data will be destroyed at the end of the three year holding period.

If you agree to participate, I will be meeting with the nurse manager group at your facility to provide further information, the consent form and the Nurse Manager Inventory Tool and the demographic form to complete in four weeks. Upon receipt of the tool, I will schedule the interview.

I appreciate your assistance in this study. Your interest and cooperation will support a further understanding of the nurse manager role in the long-term care environment. You can contact me at the e-mail address listed below to provide your agreement. Thank you for your consideration of my request.

Sincerely,

Kathleen Hodgson Dever MS, RN
St. John Fisher College Executive Leadership Program
Appendix G
Nurse Manager Demographic Information

Survey Instructions: Please complete all sections of the survey. Your information will remain confidential.

Name: ____________________ Facility: ____________________ Unit: ________

Education Level and Year of Graduation: Check all education obtained.

CNA ___ Grad. Yr. ___ Comment: ____________________________

LPN ___ Grad. Yr. ___ Comment: ____________________________

RN AAS ___ Grad. Yr. ___ Comment: ____________________________

RN Diploma ___ Grad Yr. ___ Comment: ____________________________

BSN ___ Grad. Yr. ___ Comment: ____________________________

BA/BS ___ Grad.Yr. ___ Comment: ____________________________

BS ___ Grad. Yr. ___ Comment: ____________________________

Masters ___ Grad. Yr. ___ Comment: ____________________________

Other ___ Grad. Yr. ___ Comment: ____________________________

Work Experience the past 15 years: Indicate the most recent first; and also include work as a CNA, LPN, and/or RN.

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Appendix H

Nurse Manager Interview Questions

You have previously completed a survey that rated the various skills and competencies for a nurse manager in a healthcare setting from novice to competent to expert. The responses from nurse managers and Directors of Nursing were compiled. The aggregated data has led to the questions that will be asked today. This interview is digitally recorded and will be transcribed by an outside transcriptionist who has signed a confidentiality agreement. Confidentiality will be maintained at all times. I have provided a copy of the novice, competent, and expert level descriptions for your review. Do you have any questions before we begin?

1. The survey data shows that nurse managers identified financial management (budget creation, analysis, evaluation) at a novice level. Why do you think that long-term care nurse managers rated themselves as novices for financial management?

   Probe: What is your responsibility for the unit staffing and operations budgets? Have you ever been involved with creating or monitoring a unit budget, either at this facility or another job?

2. Also identified at a novice level was strategic management. This includes developing an annual strategic plan for your unit including identification of unit goals, development of specific projects for the unit and the ability to sell the strategic plan. Why do you think long-term care nurse managers rated themselves as novices regarding strategic management?

   Probe: How does strategic planning work in your facility? What is your responsibility for unit strategic planning?

3. The data shows that the Nurse Manager rated clinical skills close to the expert level. Why do you think long-term care nurse managers rated themselves with expert clinical skills?

   Probe: What clinical skills are most useful in long-term care? How do you manage the clinical skills of other nurses? How do you maintain your clinical skills? Conferences? In-services?
Professional Journals?

4. According to the survey data, the nurse managers identified the following items to be at a competent level. Why do you think long-term care nurse managers rated themselves as competent regarding __________? What in your experience has allowed you to become competent in __________?

   a. Human Resources (including interviewing, hiring, and staff orientation)
      Probe: on-the-job training, in-services, previous experience
   b. Human Resource leadership (staff development, coaching, mentoring)
      Probe: on-the-job training, in-services, previous experience,
      Off- shift responsibility
   c. Performance Improvement (including patient, workplace safety and quality)
      Probe: on-the-job training, in-services, previous experience
   d. Problem solving, Decision making, systems thinking
      Probe: on-the-job training, in-services, previous experience,
      Off-shift responsibility
   e. Do you have electronic medical records or a call bell system in the facility?
      Information technology (electronic medical records and call bell system)
      Probe: on-the-job training, in-services, previous experience
   f. Relationship management (communication skills – how you communicate with peers and staff, team dynamics, conflict management, and negotiation)
      Probe: on-the-job training, in-services, previous experience, off-shift
   g. Diversity (ability to work fairly with differences in staff or residents – race, gender, religion, sexual orientation, generational)
      Probe: on-the-job training, in-services, previous experience
   h. Leadership reflective practice (constant state of learning)
      Probe: on-the-job training, in-services, previous experience

