Evaluation of the LVN Leadership Enhancement and Development Program (LVN LEAD)

A Pilot Training Program to Strengthen the Leadership Capacity of Charge Nurses in California's Nursing Homes

February 2008

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Table of Contents

Executive Summary

The purpose of this project was to develop, pilot test and evaluate the impact of a training program to help licensed vocational nurses (LVNs) who act as charge nurses and team leaders in California nursing homes become more effective leaders and supervisors of frontline staff. The project, funded by the California HealthCare Foundation, was conducted by a team of researchers led by Dr. Robyn I. Stone from the Institute for the Future of Aging Services and Dr. Barbara Bowers, University of Wisconsin-Madison School of Nursing. Four nursing homes in the Oakland, California metropolitan area were selected to pilot test the program.

Overview

LVNs play a critical role in nursing homes in motivating, teaching and improving the skills and performance of certified nursing assistants (CNAs) who deliver the bulk of hands-on care to residents. More than 60 percent act as charge nurses or team leaders with responsibility for supervising and directing the care provided by CNAs. Past research has demonstrated that most of these nurses are poorly prepared to assume supervisory and leadership responsibilities.

The training intervention developed for LVNs in the four pilot sites consisted of the following components:

- Orientation sessions to introduce the participating facilities to the purposes of the project and solicit their input into the content of the training.
- One full-day of training to improve the knowledge and skills of LVNs in the areas of critical thinking, supervision and coaching, conflict resolution, communication and cultural competency.
- One half day booster session, held about six weeks after the initial training, to review supervisory and leadership skills and techniques and resolve problems in applying them to the on-the job challenges faced by LVNs.
- Discussions with facility managers about the infrastructure necessary to sustain the intervention over time.

Summary of Findings

The study employed qualitative and quantitative data to:

- pre-test the training program in a small number of sites;
- assess the feasibility of implementing and evaluating it on a broader scale; and
- identify barriers to wide scale implementation and how they might be resolved.

The research team's analyses affirmed the need for a training program to help build the leadership and management capacity of the LVNs in California nursing homes. The study found that LVNs in the pilot sites did not initially recognize themselves as managers and leaders of their units. They had no formal training in this area and no professional association that helped them to define this role. Most saw themselves as floor nurses who were primarily responsible for "passing meds" and helping to insure resident safety. One of the major successes of this pilot was the recognition by many of the LVN participants that they were leaders and that they had a

responsibility to manage their units, communicate with and mentor CNAs and develop a team approach to service delivery.

The pilot also reinforced the importance of certain aspects of the training program. The information about leadership, particularly the scenarios presented in the training sessions that highlighted why and how LVNs are (or could be) leaders on their units provided the "a-ha moment" for a number of participants. The module related to the teaching/mentoring role was found to be very effective in providing LVNs with an overview of the differences between "command and control" supervising and a coaching approach. The evaluation also found consensus among many of the LVN participants, facility managers and CNAs that at least some of the knowledge and skills taught in the training program were being applied to daily work life up to six months after formal training was completed. A number of LVNs reported they had become better at listening to and soliciting input from CNAs on patient care needs and communicating with them in a respectful manner. Managers also noted that interpersonal relations between CNAs and LVNs seemed to be improving and that their charge nurses appeared to be giving more information to the CNAs on patient conditions. A survey administered to CNAs at the pilot sites also found that CNAs perceived communication between themselves and their charge nurses was improving, and that LVNs were doing more coaching.

The study also concluded that replication of the program should include more specific involvement of the facility's management/leadership team. While the administrators and Directors of Nursing agreed, prior to project implementation, that a lack of leadership and supervisory skills among LVNs was a significant problem, they had not bought into the necessity of putting policies and practices into place to support and sustain these skills by the end of the project. Research shows that without follow-up to put such an infrastructure into place, organizational change is not likely to be continued over time.

A further conclusion of the study is the significant potential of Directors of Staff Development (DSD) to become the glue that continues and enhances the LVN training program and that creates the pivotal link between the LVNs and upper management. These positions, which are mandated by the state of California, appear to be seriously underutilized, particularly as they relate to educating and supporting LVNs. The research team observed that the DSDs in the pilot sites had important relationships with the CNAs and LVNs, and in most cases, seemed to be respected and trusted by both groups. Building on these relationships to continue and strengthen the performance of charge nurses seemed to the project team a promising future direction.

Finally, the study clearly underscores the importance of including cultural competence elements in any leadership training program as well as the application of this knowledge in daily practice on the unit.

Implications

This leadership training program is a promising approach to improving the performance of LVNs working in nursing homes. It highlights the often overlooked role of charge nurse played by LVNs and how important this role is in determining the quality of the nursing home work environment and resident care. Building leadership and supervisory training into the preparation, certification and on-going training of LVNs is a logical and worthwhile next step.

1. Introduction, Rationale and Purpose

Project LVN Leadership Enrichment and Development (LVN LEAD) is a training program, funded by the California HealthCare Foundation, to help licensed vocational nurses (LVNs) who act as charge nurses and team leaders in California nursing homes become more effective leaders and supervisors of frontline staff. LVNs play a critical role in nursing homes in motivating, teaching and improving the skills and performance of certified nursing assistants (CNAs) who deliver the great bulk of hands on care to residents. According to surveys by the National Council of State Boards of Nursing, more than 60 percent of LVNs act as charge nurses or team leaders with responsibility for supervising and directing the care provided by CNAs (Smith & Crawford, 2003). Anecdotal evidence suggests that because of the difficulty recruiting RNs in the majority of states, it is not unusual for an LVN/LPN to be the only nursing presence in some nursing homes, other than the Director of Nursing (DON). Past research has demonstrated that most long-term care nurses are poorly prepared to assume supervisory and leadership responsibilities (Institute for the Future of Aging Services, 2006). It is little wonder that many are uncomfortable with taking on these roles.

Inadequate leadership and supervision of frontline nursing home staff is a major contributor to job dissatisfaction and high vacancy and turnover. Many research studies have also linked high vacancy and turnover rates to poor quality nursing home care (Bowers, et al, 2003; Parsons, et al, 2003; Pennington, et al, 2003; Brannon, 2002; Bowers, 2000). The purpose of this project was to develop, pilot test and evaluate the impact of a leadership training program for LVNs in four nursing homes in the Oakland, California metropolitan area. The following report describes the results of the evaluation.

2. The Intervention

The intervention consisted of the following components:

1. Orientation sessions for each of the participating nursing facilities to introduce them to the purposes of the project, solicit their input into the content of the training, and encourage them to think about the infrastructure necessary to support and sustain it after the project was completed.
2. One full-day training for the LVN participants to improve their knowledge and skills in the areas of critical thinking, supervision and coaching, conflict resolution, communication and cultural competency.
3. A half-day booster session, held about six weeks after the initial training, to provide participants an opportunity to review the skills and techniques learned in the initial training and to resolve problems in applying them to their daily work.
4. Discussions with facility managers to encourage them to consider how the intervention could be sustained over time.

2.1 Description of the Training Topics

The training curriculum was developed by the project team based on: (1) a review of the literature on nurse leadership and supervision in long-term care and adult learning techniques;

(2) the project leaders own vast experience in working with nursing assistants and nurses in nursing home settings; and (3) input from the pilot site management teams, selected LVNs and CNAs and interested stakeholders. The full-day training curriculum was designed to help participants:

1. Enhance critical thinking skills by learning to:
    - identify problems through listening and observing
    - evaluate problems by obtaining multiple sources of information and perspectives before getting to solutions
    - evaluate the credibility and sufficiency of information
    - formulate solutions, attempt to resolve problems and anticipate and assess consequences

2. Improve coaching and supervisory skills through:
    - better self awareness and understanding of what others need
    - strengthening the ability to communicate with other staff
    - identifying and capitalizing on teachable opportunities
    - eliminating barriers
    - handling conflict and focusing on what is done well
    - insuring follow-up and follow through
    - encouraging/initiating discussion, maintaining confidentiality and applying information and insights

3. Develop better conflict resolution techniques including:
    - recognizing and responding to conflict
    - making good use of conflict by bringing about a respectful, open discussion of problems
    - learning effective negotiation principles

4. Strengthen communication proficiency by:
    - defining the goal
    - building relationships and trust
    - providing positive and corrective feedback
    - sharing important, timely information
    - being clear
    - setting the tone, e.g., praising in public, correcting in private, not being reactive

5. Increase cultural competency by:
    - identifying barriers to coaching, disciplining, feedback resulting from age, culture and experience differences across staff
    - addressing/confronting cultural, age and experience barriers
    - honoring differences and giving feedback

The half-day booster session was intended to: (1) review the knowledge and skills learned during the full-day training, (2) address any success and challenges participants may have encountered in attempting to apply these new techniques to their work life, and (3) work on additional issues participants identified as important during the first training session.

Nurses in the pilot facilities expressed concern about how to "communicate up" to the DON and other senior managers so their voices would be heard and their issues acted upon. A component was therefore built into the booster session for this pilot group that focused on effective techniques for communicating with senior management. The booster session, however, is intended to be responsive to the needs of the participants. Other trainee groups may have different concerns, and the content may need to evolve to address their particular needs and concerns.

2.2 Pilot Site Characteristics

Four nursing homes in the Oakland, California metropolitan area were selected for the pilot study based on multiple criteria. The nursing homes were regarded by informed experts as high quality facilities. They represented both for-profit and not-for-profit ownership types. They varied in bed size and employed a sizable number of LVNs acting as charge nurses on a consistent basis so that the project team could adequately test the training program. Finally, facility administrators expressed their commitment to project goals and pledged their willingness to encourage and support LVN participation during regular work hours and pay for their attendance at the training sessions. During the course of the project, Facility #2 was dropped from the project because an insufficient number of nurses were able to attend the training sessions. Table 1 below summarizes the characteristics of the four pilot sites.

Table 1: Pilot Site Characteristics

	Facility #1	Facility #2	Facility #3	Facility #4
Ownership	For-Profit	For-Profit	Non-Profit	Non-Profit
Number of Beds	174	124	63	59
Care Giving Staff	CNA: 84 LVN: 13 RN: 15 ADON: 3 DON: 1 DSD: 1	CNA: 65 LVN: 23 RN: unknown ADON: unknown DON: 1 DSD: 1	CNA: 38 LVN: 12 RN: 6 ADON: 1 DON: 1 DSD: 1	CNA: 33 LVN: 7 RN: 4 DON: 1 DSD: 1

Table 2 describes the characteristics of the CNAs in each of the pilot facilities. CNAs were predominately female, although the proportion fluctuated across the four sites. The median age of CNAs was 44, with Facility #3 having an older population and Facility #4 younger. In Facilities #1 and #2, the CNAs were predominately Asian, while the population in the other two facilities was slightly more diverse. The median number of years CNAs had worked in their respective facilities ranged between two and five years.

Table 2: Characteristics of Pilot Site CNAs*

	Pilot Facilities				
	Facility #1 (n=53)	**Facility #2** (n=31)	**Facility #3** (n=21)	**Facility #4** (n=25)	**Total** (n=130)
Gender					
Female	86.8%	71.0%	95.2%	64.0%	80%
Male	13.2	29.0	4.8	36.0	20
Median Age	44.4	34.0	54.0	42.8	44
Race/Ethnicity					
White	6.0%	3.2%	5.5%	12.5%	6.4%
Hispanic	16.3	0	0	4.2	7.4
Black	4.0	58.1	5.0	37.5	24.0
Asian	84.0	25.8	85.0	41.7	61.6
All Other	6.0	12.9	5.0	8.4	8.0
Median years worked as CNA	5.0	4.0	7.0	2.5	5.0
Median years worked as CNA for respective facility	3.8	1.9	5.0	2.5	3.0

* Data is drawn from CNAs who completed the pre-training survey.

Table 3 describes the characteristics of the nurses in each of the pilot facilities. The nurses in each facility were predominately female. The median age of nurses ranged from 32 years to 52 years. Across the facilities, the nurses were predominately Asian. The project team is aware that this group is largely Filipino. Likely reflective of the median age of nurses, Facility 1 had shorter-term nurses, while those in the other facilities had been nurses for a much longer period.

Table 3: Characteristics of Pilot Site Nurses*

	Pilot Facilities				
	Facility #1 (n=16)	**Facility #2** (n=19)	**Facility #3** (n=13)	**Facility #4** (n=9)	**Total** (n=57)
Gender					
Female	81.3%	89.5%	92.3%	100.0%	89.5%
Male	18.8	10.5	7.7	0	10.5
Median age	32.0	43.0	47.0	52.0	43.5
Race/Ethnicity					
White	6.3%	5.3%	0%	0%	3.5%
Hispanic	0	0	0	0	0
Black	0	31.6	0	11.1	12.3
Asian	93.8	57.9	76.9	88.9	77.2
All Other	0	5.3	23.1	0	7.1
Years worked as nurse	4.0	11.8	18.0	13.0	10.8
Years worked as nurse for respective facility	4.0	4.5	9.0	11.3	4.7

* Data is drawn from nurses who completed the pre-training survey.

2.3 Implementation Strategy

The development of the formal training program was grounded in adult learning theory. Training content was adapted to respond to the practical problems that charge nurses confront in their daily routines. Ample opportunity was provided for participants to interact, raise questions and comment on what was covered. Case studies and simulations were presented so that participants had an opportunity to role model solutions to problems and critique different problem solving approaches.

Replicability of the training program was a key consideration from the outset. The duration of the training was limited to one full-day training session and one half-day booster session to minimize the amount of time charge nurses needed to be pulled from the floor. The formal training content was designed in segments so that it could be further broken down into discrete components to fit the available time a particular facility could allot to an in-service training. The expectation of the project team was that the Directors of Staff Development (DSDs) within a facility and/or outside entities such as community colleges, the state nursing home associations or the LVN or other nursing associations would be able to continue the program after the formal project period was completed.

The training program was organized to maximize the participation of all LVNs at each of the pilot sites. Two separate rounds of each session were held to assure facilities would have adequate nurse coverage while others were being trained. RNs functioning as charge nurses

were also given the opportunity by two of the facilities' leadership team to participate. Table 4 below shows the total number and type of nurses from the participating nursing homes who participated in the training sessions. In the three sites that remained in the pilot, all of the participating nurses completed both the full-day and half-day session. The format for the program enabled nurses from more than one facility to attend together, encouraging the sharing of ideas and experiences.

Table 4: Training Session Participants

	Facility #1	Facility #2	Facility #3	Facility #4
Number of Charge Nurses	13 LVNs 15 RNs (supervisor/charge nurse)	23 LVNs Unknown RNs	12 LVNs 5 RNs (floor supervisors)	7 LVNs 6 RNs (floor supervisors)
Total number of Participants	12 (all LVN)	5 (split unknown)	10 (7 LVN, 3 RN)	10 (6 LVN, 4 RN)

Prior to conducting the training sessions, the project team held an in-person meeting with the leadership team (administrator, DON and DSD) at each pilot facility. The purpose of the meeting was to help managers identify the structures that needed to be in place to help implement the training with new nurses as well as support the knowledge and skills acquired by current participants. During the meeting, the team discussed that policies, procedures and practices currently in place at the facility that would help sustain the new management/supervisory practices gained in the training over time, as well as additional ones the facility might consider adding.

3. Evaluation Design

LVN LEAD is a pilot study that employed qualitative and quantitative data collection and analysis methods to:

- pre-test the training program in a small number of sites,
- assess the feasibility of implementing and evaluating the training program on a broader scale, and
- identify barriers to wide-scale implementation/evaluation and how they might be resolved.

3.1 Study Questions

The study was designed to answer the following questions:

1. Did California stakeholders in long-term care nursing, including LVNs and CNAs, perceive the need to strengthen the leadership and supervisory skills of LVNs?

2. How did LVNs and CNAs in the pilot nursing facilities view their jobs prior to the implementation of the training program?

3. Did the leadership team in each of the pilot facilities see the need to strengthen the leadership and supervisory knowledge and skills of their LVN charge nurses?

4. Were the participants satisfied with the training program and did it have any effect on their supervisory and leadership skills?

5. What actions were identified in the pilot sites to support and reinforce the goals of the training program and sustain it after the project is completed?

6. Could the DSD be a potential lever for helping to implement and sustain the training program?

7. What barriers were encountered in implementing the project?

8. Is there any evidence the leadership training will be sustained in the pilot sites after the project is completed?

3.2 Data Collection

The above research questions were explored through the joint use of qualitative and quantitative data. Table 5 details each of the data collection methods employed and their purpose.

Table 5: Data Collection Methods and Purposes

Method	Purpose
During Project Planning Phase	
Review of the literature *(See Appendix A)*	Review evidence base on nurse leadership and supervision in long-term care and adult learning techniques.
CNA and LVN focus groups *(See Appendix B and C for protocols)*	Obtain feedback on what a good charge nurse looks like and the areas in which charge nurses need training.
Stakeholder interviews *(See Section 4.1 for a list of stakeholders)*	Obtain input on the role of charge nurses and what is needed to strengthen their leadership and supervisory capacities.
Telephone and in-person interviews with pilot site management team members—administrator, director of nursing, director of staff development *(See Appendix D for protocols)*	Solicit perspectives on their concerns about the performance of charge nurses in the facility and the areas in which they need to strengthen leadership/supervisory abilities. Identify the organizational structures necessary to help implement/sustain the knowledge and skills acquired by participants in the training program.
Baseline survey of CNAs in pilot facilities *(See Appendix E for survey)*	Gather CNA perspectives on their job satisfaction, support received from charge nurse, communication across staff, and issues with cultural diversity within their facility.

Baseline survey of charge nurses in pilot facilities *(See Appendix F survey)*	Obtain nurse perspectives on their supervisory responsibilities and skills, support received from facility leadership, communication across staff, and issues with cultural diversity within their facility.
After Project Implementation	
Survey of nurse participants directly after the training sessions *(See Appendix G for survey)*	Evaluate their satisfaction with the training session.
Telephone interviews with pilot facility leadership team approximately one month following full-day training sessions *(See Appendix D for protocol)*	Obtain their assessment of the utility of the training and whether they perceive any impact from the training on participants.
Telephone interviews with nurse participants approximately one month following full-day training sessions *(See Appendix H for protocol)*	Obtain feedback on content of program and whether and how they are using the knowledge and skills taught.
In-person interviews with nurse participants at end of project period, approximately six to seven months after the training *(See Appendix H for protocol)*	Obtain feedback on content of program and whether they perceived any changes in their leadership and supervisory abilities.
In-person interviews with CNAs in the pilot facilities approximately six weeks following full-day training sessions *(See Appendix I for protocol)*	Obtain on whether they perceived any differences in their charge nurses supervisory performance.
Follow-up survey of CNAs in the pilot facilities *(See Appendix E for survey)*	Measure project impact by observing changes from the baseline survey.
Follow up survey of charge nurses in pilot facilities *(See Appendix F survey)*	Measure project impact by observing changes from the baseline survey.

3.3 Analysis

The pilot project employed both quantitative and qualitative data collection methods. The project team interwove findings from both the quantitative and qualitative techniques to provide a comprehensive analysis. Quantitative data was collected through baseline and follow-up surveys with the CNAs and nurses in the four pilot sites and a satisfaction survey with the nurses who attended the full-day training sessions. All survey data was entered into SPSS and various statistical tests were run, including basic statistics establishing means and medians and cross-tabulations. Significance tests (chi-square) were also run on the baseline and follow-up survey data to look for any statistically significant differences. Qualitative data was collected through focus groups with CNAs and nurses and interviews with stakeholders, management in the pilot facilities and nurse participants in the training program.

3.4 Study Limitations

The evaluation study was subject to a variety of limitations. Since its purpose was to develop and pilot test the leadership and supervisory training program, it was implemented in only four nursing homes, each of which was regarded by knowledgeable sources as high performing. The nursing homes were also in the same metropolitan area to facilitate logistics and limit the costs of providing the training and conducting the evaluation. Nursing facilities in other localities, particularly those not so highly regarded, may achieve different results and face different implementation issues. In addition, one of the four sites dropped out, further limiting the

participant sample and the ability to detect impact. In addition, although participation was high among charge nurses in the three pilot facilities that remained in the study (see Table 4 above), not all charge nurses in each facility attended the training, potentially weakening some of the impact.

The study also faced data collection challenges. To garner a high response rate on the baseline and follow-up surveys, a drawing was held offering a chance for a cash prize to those who completed each survey. Although a good response was attained for the baseline survey, full-participation was not achieved. The response rate among CNAs at each facility ranged from 48 to 76 percent and among nurses, it ranged from 53 to 100 percent. In the follow-up survey, the response rate among CNAs remained comparable to the baseline, ranging from 52 to 72 percent. The rate dropped for nurses, however, ranging from 36 to 69 percent across the pilot facilities. The rate was even lower for nurses who participated in the training. Given this small population, it was difficult to detect any response differences.

The team attempted to conduct telephone interviews with participants approximately one month after attending the full-day training session. Because they worked various shifts, it was difficult to get the nurses on the phone. When the team was able to reach them during their shift, they were either not able to step off the floor or were limited in how long they could talk. Some nurses provided the project team with home phone numbers, but it also proved difficult to reach them at these numbers.

As with all field studies conducted in the real world, events were also encountered that affected implementation of the project and may have impacted its sustainability after the project period. The most significant of these was the departure of the administrator at one of the four sites shortly after the start of the study. His leaving resulted in a variety of staffing problems for the facility and as a result, the interim leadership team was not able to follow through on the commitment to send all LVNs to the training program. After limited nurse participation during the first training session and failure of the nurses in the second training group to attend the booster session, this home was dropped from the study. During the course of the study, the DONs at two of the remaining facilities also left, leaving their positions vacant for part of the project period. The project team had expected that the DON would play a major leadership role in motivating staff to participate in the training and reinforce what they were learning. One of the facilities was also without a DSD during the entire course of the study. Again, this left participants from this facility without an important staff member who might have helped them apply the skills they were learning as well as teach new nurses similar skills. Finally, at each of the pilot facilities other new initiatives were also being implemented that may have diluted management's focus on the implementation and sustainability of our project.