5. What does the data suggest to you about the future of leadership development for long-term care nurse managers?
   Probe: What changes to leadership development in long-term care, would you recommend?
   Probe: Does the long-term care setting demand a different set of nursing skills from nurse managers in other clinical settings?

6. Is there anything else that you would like to say about nurse manager leadership development in long-term care?
Appendix I

Nurse Manager Education and Experience

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Independent Samples t-test Means Leadership Categories Group Statistics

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## Appendix L

**Summary of Nurse Leadership Research in Long-Term Care**

<table>
<thead>
<tr>
<th>Authors</th>
<th>Leadership Practice Findings</th>
</tr>
</thead>
<tbody>
<tr>
<td>Anderson, Corazzini, and McDaniel (2004)</td>
<td>Reward climate, and communication will lower RN staff turnover</td>
</tr>
<tr>
<td>Anderson, Issel, and McDaniel (2003)</td>
<td>( n = 997 ) survey, 67% has &lt; Bachelors degree – communication, RN decision-making, relationship leadership improve resident outcomes</td>
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<tr>
<td>Burke and Collins (2005)</td>
<td>( n = 18 ) manager interview, conflict skills include both tactical (procedural) and strategic (declarative) knowledge</td>
</tr>
<tr>
<td>Byers (2000)</td>
<td>( n = 1714 ) nursing and non-nursing leaders (48% Master’s level), (16% return); nurse leaders ranked highest clinical knowledge, HR skills, trustworthiness, humor, communication, quality management, decision making</td>
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<tr>
<td>Byers (2001)</td>
<td>( n = 175 ) nurse and non-nurse leaders (37.4% Bachelor's degree, 23% Associate degree); knowledge, skills, and attributes ranked high</td>
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<tr>
<td>Cook (1999)</td>
<td>( n = 477 ) articles; empowerment of others,</td>
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<tr>
<td>Authors</td>
<td>Leadership Practice Findings</td>
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<tr>
<td>Dellefield (2008)</td>
<td>n = 40 (7 focus groups); advocate, teamwork, professionalism, positive reinforcement, trust, respect, role model, positive, clinical competence, listening</td>
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<tr>
<td>Hall, McGilton, Krejci, Pringle, Johnston,</td>
<td>n = 30 supervisors and 26 support staff; focus groups; communication, role-modeling, listening, praise, recognition, positive reinforcement, respect, trust, helping</td>
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<tr>
<td>Fairley, Brown (2005)</td>
<td></td>
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<tr>
<td>Jennings, Scalzi, Rodgers, and Keane (2007)</td>
<td>n = 140 articles lit review; leadership competencies included vision, staff development, independent thinking</td>
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<tr>
<td>Kruzich, Clinton, Kelber (1992)</td>
<td>n = 289 residents LTC; interview DON and NM- fairness of charge nurse by aide, DON longevity and turnover to resident satisfaction</td>
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<tr>
<td>Luggen (1997)</td>
<td>n = 100 DON; communication, health care knowledge, planning ability, organizational skills, negotiation skills, vision, clinical nursing skills. Power was rated last.</td>
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<td>Authors</td>
<td>Leadership Practice Findings</td>
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<tr>
<td>O’Neil and Morjikian (2003)</td>
<td>Identified leadership competencies: self-knowledge, interpersonal and communication effectiveness, risk taking and creativity, inspiring and leading change</td>
</tr>
<tr>
<td>O’Neil, Morjikian, and Cherner (2008)</td>
<td>n = 27 healthcare leaders; survey 54 nurse leaders; build effective teams, vision to strategy, communication, conflict management, customer focus</td>
</tr>
<tr>
<td>Parsons, Simmons, Penn, and Furlough (2003)</td>
<td>n = 550 nursing assistants; aide turnover related to supervisory support, competence, skills, management loyalty, work load and schedule, communication with management, fairness in hiring and promotion</td>
</tr>
<tr>
<td>Pearson, Laschinger, Porritt, Jordan, Tucker and Long (2007)</td>
<td>n = 44 meta-analysis; leadership behaviors – collaboration, education, emotional intelligence, positive organization climate, knowledge, promote growth, positive leadership attributes, supportive environment</td>
</tr>
<tr>
<td>Scott-Cawiezell, Schenkman, Moore, Vojir, Connolly, Pratt, and Palmer (2004)</td>
<td>n = 995 staff (15% RNs); need improvement in communication and leadership strategies</td>
</tr>
<tr>
<td>Sheridan, White, and Fairchild (1992)</td>
<td>n = 530 staff; human relations and organization</td>
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<td>Authors</td>
<td>Leadership Practice Findings</td>
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<tr>
<td>Shirey (2007)</td>
<td>Excellent leadership: identify core values, vision, alliances, collaboration, change agent, advocate, create joy, invest in people, lead with passion, determination, self discipline, correct hiring, share power, decision making, accountability, good stewardship</td>
</tr>
<tr>
<td>Sullivan, Bretschneider, and McCausland (2003)</td>
<td>n = 94 focus groups; NM satisfaction, autonomy, flexibility, patient intervention, staff mentoring, ability to influence and change practice. Challenges: staffing, lack of systems support, minimal control over work environment, conflict management; Needs were conflict resolution, recruitment and retention, regulatory compliance, time management</td>
</tr>
<tr>
<td>Swagerty, Lee, and Smith (2005)</td>
<td>n = 17 residents, 77 staff, 9 managers, observation and interviews; Effective leadership is key to change, shared values, teamwork, identify fragmenting or promoting</td>
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<tr>
<td>Authors</td>
<td>Leadership Practice Findings</td>
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<tr>
<td>Tellis-Nayak (2005)</td>
<td>n = 103 DONs Virginia LTC; educational levels in Virginia 15% no degree, 50% Associate or Diploma degree, 28% Bachelors degree; need for training on resident centered care, leading and managing, family, time management, good clinical practice</td>
</tr>
<tr>
<td>Upenieks (2003)</td>
<td>n = 16 Nurse leaders acute care, interviews; either Bachelor or Master’s degree; formal and informal power, access to information and resources, opportunity to grow; visibility, responsiveness, passion, business savvy, trust, responsiveness, communication, credibility, self-confidence, honesty, vision, knowledge, clarity of thought and action</td>
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Appendix M