It is not unusual to see these types of events in nursing home settings. This underscores why it is difficult to both execute training and implement learning in nursing facilities as well as to conduct evaluations to help build an evidence base. The fact that the four pilot sites were considered high performers highlights the struggle to improve and sustain quality. It also highlights the importance of a stable work environment to achieve successful training interventions.

3.5 Composition of the Project Team

The project was conducted by Aging Services of California, the Institute for the Future of Aging Services, and the University of Wisconsin-Madison School of Nursing. Funding was provided by the California HealthCare Foundation.

4. Evaluation Questions and Findings

4.1 Did California stakeholders in long-term care nursing, including LVNs and CNAs, perceive the need to strengthen the leadership and supervisory skills of LVNs?

While California's nurse leaders supported the project goals, they appeared to hold some mixed views about the importance of the LVNs leadership and supervisory role in nursing homes.

During the project planning phase, the project team held numerous discussions with key stakeholders at the state level representing different perspectives on long-term care nursing, including nursing home facility administrators, the chair of the LVN association, representatives of community colleges that train LVNs, representatives of the state board of nursing, nurse educators, policy officials and researchers. These interviews and focus groups yielded a number of insights that aided the development and implementation of the training program.

Nursing home administrators who were interviewed were asked to identify the tasks for which LVNs were responsible. While all mentioned medication pass, clinical treatments and monitoring patient conditions, only one identified that LVNs were responsible for supervising CNAs. One administrator pointed out that LVNs are very narrow in how they define their jobs—seeing their role almost exclusively as passing out medications and taking as much time as possible to do it. The question, of course, is whether nursing home administrators clearly see leadership and supervision as part of the LVN's role. If not, they are unlikely to support or reinforce LVNs acting in this capacity.

Some stakeholders also pointed out that LVNs do not engage in typical supervisory activities such as participating in decisions about hiring, firing or disciplining CNAs— considering such tasks as the purview of the DON. The baseline survey of LVNs in the pilot sites confirmed this perception (see section 4.2 below). Several stakeholders also observed that continuing education requirements (CEUs) for LVNs tended to blur the distinction between CNAs and LVNs since both groups often took the same courses. Stakeholders also revealed that LVNs often come from the ranks of CNAs, perhaps making it more difficult for them to act in a position of authority over individuals who used to be their peers.

Most stakeholders agreed that the preparation of LVNs failed to address long-term care needs or their supervisory responsibilities with CNAs. One observed that LVNs lacked a real professional identity and were underutilized by administrators and DONs who did not create clear expectations for them regarding their role in motivating, teaching and coaching CNAs.

Focus groups with CNAs and LVNs confirmed the need to strengthen the supervisory and leadership performance of charge nurses.

Four focus groups— two with CNAs (23 participants) and two with LVNs (13 participants) —were convened during the project's planning phase. The composition of the CNA focus groups was diverse, with participants identifying themselves as African American, Nigerian, Ethiopian, Croatian, Korean, Filipino, Hispanic and Caucasian. Like many of the other stakeholders interviewed, these focus groups identified cultural barriers as impeding constructive working relationships between Filipino charge nurses and non-Filipino staff, particularly CNAs. When asked to talk about what made a good charge nurse, CNA focus group participants mentioned:

- previous experience as a CNA, which makes a charge nurse more likely to help CNAs when needed;
- previous employment in a hospital, which was perceived as akin to being a CNA in a nursing home;
- prior experience as a doctor or nurse in their native country;
- cares about residents—has a willingness/ability to listen to them and respond to their needs;
- does not play favorites or become part of a clique within the facility;
- knows residents and shares important resident information with CNAs;
- is accountable for their own job and does not make others do it;
- has good communication skills;
- has positive energy;
- believes in teamwork;
- helps CNAs (but does not do their job for them);
- offers compliments and recognition to CNAs;
- coaches and mentors CNAs; and
- provides in-service training.

CNA focus group participants also raised several concerns about the performance of charge nurses including:

- an unwillingness or inability to share important information about residents, particularly at the time of admission and between shifts;
- failing to perform tasks that are their responsibility, e.g., failing to give medications on time or making CNAs administer them;
- refusal to help out CNAs with call lights and taking vital signs; and
- treating CNAs like second class citizens.

Participants in each group also indicated that CNAs were reluctant to confront LVNs if they thought they were not doing their job appropriately or take concerns about poor performing charge nurses to management.

Participants in the LVN focus groups raised several issues related to the charge nurse role. Several participants felt they were too busy to handle supervisory tasks in addition to all their patient care and regulatory-related requirements. When discussing some of the potential responsibilities of a charge nurse, there was debate among the focus group participants as to whether it was the charge nurses' role to educate CNAs about proper patient care techniques. Some believed it was and said they would spend time working with CNAs one-on-one to

develop their skills. Others felt it was the role of the staff developer, with some saying they did not have the time to fill this role. Some participants also found it difficult to teach some CNAs, saying some get defensive when they are trying to correct them on the proper way to do things. Some participants also did not see it as their role to resolve conflicts between staff or shifts. Some said it was because they did not have time to deal with these issues, but others felt it was the role of the DON or other supervisors to handle such issues. Focus group participants also discussed the tensions between cultural groups within their facilities, particularly Filipino and non-Filipino groups. Many were frustrated by groups who spoke their own language on the floor in front of other staff and residents who do not speak their language. Some groups were also very cliquish, they believed, and there was a perception that they protected and played favorites with members of their own group.

4.2 How did LVNs and CNAs in the pilot nursing facilities view their jobs prior to the implementation of the training program?

Several LVNs did not report carrying out activities typically associated with a supervisory role.

All LVNs and CNAs in each of the pilot sites were asked to complete a baseline survey prior to the initiation of the training session. Nurses were asked questions pertaining to their perception of their supervisory responsibilities as charge nurses, their performance as charge nurses, the support they receive from the facility management, communication within the facility, and cultural diversity within the facility. CNAs were asked questions about satisfaction with their job and identical questions to the nurse survey about their perception of their charge nurse's performance, communication within the facility, and cultural diversity within the facility. All CNAs and LVNs were asked to complete the same survey approximately six months after the completion of the full-day training sessions. It was not known at time of the baseline survey which nurses in each pilot facility would complete the training program. In addition, the project team assumed there might be a possible spillover effect from the nurses who attended the training on those who did not.

Table 6 shows the types of supervisory responsibilities that nurses reported carrying out in the baseline survey. As the table demonstrates, almost all of the charge nurses in each of the pilot facilities perceived themselves as mentoring CNAs, providing feedback on their job performance and ensuring that they were giving proper care to residents. There was significant variation across the sites in the proportion of charge nurses who said they conducted on the job clinical training for CNAs. Across all the facilities, fewer nurses reported carrying out responsibilities typically considered part of being a supervisor such as scheduling, documenting performance and initiating disciplinary action, interviewing CNAs for jobs or recommending training for them.

Table 6: Supervisory Responsibilities of Pilot Facility Charge Nurses

Types of Supervisory Responsibilities	Facility #1 (n=16)	Facility #2 (n=19)	Facility #3 (n=13)	Facility #4 (n=9)
Act as a mentor to CNAs.	92.9%	100.0%	100.0%	100.0%
Ensure CNAs are giving proper care to residents.	100.0	90.9	90.9	100.0
Schedule CNAs.	78.5	81.8	81.8	25.0
Provide feedback to CNAs on job performance	85.7	90.0	90.0	88.9
Document CNAs' performance problems.	64.3	72.7	72.7	75
Initiate disciplinary action.	28.6	60.7	60	62.5
Conduct on the job clinical training.	14.3	81.6	81.8	50
Interview CNA job applicants.	0	30.0	30.0	10.0
Recommend training for CNAs.	7.1	36.4	38.4	22.2

Most CNAs in the pilot sites said they were very satisfied with their jobs.

As shown in Table 7 below, most CNA survey respondents in the pilot sites appeared to be very happy with their jobs prior to the implementation of the training project. About three-quarters stated they were very satisfied with their jobs, while relatively few thought about quitting. Interestingly, significantly more CNA respondents perceived that their peers in the facility were thinking about quitting their jobs than reported that they themselves thought about quitting.

Table 7: Job Satisfaction of CNA Survey Respondents

	Facility #1 (n=53)		Facility #2 (n=31)		Facility #3 (n=21)		Facility #4 (n=25)	
	Agree/ Agree Strongly	Disagree/ Disagree Strongly	Agree/ Agree Strongly	Disagree/ Disagree Strongly	Agree/ Agree Strongly	Disagree/ Disagree Strongly	Agree/ Agree Strongly	Disagree/ Disagree Strongly
Generally speaking, I am very satisfied with this job.	77.1%	4.2%	70.0%	16.7%	80.9%	4.8%	76.0%	4.0%
I frequently think of quitting this job.	12.7	55.4	21.4	50.0	4.8	66.7	17.4	43.4
I am generally satisfied with the kind of work I do in this job.	89.8	2.0	82.8	3.4	71.4	4.8	48.0	4.0
Most people on this job are very satisfied with the job.	33.3	17.7	53.3	26.6	47.6	19.0	36.0	20.0
People on this job often think of quitting.	31.3	16.7	30.0	23.3	9.6	47.6	16.0	24.0

LVNs seemed to think they were doing a good job in their supervisory role. While the majority of CNAs agreed with this perception, there were some important differences.

Both LVNs and CNAs at each of the pilot facilities were asked to address similar questions in the baseline survey about the support LVNs provided to CNAs and the support CNAs received from charge nurses. All LVN respondents to the baseline survey said they agreed or strongly agreed with statements such as "I provide clear instructions when assigning work," "I treat all nursing assistants equally," "I help CNAs with their job when they need it," "I listen to CNAs when they are concerned about a residents care," "I discipline or remove CNAs who do not do they job well" and "I tell CNAs when they are doing a good job." The vast majority of CNA respondents also gave their charge nurses good marks, agreeing or strongly agreeing, for example, that charge nurses gave them clear instructions in assigning work, provided them help when needed, listened to their concerns, etc. Since the pilot sites were selected based on their excellent reputations, this finding is probably not surprising. There were two areas however, where a significant minority of CNAs did identify issues with their charge nurses. From 23 to 37 percent disagreed that their charge nurse treated all CNAs equally. This result could reflect the fact that most charge nurses in the pilot sites were Filipino, while there was greater diversity among nursing assistants. It is possible that non-Filipino staff perceived some favoritism. It could also reflect language and cultural differences within the organization. There was also a significant minority of nursing assistants—from 30 to 41 percent—who did not perceive their charge nurse disciplined or removed CNAs who were not doing their job well or their share of the work.

The survey data are supported by interviews with a small sample of CNAs from the pilot facilities. The CNAs were largely happy with the charge nurses in their facility. They felt most charge nurses were respectful to them, kept them informed about residents, listened and responded to their concerns about residents and worked as a team with the CNAs. However, they did raise concerns about some of the charge nurses in their facility. While happy with most nurses, CNAs believed some charge nurses did not treat CNAs respectfully. Some charge nurses talk rudely to them, correct or discipline them in front of others and ignore them when they tell the nurses things about the residents. CNAs also said some charge nurses do not always give a report on residents or tell them if they have followed up any problems identified by the CNA. Although most CNAs said they have little conflict on their unit, some charge nurses do not attempt to resolve it and will instead let their supervisors handle it. Some CNAs were also frustrated by charge nurses who speak their language when other staff and residents are around who do not understand the language.

A sample of nurse participants in the training program was also interviewed at the end of the project. One of the questions they where asked was whether they thought they needed supervisory and leadership training prior to attending the training. Several of their responses suggest they had previously given little thought to the leadership and supervisory roles they were at least hypothetically expected to play. One nurse commented, "I felt like any time I can learn is good. There might be something I don't know; there's always something you might think you know." Another nurse said, "I felt it would be good for us. You could tell us something new, you could bring us new material to use, and it's always good." Similarly, when asked what they hoped to get out of the training program, most of the nurses interviewed did not seem to have specifics in mind. Responses ranged from "I was thinking maybe I can get some tools or new

ideas on being a leader" to "I was expecting to learn something that I can apply to my every day work." and "Maybe something new, like something that I could do with my job, make my job easier."

A few of those interviewed did acknowledge their lack of supervisory training and experience. One said, "I was thinking because I have very minimal knowledge about management, I might be able to apply what they say." Another stated, "Since I'm new to being a leader, I expected I would be able to know how to be a good leader, supervisor." Still another observed, "I'm the day charge nurse. I needed more help. It's not that I can't communicate with them, but I needed more ideas on how to talk with them." A few nurses also identified specific topics they wanted help on such as managing CNAs, how to communicate and how to deal with staff. As one nurse said, "Sometimes it's hard dealing with different cultures and personalities, sometimes you give up, you get frustrated."

The majority of LVN respondents to the baseline survey claimed that management supported them in their job. However, although they felt generally supported, CNAs were even more positive about the support they received from charge nurses.

The baseline survey included questions about the support LVNs received from the facility's leadership team. The majority of LVN respondents across all the facilities agreed with such statements as "management responds to staff concerns," "management is clear about what they expect from staff," "management praises staff for a job well done" and "management supports staff and works with them to learn new things." However, when CNAs were asked similar, although not identical questions, they were more likely to respond affirmatively. For example, 69 percent of LVNs across all the facilities stated that management responds to staff concerns. When CNAs were asked if they agreed with the statement "my charge nurse deals with the complaints and concerns of nursing assistants," almost 75 percent said they agreed. About 81 percent of CNA baseline respondents said they agreed that their charge nurse tells them when they do a good job. When charge nurses were asked if they received praise for a job well done, 72 percent across all four facilities agreed.

There were also substantial differences in nurse perceptions of management support across the four pilot sites. For example, from a little over half to 100 percent of LVN respondents agreed that staff respects the facility's management. Even more variation between facilities was noted when respondents were asked whether they thought management valued the work done by staff at all levels, with a range of 25 percent to 82 percent agreeing with this statement. This variation makes these data difficult to interpret. However, it does contribute to an overall impression that any replications of the leadership and supervisory training program would be enhanced by the direct participation of management.

The importance of recognizing and addressing cultural differences among nursing home staff was identified as a necessary element in the training program.

Interviews with stakeholders during the planning phase drew attention to the wide range of ethnic diversity that characterizes many California nursing homes. Tensions between staff of different ethnic groups were highlighted in these interviews to illustrate the supervisory and communication issues posed by the languages and patterns of communication in different

cultures. For example, stakeholders noted that Filipino nurses, who represented the great majority of LVNs in the projects pilot nursing facilities, were very deferential to CNAs who were older or who had more years of experience, and were not comfortable with confrontation. As a result, the implications of cultural diversity among nursing home staff became an important component of the leadership and supervisory training curriculum. Most felt unprepared to deal with this effectively.

Interviews with each pilot facility's leadership team also highlighted cultural issues that impeded their charge nurses from effectively carrying out leadership and supervisory roles. Their insights are discussed below in Section 4.3.

CNAs and LVNs were asked questions in the baseline survey about the impact of cultural differences within their facilities. While both CNAs and LVNs largely agreed that their facility was a comfortable place for staff of different races and cultures to work, there were significant numbers across each of the pilot facilities—from 42 to 60 percent of nurses and 30 to 53 percent of CNAs—who agreed that there were problems between staff of different races and cultures. Communication issues were flagged by a sizable minority of both CNAs and nurses. Well over one-third of CNA respondents (from 34 to 42 percent) reported that some staff members had a hard time doing their jobs because of language and/or reading difficulties. In three of the four pilot sites, an even larger proportion of nurses agreed that language and reading difficulties interfered with the ability of some staff to do their jobs. Other issues flagged by CNAs and LVNs in the baseline survey included "not enough supervisors from different cultures" and "difficulties communicating with staff who speak a different language."

4.3 Did the leadership team in each of the pilot facilities see the need to strengthen the leadership and supervisory knowledge and skills of their LVN charge nurses?

The project team interviewed the facility leadership teams—typically the administrator, DON and DSD—at the beginning of the project about the supervisory and leadership capabilities of their LVNs. Across the board, managers agreed that a lack of leadership skills among nursing staff was a significant problem and that most nurses were simply not confident or comfortable in their supervisory roles. One administrator observed that LVNs are taught in school to pass medications and to be kind to residents, not to supervise or lead. Several commented that charge nurses do not see supervision as their job, even when it is clearly in their job description. As was previously pointed out, some management staff also observed that many LVNs were once CNAs themselves, making it more difficult for them to exert leadership over CNAs who had been their peers.

A common perception of managers was that their Filipino LVNs, who make up the great majority of their charge nurses, were not very assertive and tended to be deferential to experienced and older CNAs. In their judgment, these traits helped to make charge nurses reluctant to teach CNAs new skills or deal with conflict or disciplinary issues. Managers observed that some cultural beliefs important to Filipinos, in particular the granting of respect and deference to one's elders and superiors, potentially hindered the charge nurses in their leadership and supervisory roles. Management told the project team that younger and/or newer charge nurses were hesitant to step in to correct and coach CNAs who had been at the facility for a long time, even when they made mistakes or created conflict with other staff. They further

indicated reluctance on the part of charge nurses to bring problems on the floor and/or changes they would like to make to work practices to management's attention. One DON referred to her charge nurses as the "silent sufferers." In their judgment, some nurses did not have control of the floor because of their cultural orientation. Nevertheless, there was agreement that some of their Filipino charge nurses were able to step out of their comfort zone and become effective supervisors.

The project team asked management at each facility to identify the issues and topics that should be addressed in the training program. Coaching and mentoring skills were highlighted in most of the interviews. Several managers mentioned the importance of helping nurses identify "teachable moments" that provide an opportunity for them to mentor and coach CNAs on the job. As one manager pointed out, "If an aide is caring for someone incorrectly, I'd like to see the LVN say can we take some time here and then model the care for them and then follow up a few times and see how they're doing and then praise them for picking up the skill." One administrator also saw the scope of practice limitations that prohibit LVNs from doing formal resident assessments as a barrier to LVNs teaching CNAs new skills. Because of confusion around scope of practice limits on LVNs, some LVNs may incorrectly perceive they are not allowed to coach CNAs on care practices. Another manager pointed out that in his facility, which was unionized, LVNs shied away from exercising supervisory roles because they associated supervision with discipline and conflict resolution, which could trigger union involvement. The administrator thought it was very important to help nurses in a union shop understand that supervision involves coaching and teaching as well as discipline, and that coaching CNAs on how to do particular tasks might actually avoid more formal disciplinary actions.

Managers also identified improving nurses' communication skills as another important issue. One commented that LVNs do not think they have time to communicate with CNAs about resident issues or to listen to what they say because they are too busy passing medications. This manager thought the real problem was not limited time, but rather an inability to manage time and a lack of communication and listening skills. There was a generally shared sense that many nurses failed to listen to the CNAs. Communication was thought to be one sided, with CNAs telling their charge nurses about a resident issue and not being told what happens after that. As a result, CNAs think their advise is ignored and do not feel their opinions are respected.

Problem solving and critical thinking skills were also mentioned by several managers. They wished to see their nurses coming up with the solutions to problems or suggestions for new interventions to better care for residents, rather than expecting managers to come up with all the answers. For example, the DON of one facility said if a patient falls on one shift, they would like the nurses to think about how that might be an issue to address more systemically and then spread the new practice. One DON admitted her tendency to solve problems for staff instead of motivating them to find solutions. She said she needed to stop herself and learn to model the critical thinking skills she wished her LVNs to adopt.

Creating a "culture of respect" between charge nurses and CNAs was also identified as an important goal for the leadership training. As one administrator put it, the facility's management team must reinforce that LVNs need to give instructions respectfully, project a positive

orientation to CNAs, admit to CNAs when they are wrong and apologize and not talk down to CNAs as if they are children. Others mentioned that CNAs who have been in the facility for a long time tend to be very bossy and intimidate new employees. Charge nurses do not seem to have the skills to help create a more supportive environment.

4.4 Were the participants satisfied with the training program and did it have any effect on their supervisory and leadership skills?

Given the preliminary nature of this project, the evaluation component was not designed to provide definitive data on the effectiveness of the training program in meeting its goal. However, both quantitative and qualitative data were collected to give the project team a good sense of how nurses and managers felt about the training and whether they thought it had some impact. The results presented below should be viewed with caution. Data were not collected that would allow the study team to know if the project had any lasting impact or if the pilot facilities actually followed through on plans to continue it in the future. It is possible that favorable interview responses reflected participants simply telling the team what they thought they wanted to hear. It is also possible that favorable behaviors observed should not really be attributed to the training program. However, when considering the qualitative and quantitative data in sum, it appears the training program indicates promising results.

Virtually all participants in the training sessions were highly satisfied with the content and format of the program.

Participants completed an evaluation form at the end of each full-day training session. Eighty-two percent rated the sessions as very good to excellent. Over 80 percent found each of the topics covered in the training sessions, as well as the way they were presented, to be very useful and relevant to their daily work life. The evaluation form also asked participants to identify two examples of how they thought they would apply what they had learned in the training session. A majority of nurses noted communicating more respectfully, including listening to and providing feedback and information to CNAs. When a sample of nurses was interviewed six-weeks following the first training session, several noted they are more conscious of talking and acting more respectfully to the CNAs. Some also noted that they are concentrating on giving more details to CNAs about residents' conditions and treatments and on coaching them on proper care methods.

A sample of participants interviewed at the end of the study were asked what they liked about the training and what they would improve. Most of the interviewees appeared happy with the format as well as the presenters. Several participants liked the interactive discussions of examples and case studies, and some would have liked there to be even more. A few nurses mentioned they liked attending the training with nurses from other facilities. They said it gave them the opportunity to hear the issues other facilities are facing, as they can be isolated in their own facility. One also mentioned that they would have liked to have been forced to interact more with participants from other facilities (participants sat at tables with nurses from their own facility), as it would help them relate to each other as co-professionals. Some participants also liked attending with colleagues from their own facility. One participant said, "It's good to be with the group of other LVNs in the training. You learn from each other. We drove together as a group and when we were coming back we discussed ideas." Another nurse observed that while

it would be good to have more training in her facility, having outside training sessions provides an opportunity to discuss things you might not otherwise discuss in the workplace. She commented, "I said things there I've never said in my facility." There was some debate about the length of the 8-hour training session. While some people thought the length was fine, others felt the day was too long. They believed that participants got tired in the second half of the day and it was difficult to remain focused.

At the end of each full-day training session, participants were asked if there were any additional topics they would like to see added. Several individuals from the first group of trainees requested that a section be added on how to communicate with management so that their concerns and problems were heard and considered. A similar desire was echoed by participants in the second training session. One nurse interviewed at the end of the project suggested there be more emphasis on how they should be dealing with their supervisors. Another suggested, "Maybe you guys can have a training session with management. Maybe something where everyone can get together so they can troubleshoot and have a better understanding of what everyone is supposed to do and kind of play different roles and get an idea of what they're jobs are, respect what people do."

Many participants said they were applying some of the knowledge and skills learned from the training to their work with CNAs.

Approximately six months after they completed the full-day training session, the project team interviewed 20 of the 32 participants who had completed the training program and asked them if and how they were applying what they had learned to their daily work. Many nurses said they had become better at listening to and soliciting CNAs' input on patient care needs and keeping CNAs in the loop regarding patient status and care actions. One nurse said, "I listen to their ideas now and I didn't before. Before, I said *'you need to do it this way.'* I didn't realize that they could have some good ideas, because they deliver so much of the care." Another nurse commented, "I'm not just a charge nurse; I'm a team leader too. It's not just *'do this, do that,'* we work together." A third said, "I'm on top of the follow-up. I think I'm doing more of it than I was. I'm kind of quiet, but since the training I've learned to communicate more." Still another nurse observed, "I tried to be more assertive; I tried to talk to CNAs. I asked them *'what are your suggestions?'*"

Some of the nurses interviewed also reported they were focusing more on coaching CNAs. One said, "I relate more with my CNAs on their level, things that need to be explained more if they are having difficulty dealing with residents or their job. I try to give my clinical ideas and they will be able to learn the clinical side and they understand better, they are better informed." Another commented, "as far as the knowledge level of my CNAs you often have to explain to them why something is happening. You are teaching them all the time, especially the new ones. It opened my eyes. I needed to put extra attention to make sure they would produce good quality work." "I'll tell them *'I'll show you and you watch and then you try it and I'll watch you.'* I've learned to be more aggressive in expressing what I know and then letting them try to learn," said one training program participant. Still another nurse, talking about methods of providing clinical care that may not be familiar to a CNA, stated, "It's my responsibility to show to them how to do it, so that next time they will know how to do it." Another nurse, saying she had needed to learn more about coaching said, "When I talked to them before, I was always in a hurry. I would just

say I need a urine stick. But now I try to tell elaborate and tell them why and then what we found out."

Many of the nurses who went through the training also felt they were becoming better at communicating with CNAs in a respectful manner. One nurse stated, "The very best thing I learned is that I have to stop talking to the CNAs in the hallway. When I talk to them I make sure nobody can hear; not like before where everyone can hear. I didn't realize that if I say something and others can hear it they feel offended." Another said, "I learned that to get good feedback, you have to do it properly. Not just say *'why did you do it that way?'*" Another nurse stated, "I think I learned how to communicate. First, I have to be a good listener. I have to listen to both sides; don't focus on being judgmental, but listen to both sides."

Some of the nurses interviewed believed that the CNAs were noticing changes in the way they are interacting with them. One nurse, talking about the CNAs she supervises, said, "They used to be pretty quiet. They're telling me more about the patients now. I think now they feel included. Before, they just finished their shift and left." Another stated, "They've said you're not like her, she just sits down or she just walked passed that light, not like you. So now I know what they feel like when they're being pushed to do things." Asked whether she thinks the CNAs have noticed that she is trying to do more coaching with them, one nurse said, "I think so, it's more informative for them. I think it has changed the relationship a little bit. A few have tried to ask me questions about personal situations. It makes them think you're more knowledgeable."

The nurses' perception of their changed performance is supported by some changes in CNAs' responses to the post-training survey. All CNAs in the pilot facilities were asked to complete a follow-up survey approximately six months after the completion of each full-day training sessions. The responses were compared to those from the baseline survey to measure whether the training program had any effect on CNAs' perception of their charge nurses. Although a significant change was not found in the response to most survey questions, a few areas indicate the training program may have had an effect. There were significant differences in the number of respondents agreeing that their charge nurse "provides clear instructions when assigning work," and "is supportive of progress in my career, such as further training." Although not statistically significant, there was also a larger percentage agreeing their charge nurse is "open to new and different ideas, such as new or better ways of dealing with resident care" and that they have a "good understanding of the goals for each resident." These results can be seen below in Table 8. The changes appear to support claims made by the participating nurses that they were attempting to improve their communication and increase their level of coaching with CNAs.

Table 8: Selected CAN Baseline and Follow-up Survey Comparisons

Survey Question	Percent Agreeing Across all Pilot Facilities		
	Baseline Survey (n=99)	Follow-up Survey (n=100)	p
My charge nurse provides clear instructions when assigning work	85.3%	93.9%	.047
My charge nurse is supportive of progress in my career, such as further training	77.1	89.0	.041
My charge nurse is open to new and different ideas, such as new or better ways of dealing with resident care	77.9	88.3	.062
I have a good understanding of the goals for each resident.	77.1	85.6	.105

One of the issues managers raised early on to the project team was that charge nurses lacked confidence as supervisors. Interviews with the participants suggested that at least some of the nurses who had gone through the training seemed to have gained more confidence in their role as charge nurses. A nurse from one of the pilot facilities said, "I try to be more assertive. In the past, I would have told the supervisor to deal with problematic people, but now I'm trying more on my own." Another said, "I think I feel more secure. I can express myself now better than before." One nurse also observed that he thought the training had helped build the confidence in a fellow nurse, saying, "she need a little boost to take a little more control and it seemed like she did."

Most of the nurses interviewed for the evaluation said they had never had any leadership education prior to this training program. Some may have lacked confidence in carrying out leadership roles simply because they had never been educated on how to handle themselves as supervisors or how to deal with potential situations. It also appeared that a few nurses might have gained some level of confidence as a leader, simply by being told that they were leaders and what was expected of them. In this way, the training may have helped to give them permission to act as supervisors.

Managers in the pilot sites reported the training program had an effect on the way some of their charge nurses related to CNAs.

Each facility's leadership team was interviewed one month after the first full-day training session and two months after the second to solicit their perspectives on how the program had been viewed by participants and if charge nurse behaviors had changed any as a result. Two administrators said they asked for feedback from participants after each training session. One administrator pointed out that participants were excited about what they had learned after the first training session. However, the administrator observed that some of the participants at the second session were more negative, saying they found the training boring. The administrator said the first group represented the best of the facility's charge nurses, while the second group was less mature and not as high performing as the first group.

Managers at all three facilities stated that some of their nurse participants seemed to be working harder and more effectively in their interpersonal relationships with CNAs since attending the training. Several mentioned that charge nurses were approaching CNAs in a more respectful manner. Managers at two of the facilities noticed an improved level of reporting, saying that charge nurses appeared to be giving more information to CNAs regarding patient conditions. During their annual performance review, one facility's DON requires all nurses to select a goal they want to work on over the next year. She said many of her nurses picked coaching, recounting to her that they had learned they needed to be more respectful of the CNAs, an observation this administrator had not ever heard before. Another administrator asserted that the project helped him to understand that supervising and disciplining staff was more of a coaching process than a punitive one. He went on to say that he thinks he needs to think about staff individually and focus on their individual needs rather than thinking of them as a group of nurses.

A DSD at one of the facilities was asked whether she thought the nurses benefited from the training. She responded, "I think that they did, a few of them no, but the majority of them realized they need to share more hands on things with the CNAs, that they need to make the CNAs feel more important and not so menial." She thinks some of the charge nurses are now being more patient with the CNAs, taking the time to give them feedback. "I see a couple people out on the floor who would never go out on the floor before and are now working with CNAs and answering lights," she says. Another DSD observed a few nurses who seemed to be more interactive with the CNAs, adopting coaching techniques as part of their role. She commented she was excited to walk in on one particularly quiet charge nurse and see her coaching a CNA, something she had not seen the nurse do before.

Management at the facilities felt they were seeing a subtle increase in the level of assertiveness and confidence in the participating nurses. They felt some nurses were becoming more vocal and were speaking up about their needs and/or ideas. One DSD noted that more nurses were coming to her to request information and in-services. A manager at one of the facilities told a story to illustrate her perception that charge nurses were becoming more assertive. At the beginning of the project, this facility's leadership team had expressed frustration that charge nurses would suffer through problems on the floor rather than raise them to management and help to solve them. After the first training session, a group of nurses came to the DON with a concern that too many patients were being given stool softeners that were not working. In response, the DON and nurses decided to invite the pharmacist to come in and do medicine reviews of the patients, thereby modeling some of the critical thinking and problem solving skills encouraged in the training program.

Few significant changes in the behavior of charge nurses were detected between the baseline and follow-up survey; however, a few trends were observed.

All LVNs in the pilot facilities were asked to complete a follow-up survey approximately six months after the completion of each full-day training session. Responses were compared to those from the baseline survey to measure any differences in the training participants' perception of their supervisory responsibilities as charge nurses, their performance as charge nurses, the support they receive from the facility management, communication within the facility, and

cultural diversity within the facility. Due to the small sample size of both the baseline (n=38) and the follow-up survey (n=18), it is difficult to detect any statistically significant differences between the two timeframes. In addition, because the nurses rated their own performance so highly in the baseline survey, it would be difficult to see a difference. However, a few trends can be noted.

In the set of questions asking LVNs what activities they carried out as charge nurses, a change was seen in only one area. A higher proportion of nurses (58.5 versus 33.3 percent; p=.084) stated they were responsible for initiating disciplinary action. As the training program contained a module on conflict resolution and attempted to help participants see coaching as a method of correcting CNA performance and behavior problems, participants may have begun to recognize and feel more comfortable with this aspect of their charge nurse role.

Changes were not seen across the questions regarding support received from facility management and communication within the facility. Since the pilot program did not involve a direct intervention with the management team, it is not surprising that significant changes were not found in these two areas. However, it does reinforce the impression that a replication of the training program must more directly involve management.

In the questions regarding cultural diversity in the facility, one change was noted. Fewer respondents agreed (11.8 versus 36.1 percent; p=.147) that "sometimes there are problems between staff of different races and cultures." This could indicate that after the training, participants were more cognizant of cultural differences and attempted to work more effectively with CNAs of different races and cultures.

4.5 What actions were identified in the pilot sites to support and reinforce the goals of the training program and sustain it after the project is completed?

Prior to conducting the training sessions, the project team held in-person meetings with the management team in each pilot facility to identify the policies and practices that currently exist or may be needed to maximize the potential for the participating nurses to implement the knowledge and skills acquired in the training program. The hope was that they would develop a facility specific plan to sustain the training after the project was completed, although this did not turn out to be the case. Because the project was heavily focused on developing and implementing the actual training program, no detailed guidance was provided to site managers about what this plan should contain. Nevertheless, at several points during the project implementation period, site managers and the project team talked about how project goals might be reinforced and sustained. Many ideas were suggested including:

- Designating the DSD to do supervisory and leadership training with new nurses rather than just addressing training needs of CNAs;
- Using high performing nurses to mentor new nurses in supervisory and leadership skills;
- Including a component on nurse leadership in the orientation program for new nurses;
- Clarify supervisory duties and expectations in the job description for charge nurses and/or making specific supervisory and mentoring part of a career ladder for LVNs;
- Providing a merit bonus for charge nurses who exhibit outstanding leadership skills;
- Incorporating supervisory and leadership benchmarks as part of the annual performance evaluation and/or required tests of competencies;

- Adding components of the training program to the required in-services and using nurses to conduct in-services so that they see themselves as teachers and coaches;
- Integrating leadership and supervisory issues into regular staff and floor meetings;
- Having the DON and other RNs model coaching, critical thinking, problem solving and conflict resolutions skills on the floor as part of the daily work process.

Ideally, the project team would have conducted in depth site visits about six months after the completion of all training to asses the extent to which managers followed up and actually implemented specific strategies to sustain the training program. However, the project timeline did not permit these visits. Future research should focus more on this issue, as informal discussions with administrators and LVNs indicate some initiatives were started, yet depth and breadth are unclear. In-depth site visits, ideally, would provide useful data around management interventions.

4.6 Could the DSD be a potential lever for helping to implement and sustain the training program?

California requires all nursing homes to have a DSD. Candidates must be an RN or LVN and have: (1) one year experience as a licensed nurse providing direct patient care in a long-term care facility, in addition to one year experience planning, implementing and evaluating educational programs in nursing; or (2) two years experience as a licensed nurse, at least one of which must be in the provision of direct patient care in a nursing facility. Within six months of employment, DSD candidates must obtain a minimum of 24-hours of continuing education courses in planning, implementing and evaluating educational programs.

Two of the three remaining pilot sites had a DSD, while the position remained vacant in the third pilot site for the duration of the study. Management in this pilot site was committed to recruiting someone who they believed was an experienced and enthusiastic educator and not simply a nurse interested in getting off the floor. Since the management team believed that they had not found a suitable candidate, the position remained vacant. The project team held telephone and in-person interviews with both DSDs to: (1) learn more about their responsibilities, (2) solicit their perspectives on the training program and (3) gauge their potential for helping to sustain it.

The two DSDs held other responsibilities in addition to their staff educator role. At one facility, the DSD was also responsible for infection control. At the other, the DSD was also responsible for infection control, hiring and managing the facility's workers' compensation program. Both believed the majority of their time was still devoted to staff education efforts, although one believed she was able to do so because she worked in excess of 40 hours per week. The project team understands it is common practice for DSDs in California to have other responsibilities in addition to their educator role.

Both DSDs defined their staff educator role as arranging and/or conducting in-services, making rounds on the floor to observe whether staff is performing procedures properly and following regulations, and conducting orientations with new nurses. Both said that they respond to "teachable moments" observed on the floor and work one-on-one with staff to correct and improve performance. One DSD also says she will hold "mini in-services" with staff at shift changes in order to discuss specific issues with the entire team.

In-service subjects are generated by: (1) mandatory monthly topics directed by the state, (2) issues the DSD identifies when out on the floor observing staff and (3) topics identified by facility administrators, DONs or other management staff. In the for-profit facility, topics are also sent from the corporate headquarters. One DSD says that about three-quarters of topics addressed in in-services are around clinical and regulatory issues and about one-fourth are around communication-related issues.

Both DSDs say the majority of their educator time is spent with CNAs, through either in-services or one-on-one coaching. Nonetheless, both say they do also work with the licensed nursing staff. Nurses interviewed from one of the pilot facilities said their DSD currently deals mostly with CNAs, while the floor supervisor works with nurses. The nurses did believe, though, that the DSD could conduct trainings around leadership and supervisory topics with the nurses. Nurses from the other facility had more mixed feelings on whether their DSD could conduct such sessions. Some felt the DSDs could, but others did not know whether she knew enough to cover all of the topics. When asked whether she felt she had the skills to conduct such training, one of the DSDs hesitated a bit and said, "I do a lot of research." She believed having some form of guidelines would help her conduct such a program and she could see using the training manual being developed for this project on an on-going basis. The other DSD noted that she would like someone to keep her aware of new techniques and ideas so she is not always teaching the same old thing. She would also like to have some in-service examples and tips to follow.

Indicating there would be a place for on-going training opportunities in the facility, several nurses interviewed across the three pilot facilities said they would like to have additional training on the topics covered in the project curriculum. Some said that some times you forget the things you learned and you need a refresher. One nurse said that you are often so busy on the floor that you forget the things you learned, which might imply that it would be helpful to have on the spot coaching. Others said that you cannot learn everything the first time around and you need to hear it again. One participant said you cannot master everything at one; you have to practice what you learned and then learn more. Some mentioned they would like to have in-services that focused on one topic at a time.

Although the DSDs may focus more on CNAs, the project team did observe that the nurses and DSDs appeared to have a very good rapport with each other. Both DSDs attended the full-day training session and one attended the half-day booster session. The participating nurses appeared to respect and trust the DSDs and were not afraid to discuss issues in front of them, including concerns they had with upper management. Both DSDs believed their facility's administrator viewed the project's effort to strengthen LVNs leadership and supervisory capabilities as important and that they would support the DSDs to develop in-services around these topics. They did believe it was the DSD's role to provide support around these issues and, as one put it, "ingrain in the LVNs that this is their job, that they are in charge and have to watch and teach and assist the CNAs."

4.7 What barriers were encountered in implementing the project?

The most significant barrier to implementing the training program was turnover of management staff in the pilot sites. Turnover of the top leadership position in one facility resulted in it being

dropped from the project entirely when the interim leadership could not arrange for most nurses to participate. The DONs at two of the remaining facilities also left, leaving their positions vacant for part of the project period. The project team had expected that the DON would play a major leadership role in motivating staff to participate in the training and reinforce what they were learning. One of the facilities was also without a DSD during the entire course of the study. Again, this left participants from this facility without an important staff member who might have helped them apply the skills they were learning as well as teach new nurses similar skills. While staff changes did not interfere with gaining the participation of charge nurses in the training, except at the one site mentioned previously, it did make it difficult for the facilities to work on developing strategies and processes for institutionalizing the training at each facility.

The institutionalization of the project was also impeded by a somewhat narrow view of the role of the staff developer. Although staff developers seem to spend most of their educator time addressing facility-wide needs relating to clinical practices and regulatory requirements and working with CNAs, they appear to be in an ideal position to take up the mantle of nurse leadership and supervisory training.

The project team also found that in spite of the initial orientation with each facility's leadership team and their expressed commitment to project goals, there was ambiguity around what they really expected in the way of leadership and supervision from their charge nurses. The project team now strongly believes that future iterations of the nurse training and leadership program need to include a separate component for the facility's management team.

4.8 Is there any evidence the leadership training will be sustained in the pilot sites after the project is completed?

There was a clear interest and willingness on the part of the management teams in the pilot facility to build the leadership capacity of their charge nurses and to sustain the training program within the organization. It was not clear, however, that concrete steps were taken to implement the policies and practices in the organization that would be necessary to support and sustain the new leadership and supervisory skills the charge nurses had learned. Research shows that without the follow-up to embed the systems changes needed to support new efforts, these efforts are not sustained. As this was a pilot program focused on developing the training program, the project team did not work with the pilot facilities to this end. The next challenge, however, is to design a companion component to the training program that will help organizations and their management teams develop the organizational structures to support the results of the leadership training program over time.

5. Lessons Learned

Affirmation of Program Goals

The evaluation has supported the goals of this program. The qualitative and qualitative data affirmed the need for a training program to help build the leadership and management capacity of the LVNs in California nursing homes. Previous research has identified the lack of adequate and appropriate supervision of CNAs by charge nurses as a major contributor to staff turnover,

instability in the workforce and ultimately poorer quality of care. This study found that LVNs do not recognize themselves as managers and leaders of their units. They have no formal training in this area and no professional association that helps them to define this role. Most see themselves as floor nurses who are primarily responsible for "passing meds" and helping to ensure resident safety.

The attitude of many RNs toward the LVNs that they are "lesser nurses" further discourages efforts on the part of LVNs to assume any leadership role. While the scope of practice in California does not identify management as a core responsibility of the LVN, most of these nurses do become charge nurses on their units and are responsible for the activities on the floor and CNAs who provide most of the direct care. One of the major successes of this pilot program was the recognition by many of the LVNs that they were leaders and that they had a responsibility to manage their units, to communicate with and mentor the CNAs and to develop a team approach to service delivery.

Content of the Training

A second lesson learned was the importance of certain aspects of the training program. The information about leadership, particularly the scenarios that highlighted why and how LVNs are (or could be) leaders on their units, provided the "a-ha moment" for a number of the participants. Some were natural leaders who simply had their roles better articulated. Others recognized for the first time the potential to develop their leadership skills and found the training and booster sessions helpful in laying out steps for successful management of the unit.

The module related to the teaching/mentoring role was found to be very effective in providing the LVNs with an overview of the difference between "command and control" supervising and a coaching approach. Through scenarios and interactive role playing, the participants learned how to use "teachable moments" on the floor with CNAs to help the direct care staff better perform hands on care and communication with residents. DSDs in the pilot facilities noted that they observed a number of the LVNs in their facilities coaching CNAs following the training.

A final module, added to the training program after the first booster session, focused on how LVNs can communicate better with upper management. While the initial training primarily addressed communication with CNAs, many of the participants noted that they were more uncomfortable expressing concerns to their DONs and administrators. In response, additional materials were developed, including scenarios and some role playing activities, to help the LVNs formulate and express their concerns to upper management in a way that they could be heard and acknowledged.

Natural Mentors

One assumption in developing this program was that indigenous LVN leaders could help disseminate and sustain the program within each facility. While the pilot was not intended to develop a mentor program, e a number of natural mentors who participated in the program were observed. These LVNs were more vocal in the training and booster sessions, volunteered for role-playing activities and seemed intuitively to understand the teaching/coaching role. In subsequent conversations with the facilities' leadership teams, they also mentioned the potential

role of these natural leaders in helping to take the training program to other incumbent LVNs as well as newly hired charge nurses. Suggestions for management on how to formally utilize these natural mentors should be considered in future nurse leadership programs.

Lack of Facility-Level Implementation Plan

As was previously highlighted, the project team met with the upper management of each facility to discuss the program's goals and objectives and to ask them to consider how they would help the LVNs implement what they had learned once they were back at the nursing home. Despite multiple conversations, one of the lessons learned is how difficult it is for DONs and administrators to create the infrastructure and ongoing support that maximizes the potential for implementation, diffusion and sustainability. Several of the administrators did provide some acknowledgment of the training and support for the LVNs, but this occurred on an ad hoc basis rather than in any type of formal, consistent manner.

None of the managers set any real expectations for the LVNs prior to their attending the training program and few provided concrete follow up. There seemed to be some cognitive dissonance between what upper management felt they were doing and what they actually did to support the program. That is, several administrators expressed significant interest in and enthusiasm for, the training program and believed that they were supporting staff to implement what they had learned. The LVNs were told about the program prior to their attending the sessions and were asked how they liked it following the training. For the most part, though, that was the extent of support. This lack of formal acknowledgement and infrastructure was expressed by some of the LVNs who attended the booster sessions. While they now recognized their leadership and supervisory roles, they were not certain how to execute their newly acquired skills within their organizations.