Nurse Manager Inventory Tool (NMIT) Survey
I. The Nurse Manager uses the Inventory Tool to review and rate themselves in each of the content areas, along a scale from Minimal Skill/Experience to Expert.

II. The Nurse Manager's Supervisor does the same, rating the Nurse Manager in their specific role.

III. The Nurse Manager & Supervisor meet to review the two assessments. For areas where assessments differ they can:
   a. Discuss why the perceptions differ
   b. Discuss and develop plans for improvement/professional development

IV. This Inventory tool can become the basis for career pathway planning and delineating professional targets.
I. FINANCIAL MANAGEMENT

1. Understanding of healthcare economics & healthcare public policy as it applies to the delivery of patient care - Includes reimbursement, Medicare, Medicaid, managed care, third party providers, challenges to the current healthcare policies, key legislative initiatives at local, state and national level.

   - Creating a budget
   - Monitoring a budget
   - Analyzing a budget
   - Reporting on budget variance
   - Revenue forecasting
   - Expense forecasting
   - Interpreting financial information

3. Concepts of capital budgeting - Includes financial definitions for capital categories, depreciation; justification and ROI (Return on Investment) and ROA (Return on Asset).
   - Cost-benefit analysis (e.g. new program assessment, purchase vs lease options)

II. HUMAN RESOURCE MANAGEMENT

1. Recruitment techniques - Includes an understanding of institution’s recruitment strategies & initiatives, various alternatives, competition, marketing of facility/unit/department.