It is clear to the project team that replication of the training program should include more specific involvement of the facility's management group. A management-oriented module should be incorporated into the program to assist management in developing a formal implementation plan with input from and ownership by all staff. The plan should include policies and procedures that will support the new LVN roles, including new job descriptions, criteria in performance evaluations, inclusion in orientation programs and in-services and other mechanisms for supporting the LVNs and holding them (and others such as the DONs) accountable. In order to implement and sustain this type of program, there must be opportunities for encouragement to provide "teachable moments" where LVNs can work with CNAs and others on their units to build teams and to help their staff perform efficiently and effectively. Incumbent and newly hired LVNs should be exposed to this program and the natural mentors who emerge should be used to help sustain the training and skills and expertise acquired.

The Essential Role of the DSD

Another lesson learned is the current and potential role that DSDs play in training LVNs to be better leaders and unit managers and in supporting them as they work with CNAs to build teams and create a healthier work/care environment. Despite the fact that California mandates the DSD position, these individuals appear to be seriously underutilized, particularly as it relates to educating and supporting LVNs. The DSDs in the pilot sites had important relationships with

both the CNAs and the LVNS and, in most cases, were respected and trusted by both levels of staff. DSDs, therefore, could be the glue that supports the LVN training program and that creates the pivotal link between the LVNs and upper management.

Unfortunately, the DSDs are often spread too thin. The project team believes their fulltime role should be as a staff educator and that they should focus on leadership/management training as well as clinical issues, infection control and other topics generally addressed through in-services. California does require DSDs to obtain limited hours of training on how to fulfill their DSD responsibilities. One way to strengthen the LVN training program could be to incorporate this training into the DSD training to help DSDs become ongoing trainers and sustainers in this area.

Cultural Diversity

Recognizing that California is a very diverse state, the project team expected to find cultural diversity issues and challenges in developing this program. Focus groups with CNAs and LVNs, interviews with management and the training and booster sessions with the LVNs underscored the need to address ethnic and cultural diversity in the leadership training program and in the implementation back at the facilities. The majority of the LVNs (as well as most of the DONs and many of the CNAs) employed by the pilot facilities were from the Philippines. Through observation of the nurses during the training sessions and conversations with facility management, the project team learned that a number of cultural issues may impede the ability of these charge nurses to assert themselves in a leadership position. For example, the Filipino culture encourages deference to one's elders and superiors. This, of course, would make it very difficult for an LVN to see him or herself as a mentor to a seasoned CNA. The LVNs also expressed discomfort in the notion that they should approach and even confront upper management with their concerns about lack of support and their ideas about how to assume more of a leadership role. Some CNAs and LVNs from other backgrounds noted that the Filipino nurses often talked among themselves in their native tongue, a practice that created a sense of insecurity and discomfort among the non-Filipino staff. These examples underscore the importance of including cultural competence elements in any leadership training program as well as in the application of this knowledge in daily practice on the unit. While it is helpful to have a general cultural diversity session as part of an overall leadership program, some organizations may need a stand-alone program targeting the specific issues faced in their facility and taught by a cultural diversity expert.

6. Sustainability and Next Steps

To continue this project and engage others in providing LVNs with the skills needed to most effectively manage and supervise staff within long-term care communities, the project team has identified four potential strategies. These are:

- Dissemination of the project results and the training curriculum to interested stakeholders within California;
- Heightened awareness of the role the charge nurse plays in the delivery of high quality care;

- Development of educational programming designed to prepare a more sophisticated and knowledgeable LVN; and
- Expansion of the scope of the training program to improve its effectiveness and impact.

Each strategy is explained in further detail below.

Dissemination of the Project Results and Curriculum to Key Stakeholders

During the project planning phase, the project team identified four key stakeholder groups:

- LVN professional groups;
- The State Board of LVNs and Psychiatric Technicians;
- Associations, including Aging Services of California, the California Association of Health Facilities, the California Nursing Association, the Long Term Care Medical Directors Association and the Filipino Nurse Association; and
- The LVN educational system, including community colleges and private vocational training programs.

During the follow-up period of this project, the report and curriculum will be distributed to these stakeholders. In addition, meetings will be scheduled with certain key individuals and/or associations to provide a one-on-one debriefing of the project and recommendations on how best to use the teaching curriculum. These in person meetings are felt to be critical since the engagement level and support for the professional LVN is not strong in California and it is valuable to get people engaged in methods for better utilizing the LVN role. During these discussions, methods will be explored for how the curriculum components can be incorporated into educational programs and/or supported by CEU programming. Western Career College, one of the state's largest vocational educational schools, has already expressed interest in having the project presented to its program deans and instructors.

The project team will also work with peer associations to make presentations on the project and its findings. An educational session, for example, was held at the American Association of Homes & Services for the Aging Annual Meeting in October 2007. Through this presentation and conversations with other entities around the country, the project team has found high interest in this type of training program in other states as well. A full-day session of the LVN training program will be presented at the May 2008 Aging Services of California Annual Meeting. Aging Services will also present on the leadership training program at the California LVN Association meeting in April 2008.

Heighten Awareness of the LVN Role in Quality Care

As noted in the project team's early stakeholder interviews, the LVN and his or her charge nurse role is commonly overlooked. To increase awareness of the LVN and the role they play in the delivering high quality care, Aging Services of California intends to establish an LVN of the Year Award. The award would be presented annually during the association's Annual Meeting. The association is also developing a section on its website highlighting staff in retirement housing and other long-term care communities and will emphasize several LVNs from communities throughout the association's membership.

The project team also met with the state's Culture Change Coalition early in the project's development to discuss the program's goals and the connection to the Coalition's efforts. A more formal presentation will be made to the Coalition sometime over the next six months. It will be discussed whether the LVN role and/or portions of the curriculum could be used as part of the regional collaborative work being conducted by the Culture Change Coalition.

The project team has also discussed the role of the LVN and educational opportunities in California with the Legislative Analyst's Office (LAO). The LAO has a staff person dedicated to issues surrounding community colleges and has written an outstanding report on RN education. It is hoped that the office will similarly examine LVN training in community colleges.

Development of Educational Programming

Through the stakeholder interviews, it became apparent that many LVNs secure their required continuing educational units through CNA programs offered on site at the facilities. Offerings dealing with non-clinical issues are rarely available in these settings. Aging Services of California clearly sees a need and an opportunity for the development of focused LVN training. To that end, the Association has become a licensed CEU provider for the State LVN Board and intends to offer at least one one-day program for LVNs. In 2008, this program will build from the training program developed in this project. In the future, the Association will explore one-day meetings for LVNs held in both Northern and Southern California.

The Association is also plans to explore the concept of an LVN Geriatric Certification, which could be offered through certain vocational schools. Western Career Colleges is very interested in this concept and is willing to work with the LVN Board in developing such a program. The college has also indicated a willingness to offer scholarships to the program.

Expanding the Scope of the Training Program to Improve its Effectiveness and Impact

A key lesson learned in the pilot test is the importance of a direct link between the LVN training and a formal role for the facility's leadership team and staff developer. The project team will seek funding to develop and field test two new modules that can be integrated into the LVN training curriculum, including: 1) a module to assist nursing home managers to incorporate and support LVN leadership and supervisory responsibilities in their on-going operations, and 2) a module to train staff developers to implement and coordinate supervisory and leadership training for LVNs with their program of in-service education.

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Appendix A: Literature Review of the Role of the LVN in Long Term Care

A literature review was conducted to explore the role of the LVN, and to supplement the research team's experience in long term care research and development of adult education programs. Journal articles from 1990 onward were considered, along with applicability to this project. Nursing and business literature was reviewed using Proquest and Pubmed article databases. Relevant articles on mentoring and coaching and nursing supervision were reviewed. Articles specific to the LVN role were also sought using the terms "licensed nurse, LPN, LVN, and charge nurse." Due to the need to develop a training curriculum for LVNs, articles were also sought on adult education.

The article annotations contained on the following pages give a useful view of the plethora of literature available on adult education, mentoring and supervision. Though few articles were found specific to LVNs, relevant articles were reviewed and summarized. A brief description of themes is given below.

Mentoring and Coaching

A review of the literature resulted in a clearer understanding of what mentoring and coaching mean in the nursing literature. Within the profession, the differences between coaching, mentoring and preceptorship are blurred. Mentorship is a long-term relationship to improve both professional and psychological growth. Coaching is a continual process that focuses on the future, fosters communication and problem solving and nurtures trust. In contrast to both of these, preceptorship is for new nurses only, is short-term and focuses on job tasks only.

The literature recognizes several benefits of each type of professional activity. Mentoring has grown in nursing over the last decade and several interventions have been tested in hospitals and nursing homes, across various classifications of staff. While programs have faced several obstacles, including sustainability, there are several benefits to mentees that have come from mentoring type relationships such as increased intent-to-stay, personal growth and job satisfaction. The mentoring literature emphasizes the importance of “fit” between the mentor and protégée, as well as the need for incentives for mentors.

Coaching is seen as an essential skill for all nurses. It can be used for several purposes, such as coaching new nurses, peers and nursing assistants. There was little evidence in the literature that nurses were effectively using coaching in daily work, however. Coaching appears to be most commonly used in a preceptor model with student and new nurses.

Supervision and Leadership

Several studies have linked the supervisor-supervisee relationship to job satisfaction, self-confidence, burnout and absenteeism. In long term care, supervisors of nursing assistants are often LVNs/LPNs, thus the literature was reviewed with the intent of identifying essential skills for supervision and reviewing the outcomes of training programs.

Supervision is a complex and multifaceted role: managing knowledge, being a change agent, a team champion, a performance improvement facilitator and a customer advocate. In addition, supervisors need to look at big picture and analyze organizational support for employees. It is widely recognized that licensed nurses receive little or no training in supervision, with most nurses reporting it is a skill learned on the job, as they go.

A major theme in many nurse supervision studies is the need for organizational support of supervisors. This includes offering supervisor training and supporting attendance, opportunities for practice and follow up within the organization, and management acting as mentors for supervisors.

Staff Development/Adult Learning Strategies

Adult learners have unique needs in the classroom, and the literature offers strategies to address these needs. Studies from across disciplines report adults learn best by using experiential, action, and problem-based learning. These approaches might use strategies such as case studies, reflection and storytelling to encourage learners to engage in the curriculum.

LPNs, specifically, reported several barriers to participating in continuing education: cost, lack of time, relevance of offerings, personal priorities and lack of confidence. Nurses also reported the following problems with some training programs: they did not teach actual performance of skills, there were competing variables that conflicted with skill execution, and conditions in practice were different from the training scenarios.

As with supervision literature, the staff development literature supports the necessity of organizational support for staff attending trainings and transferring the knowledge they gain to the work setting. Organizational factors that contributed to training participation & knowledge transfer, as cited by nurses, included: funding available, staff coverage/scheduling, ability to implement new strategies.

To increase organizational involvement, some training programs successfully approached nursing home staff education by training multiple levels of staff (NAs, LVNs, RNs, etc) on the same topic, using some similar and some different materials targeted specifically to the trainees position. It did not appear that there were specific trainings for management for management beyond direct care staff supervisors.

The following pages contain article summaries arranged around the key topics of:

- Mentoring and Coaching
- Supervision and Leadership
- Staff Development/Adult Education
- Miscellaneous Relevant Articles

Mentoring and Coaching

Allen, T. D., Eby, L. T., & Lentz, E. (2006). Mentorship behaviors and mentorship quality associated with formal mentoring programs: Closing the gap between research and practice. *Journal of Applied Psychology, 91*(3), 567-578.

The authors conducted a study of 175 protégés from four different companies. The aim of the study was to examine the relationship between participant-reported formal mentoring program characteristics and perspective of both the mentor and the protégés relationship. A pencil and paper and Web-based survey were used to gather data. The Scandura 15-item scale was used to measure the extent of which mentoring was provided. A five-item scale developed by the authors was used to measure mentorship quality. Program characteristics and interaction frequency between mentor and protégé was also collected. Results showed that input into the matching process between mentor and protégé is more satisfying to both mentor and protégé. Mentors and protégé demographics do not play a significant role in the quality of interactions. Greater career mentoring occurred when mentor and protégé were paired in the same department. Rank did not determine a difference in relationship between mentor and protégé. Mentors who reported having high-quality mentor training were better able to provide psychosocial mentoring. Limitations to this study include: results from this study cannot be used to predict mentoring behavior or quality and all but two mentors were in a voluntary mentoring program. This study provides a first step in refining mentoring theories. Replication of this study and further studies are needed to develop mentoring programs.

Andrews, M. & Wallis, M. (1999). Mentorship in nursing: A literature review. *Journal of Advanced Nursing, 29*(1), 201-07.

This literature review centers around the history and outcomes of Project 2000, a curricula that changed clinical preparation of nurses in the United Kingdom. Project 2000 moved nursing preparation from a largely apprenticeship model to an academic course with a mentorship component. Mentors must be formally prepared via an academic course or 2-day preparation program. The literature review found a lack of clarity around definitions for mentors, and the United Kingdom relies on governing bodies to form the working definitions. the author asserts more training, monitoring and regulation is needed to formalize mentoring for nurses. The author found literature consistent around the idea that the rewards of mentoring are intrinsic for the mentor and more tangible for the mentee.

Barker, E. R. (2006). Mentoring--a complex relationship. *Journal of the American Academy of Nurse Practitioners, 18*(2), 56-61.

The article addresses the mentoring process for advanced practice nurses (APNs) and also gives suggestions regarding the formation, implementation, and termination of the mentoring relationship. Mentoring, although researched in other disciplines, hasn't been researched regarding APNs. It is important to first define the type of relationship between the new APN and mentor. If the relationship is more short-term, a preceptor relationship may be more sufficient. Expectations of both mentor and protégé need to be clearly defined before beginning the mentoring process. The author discusses poor qualities of a mentor such as, avoiders, dumpers, blockers, and destroyer/ criticizers. Protégés also have poor characteristics, such as smothering. If a problem occurs while mentoring, the first step is to acknowledge and identify the problem and determine the circumstances, which surround the problem. Both the protégé and mentor need to be honest and open to work on the problem. Perhaps a network involving others needs to be implemented. Mentoring is an important part of professional development in nursing and with open communication and working through problems, relationships can be maintained and flourish. Successful mentoring relationships improve professional growth, competency, and productivity. They also form the basis for ongoing preparation of a new generation of APNs.

Beverly, P. (2005). Mentoring in multiple dimensions. *Journal of Cultural Diversity*,*12*(2), 56-8.

Mentoring has become the hallowed pathway to success in almost every profession. However, life is more than a cause and effect equation. This article examines mentoring from a multi-dimensional perspective, with those dimensions encompassing the generational history, family belief system, cultural archetypes, individual learning style, and physical challenges inherent in people of one culture moving through a rigid educational system designed by people of another culture.

Block, L. M., Claffey, C., Korow, M. K., & McCaffrey, R. (2005). The value of mentorship within nursing organizations. *Nursing Forum, 40*(4), 134-140.

The article describes how mentorship programs may help to retain bedside nurses. By implementing mentorship programs, nursing satisfaction will be enhanced, therefore it will improve nurse retention and ultimately patient outcomes. Financial increases for the organization gained by implementing nurse mentorship programs are highlighted. Previous studies regarding the outcomes of mentorship programs are also mentioned, however, many of these studies were surveys to nurses with a low response rate. This article encourages hospitals to implement nurse mentorship programs.

Bryson, C. (2005). The role of peer mentorship in job satisfaction of registered nurses in the hemodialysis unit. *CANNT Journal, 15*(3), 31-4.

The effects of health care economic constraints and restructuring have had a deleterious effect on the job satisfaction of registered nurses. Canada is also experiencing an aging nursing workforce, and a nursing shortage due, in part, to stressful work environments. Concurrently, workloads are increasing as nurses in dialysis units care for older patients with many co-morbid conditions. Mentorship has been shown to positively impact workplace culture and job satisfaction for both the mentor and the individual being mentored. The role of peer mentorship within the context of a community-based hemodialysis unit is explored as a potential strategy to improve job satisfaction of dialysis nurses.

Cohen, N. H. & Galbraith, M. W. (1995). Mentoring in the learning society. *New Directions for Adult and Continuing Education, 66*, 5-14.

The authors explain the benefits of mentoring for adult learners as providing significant opportunities for personal and career development. In the workplace, it's noted that members of management are now expected to function more collaboratively with colleagues, thus creating a ripe field for mentoring. The author argues this can create synergy in the workplace, resulting in an improved organization and states managers that can function also as educator, or mentor, necessarily evolve into an orchestrator of human resources by increase staff effectiveness and efficiency.

Ehrich, L. & Hansford, B. (2002). A review of mentoring in education: Some lessons for nursing. *Contemporary Nurse, 12*(3), 253-264.

Ehrich & Hansford discuss the confusion about the terms mentoring and precepting, clarifying preceptorship as a relationship between an experienced nurse and novice colleague, usually for a short period of time on tasks specific to the job. A mentor, in contrast, can happen at various stages of experience, have a lasting relationship and works on person, career and professional development. The authors analyzed education literature for studies conducted between 1986 and 1999. Outcomes associated with mentoring were: collegiality, reflection, professional development, personal satisfaction, interpersonal skill development and stimulation (for mentors). Negative outcomes for mentors were: lack of times, mismatch, lack of training, extra burden, frustration with mentee performance, and conflicting role. For mentees, support, assistance with strategies, discussion, feedback, increased confidence and career affirmation were positive

outcomes. Negative outcomes were lack of mentor time, mismatch, critical mentors, difficulty with meeting/observation, lack of support and guidance, and lack of mentor training.

Fields, H. (1994). Coaching and mentoring (continuing education credit). *Nursing Standard, 8*(30), 105-110; quiz 111-112.

Fields describes general concepts of mentoring through a literature review and a focus on the relationship between managing and mentoring. This article aims to help better understand the process of mentorship that can help facilitate role development and personal support. Fields lays out four stages of mentoring which begin with initiation, continue with the middle and dissolution stages and ends with the restart stage. Through all of these stages, the mentor needs organizational knowledge, a good network, and the ability to open doors for the mentee and should continuously think about what they as the mentor will gain from the relationship. To frame the mentoring relationship and process Fields proposes a "Mentoring Contract" with seven points: 1) objectives should be outline carefully and in a way that it can be determined whether they have been met 2) necessary resources must be identified jointly (human and material) 3) actions to be taken should be clear 4) it must be clear how actions will be organized 5) it must be clear how progress will be demonstrated 6) it must be clear how progress will be evaluated 7) evaluation should be built into contract and include specific behavior change, areas that need work and who else will have input into evaluation, when that will be done and how it will be done. Fields states having more structure will make mentoring more effective and meaningful in all settings and will lead to improved job performance.

Firtko, A., R. Stewart, et al. (2005). Understanding mentoring and preceptorship: clarifying the quagmire. *Contemporary Nurse 19*(1-2), 32-40.

Mentoring and preceptorship; these two terms are widely used within nursing. The vast literature on mentoring and preceptorship defines these concepts as discrete roles. However, confusion exists as to what defines mentorship when compared to preceptorship. It is apparent that these terms are being used interchangeably, despite the obvious and not so obvious differences portrayed in the literature. The authors therefore have questioned whether the roles of a mentor and preceptor are discrete and unique or can be integrated into one role? Furthermore, is one of these constructs more appropriate to new academics whilst the other is more appropriate for nurses in the clinical setting? This discussion paper is a journey into understanding preceptorship and mentoring and the value of sustaining a relationship with both.

Greene, M. T. & Puetzer, M. The value of mentoring: A strategic approach to retention and recruitment. *Journal of Nursing Care Quality, 17*(1), 63.

The authors suggest the nursing process is an excellent template for mentorship. By taking the time to mentor in the beginning, problems can be curtailed later on. The authors developed guidelines for meeting times, a checklist and mentoring calendaring system to assist mentors and mentees in operating effectively. The guidelines for meeting times suggests a one-year relationship, with varying meeting frequencies and lengths based on stage of the mentoring relationship (there are five week-based stages). The mentee and mentor both complete a checklist that includes skills and competencies to discuss practice, and areas to establish goals around. Additionally, a calendaring system to support mentors and mentees is suggested for use. The system was implemented in one facility. An analysis of hiring and retention data showed a significant decrease in novice staff terminations since the inception of the mentoring tools.

Guidi, M. A. (1995). Peer-to-peer accountability. *Nursing Management, 26*(10), 48R.

Peer-to-peer accountability is an essential component of empowerment-based management models. To foster this environment, skills such as conflict resolution, team building, communication and group dynamics need to be identified and supported. The lack of peer-to-peer accountability can seriously hinder the development of management models. Guidi describes how

peer-to-peer accountability was developed and improved in her work unit. Strategies included consulting an organizational psychologist and implementing role modeling by a Coordinating Council and establishing a peer review committee to work through accountability issues in a positive and constructive manner. The role of the nurse manager is critical and the nurse manage needs to be able to assess the staff's communication and interaction style as well as be comfortable with relinquishing some of the control that is inherent in the traditional management structure. Developing peer-to-peer accountability fosters improved productivity and job satisfaction because of the increased amount of control given to staff.

Hurst, S., & Koplin-Baucum, S. (2003). Role acquisition, socialization, and retention: Unique aspects of a mentoring program. *Journal for Nurses in Staff Development, 19*(4), 176-180; quiz 181-172.

The authors are clinical nurse specialists at Banner Good Samaritan Medical Center in Phoenix, Arizona. To address the nurse shortage and retain nurses at their hospital, they developed an 18 month nurse mentoring program. Upon hiring, a new RN will be paired with a nurse preceptor. At three months, the new nurse may choose the preceptor as their mentor, or another nurse. Six month intervals goals are formulated and evaluated. A class was developed for the mentor to instruct how to be a mentor, tools a mentor may use, and how to deal with problems. A database was created to follow the mentor program. Mentors receive monetary incentives and an annual Nightingale Award is given to a nurse who was an exemplary mentor. Currently, the program has been in place for 1 year and facility data shows a 3.1% decrease in nurse turnover. A program such as this may be helpful to retain nurses, however, further research is necessary.

Hurst, S. M., & Koplin-Baucum, S. (2005). Innovative solution: Mentor program: Evaluation, change, and challenges. *Dimensions of Critical Care Nursing, 24*(6), 273-274.

This article is a further evaluation of the authors' mentoring program described in the article above. This article describes the BGSMC Mentor program implemented three years ago. Because this is a new program aimed at mentorship to retain nurses, it is reviewed frequently. Particular to this article, there are 181 mentor/ mentee pairs and 56 have completed the 18-month training. The reasons for drop out of the program include: physical difficulties, retirement, psychological changes to include suicidal ideation, advancement to another job, or illicit drug use. The two largest challenges of the program include: as the program grew, more time was needed from the creators to teach, and small nursing departments without many fulltime employees had less interaction with the program. Upon more evaluation, this program could possibly be used as a model for other hospitals to establish a nurse mentorship program.

Kalbfleisch, P. J. & Bach, B. W. (1998). The language of mentoring in a health care environment. *Health Communication, 10*(4), 373-92.

These U.S. communications professors tested 4 models on the relations among mentoring, job expectations, job reward value, job involvement, and organizational commitment of hospital nurses. Participants included 84 nurses from a 300-bed primary and secondary care hospital who previously had a mentor. Post-interview, participants received questionnaires focused on job involvement, mentoring, and job expectations. All of the questionnaires were based on a seven-point Likert scale. Results showed organizational commitment and job involvement were increased by job reward value. A direct effect on organizational commitment was found for mentor assistance in learning skills. The qualitative data showed that nurses mention a lack of respect that they receive from other workers and patients; this may be improved with informal mentor relationships. Limitations to this study include: the support given by mentors was not measured quantitatively and a control was not used in this experiment. Specific methods used by mentors to counteract perceptions of lack of respect conveyed supportive communication to their protégés by encouraging them to do their best, helping them gain additional training, providing support and encouragement when others criticize, helping deal with jealousy, and providing protégés with needed information. Nurse mentors were admired for standing up to administration and for challenging unfair decisions, thoughtless actions, and lack of respect on the part of

administrators, doctors, and patients. The qualitative data showed that nurses mention a lack of respect that they receive from other workers and patients; this may be improved with informal mentor relationships. Limitations to this study include: the support given by mentors was not measured quantitatively and a control was not used in this experiment. Implications of this study for nurses and those working in health care environments are that mentoring and organizational commitment may be avenues for increasing the degree to which nurses feel that their job is rewarding.

Kopp, E. M., & Hinkle, J. L. (2006). Understanding mentoring relationships. *Journal of Neuroscience Nursing, 38*(2), 126-131.

Kopp & Hinkle, researchers from England, describe mentoring as a career-development relationship and interpersonal process. In a traditional sense, mentoring is based on a business hierarchical pattern. A mentor chooses a mentee' and advises them as a subordinate. The mentor works towards increasing the power of the mentee.' There are limitations to this way of mentoring such as: misuse of power by the mentee' or unsatisfactory mentor relationships for women. Contemporary arrangements for mentoring permit an interpersonal relationship between the mentor and mentee.' A negotiable pact is decided between both mentor and mentee.' An open exchange of ideas enhances a greater communication. In the end, the mentee' should become a peer to the mentor and the mentee' may mentor others. Other means of mentoring can be accomplished through precepting, role modeling, and coaching. Nursing can benefit by contemporary mentorship because it passes quality nursing skill and knowledge from one nurse to another easily and enhances both the expert and new nurse's relationship.

Lankau, M. & Scandura, T. (2002). An investigation of personal learning in mentoring relationships: Content, antecedents, and consequences. *Academy of Management Journal, 45*(4), 779-790.

Lankau and Scanduras' study develops a taxonomy of personal learning, and introduces new 'measures' and explores personal learning as a mediator between mentoring and organizational consequences. Their study examines the relationship between mentoring and personal learning, as well as the impact of personal learning on satisfaction and turnover. Learning in the management literature is information seeking during socialization. Socialization includes acquisition of knowledge about: performance standards, important people, organizational goals and values, and jargon. These studies have all focused on newcomers and job changers. The research has touched on the need for ongoing learning in organizations. People need systems knowledge, the ability to look beyond themselves see relationships among organizational aspects. This sort of learning, according to researchers in adult learning, causes changes in behavior, attitudes and even sometimes the personality of the learner. Adult learning is actually the transformation of how someone sees themselves in relation to others. This requires sophisticated interpersonal skills. Personal learning is defined by Kram as "knowledge acquisition, skills or competencies contributing to individual development, including the interpersonal competencies of self reflection, self disclosure, active listening, empathy, and feedback." This involves people seeing themselves as increasingly connected to others. There are two important kinds of personal learning. First is learning about the context of work to see one in relation to others. The second is about developing interpersonal skills. Personal learning is not done in training programs, but comes from relationship to others. Interaction with others promotes self reflection. Encouraging someone to step into someone else's frame helps form a relationship with managers. Mentoring is important during organizational change as well.

Mills, J. E., Francis, K. L., & Bonner, A. (2005). Mentoring, clinical supervision and preceptoring: Clarifying the conceptual definitions for Australian rural nurses. A review of the literature. *Rural Remote Health, 5*(3), 410.

These Australian nurse midwife researchers discuss the similarities and differences of clinical supervision, mentorship, and preceptorship. In rural Australia, as in other parts of the world, nursing shortage is an issue. According to the authors a relationship between an expert and a

beginner, in the form of mentor, preceptor, or clinical supervisor, would help retain nurses. The three types of relationship are discussed via a review of literature. No conclusion was made to define each type of relationship. The information was displayed in a way for future nurses to read and explore the type of nurse mentor and mentee' relationship desired.

Nedd, N., Nash, M., Galindo-Ciocon, D., & Belgrave, G. (2006). Guided growth intervention: From novice to expert through a mentoring program. *Journal of Nursing Care Quality, 21*(1), 20-23.

Nedd and colleagues from the Miami VA Healthcare System discuss ways to empower nurses through a mentor program to facilitate development from novice to expert. Kanter first developed the empowerment theory for business world. This theory sparked the "Guided Growth Intervention," developed by the authors of this article, to empower those working in long-term care settings. The "Guided Growth Intervention" was also based on Benners "Novice to Expert" model, which focuses on the learners needs. A pilot study of the Guided Growth Intervention was conducted with 10 novice, full time nurses, five received the intervention, while five did not. In each group, there were four female and one male nurse. The perceived level of expertise was scored by the Guided Growth Self Assessment (GGSA). The nurses in the intervention group scored higher on the GGSA, meaning, their perceived level of expertise improved. This is a promising result to further develop a mentoring program, focusing on empowerment for nurses.

North, A., Johnson, J., et al. (2006). Ground instability with mentoring. *Nursing Management,* 37(2),16-8.

More than fifty percent of new graduate nurses leave their jobs in less than one year. Research on the issue has revealed this high rate of turnover is due to an inability to assimilate. North et al propose this situation can be changed through mentoring. Their description of mentoring involves mutual sharing and learning, a nurturing environment, respect, collegiality, affirmation, patience, loyalty and caring. The end result of mentoring should be both personal and professional growth. Many individuals may play a mentor but the mentor's job description must be clear and comprehensive so both the mentor and the mentee are aware of what will be involved in the mentoring role. In choosing the right mentor, North et al suggest following an interview guide to assess the skills, knowledge and motivation of the application. The authors believe effective mentoring programs can help with the difficulty new graduate students have in assimilating to new environments and remaining in their first position for longer periods of time.

Owens, J. K. & Patton, J. G. (2003). Take a chance on nursing mentorships. *Nursing Education Perspectives, 24*(4), 198-204.

The author uses mentoring literature and examples of dialogues that illustrate mentorship concepts. Factors impacting mentorship the author illustrates include, 1) Antecedent relationship factors such as individual characteristics, environmental factors, etc., 2) Relationship phases including recognition/development, emerging independence and letting go, and 3) Mentorship outcomes including perceptual and tangible outcomes. The author argues nursing must strengthen mentor connections to increase recruitment and retention and using e-mail to foster mentorships.

Rosenthal, S. L., & Black, M. M. (2006). Commentary: Mentoring--benchmarks for work performance. *Journal of Pediatric Psychology, 31*(6), 643-646.

Rosenthal and Black, hospital-based pediatric psychologists, address mentoring in terms of a professional activity. Although the authors declare mentoring is important in all professional settings, they focus on psychology. Awards, such as the Martin P. Levin Leadership Award given annually to a pediatric psychologist, are a good way to reflect on the importance of mentoring in a professional field. The authors also suggest that monetary compensation or promotion could be given to those who focus some of their work on mentoring others. The authors note benchmarks are needed to evaluate mentoring and state pediatric psychology is an exceptional field to

develop benchmarks for mentoring because they have the motivation and skills to develop empirically based benchmarks.

Stedman, M. & Nolan, T. L. (2007). Coaching: A different approach to the nursing dilemma. *Nursing Administration Quarterly, 31*(1), 43-49.

Stedman and Nolan posit that coaching is an answer high nursing turnover and the need for nursing retention. They argue unmet expectations are a primary reason for job dissatisfaction and resulting turnover. They suggest long term strategies such as changing to hiring practices that result in better fit, focusing on benefits the organization can offer and creating more beneficial polices are not enough to fill the short term needs in the industry. The short term strategy suggested is the Why We Work Here coaching program. The authors state coaching in terms of focusing on the future, creating strategies, creating trust, and two-way communication. A problem-solution matrix for Why We Work Here is presented with the WWWH intervention as the solution to worker dissatisfaction. No description of the program, nor an intervention study, are described in the article.

Tepper, B. (1995). Upward maintenance tactics in supervisory mentoring and non-mentoring relationships. *Academy of Management Journal, 38*(4),1191-1205.

Tepper explores the actions mentored individuals take in order to maintain stability in the relationship between themselves and their mentors. Tepper also explores the use of immediate supervisors as mentors, an area of mentoring that has not received a great deal of research attention even though these are the individuals most likely to be engaged in a mentoring relationship. Types of upward maintenance tactics discussed are: direct tactics such as joking, sharing personal experience, interaction at social events and unedited communication of personal views, regulative tactics such as limit or manage contact, limit emotional displays with superiors, avoiding delivery of bad news not asking for direction, overlooking negative comments, contractual tactics encompassing conformity to role, conformity to supervisor expectation. In-group subordinates were most likely to use direct tactics to achieve stability of relationship, while out-groups were more likely to use regulatory tactics. Supervisory literature suggests that supervisors use more democratic tactics with in-group mentees and more dominant styles with out-group people. Outgroup member interaction style reflects their powerlessness. Subordinates who trust mentors use personal and direct tactics. Tepper hypothesized both personal and direct tactics are used from most to least frequently: informal supervisory, formal supervisory, non-supervisory, non-protégé. The author was partially supported with results showing informal supervisory protégés reporting the use of more personal and extra contractual tactics and less use of regulative tactics. People in formal mentoring relationships were no different than non-supervisory protégés. Examining the tactics used by individuals in mentoring relationships can help with the development of mentoring programs which foster the development of stable relationships between mentors and mentees.

Tourigny, L., & Pulich, M. (2005). A critical examination of formal and informal mentoring among nurses. *Health Care Manager, 24*(1), 68-76.

In this article, the authors discuss how formal and informal mentoring can help both nursing profession and organizations by presenting advantages and disadvantages of each. Formal mentoring programs are implemented with assistance and approval from the organization, usually a contract exists between the mentor and protégé. According to the article, mentoring role should include career related roles and psychosocial roles which focus on development of the protégé while keeping organizational guidelines in mind. Advantages to a formal mentoring program include a protégés career enhancement from hierarchical mentoring, more job involvement, mentors may receive recognition such as compensation, and a mentor program can be designed to focus on nursing needs. Disadvantages of a formal mentoring program include: an experienced nurse may be an expert, but a poor mentor, their may be a role conflict, a contract may not permit a protégé to choose another mentor if the relationship is poor, and organizational

constraints may not allow mentors to feel inner compensation for their work. Informal mentoring is more unstructured, longer period of time, and the roles depend on the needs of both mentor and protégé. Advantages include: more personal feedback may be given from the mentor. Increased interactions with other nurses improve learning for the protégé. A less stressful environment may lead to a higher self esteem and willingness to improve. Disadvantages include: not integrating with the organization may lead to no future career planning. There is a general lack of recognition of a mentors' efforts. The lack of organization control may lead to poor and inconsistent mentor relationships. If an organization decides to implement a formal mentoring program, certain features must be taken into account. The organization must carefully plan and consider the needs of all involved in the program. For example, the period of time the program will need will be considered in the context of a nurses schedule. Mentors and mentee's should be evaluated and a discussion should occur at the end focusing on how the program will benefit them. Both mentor and mentee' should discuss when mentoring is no longer needed. This article is useful to nurses, both mentors and protoeges, or organization interested in mentoring programs.

Tourigny, L. & Pulich, M. A critical examination of formal and informal mentoring among nurses. *The Health Care Manager, 24(1)*, 68-76.

Tourigny and Pulich, management researchers, discuss the advantages and disadvantages of informal and formal mentoring programs amongst nurses. Advantages of formal mentoring programs are that the program objectives usually in line with the overall objectives of the organization, leading to higher levels of job involvement and organizational commitment, mentors receive formal recognition, and the organization reinforces its belief in the importance of the nursing professional through such programs. Disadvantages are that random assignment of mentors and mentees can lead to dissatisfaction and because the mentoring relationship ends with the end of the contract, the learning effects of such a relationship may be shorted lived. Advantages of informal training are: mentors are given more latitude in picking their mentees, nurses who are truly committed to the relations are more likely to participate in informal training, and the longer duration of these relationships lends to a greater learning potential. Disadvantages are that those outside the relationship may view the mentoring as favoritism, there is greater potential for role conflict, nurses who would make good mentors may never have an opportunity to find mentees, and the lack of organizational control means assessment of the mentoring can not be effectively done. Important to things to consider when developing a formal mentoring program are: selection of mentors and protégés, training of mentors, co – mentoring, duration and frequency of time dedicated to mentoring, contractual agreement, performance appraisal and compensation, budget and program effectiveness. The authors believe these elements must be thoroughly addressed when developing a nurse mentoring program; otherwise the program may do more harm than good.

Supervision and Leadership

Brocklehurst, N. (1997). Clinical supervision in nursing homes. *Nursing Times, 93(12)*, 48-49.

Brocklehurst is a research fellow in nursing at the Birmingham University's Health Services Management Centre. The author argues that the recent reorganization of the NHS and increased demand for nursing home services in recent years has created unsupportive environments for the professionals who work in these homes and as a result, the quality of the care they provide has suffered. Recent research on the impact of clinical supervision, mainly from Scandinavia, has led to findings indicating that clinical supervision can help to decrease burn out, improves colleague cooperation, increased self-confidence in one's work, and decreased absence rates among nurses. The author believes clinical supervision should be a part of all nursing homes, but this is not the case many government sponsored nursing homes or in the majority of independent nursing homes. As a result, nurses have become more creative in developing clinical supervision

networks due to the lack of support from the government or stakeholders in charge of the nursing homes. The author encourages great support by the government and independent sector for clinical supervision so that the work environment and care given in these facilities is improved.

Cromwell, S.E. & Kolb, J.A. (2004). An examination of work-environment support factors affecting transfer of supervisory skills training to the workplace. *Human Resource Development Quarterly, 80(4)*, 449-471.

Based at The Pennsylvania State University, Cromwell, the assistant manager of the Human Resource Development Center, and Kolb, an associate professor of workforce education and development conducted this study examining the effects four specific work-environment factors (organization support, supervisor support, peer support, and participation in a peer support network) had on transfer of training at one-month, six-month, and one year points following supervisory skills training. Trainees and their supervisors completed questionnaires collecting quantitative and qualitative date on the participant's perception of their own transfer of key skills from the training program and their perceptions of the four work-environment factors listed above. Results indicated that individuals who perceived greater support at various levels and participated in the peer support network transferred a higher amount of the skills and knowledge they had learned in their training session than those who perceived themselves and being less supported and who did not participant in the peer support network. It should be noted that this relationship among perceived support, participation in the peer support network, and transfer of skills and knowledge did not become statistically significant until the one year time point, suggesting the role time plays in creating and solidifying this relationship. This study provides evidence for the important of support from multiple levels and future research should include a larger sample and focus on each level of support so that its influence on transfer of skills and knowledge can be understood.

Ford, W. D. (1996). Shoring up nurse supervisors. *Nursing Homes: Long Term Care Management, 45*(5).

The article describes ways in which supervision can be strengthened. Seven keys are: respect, role clarification, communication, written policies, consistency, honesty, and training. Training is considered the key to making all keys work. The authors suggest that supervision training be an ongoing part of staff education and its importance emphasized by committing resources to it and personally participating in it.

Hoon Tan, H. & Tan, C.S.F. (2000). Toward the differentiation of trust in supervisor and trust in organization. *Genetic, Social and General Psychology Monographs*, 126(2), 241-260.

This study sought to expand the literature on trust by testing four hypotheses: (1) trust in supervisor is positively correlated with the ability, benevolence, and integrity of the supervisor, (2) trust in supervisor is positively correlated with a subordinate's satisfaction with his or her supervisor and the subordinate's innovative behavior, (3) trust in organization is positively correlated with procedural justices, distributive justice, and perceived organizational support, and (4) trust in organization is positively correlated with organizational commitment and negatively correlated with turnover intentions. The authors discuss a spill-over effect in which means that a subordinate may make inferences about the organization based on interactions with the supervisor. If this subordinate and supervisor have a mutually trusting relationship it effects the whole organization. Convenience and snowball sampling were used resulting in 220 (usable returned) self report questionnaires. Multiple scales were used to measure antecedents related to trust (satisfaction, innovative behavior, integrity, benevolence, ability) and outcomes of trust (commitment, turnover intention, distributive justice, procedural justice, and perceived organizational support). Regression analysis was used to arrive at results. All four hypotheses were supported. Multiple complicated relationships are described more clearly in the paper regarding specific antecedents and outcomes as they relate to trust in supervisor and organization. The total result indicates however that although trust in supervisor and organization

are significantly correlated, each has its own sets of antecedents and outcomes. Findings indicate that in order to strengthen the organization, managers should increase employee's perceptions that they are valued by the organization by offering rewards.

Jung, F. D. (1991). Teaching Registered Nurses how to supervise nursing assistants. *Journal of Nursing Administration, 21*(4), 32-36.

Most RNs have received little instruction in personnel supervision and this has led to reduced productivity and ineffective use of nursing assistants. A program was developed in a 40 bed med-surgical hospital unit to teach RNs how to supervise assistive staff and coordinate the delivery of patient care. A 4 hour educational program (given in 2 parts four weeks apart) was developed based on a prior pilot study. Role playing was included. The program had two underlying principles: RNs focus was on professional activities and they were responsible for directing NAs to meet patient basic needs. CNAs were observed better completing their jobs. RNs have been able to take more time for professional activities and have breaks and lunches. RNs were still uncomfortable evaluating CNA performance. Initial evaluation indicates RNs can be taught to use NAs effectively and increase productivity. In addition to the program, changes were made to job descriptions, work performance evaluation, and staff work load distribution.

Kleinman, C. S. (2003). Leadership roles, competencies, and education: How prepared are our nurse managers? *Journal of Nursing Administration, 33*(9), 451-455.

In the article, Kleinman, a professor of nursing, discusses the role of both nurse manager and nurse executive, focusing on the roles of each and their educational background necessary. Particularly, the article describes the perceptions nurse managers and nurse executives have about the other. After 35 nurse managers and 93 nurse executives completed a 22-item survey, findings showed that mangers and executives perceive their roles and necessary education differently. For example, 11% of nurse managers felt a graduate education was unnecessary to carry out their occupation, while 69% of the nurse executive group felt a masters degree was 'very to extremely important.' It is unclear how many nurse managers obtain a graduate degree. The author suggests that in order to further nursing leadership and maximize, nurse managers must be prepared in both management and practice.

Kroll, C. & Hoogendijk, L. (1996). Delegation and supervisory skills used by associate degree nurse graduates working in nursing homes. *Nurse Educator, 21*(5), 19.

The authors, masters prepared Registered Nurses, conducted a study to find out what supervisory skills were used by Associate Degree Nurses (ADNs). Nursing home ADNs were mailed surveys to find out work history and responsibilities that related to delegation/supervision. Twenty-two ADNs responded. The nurses were then interviewed in groups to find out what and how their approaches to supervision were learned and used. Results indicated delegation and supervisory skills were acquired through trial and error, consultation with supervisors, and watching others. Some nurses reported using the skills learned in school. The authors concluded there should be a delegation/supervision curriculum added to the ADN program and should include role-playing and simulated clinical situations.

Noelker, L. S., & Ejaz, F. A. (2001). *Improving work settings and job outcomes for nursing assistants in skilled care facilities*: The Benjamin Rose Institute, Cleveland, OH.

As part of a larger study of nursing assistants' job satisfaction, commitment and well-being, supervision of nursing assistants was investigated. Focus groups were held with approximately 40 nurse supervisors from five facilities. Most nurses reported their only supervision training was learned on the job. Some also experienced one seminar, in-services, workshops or a one-day orientation to supervision. Only 16 of 40 nurses reported learning any management topics in nursing school. When asked what they would like to learn about in general, nurses reported the desire for training in five areas: 1) How to be a manager, 2) Communication skills, 3) Motivating

staff, 4) Specialized Care, and 5) Miscellaneous issues such as refresher courses on vital signs, new medications, death and dying. When asked what would make their jobs better, nurses reported, reduction in documentation required, permanent assignment of nursing assistants to residents, hiring more staff, more support and understanding from management, limited use of agency nurses, training for head nurses, better supplies and equipment, on-site childcare and better pay. Four of these areas were similar to requests of nursing assistants: more staff, more money, better ability to motivate staff, better equipment and supplies. Nursing assistants had five areas different from nurse supervisors: better benefits, teamwork, more frequent union meetings, have nurses step into their shoes for a day and more respect.