2. Interviewing techniques - Includes individual and team interviewing, skills/techniques and “key success criteria” interviewing programs.

3. Labor laws pertaining to hiring - Includes state scope of practice laws, and federal and state HR laws, such as family medical leave.

4. Hiring policies and procedures from the facility HR Department.
   - Identification of key skills and attributes for each role.
   - Ability to implement changes in roles based on changing department and healthcare environment needs.

5. Orientation of new employees - Includes development and implementation of appropriate plans for each employee.
III. PERFORMANCE IMPROVEMENT

1. Knowledge of Continuous Quality Improvement (CQI)/Total Quality Management (TQM) processes – Includes CQI, TQM, Six Sigma, Balanced Scorecards, or whatever model is used to measure quality and outcomes in the facility. Also includes quality improvement tools such as pareto charting, control charts, workflow charting, and process charting.

2. Patient safety – Includes sentinel event monitoring and reporting, root cause analysis, JCAHO requirements, incident reporting, medication safety policy/procedures.

3. Workplace safety – Includes knowledge of regulatory requirements (Department of Public Health, JCAHO, OSHA, etc.)

4. Promoting intradepartmental/interdepartmental communication

IV. FOUNDATIONAL THINKING SKILLS

1. Systems thinking knowledge as an approach to analysis and decision-making.

2. Complex adaptive systems definitions and applications.

3. Understanding organization behaviors — Includes planning, organizing, and leading. Also includes four skills essential in influencing nursing practice: self-awareness, dialogue, conflict resolution and navigating change.

4. Decision making skills – Includes use of data driven decision making profiles/models.

5. Problem solving skills – Includes defined models for problem solving.

V. TECHNOLOGY

1. Basic computer skills – Includes word processing, data management, Internet/Email, skills to access information as it applies to facility information systems.

2. Information technology – Includes an understanding of the effect of IT on patient care and delivery systems to reduce workload (i.e. bar coding, processing patient charges, understanding of master and patient billing computerized physician order entry (CPOE), staff scheduling program)

   a. Knowledge of the patient medical record utilized in the institution

   b. Knowledge of the supply/medication management systems utilized in the institution
c. Ability to integrate technology into patient care processes

d. Using information systems to support business decisions

VI. STRATEGIC MANAGEMENT

1. Project management – Includes understanding roles, timelines milestones, and resource utilization. Ability to develop (or participate in the development of) a project plan.

2. Business development – Includes knowing the content of a business plan.

3. Business plan development – Includes the ability to create a business plan for specific projects.

4. Presentation skills
   a. Written – Includes reports, program descriptions, evaluations and correspondence.
   b. Oral – Includes educational presentations, project presentations, media and meetings skills.

5. Persuasion skills – Includes influencing/selling skills.

6. Developing strategic plans – Includes various methodologies for strategic planning, such as scenario planning, environmental scanning.

7. Developing operational plans – Includes annual tactics that support and move the unit/department to accomplish a strategic plan.

VII. APPROPRIATE CLINICAL PRACTICE KNOWLEDGE

(Determined by specific role and institution) – Each role and institution has expectations regarding the clinical knowledge and skill required of the role. These expectations should be established for the specific individual based on organizational requirements.
I. HUMAN RESOURCE LEADERSHIP SKILLS

1. Performance management – Includes staff annual evaluation, goal setting, continual performance development, “crucial conversations,” corrective action and disciplinary processes, termination.

2. Staff development — Includes staff education/needs assessment, education programming, competency assessment (recommendations and development).