Pacheco, L. (2005). The Southern California Presbyterian Homes licensed nurse leadership development model.

This article is a record of the discussion which took place regarding the SCPH Leadership Development Model. The purpose of this discussion was to strengthen the quality of nursing care for SCPH residents using the SCPH model which reinforces skills and best practices across the organization. The Model is an educational tool, assessment tool and personal and professional development tool. It aims to help new nurses learn how the best nurses work. It guides the identification of nurse's strengths and developmental needs and from this identification; professional development plans can be created. The components of the model are: knowledge manager, change agent**,** team play champion**,** performance improvement facilitator, and customer advocate. Each of these components highlights an essential part of the nurse's responsibilities and is aimed at improving nurse performance and the overall quality of care in nursing homes.

Patterson, T. (1996). Caught in the middle. *The Journal of Long Term Care Administration, Summer,* 37-38.

This article describes supervisors as the forgotten middle person between the front line workers and administration that are neglected to be trained well for their jobs. Many suggestions are made in this brief article about what training should include: job specific, people specific, and company specific components. Suggestions on implementation were not presented, nor was evidence of the effectiveness for any of the suggestions.

Rayner, D., Chisholm, H. & Appleby, H. (2002). Developing leadership through action learning. *Nursing Standard, 16*(29), 37-39.

This article seeks to explore how nurses gained leadership skills through action learning. The authors used action learning to help nurses in hospitals in the United Kingdom to develop leadership that focused on clinical care. Action learning offers a unique opportunity to develop leadership skills. Experiential learning cycles as described by Kolb and Pedler support this method of learning. Action learning must be voluntary with self-motivated participants. For this study, participants were nurses at two hospitals in the UK. Nurses were given ten sessions over a six month period and then asked to evaluate their personal experiences and the effect on patient care. Members of the group reported feeling more self confident. This article offers limited findings, as it offers only anecdotal evidence.

Sheridan, J. White, J. & Fairchild, T. (1992). Ineffective staff, ineffective supervision, or ineffective administration? Why some nursing homes fail to provide adequate care. *The Gerontologist, 32*(3), 334-341.

This study sought to test three hypotheses to investigate the extent to which the care provider's work attitudes, the supervisor's leadership behavior, and the administration's human resource management practices vary between nursing homes that provide adequate care and those that fail to meet quality standards. Sheridan, et al (1984) described 7 leadership behaviors that nursing supervisors demonstrate on a day to day basis: direction, delegation, assertiveness, recognition, reprimand, liaison and sensitivity. The sample for this study included 25 nursing

homes in Texas and Florida, a convenience sample was chosen to select facilities based on variety of ownership, size, and location. 530 staff members responded to a questionnaire that included three measures of staff member's attitudes: organization commitment, job tension, and cohesion. A varimax factor analysis was made of responses. A one-way MANOVA design was used to test the three hypotheses. There was a significant difference in workers attitudes between successful for profit and non profit homes, however, hypothesis 1 was weakly supported: nursing staff employed in homes providing adequate care will report higher commitment to the nursing home, higher staff cohesion, lower job tension, and more positive opinions regarding elderly residents than those working in homes that fail to provide adequate care. While there were significantly different supervisor leadership behaviors in for profit vs. non profit homes, hypothesis 2 was not supported: supervisor nurses employed in homes providing adequate resident care will demonstrate more active behavior on all leadership dimensions than those supervisors working in homes that fail to provide adequate care. Hypothesis 3 was supported: the organization climate in homes providing adequate care will be perceived as being significantly higher on human relations and task orientation dimensions and significantly lower on laissez-faire and status orientation dimensions compared with the organization climate in homes that fail to provide adequate care.

Smith, H., & Ortigara, A. (2006). A leap towards culture change. *Provider, 32*(2), 35-38.

LEAP is a research-based program targeted to nurses and CNAs in nursing homes working towards culture change. LEAP embraces the concepts of learning, empowering, achieving and producing. The LEAP program holds train-the-trainer sessions, where facilities can send two staff members (usually the Director of Nursing and another staff member) to be trained as LEAP specialists. These specialists return to facilities with plans, educational materials and tools to train nurses and CNAs in two core modules. Model one is targeted to nurses about their role in long term care. Module two, targeted to CNAs, is focused on developing care knowledge and advancing through career ladders. Additional training is offered for CNAs to advance to another level. In 18 organizations, 900 CNAs and nurses participating in LEAP were surveyed at baseline (pre-LEAP) and at three intervals post LEAP (6, 12, 24 months). Significant findings included improvement in job satisfaction for nuses and CNAs over time and sustained.

Thompson, N. (1992). Staff supervision: No place for on-the-job training. *Nursing Homes, 41(5)*, 15-18.

Thompson is Director of Corporate Training and Quality Assurance at the Ebenezer Society in Minneapolis, MN. In the article she discusses how their personal experience she realized that being a supervisor requires looking at the "big picture" and how supervisors must see how the organization is either supporting or hindering employees' abilities to perform their jobs. She lists several questions supervisors should ask themselves about the managers in the organization in order to assess how successful those managers have been in creating an environment conducive to productivity. Recommendations to meet management development training needs are listed and include planning, developing, and conducting programs using in house talent, hiring a consultant to provide training, or purchasing a packaged program. Whatever option is chosen, the author believes it is essential that follow-up systems be built into programs so that feedback regarding the effectiveness of the program can be attained and necessary adjustments made.

Staff Development/Adult Education

Amos, E. & White, M. J. (1998). Problem-based learning. *Nurse Educator, 23*(2), 11-4.

Amos and White from the Texas Tech University School of Nursing conducted an evaluation study on adult learning strategies. The researchers used a problem based learning strategy concerning specific patient case studies with groups of returning RN students. Analysis of the students' evaluation of the strategy revealed seven outcomes considered by the researches as

having stemmed from the PBL strategy: critical thinking, learning how to learn, creativity in learning, the link to community, teamwork, research skills and personal growth. The study concluded that adult learners evaluated problem-based learning activities very highly and reported better retention of knowledge than through other learning methods. The validity and value of this study are questionable.

Baillie, L. (1999). Preparing adult branch students for their management role as staff nurses: An action research project. *Journal of Nursing Management, 7*, 225-234.

Baillie, a nursing instructor in London, noted specific anxiety of diploma prepared nursing students surrounding the need for them to have "management skills." They did not feel they were adequately prepared and had varied experiences in the clinical setting. Senior nursing students, newly qualified staff nurses and ward managers were asked about their perceptions of skills and knowledge required of new staff nurses. Focus groups were used for students and new staff nurses, while questionnaires were used to collect data from ward managers. Students were most concerned about their ability to manage, especially given scare resources. They felt they did not have adequate preparation in dealing with a whole group of patients throughout nursing processes (e.g., referrals, discharges) nor did they work enough with supervising nurses given clinical scheduling. Staff nurses felt similarly, though identified delegation as an area they were inadequately prepared for, and felt a list of management skills to carry with them would be useful. Ward managers said their expectations of new staff nurses were maintaining health and safety procedures, working as a tem, handling issues with confidentiality, handling conflict, dealing with complaints, and acting as a mentor. The author modified student experiences in a test group of 28 students. Modifications in preparation included adding two more weeks of clinical placement with a focus on management, shadowing a supervising nurse for a shift, and the requirement of students to visit with different departments in the facility to understand how they all interact. 73% of the 28 students thought the extra time and work was worthwhile or very worthwhile.

Banning, M. (2005). Approaches to teaching: current opinions and related research. *Nurse Education Today, 25*(7), 502-8.

Banning performed a comprehensive literature review of computerized bibliographic databases, manual searches of journals, the bibliographies of retrieved articles and information from key informants. Her results revealed that many of the studies lacked follow-up evaluations, so evidence that knowledge from training programs is sustained in the long term is minimal. Many of the studies reviewed were marred with methodological issues detracting from internal validity. Additionally, attrition rates were very high, often near 50%. Therefore, the findings from evaluation studies of continuing education in LTC should be interpreted with caution. Most studies failed to consider organizational and systems factors that contributed to the implementation (or lack thereof) of new knowledge. The importance of considering organizational and systems factors was reinforced by the finding that several studies concluded that although training impacted knowledge as measure shortly after the training session, it rarely impacted behavior.

Bennett, J. (1999). Learning circles: Collaborating to promote RN and LPN role enhancement. *Nursing Leadership, 16*(1), 99-109.

Bennett, project coordinator for Learning Circles Project in Newfoundland, tells of the development of the project and results from the LPN and RN perspective. The project was mandated by Newfoundland nursing associations and was intended to "enhance the practice environments and working relationship between RNs and LPNs." The working relationship had become quite unclear to RNs and LPNs over the years due to changes in educational curriculums. Concerns regarding job protection and erosion were voiced by RNs, and LPNs expressed not being able to practice their full scope of work. Based on other countries success with learning circles in changing attitudes, clarifying professional roles and boundaries, the project adopted the model which included guiding principles and decision-making tools. Two-day workshops were directed by the project staff for RNs and LPNs develop skills in utilizing learning

circles. 20 regional sessions were held and each included a "project champion" from national nursing associations and councils. A Decision Matrix Tool was developed by the project staff to facilitate discussions and become a working tool. 292 nursing staff and 121 nurse managers completed the training. A questionnaire pre-training and post-training completion, with a follow up at three months post-session, was administered to all training participants. Results indicated few workplaces had fully implemented learning circles. Barriers reported were fiscal restraints, negative impact of vacations on the process, lack of management support. However, surveys indicated more clarity and positivity about LPN scope of practice changes from both RNs and LPNs. Results also indicated learning circles were effective as a method to respond to key issues.

Berta, W., Teare, G. F., et al. (2005). The contingencies of organizational learning in long-term care: factors that affect innovation adoption. *Health Care Management Review, 30*(4): 282-92.

Berta and colleagues from University of Toronto developed a contingency model of innovation adoption in long term care (LTC) facilities by applying the theoretical frameworks of knowledge transfer and organizational learning, and findings from studies of clinical practice guideline implementation in health care. They developed a set of 15 testable propositions that relate to factors operating at the guideline, individual, organizational and environmental levels in LTC institutions to stages of guideline adoption/transfer. Being based in both theory and research, this model offers insights in to the difficulties which often accompany adopting and retaining innovations in LTC institutions.

Brooks, N., & Moriarty, A. (2006). Development of a practice learning team in the clinical setting. *Nursing Standard, 20*(33), 41-44.

Brooks and Moriarty discuss practice learning teams (PLTs), primarily in the field of nursing. PLTs are a partnership between two organizations which use an action learning approach to provide support in the professional development of students and mentors. The action learning approach brings learners and teachers together in a setting to find solutions to a given problem. In finding a solution together, members of the group are able to develop themselves and a group as a whole. A PLTs success is determined by the groups' enthusiasm and motivation of the members. Institutions do not set aside time for PLTs, thus extra time is needed from both students and teachers. Although PLTs hold a promising framework to develop nursing students, much work needs to be done to further test and evaluate PLTs.

Cherry, B., Marshall-Gray, P., Laurence, A., Green, A., Valadez, A., Scott-Tilley, D. & Merritt, P. (2007). The Geriatric Training Academy: Innovative education for Certified Nurse Aides and Charge Nurses. *Journal of Gerontological Nursing, 33*(3): 37-44.

In 2002 the Texas Tech University Health Sciences Center and Garrisson Institute established the Geriatric Training Academy. Stakeholders helped shape the mission, which was "to advance the health care and quality of life for the ever-growing geriatric population, especially in minority and rural geriatric populations." In response to little geriatric training in CNA educational programs, the CNA curriculum included a 10 day session of modules focused on the role of the aide, resident rights, communication, self-care, and skills for the CNA in relation to geriatric care (resident environment, clinical skills, needs of older adults, and specialized care topics such as dementia and psychosocial needs). A clinical component of 24 hours of "hands-on" patient care, directed by the course instructor, is also included. An advanced CNA curriculum was also developed to look deeper at the issues of aging, elder abuse, nutrition, dementia, strokes, restraints, team building and conflict resolution. Applicants to the program must complete an interview questionnaire, a short essay and complete an interview and pass a criminal background check. The fee for the basic course is $50, as it had been the school's experience that those with no financial investment are less likely to complete a program. The LVN curriculum focuses on supervisory skills and advanced geriatric care training for charge nurses in long term care facilities. Topics of the coursed include leadership styles, organizational theory, conflict

resolution, communication, coaching, time management, problem solving, quality improvement, team building and compliance. There appears to be no formal application process for LVNs, as trainees are accepted upon recommendation from long term care facility leaders. A 3-day intensive RN program is also offered, focusing on aging, networking, sensitivity, cultural competence, end of life, and clinical issues of the aging. From 2003 to 2005, 749 nursing staff participated in training (167 basic nurse aide training, 276 advanced nurse aide training, 212 LVN training and 94 RN training). Initial evaluation has helped to modify content and resources available to trainees. Participants have also indicated a high level of satisfaction with the program.

Clayborn-Watson, M. F. (2004). Reasons for and barriers to participating in continuing education among licensed practical nurses in New York state. (Doctoral dissertation, Teachers College, Columbia University, 2004).

Clayborn-Watson presents literature to support the changing health care systems and the need for more generalists, thus indicating a need for more training and re-training of nurses. A randomly drawn sample of New York LPNs was mailed the Practical Nurse Continuing Education Survey developed by the author. The survey measured five factors to participation in continuing education: 1) escape/stimulation, 2) professional advancement, 3) social welfare, 4) external expectations, and 5) cognitive interest. 288 LPNs completed the survey. The most important reasons to LPNs to get continuing education (as reported in survey responses) were, in order of importance: professional advancement, desire for learning, social welfare, compliance with state mandates and escape/stimulation. The barriers reported, in order of importance, were: cost, time constraints, relevance of offerings, personal priorities, and lack of confidence.

Dwyer, R. J. (2004). Employee development using adult education principles. *Industrial and Commercial Training, 36*(2), 79-85.

This article provides a theoretical background, general principles and practical components of designing employee training and development activities reflecting the unique needs of adult learners. In adult education, the "teacher" becomes facilitator or guide. Learning is greatly facilitated by drawing on the students' life experiences. The author provides insights into 4 categories of methods for helping adult learners to learn as well as some other "pearls" of wisdom. Four categories of methods for helping adults learn (Cranton, 1989):

1. Instructor-centered (e.g. lectures, demonstrations, questions): efficient for low-level learning. Useful for starting a training session for anxious or dependent learners lacking knowledge or confidence in the material.
2. Interactive (e.g. discussion groups, group projects and peer teaching): facilitates cognitive and affective learning for adult learners who already have a firm grasp on the material. May cause anxiety in "new" learners.
3. Individualized (e.g. pre-fabricated packets based on particular learner characteristics). Based on the premise that people learn at different rates. Requires continual feedback to facilitate the learning process. Does not incorporate the learner's desire for peer interaction since the packets of info are often pre-generated based on particular characteristics.
4. Experiential (e.g. role playing, games): provides an opportunity for "learning by doing," particularly valuable for higher level cognitive learning as well as affective and psychomotor learning.

The author described the need to choose the category best suited to the unique group of adult learners and the need to provide a relaxed, comfortable and safe learning environment. The author also recommends coming up with ways to have the learners evaluate their own learning.

Flinn, J. B. (2004). Teaching strategies used with success in the multicultural classroom. *Nurse Educator, 29*(1), 10-2.

Flinn, from the Nassau Community College Department of Nursing, shares her personal experience teaching and later researching education in diverse classrooms. She includes her thoughts on the use of popular classroom teaching methods in diverse classrooms. Her literature review concluded that the literature recognizes a cultural divide between nursing students and nursing faculty wherein nursing students are increasingly culturally diverse, whereas faculty continue to be predominately White. Cultural differences may manifest themselves in communication and learning styles, ways of thinking and responding, and behavior that is thought to be appropriate in the classroom. Culturally diverse students often encounter difficulties in the classroom since the teaching/learning styles are often more consistent with the Euro-American worldview. Students (both White and non-White) agreed upon the importance of reinforcing communication skills, including reading, writing and speaking. The author offered her thoughts on popular classroom methods such as lectures, consistent outlines, visuals, content review, questioning, group work, cultural aspect of disease and note taking. This article can contribute to more culturally sensitive and effective teaching of both nursing student and nursing professionals.

Kaufman, D. M. (2003). Applying educational theory in practice. *British Medical Journal, 326*(7382), 213-6.

Kaufman discusses the implementation of adult learning strategies in medical education. His discussion on the theory behind these adult learning strategies includes examination of Knowles' 7 principles and how to get participants to reflect/share experiences from their own practice. Knowles' 7 principles include establishing an effective learning environment along with involving, encouraging and supporting the learner in multiple areas during the learning process. This discussion emphasizes the importance of asking learners, i.e. nurses, to reflect on their own practice when learning new ideas which may help to overcome some of the barriers to implementing new knowledge in practice.

LeCount, J. (2004). Education, empowerment, and elderly adults--enhancing nursing expertise in the long-term care setting. *Journal of Gerontological Nursing, 30*(3), 6-13.

LeCount describes a collaboration among a long-term care facility and local universities created to provide an advanced practice degree program for working nurses interested in gerontology. 20 RNs who graduated from the master's level program anecdotally reported increased confidence, critical thinking skills and use of research and evidence-based practice as a result of their graduate studies. The author concluded that more programs accommodating the complex needs of working nurses are needed to develop nursing expertise in gerontology. In a meta analysis of 34 studies on the effects of continuing education on nursing practice, Waddell (1992) reported positive effects; however, inconsistencies existed between the benefits claimed and the outcomes actually measured. RNs who graduated from the master's level program anecdotally reported increased confidence, critical thinking skills and use of research and evidence-based practice as a result of their graduate studies. The author concluded that more programs accommodating the complex needs of working nurses are needed to develop nursing expertise in gerontology.

Kemeny, B., Boettcher, I.F., et al. (2006). Using experiential techniques for staff development: liking, learning, and doing. *Journal of Gerontological Nursing, 32*(8), 9-14.

Kemeny and colleagues from the Project RELATE review the findings of a pre-experimental study examining the nursing staff's reactions to and the benefits from experiential techniques used in Project RELATE. A total of 77 nurse and CNA volunteers completed training reaction and knowledge scales following each training session during a 5-week period and a final scale 2 months following the last training session. The results suggest that experiential learning is an effective and enjoyable educational technique for continuing education for nurses and CNAs. There was a high amount of agreement among participants that the training sessions were enjoyable. Two months following the training, both CNAs and nurses reflected positively on the training, but CNAs were significantly more positive than RNs. CNAs and nurses retained most of the knowledge gained during the training, but nurses answered significantly more questions

correct than CNAs. This finding may be related to greater comfort taking written tests by nurses than CNAs. The most important limitation of this study was that it failed to examine indicators of implementation of the new knowledge. Findings suggest experiential techniques are efficacious as learning methods.

Koenig, J. M. and C. R. Zorn (2002). Using storytelling as an approach to teaching and learning with diverse students. *Journal of Nursing Education, 41*(9), 393-9.

Koenig and Zorn describe storytelling as an approach to teaching and learning that develops from the lived experiences of those involved that is useful for helping students to make sense of their lives and an approach to help diverse students with various learning styles. The value of storytelling as a teaching-learning approach is storytelling's facilitation of thinking, enhancement of imagination and visualization, fostering development of appreciation of the beauty and rhythm of the language, support for review and understanding of nursing situations, strengthening the creation of caring communities and linkage of theory and practice. Koenig and Zorn also advocate storytelling's ability to help a diverse population of students such as those with academic difficulties, physical disabilities, older students and culturally diverse students.

Methot, L. L., Williams, W. L., Cummings, A. & Bradshaw, B. (1996). Measuring the effects of a manager-supervisor training program through the generalized performance of managers, supervisors, front-line staff and clients in a human service setting. *Journal of Organizational Behavior Management, 16*(2), 3-25.

This study aimed to evaluate the effects of a supervisor training program which was designed to increase the extent to which supervisors use objective measures and contingent consequences when monitoring performance of direct care staff. The authors cite Reid's three reasons for unsatisfactory training outcomes: programs do not teach the actual performance of skills, there are competing contingencies and variables that conflict with execution, and conditions in practice are different from training situations. There is a need for organizational support to carry out and maintain a program, development of skills is not enough. Additionally, performance feedback has been demonstrated to be a necessary component in changing on-the-job skills. This works best when in combination with other behavior change procedures. Komaki, et al. (1986) have developed the Operant Supervisory Taxonomy and Index (OSTI) tool to facilitate the measuring of supervisor behavior, however it has not been tested in human service settings. For this study, the authors used measures of skills from the training program in on the job interactions. Portions of the OSTI were used to accomplish this. In addition, measures of performance were collected and data that indicated whether there were noticeable changes in direct care staff and client behaviors. Study was conducted in an employment training center and residential facility for persons with developmental disabilities. Participants in the training were one manager and four supervisors. Observation of seven direct care staff and 16 clients was also a component of this study. Supervisors were exposed to a three hour session of didactic training, outlining the need for goal setting and feedback. After the session the participants watched a video that described performance feedback in human service settings and demonstrated 10 components of a formal supervision meeting. Behaviors (negative, positive, or neutral) of supervisors, direct care staff, and clients were observed randomly. Desired behavior changes occurred for all subjects at the supervisory/management level, 6 of 7 staff subjects and 9 of 15 clients (for target behaviors measures) and 8 of 12 clients (for on-task measures). However, there was much variability among baseline and post training outcomes and authors relate finding the variability to random sampling and the other duties that each subject is responsible for.

Morse, J. S., Oberer, J. et al. (1998). Understanding learning styles. Implications for staff development educators. Journal *of Nursing Staff Development, 14*(1), 41-6.

Morse and colleagues survey learning styles, how to assess RN learning styles and the implications of using a learning styles approach. The authors argue that understanding learning styles is important for optimizing the learning experience for each participant. An overview of

learning styles as articulated by Dunn and Dunn (1993) as well as strategies for teaching tactual and kinesthetic learners was provided. An unstated assumption in this article was that strategies for teaching tactual and kinesthetic learners are not as obvious as those visual and auditory learners. The authors present information for understanding diverse learning styles among RNs. Various learning-style assessment tools are presented. Emphasis is placed on the use of a learning-style instrument that addresses multiple learning-style constructs. Implications for staff development educators are discussed.

Sadler-Smith, E. (1996). Learning styles: A holistic approach. *Journal of European Industrial Training, 28(7)*, 29-36.

Smith, a researcher in the Human Resources Studies Group in the United Kingdom, argues there is a lack of a common framework and understanding of the concept "learning style" amongst research and human resource development practitioners. He suggests that "learning style" is a dimension of a larger concept that is "personal style". The author examines how personal style can affect learning preferences and performances and supports his argument by citing several research studies. Profiling personal styles is then discussed in terms of how to identify an individual's learning style so that that the training can be tailored to each individual. Understanding, identifying and adapting to an individual's style is an important ability for human resource development practitioners because individual may be more apt to retain their training if it is done in a way that suits their needs.

Shanley, C. (2004). Extending the role of nurses in staff development by combining an organizational change perspective with an individual learner perspective. *Journal for Nurses in Staff Development, 20*(2), 83-89.

Shanley categorizes nurses in staff development as occupying several "middle grounds" between clinicians and researchers and clinicians and administrators. The article suggests staff developers need to focus beyond individual learners and look at how education programs support ongoing change in the organization. The concept of "action technologies" (Marsik & Watkins, 1999) provides a framework that encourages learners to work together to develop solutions to real-life problems and promoting systems change. Shanley explores characteristics that might enhance the staff developer in using this technique: 1) Becoming familiar with issues in the workplace, 2) gaining support from management, 3) gaining support from learners, 4) introducing systems for ongoing use in the workplace, 5) encouraging a comprehensive analysis of existing systems, 6) providing resources for training other staff (train-the-trainer), and 7) providing directed support to learning in the workplace (developing structure). Shanley then provides a case study of a staff development program and walks through how the program addresses each step.

Stevens, A. B., Burgio, L. D., Bailey, E., Burgio, K. L., Paul, P., Capilouto, E., et al. (1998). Teaching and maintaining behavior management skills with nursing assistants in a nursing home. *Gerontologist, 38*(3), 379-384.

This article describes the results of a behavior management skills training program in a 238-bed nursing home. Nursing assistants, registered nurses and licensed nurses on the weekday shift participated, thought the material and session was directed at NAs. Research staff taught behavior management content over three days for a total of a five-hour inservice. LPNs were separately taught supervisory skills over three weeks by the research staff. Following the training, nursing assistants began on the job training in collaboration with RNs and LPNs on their units. Research staff evaluated NAs during bedside ADL provision using the Behavior Management Skills Checklist. Self-monitoring and Behavioral Disturbance checklists were completed by NAs for at least four weeks post training. LPNs completed Feedback evaluations and Behavioral disturbance checklists for some participants during this time, also (titled Formal Skills Management unit). Observational data was collected pre-training, immediately post-training, and every four weeks for one year. Findings indicate NAs behavioral management skills knowledge increased post-training and on-the-job training appeared to increase performance.

Additionally, the unit with Formal Skills Management (LPN monitoring) demonstrated greater skill usage over time.

Stolee, P., J. Esbaugh, et al. (2005). Factors associated with the effectiveness of continuing education in long-term care. *Gerontologist, 45*(3), 399-409.

Stolee and colleagues present the results of two related studies that examined factors within the long-term care environment that affect the use of knowledge gained from continuing education programs. Study 1 consisted of focus group interviews of nursing home staff and management to elicit information about moderators and inhibitors of implementation of new knowledge from continuing education. Study 2 utilized the Delphi technique to enable a panel of long-term care stakeholders to evaluate organizational factors for importance and feasibility of change. The studies collectively supported the notion that management support for continuing education and change is critical to the successful implementation of new knowledge. Indicators of unsupportive management, according to staff, limited access to CE due to limited funding, staff coverage/scheduling issues, and an inability to implement new strategies. These organizational issues need to be absence in order to maximize the effectiveness of implementation of new knowledge from CE. These findings support the notion that organizational support is necessary for continuing education programs to be effective and support is needed to reinforce learning.

Tryssenaar, J. (2004). Providing meaningful continuing education in a changing long term care environment. *Journal for Nurses in Staff Development, 20*(1), 1-5.

This author highlights the problem of moving new knowledge gained from continuing education into practice in healthcare. For continuing education to be meaningful in long term care, Tryssenaar indicates it must be relevant, convenient to learners, brief, have low time demands, and include all staff who are involved with residents. The article then presents delivery of a CE program to all staff in municipally operated long term care facilities in Thunder Bay, Canada. The approach was a 30-minute in-service of mini-sessions at the afternoon change of shift. Each session was repeated three times to allow everyone to participate. An informal survey of staff was used to determine training topics. The content was then developed to be attitudinal, rather than skill based, based on the feedback and needs of the wide range of staff. Educators considered, 1) timing of the program, 2) what could be achieved, 3) how to link needs of all staff and resident care provision, 3) what outcomes were desired. The format of the in-services consisted of five steps: 1) warm up chat, 2) brief didactic information, 3) storytelling, 4) application and 5) cool down chat. Staff evaluated sessions positively and outcomes noted by observation of the researchers was the critical mass engaged in discussion upon return to work.

Werrett, J. A., Helm, R. H. & Carnwell, R. (2001). The primary and secondary care interface: The educational needs of nursing staff for the provision of seamless care. *Journal of Advanced Nursing, 34*(5), 629-638.

The authors sought to identify nurses' perceptions of their needs to provide seamless care to patients. To provide seamless care, state the authors, nurses need to have a clear understanding of the roles, skills and resources every department and practitioner in patient care possesses.1452 nurses across three healthcare organizations with both hospital and community based sections in the United Kingdom were targeted for participation. The nurses of varying levels of experience and responsibility participated from med surg and primary care settings. Focus groups (N=17 participants) were used to develop a questionnaire and questionnaires were distributed to 722 identified staff. 172 of nurses responded to the questionnaire. Seven training categories were identified by participants as important to provision of seamless care: information technology, awareness of roles, communication among practitioners, working across boundaries, professional issues, practice issues, delivery of patient-care issues.

Williams-Perez, K. & Keig, L. (2002). Experiential learning: a strategy to teach conflict management. *Nurse Educator, 27*(4), 165-7.

Williams-Perez and Keig of Allen College described an experiential learning activity implemented in an undergraduate nursing program to help prepare future nurses to manage conflict appropriately. The two researchers drew from David Kolb's position that learning occurs in one of four ways:

1. Concrete experience-personal involvement in a specific experience
2. Reflective observation-reflecting on the experience from multiple perspectives
3. Abstract conceptualizations-the drawing of logical conclusions or creation of logically sound theories
4. Active experimentation-decision making and problem solving

Furthermore, greater depth in learning is expected when all four ways of learning are incorporated in teaching plans. The authors reported that class participation increase substantially when implementing these learning/teaching strategies and student responses were overwhelmingly positive. This article illustrates an example where experiential learning was effective and that experiential learning's applicability is wide reaching and one to consider when planning nursing education.

Zapp, L. (2001). Use of multiple teaching strategies in the staff development setting. *Journal of Nurses Staff Development, 17*(4), 206-12.

Zapp of the King's Daughters' Hospital and Health Service examined whether the use of a variety of teaching strategies in the staff development setting would affect learner outcomes with regard to knowledge acquisition and participant satisfaction. The author recognized that most of the literature available about adult education is anecdotal as opposed to research-based. The author attributed this mainly to the idea that research on teaching is easily confounded. Zapp's theoretical framework was Watson's theory of caring. This theory emphasizes human caring as the basis for nursing education, research, and clinical practice. This study utilizes one of Watson's 10 carative factors that form a structure for studying and understanding nursing as the science of caring, transpersonal teaching-learning. This involves three processes engaged in by both the learner and the educator: imparting information, consideration of the nature of learning, and interpersonal processes that facilitate learning. This study also utilizes Watson's concept of transformative thinking, the belief that knowledge development and the teaching-learning process incorporate more than just rational, cognitive, technical and empirical domains. Factors should be considered such as promotion of active learning, acceptance and respect of the learner's individuality and uniqueness, and the use of multiple teaching strategies that appeal to a variety of learning styles and preferences. Findings indicate that the use of a variety of teaching strategies in nursing education can result in positive learner outcomes.

Other

Kruzich, J. M. (1995). Empowering organizational contexts: Patterns and predictors of perceived decision-making influence among staff in nursing homes. *The Gerontologist, 35*(2), 207-216.

The study was performed to develop measures of perceived staff decision-making influence, find patterns, and determine predictors of perceived influence for DONs, DOSS, DAT, charge nurses, and NAs in nursing homes. There is a lack of empirical evidence in the literature that discusses organizational variables believed to contribute to lowering perceived control among nursing home staff. Questionnaires were given to DON, DAT, DOSS, charge nurses and NAs in 51 nursing. The questionnaire included Likert scales on perceived influence on personnel and resident care issues. Factor analysis using varimax rotation was done as well as Eigen values and a screen test. Various relationships were found between the staff groups and their perceived control. There was a surprising amount of influence in personnel decisions by the DAT. The DON had highest level of perceived control in personnel and resident care areas. Other staff patterns were correlated either with no significant relationship, a positive one, or a negative one. Of particular note, inclusion of NAs in shift report significantly increased the NAs perceived control. NA

perceived control and charge nurse perceived control were positively correlated. Also, the article suggests because of the link between commitment to the organization and perceived control, two thing should be considered – including NAs in report and the use of staff unit meetings as an important device for team decisions.

Nolan, M., Nolan, J. & Grant, G. (1995). Maintaining nurses job satisfaction and morale . *British Journal of Nursing, 4* (19), 1149-154.

This study seeks to identify concerns and strengths in nursing profession.
Price Waterhouse (1988) suggests "concerns" of endangered nursing profession fall into five categories; 1. pay and working conditions, 2. workload factors, 3. management attitudes, 4. career prospects and 5. professional development. Strengths of the profession is the opportunities to help others. Nurses need to feel valued and respected and to have opportunities for growth and development and to feel the quality of patient care is being maintained. The authors mailed surveys to nurses, midwives and health visitors in Wales. A total of 1640 nurses, midwives and health visitors responded (41% response rate). Questions focused on perceptions of change, work environment and satisfaction & morale over the last 12 months measured. Respondents used a Likert five-point scale to answer questions and were provided with open ended questions about contributing factors. 86% of respondents gave qualitative responses to questions in the form of comments. Key findings:Only 8% cited opportunities for professional development as an available enhancer of job satisfaction and morale.

Pennsylvania Nurses Association. (1995). PNA position statement: Role of the LPN.

The Pennsylvania Nurses Association issued this position statement in 1995 in response to the growing use of LPNs in the healthcare sector. The statement distinguishes the RN & LPN. Duties not expected to be performed by LPNs include: management and direction of nursing care, comprehensive health assessment, complex problem solving and independent nursing judgments based on knowledge of nursing science, pathophysiology and social science. Accountability of the RN to the client for the quality of care delivered further distinguishes the RN from the LPN. The LPN "performs nursing acts which do not require the skill, judgment and knowledge required in professional nursing (RNs)." The LPN "shares in the giving of direct care to patients based on an education curriculum that is broad based and limited in depth."

Seago, J. (2000). Registered nurses, unlicensed assistive personnel, and organizational culture in hospitals. *Journal of Nursing Administration,30*(5), 278-286.

This study that aimed to investigate thinking and behavioral styles that are used to measure the concept of organizational culture among Registered Nurses (RNs) and Unlicensed Assistive Personnel (UAP) in acute care hospitals. The Organizational Culture Inventory was used, specifically the subscales on thinking and behavioral styles to discover if there was a relationship between job position and thinking and behavioral styles. Five tertiary care hospitals in United States were selected for participation. A convenience sample was recruited and resulted in 885 staff members that completed questionnaires. Only 525 had complete data (448 RNs and 77 UAPs). The study was cross analytic and used multiple regression analysis. Results indicated that position predicted many thinking and behavioral styles. UAPs predicted dependent and oppositional styles. Ethnicity predicted approval, avoidance, and competitiveness styles. These results are important for understanding how RNs managers can facilitate a positive work environment by increasing positive recognition of UAPs, by listening and acting on suggestions by the UAPs, and allowing UAPs to make decisions as much as possible about their work. By doing these things, the may be a reduction in criticism and resistance to authority by the UAPs. In addition, the two groups had similar scores on humanisitic, helpful, achievement, competence, and other styles meaning both groups seek positive interpersonal relationships.

Yoder, L. H. (1995). Staff nurses' career development relationships and self-reports of professionalism, job satisfaction, and intent to stay. *Nursing Research, 44*(5), 290-297.

This is a study of U.S. Army nurses' experience with career development relationships. Career development relationships were classified as coaching, precepting, sponsoring, peer-strategizing and mentoring. These relationships were correlated with variables of developer and protégé characteristics and outcomes of the relationship (intent to stay, job satisfaction). The Alleman Mentoring Scales Questionnaire was administered to 390 Army, active duty staff nurses. 61% of respondents experienced a career development relationship (50% coaching, 23% mentoring, 14% precepting, 8% peer strategizing, 5% sponsoring). Higher education and Army rank was positively correlated with coaching and mentoring. The majority of responses reported career development relationships had a high impact on their professional life, and a low impact on personal life, and only a slightly higher impact on their intent to stay. Coaching was perceived as the most valuable relationship compared to other types.

Appendix B: CNA Focus Group Protocol

1) **Introduce facilitators**: provide brief description of experience working in long term care, current position and role on project.
2) **Brief introduction of participants:** length of time in position, size of home, role in facility
3) **Explain the overall project**: purpose of the project is to create a training program for LVNs who might be interested in becoming better charge nurses, learning how to supervise, support and assist CNAs, participating in the development of CNAs who want to learn more and improve their skills and knowledge.
4) **Explain the purpose of the focus group**: to learn from CNAs how charge nurses affect their ability to do their jobs (for good or not), to learn from CNAs what nurse supervisors might do that would make them more effective supervisors, to learn from CNAs what else could be done to assist them in being more effective CNAs.
5) **Ground rules/confidentiality:** would like people to be able to speak openly so we are asking that what people share will stay in this room. Let's try not to use names or names of facilities so people feel free to say what they are thinking. We will not share anything with your employers or other employees and we ask that you do the same. We would like to record the session if everyone is comfortable with that. This is more accurate than notes. No one but the research team will hear the tapes. We will destroy them when we are finished with the study. The tapes will be kept at the University of Wisconsin, in Madison Wisconsin.
6) **Thank the group for participating**: We know you are busy and we are not paying you much, just a token. We appreciate your willingness to help us and your commitment to improving long term care.
7) **The process**: We have developed some questions that I will ask the group. We want to be sure that we hear from everyone so I will ask a question, give you a bit of time to think about it, and then ask you to respond. I hope you don't mind, but if only a few of you are talking, I may ask some of the others what they think, just so we are sure to hear from everyone. I will start by asking you some very general questions. This will give you the chance to tell me whatever you think is important. There are no correct answers. I consider you to be the experts in CNA work. You know better than anyone, what the work is like and what would improve the quality of care and the quality of your work life. I would like to hear about both of these things, quality of care and the quality of your work life. So when I ask questions, please think of both. I have a few more specific questions that I will probably ask as well. I will ask you to try to give some examples. For instance, if you tell me that there is a charge nurse who is really supportive, I will ask you to tell me what the charge nurse does, specifically, that you think is supportive. Finally, I will read a few descriptions of situations and ask you to comment.

Take questions from the group

1) Let's talk about the charge nurses you work with. How would you describe their job? What do they do? What are they responsible for?

   Now think about how their work relates to you. How do charge nurses affect you and your work? (I know that at least some of you, maybe most, will say that you work pretty

independently, that the charge nurse doesn't really affect your work. So, I would like you to think about examples of charge nurses who had some influence on what you do, how you care for residents and talk to me about that). What are some things they might do (or not do) that could have a negative affect on the care you provide?

2) Can you talk about the things charge nurses do that affects how you feel about your job, the quality of your work life?
3) Some charge nurses think that an important part of their job is supervising CNAs and the work that CNAs do. What sorts of things might a charge nurse do that is part of supervising? (in addition to things you have already mentioned). What would a good supervisor do?
4) Now imagine that you are a charge nurse. You have worked as a CNA for many years and have just finished the LVN course. How will you work with the CNAs on your unit? What would you do that is the same or different than what you are used to seeing charge nurses do? For each suggestion you have, tell me what difference you think it would make o the CNA and to the residents they are caring for.
5) When a resident with a condition you are not familiar with is admitted, how would you learn the best way to take care of the new resident? What is the supervisor's role if any?
6) When a new CNA is hired, what is the supervisor's role?
7) Can you think of a time when you had been doing something in a particular way for a long time (toileting residents every two hours)? Then you learned that there was a better, more beneficial or easier way to approach the care. (Stop and get them to think of something).
   - Were you able to use the new approach?
   - How did you learn the new skills, organize your work differently, or whatever was required to provide more effective care?
   - What, if anything, did the charge nurse do to help you change the way you were doing this?
   - What might she have done that would have helped?

Case I: Let's talk about how new CNAs learn their work and how CNAs learn to care for residents with conditions they are not familiar with. For example, let's say that a new resident is admitted to the unit where you work. The resident has right-sided paralysis and is unable to speak. That's all you know about her. A new CNA has been assigned to her. You notice that both the breakfast and lunch trays were taken from the resident's room with very little eaten. The CNA writes on a shift report sheet that the resident was not very hungry.

- What would a good supervisor do in this instance? (Provide as much detail as you can.)

Case II: There is a bit of tension between two groups of CNAs on a unit. They are from different cultures with very different ways of doing things and different ideas about how to show respect to co workers and residents. Can you think of any situations like this? (Discuss the situations in some detail if they offer. Otherwise go on with the scenario.) The nurse and several CNAs are from a culture where age and longevity of employment are highly respected. Nurses and CNAs who have worked for a long time in the nursing home are viewed as experts, their opinions are respected, and they are looked to for guidance on most care issues. One of the residents has become quite agitated and there is a difference of opinion on how to handle the situation. Some of the CNAs believe that the family should be involved in the discussion and should be very central in the decision about how to handle the resident. Some of the CNAs

believe they know the resident well, have known the resident for a long time, have a lot of experience in handling aggression in residents with dementia, and have clear ideas about how to proceed. The charge nurse and one of the new CNAs have attended an in-service on handling aggressive residents with dementia.

- What is the best way to proceed?
- What is the supervisor (charge nurse) role in this situation?
- Does the culture issue matter?
- What would you do?

Case III: When you arrive at work, you are disappointed to learn that you are teamed with Alice, a coworker who you think is lazy. Somehow Alice is never around when the unpleasant things need to be done. She leaves residents in a mess, just barely does what she is expected to do. You end up doing much of her work and resent it.

- What would you expect from a good supervisor?
- What usually happens?
- What would you do if you were in charge?

Summary Questions:

1) If we asked a charge nurse what her job was, and about what CNAs should expect from her, what do you think most charge nurses would say?
2) Pick out, in your mind, the best and worst supervisors (charge nurses) you have worked with. Please don't tell me their names. How do you think they would each answer the question about what CNAs could expect from them?
3) Now let's try to sum up the qualities of a good charge nurse and how that charge nurse would work with CNAs.

Appendix C: LVN Focus Group Protocol

1) **Introduce facilitators**: provide brief description of experience working in long term care, current position and role on project.
2) **Brief introduction of participants:** length of time in position, size of home, role in facility.
3) **Explain the overall project**: purpose of the project is to create a training program for LVNs who might be interested in becoming better charge nurses, learning how to supervise more effectively, participating in the development of CNAs who want to learn more and improve their skills and knowledge, and helping other LVNs learn these same skills.
4) **Explain the purpose of the focus group**: to learn from LVNs how they see their relationship with CNAs, whether you think it's your responsibility to supervise the work CNAs do, and if so, how you do that. Also, we want to know how you deal with some specific situations where you might be called on as charge nurse to oversee, mediate, and solve problems or disputes.
5) **Ground rules/confidentiality:** would like people to be able to speak openly so we are asking that what people share will stay in this room. Let's try not to use names or names of facilities so people feel free to say what they are thinking. We will not share anything with your employers or other employees and we ask that you do the same. We would like to record the session if everyone is comfortable with that. This is more accurate than notes. No one but the research team will hear the tapes. We will destroy them when we are finished with the study. The tapes will be kept at the University of Wisconsin, in Madison, Wisconsin.
6) **Thank the group for participating**: We know you are busy and we are not paying you much, just a token. We appreciate your willingness to help us and your commitment to improving long-term care.
7) **The process**: We have developed some questions that I will ask the group. We want to be sure that we hear from everyone so I will ask a question, give you a bit of time to think about it, and then ask you to respond. I hope you don't mind, but if only a few of you are talking, I may ask some of the others what they think, just so we are sure to hear from everyone. I will start by asking you some very general questions. This will give you the chance to tell me whatever you think is important. There are no correct answers. I consider you to be the experts on being charge nurses. We are not the experts. You know better than anyone, what the work is like and what would improve the quality of care and the quality of your work life for yourselves and for CNAs and residents. I would like to hear about both of these things, quality of care and the quality of your work life. So when I ask questions, please think of both. I have a few more specific questions that I will probably ask as well. I will ask you to try to give some examples. For instance, if you tell me that that you see yourself as a charge nurse who is really supportive, I will ask you to tell me what you do, specifically, that you think is supportive. Finally, I will read a few descriptions of situations and ask you to comment.

Take questions from the group

1) Let's talk about the CNAs you work with, and how you work with them, what your responsibility is in relation to CNA work and the quality of care they provide. (Let people just talk if they will.) First, think about all the ways you might influence how CNAs work.