3. Succession planning- Includes developing leadership capacity of staff.

4. Coaching and guiding skills – Includes demonstrating behaviors and role modeling.

5. Mentoring – Includes modeling behaviors of leadership and developing staff as mentors.

II. RELATIONSHIP MANAGEMENT & INFLUENCING BEHAVIORS

1. Communication skills – Includes active listening, feedback, inquiry, validation.

2. Emotional IQ – Includes how well you know yourself and how you relate effectively with your environment.

3. Self awareness – Understanding one's values, beliefs, and attitudes and how they affect your responses and behaviors.

4. Effective use of dialogue – Understanding and practicing the process to encourage the free flow of ideas within groups to discover insights and lead to shared meaning.

5. Team dynamics – Understanding the functions of group process. Able to facilitate effective groups, both for nursing and intradisciplinary/multidisciplinary groups.

6. Collaborative practice – The presence of trust, respect and good communication among colleagues. How well is this developed and supported?

7. Conflict management – Understanding the process to work through opposing views in order to reach a common goal. Skill in conflict resolution.

8. Negotiation – Using conflict resolution techniques to maintain collaboration: isolate the facts, ask clarifying questions, reach common ground, interpret what is said verbally and with body language. Includes the use of “crucial conversations”.

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III. DIVERSITY
1. Cultural competence - Includes understanding the components of cultural competence as they apply to the workforce.
2. Social justice - Includes maintaining an environment of fairness and processes to support it.
3. Generational diversity - Ability to capitalize on differences to foster highly effective work groups.

IV. SHARED DECISION MAKING
1. Includes understanding the structure and processes of shared governance.
2. Implementation of shared decision-making structures and processes on the unit.

I. PERSONAL & PROFESSIONAL ACCOUNTABILITY
1. Personal growth & development - Includes education advancement, continuing education, career planning, and annual self-assessment and action plans.
2. Ethical behavior and practice - Includes practice that supports nursing standards and scopes of practice.
3. Professional association involvement - Includes membership & involvement in an appropriate professional association that facilitates networking and professional development.
II. CAREER PLANNING

1. Knowing your role – Understanding current job description/requirements and comparing those to current level of practice.

2. Knowing your future – Planning where you want to go in your career and what you need to get there. What are the needs of healthcare in the future and where will you fit?

3. Positioning yourself – The development of a career path/plan for yourself that provides direction while offering flexibility and capacity to adapt to future scenarios.

III. PERSONAL JOURNEY DISCIPLINES

These skills assist in developing the individual strengths of a leader.

1. Shared leadership/council management – Includes knowledge of and skill in managing councils that promote shared leadership.

2. Action Learning – Includes use of techniques of “Action Learning” to problem solve and personally reflect on decisions.

3. Reflective Practice – Includes knowledge of and active practice of reflection as a leadership behavior.

IV. REFLECTIVE PRACTICE REFERENCE BEHAVIORS/TENANTS

Utilizing a set of guidelines and tenants that facilitate reflective practice. These may be individually developed or can be based on specific models developed by others. Below are the Dimensions of Leadership developed by the Center for Nursing Leadership, which offer an example of a set of guidelines/tenants that can be used as a tool to guide personal reflection of an individual’s leadership behaviors.

1. Holding the truth – the presence of integrity as a key value of leadership.

2. Appreciation of ambiguity – Learning to function comfortably amid the ambiguity of our environments.

3. Diversity as a vehicle to wholeness – The appreciation of diversity in all its forms: race, gender, religion, sexual orientation, generational, the dissenting voice, and differences of all kinds.

4. Holding multiple perspectives without judgment – Creating and holding a space so that multiple perspectives are entertained before decisions are rendered.

5. Discovery of potential – The ability to search for and find the potential in ourselves and in others.

6. Quest for adventure towards knowing – Creating a constant state of learning for the self as well as an organization.
7. Knowing something of life - The use of reflective learning and the translation of that learning to the work at hand.

8. Nurturing the intellectual and emotional self - Constantly increasing one's knowledge of the world and the development of the emotional self.

9. Keeping commitments to oneself - Creating the balance that regenerates and renews the spirit and body so that it can continue to grow.

Nurse Manager’s Comments:

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Supervisor’s Comments:

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