Could you give some examples of how you influenced the care CNAs provide to residents? (If they are having difficulty thinking of things, ask them to think about when they have intervened in what a CNA was doing, how the CNA was doing something. Were these only when the CNA was doing something wrong. Where is the line between their responsibility for resident care and the CNAs responsibility? What do they observe about CNAs during the shift? How do they assess the quality of CNA work, if they do? When do they assess CNAs? Is there any effort to learn what skills CNAs have, to match to residents, to suggest staff development, to support CNAs who are particularly good at something to expand what they do, what they know?

2) Is there anything you do that you think affects how CNAs feel about their jobs, the quality of their work life?
3) Some charge nurses think that supervising CNAs is an important part of their job and others don't see it as their responsibility. What are your thoughts on this?
4) Lets talk a bit about what supervising means, how it is done, what difference it makes. What sorts of things might a charge nurse do that is part of supervising? What good supervisors do?
5) When a resident with a condition that CNAs are probably not familiar with is admitted, how do they learn the best way to take care of the new resident? What is the supervisor's role if any? The staff development person? Can you give me some examples of what a supervisor might do in such a situation?
6) When a new CNA is hired, what is the supervisor's role? Think of new CNAs you have worked with. How do you (if you do) determine what the CNA can do, what instruction or oversight is needed, the quality of their work?
7) Can you think of a time when you were working with a really good CNA who had been doing something in a particular way for a long time (toileting residents every two hours). You learned from an in-service that there is a more effective way to do this. Is it your job to pass this on to the CNAs?
    - Is it your job to see that they learn this and to determine if they are doing it well, correctly?
    - What did (do) you do if they seem unable to use the new approach?
    - What if the new approach calls for a different work routine? Whose job is it to figure that out?
    - What, if anything, did you do to help the CNAs change the way they were working?
    - What else might you have done that would have helped? (Get them to come up with specific situations they have been involved in or have at least observed).

Case I: Lets talk about how new CNAs learn their work and how CNAs learn to care for residents with conditions they are not familiar with. For example, let's say that a new resident is admitted to the unit where you work. The resident has right sided paralysis and is unable to speak. That's all you know about her. A new CNA has been assigned to her. You notice that both the breakfast and lunch trays were taken from the resident's room with very little eaten. The CNA writes on a shift report sheet that the resident was not very hungry. What would a good supervisor do in this instance? (Provide as much detail as you can.)

Case II: There is a bit of tension between two groups of staff on a unit. They are from different cultures with very different ways of doing things and different ideas about how to show respect

to co workers and residents. Can you think of any situations like this? (Discuss the situations in some detail if they offer. Otherwise go on with the scenario.) The nurse and several CNAs are from a culture where age and longevity of employment are highly respected. They believe that nurses and CNAs who have worked for a long time in the nursing home should be considered experts, that their opinions should be highly respected respected, and that they should be looked to for guidance on most care issues. One of the residents with dementia has become quite agitated and there is a difference of opinion on how to handle the situation. Some of the CNAs believe that the family should be involved in the discussion and should be very central in the decision about how to handle the resident. Some of the CNAs believe they know the resident well, have known the resident for a long time, have a lot of experience in handling aggression in residents with dementia, and have clear ideas about how to proceed. A new CNA who has attended an in-service on handling aggressive residents with dementia has a different opinion from all the others. What is the best way to proceed? Does the culture issue matter? What is the supervisor's (charge nurse) role in this situation? What would you do? What would happen in an ideal situation?

Case III: You have made out an assignment for CNAs which you believe is fair. You generally try to rotate the really difficult residents so that all CNAs share equally in the most difficult work. One of the CNAs comes to you to complain about the other CNA she has been paired with for the shift. She tells you that the CNA you have paired her with is lazy, that she never seems to be around when unpleasant things or hard work needs to be done, that she leaves work undone for the next shift and never finishes her work. As the charge nurse on the unit, what would you do? What would a good supervisor do? What usually happens? If you saw yourself as a supervisor of CNAs, would you do anything differently?

Summary Questions:

1) If we asked a CNA to describe what a charge nurse does, and what CNAs should expect from the charge nurse, what do you think most CNAs would say?
2) Think back to charge nurses you have worked with. Pick out the best and worst that you can remember. What was the difference in how they worked, how they interacted with other nurses? With CNAs?
3) What should other staff expect from the charge nurse?
4) Now let's try to sum up the qualities of a good charge nurse and how that charge nurse would work with CNAs.

Appendix D: Management Team Interview Protocols

February/March 2007 ¾ Telephone Facility Management Team Interviews

In late 2006, Aging Services California and the Institute for the Future of Aging Services received a grant from the California Healthcare Foundation to develop a multi-faceted training package for currently employed Licensed Vocational Nurses (LVNs) and the nursing homes where they are employed. The objectives of this project include:

1. To create a one and a half day training program for LVNs who are on the frontline of nursing home care to understand and develop/strengthen the management, supervisory and communication skills that are needed for them to guide and support the CNAs on their units;
2. To create a half day training program that focuses on how LVNs can support and mentor each other and new LVNs to use the skills learned in the first training program to deliver quality care in a healthy, team-based work environment;
3. To work with four nursing homes in the Bay Area of Northern California to pilot test the two training programs;
4. In collaboration with each organization's CEO, administrator, DON, director of staff development (DSD), medical director and other managers, to develop an orientation program and ongoing process map that will support the LVNs in transferring their knowledge "back at the ranch" and that will ensure sustainability of the program beyond the formal training period;
5. To identify high potential LVNs who have participated in the pilot to serve as internal experts within their own organization and as external experts in helping to spread the training program to others and to create an LVN network in California's long-term care sector;
6. To identify and meet with the necessary stakeholders who will help find a home for the training programs; and
7. To evaluate the training programs and how the knowledge/skills are put into practice in each of the pilot nursing homes.

Over the past several months, Ann Burns Johnson, CEO of ASC, has met with many of the key stakeholders within the state who have a vested interest in the strengthening the supervisory /management skills of LVNs who represent the vast majority of charge nurses in California's nursing homes. The research and training development team—headed by Dr, Stone from IFAS and Dr. Barbara Bowers, Professor of Nursing at the University of Wisconsin Madison—have done an extensive literature review, have conducted focus groups with LVNs and CNAs in the Bay Area and have begun to develop the curriculum for the training programs.

It is essential, however, that the top level management staff of each nursing home (as well as the frontline staff) partner with us in the development and testing of the training materials and the infrastructure that will be needed to implement and sustain the program within each nursing

home and across the state. We are, therefore, contacting the CEO/administrator, DON, and DSD of each pilot nursing home to get your perspectives on the current status of LVNs in your organization, the training that is needed to improve their supervisory/management role as a charge nurse and the structures that you believe should be in place to help you implement and sustain the knowledge and skills acquired through the training programs.

1. Now that we have described the program to you and what we are trying to achieve, can you talk about what role you think a DSD/DON/Administrator could play in the initiation and implementation?
2. (If this has not been part of their response) Can you tell us specifically how those activities will support the implementation of the program?
3. (If they had said things like "be supportive" "encourage" etc) Those things are certainly important. Can you give us a few examples of specifically how you would do that? What specific activities would you engage in that would be 'supportive" or what ever they have said?
4. Do you have any past experience with implementing a new program here or other places you have worked? What wisdom or insights do you think you can draw from that experience that might help you here?
5. One of the biggest challenges for program development and implementation is sustaining change. Can you talk about what someone in your position might do that would help to sustain new initiatives in general, and this program in particular?
6. What do you anticipate will be the biggest challenges to implementation? Sustaining the program?
7. Can you tell me, confidentially, what role you hope the DSD/DON/Administrator will play here? What do you think would be the most important thing they could do to support this/to support you?
8. Being completely candid, what do you think of this initiative? Do you really believe it will achieve something useful? If so, what specifically do you think might come out of this?
9. Other comments on what might help get this initiative going and sustain it?

April 2007 ¾ In-Person Facility Management Team Interviews

Dear [facility management team],

We have now completed focus groups with a crossection of CNAs and LVNs working in Northern California nursing homes and phone interviews with the administrator, director of nursing and director of staff development at each facility participating in our pilot project. Your support and participation has provided us with important and valuable insights as we develop the curriculum and related materials that will help us implement the LVN supervisor training program funded by the California HealthCare Foundation. The focus groups and interviews have affirmed findings from previous work conducted by ourselves and others that training alone will not change the management culture of an organization. Leaders back at the facility must ensure that they have the structures in place to help implement and sustain the knowledge and skills acquired by the frontline nurses through the formal training program.

To help you identify the structures that are or should be in place, we have set up an intensive half-day meeting with the leadership team of your organization on April 20th from 8:30am to 11:30am. During our three hours together, we will work with you to review the policies, procedures and practices that currently exist in your facility or that may be needed to maximize the potential for your LVNs to practice what they have learned in the "real world" and to sustain these new management/supervisory practices over time. In essence, we will help you develop a "roadmap" for the successful implementation of the LVN training and mentoring program, including how to build in the levers of accountability that will make this new knowledge "stick." While each of the facilities will develop its own map, we intend to use what we learn from this pilot to develop a generic guide for other nursing homes that are committed to changing the frontline management paradigm in long-term care settings.

We are excited about this partnership and are requesting that you do three things in preparation for our meeting. The first is to promise that the full leadership team—the administrator, DON, DSD and medical director/nurse practitioner (if appropriate) attend the meeting for the full three hours. The second is that you read the attached article written by Cornelia Beck and colleagues at the University of Arkansas. Her experience in working with nursing homes to implement significant management changes underscores the challenges we all face in getting true buy-in and successful implementation of programs. The third request is that you review the following questions and come to the meeting prepared to discuss what already exists or should exist in your facility.

1. What policies are needed to allow and encourage LVNs to fulfill their frontline nurse supervisor responsibilities and to use their new leadership skills?

   Example: Having nurses participate in walking rounds with CNAs to facilitate teamwork; encouraging LVNs to offer suggestions about policies that should be changed to help them to use their new skills; including specific coaching/ supervision responsibilities in charge nurse job descriptions.

2. How will your organization reward those LVNs who demonstrate significant improvement in their supervisory and leadership skills as a result of this training program?

Example: Merit raises or special recognition programs (employee of the month/season/year); development of LVN mentor programs with modest pay increases.

3. How will you know that a nurse has improved her/his performance?

   Example: Have LVNs, upper-level managers and CNAs develop their own set of criteria for the ideal frontline nurse supervisor, compare the lists and use a consensus approach to evaluating improvement; conduct periodic staff satisfaction surveys that include specific management questions with results shared across all staff; assess changes in efficiency (e.g., med pass activities become more efficient and nurses have more time for true nursing functions).

4. How is the LVN performance assessed?

   Example: The consensus list of observable qualities of strong nurse leaders developed in #3 is integrated into performance evaluations; CNAs under the LVN's supervision as well as the LVN's supervisor conduct performance evaluations of the individual.

5. How will the organization demonstrate visible, ongoing support for the skills and new management practices gained from the training program?

   Example: Creating a formal opportunity for LVNs to share what they learned with other employees (e.g. management and CNAs) and scheduling routine (biweekly, monthly) follow-up meetings to discuss issues related to implementing the new skills.

6. How will the staff development director support this program?

   Example: Small group discussions about successes (or difficulties) implementing the new skills and scheduling routine opportunities for role play with LVNs and CNAs; developing regular in-services around management issues; create a boot camp for charge nurses.

7. How are these management changes implemented and sustained across departments? Across shifts?

   Example: Administrator discusses these changes at all-staff meetings and demonstrates ongoing support for these efforts; accountability for easy transition across shifts and departments is built into all staff job descriptions and performance evaluations; periodic unit/neighborhood meetings ensure good communication across departments and shifts.

8. How is this incorporated in orientations for new nurses? How do they learn about the organization's philosophy on nurse leadership?

   Example: Creating a training module wherein new nurses are counseled about nurse leadership; implementing a peer mentoring program where a new LVN is assigned to a nurse mentor for three to six months or longer if necessary.

9. How will residents and family members be involved?

   Example: Drafting a newsletter to tell family members and residents about the organization's philosophy on nurse leadership; adding a discussion of the training program to the resident/family council meetings.

Please let us know if you have any questions. Thank you and we look forward to our upcoming meeting.

August 2007 ¾ Telephone Facility Management Team Interviews

Today we'd like to discuss your views on what the nurses have learned through the leadership trainings, what you've observed. Additionally, one of the things we discussed early in this project was the steps managers could take, or the structures managers could establish, to facilitate the development of leadership skills in their charge nurses. These topics will be the focus of our discussion with you today.

1. How much do you know about what occurred in the leadership training program that your nurses attended?

2. How did you find out (if they did) what they learned about?

3. Have you noticed any difference in the behavior of nurses who attended the training program? What specifically? (Give some examples to que them on the areas you really emphasized, e.g. (1) Are they more involved in coaching/supporting CNAs in their daily work? (2)taking more initiative in solving problems on their unit? (3) Developing and encouraging more teamwork among CNAs and nurses within the unit and across departments?)

4. Have you noticed the nurses being supportive of each other in using leadership skills? In what ways are they/are they not?

5. Were there any processes or structures put in place to reinforce what they learned? Can you describe any of the things you have done since then to encourage the development of leadership skills?

6. Do you have any *new* ideas, at this point, about how you might be able to assist your nurses in developing leadership skills?

7. Can you think of anything that you might do to maintain the skills they have developed into the future?

8. Is there anything you were hoping for with this program that has not occurred? What do you think could be done to change that in future training programs?

9. One of the challenges frequently identified by nurses is a feeling that they are not sufficiently 'backed up' by managers when they try to assume a leadership role in managing CNAs and activities on their unit. Do you think this is an issue in your home? If so, why do you think this occurs? What do you think might be done to improve this situation? What do you think your involvement could be?

10. Another issue that nurses often describe as difficult for them is not having sufficient information about their organization and how decisions are made. Do you think this is an issue for the nurses in your organization? How do you think this occurs? What are the issues

that they might feel this way about? What, if anything, do you think could be done to improve this situation?

11. Can you describe a time when one of your charge nurses did something, made a decision that you did not agree with? How did you handle the situation? With the nurse and with anyone else who was involved? Do you wish you had done anything differently? Would you do anything differently if you had it to do over again?

12. Charge nurses are sometimes reluctant to bring important issues to their supervisors. What is your view of why this occurs? What might make it more likely that nurses would actually do this? What role might managers play in nurses' reluctance to bring issues forward?

13. What skills, experience, training, support etc would make it easier for you, as a manager, to work more effectively with the nurses in your home?

14. Do you think you will continue this type of training with other nurses on your staff and new hires? If so how will you do this?

January 2008 ¾ Telephone Interviews with Facility DSDs

1. About how much time are you able to devote to your staff developer role during the course of a week? What other responsibilities do you have beside staff development?

2. What types of staff development functions or activities do you typically carry out?

3. Do you work with the LVNs in your facility in any way? And if so how?

4. Do you believe your facility administrator/DON and/or other managers would support you to help develop the leadership and supervisory skills of your facilities charge nurses as part of your staff developer role?

5. What would you like them to do to support you in taking on this new function?

6. Do you believe the leadership and training program we recently completed with your facilities LVNs and other nurses had any impact on their attitudes, knowledge or behavior and if so, could you give us some examples of these impacts?

Appendix E: CNA Baseline and Follow-up Survey

Certified Nursing Assistant Survey

Nurse Leadership Enrichment and Development (LEAD) Project

Your participation in this survey is voluntary. Please answer the questions honestly. Remember, all your answers will be confidential. No one from your facility will see your responses. The survey is copied on the front and back of each page.

I. Questions About You

Please check the correct box or write in your answers for each question below.

1. What is your gender?
   - ☐ Male
   - ☐ Female
2. What is your age? _____
3. Are you Hispanic (Latina/Latino)?
   - ☐ Yes
   - ☐ No
   - ☐ Don't Know
4. Please read the list of race categories below and check one or more that you consider yourself to be.
   - ☐ White
   - ☐ Black or African American
   - ☐ American Indian or Alaska Native
   - ☐ Asian
   - ☐ Native Hawaiian or other Pacific Islander
   - ☐ Other (please write out) _____
   - ☐ Don't Know
5. In what country/countries have you received training for your current career (please include all countries, for example, the U.S. and Philippines)? _____
6. Are you trained in any other career? If so, please list _____
7. How long have your worked as a CNA? _____ Years _____ Months

8. How long have your worked as a CNA for this organization? _____ Years _____ Months

9. What is the status of your position at this organization?

- ☐ Part-time for this organization
- ☐ Full-time for this organization
- ☐ Agency
- ☐ Contract
- ☐ On-call or "pool"
- ☐ Per diem
- ☐ Other (please explain) _____

II. Satisfaction with Your Job

A. In the table below are five statements that relate to how you feel about your job and how you think other CNAs feel about their jobs. For each statement, mark the column that best reflects how you feel.

	Disagree Strongly	Disagree	Disagree Slightly	Neither agree or disagree	Agree Slightly	Agree	Agree strongly
1. Generally speaking, I am very satisfied with this job.							
2. I frequently think of quitting this job.							
3. I am generally satisfied with the kind of work I do in this job.							
4. Most people on this job are very satisfied with the job.							
5. People on this job often think of quitting.							

B. If a friend or family member asked your advice about taking a CNA job in your facility, would you (please check one):

- ☐ Definitely recommend it
- ☐ Probably recommend it
- ☐ Probably not recommend it
- ☐ Definitely not recommend it
- ☐ Don't know

III. Support from Your Charge Nurse

A. Below are statements that relate to how you feel about your charge nurse. Please check the area that reflects your relationship with your charge nurse. If you work with more than one charge nurse, please answer the questions in relation to the charge nurse who you work with most often.

	Strongly Agree	Somewhat Agree	Somewhat Disagree	Strongly Disagree	Don't Know	Refused
1. My charge nurse provides clear instructions when assigning work						
2. My charge nurse treats all nursing assistants equally						
3. My charge nurse deals with the complaints and concerns of nursing assistants						
4. My charge nurse is open to new and different ideas, such as new or better ways of dealing with resident care						
5. My charge nurse is supportive of progress in my career, such as further training						
6. My charge nurse helps me with my job tasks when help is needed						
7. My charge nurse listens to me when I am worried about a resident's care						
8. My charge nurse supports nursing assistants working in groups or teams with other health care workers such as physical therapists, dieticians, RNs, LVNs, or other nurses						
9. My charge nurse disciplines or removes other nursing assistants who do not do their job well or share of their work						
10. My charge nurse tells me when I am doing a good job						
11. My charge nurse intervenes when there is conflict between staff.						

B. In your own words, please write what you think your charge nurse could do differently to better support you in providing high quality care to your residents.

IV. Staff Communication in Your Organization

Please check the column that best describes how you feel about each statement.

	Strongly disagree	Disagree	Neither agree or disagree	Agree	Strongly Agree
1. Communication among staff is very open.					
2. All levels of staff communicate effectively about efforts to improve care.					
3. The information passed among staff is generally correct.					
4. I am generally well informed about what is happening during other shifts.					
5. It is easy for staff to get information they need to solve problems on the job.					
6. Some staff members have a hard time doing their jobs (for example, reading charts and notes) because they speak a different language or have difficulty reading.					
7. I have a good understanding of the goals for each resident.					
8. I have a chance to gain new skills and knowledge on the job.					

V. Cultural Competency

Please check the column that best describes how you feel about each statement.

	Strongly disagree	Disagree	Neither agree or disagree	Agree	Strongly Agree
1. This facility is a comfortable place for staff of different races/cultures to work.					
2. Not enough of the facility's supervisors are from different races or cultures.					
3. Sometimes there are problems between staff of different races and cultures.					
4. Some staff has problems communicating with other staff members who speak a different language.					
5. I understand why some cultures or races do their jobs in a certain way.					

Appendix F: LVN Baseline and Follow-up Survey

Nurse Survey

Nurse Leadership Enrichment and Development (LEAD) Project

Your participation in this survey is voluntary. Please answer the questions honestly. Remember, all your answers will be confidential. No one from your facility will see your responses. The survey is copied on the front and back of each page.

I. Questions About You

Please check the correct box or write in the answers for each question below.

1. What is your gender?
   - ☐ Male
   - ☐ Female

2. What is your age? _____

3. Are you Hispanic (Latino or Latina)?
   - ☐ Yes
   - ☐ No
   - ☐ Don't Know

4. Please indicate what race you consider yourself to be (please select one or more).
   - ☐ White
   - ☐ Black or African American
   - ☐ American Indian or Alaska Native
   - ☐ Asian
   - ☐ Native Hawaiian or other Pacific Islander
   - ☐ Other (please write out) _____
   - ☐ Don't Know

5. In what country/countries have you received training for your current career (please include all countries, for example, the U.S. and Philippines)? _____
   _____

6. Are you trained in any other career? If so, please list _____
_____

7. Are you a LVN or RN? ☐ LVN ☐ RN

8. How long have you been a nurse? _____ Years _____ Months

9. How long have you been a nurse in this facility? _____ Years _____ Months

10. Do you have supervisory responsibility for CNAs (for example charge nurse or unit leader)?
☐ Yes ☐ No

(If the answer to question #10 is "yes", please answer questions #11 and #12. If the answer is "no", please move on to Section II.)

11. How long have you had supervisory responsibilities for CNAs? _____ Years _____ Months

12. In any given shift, how many CNAs are you likely to be supervising? _____

II. Supervisory Responsibilities

Please mark the columns below that show which types (if any) of supervisory responsibilities you currently have for CNAs in your facility.

Types of Supervisory Responsibilities	My responsibility alone	My responsibility, but others do this too	Not my responsibility, but I sometimes do this	I never do this
1. Act as a mentor to CNAs.				
2. Ensure CNAs are giving proper care to residents.				
3. Schedule CNAs.				
4. Provide feedback to CNAs on job performance				
5. Document CNAs' performance problems.				
6. Initiate disciplinary action.				
7. Conduct on the job clinical training.				
8. Interview CNA job applicants.				
9. Recommend training for CNAs.				

III. About Your Skills

Please check the area that reflects how you feel about your supervisory skills with the CNAs.

	Strongly Agree	Somewhat Agree	Somewhat Disagree	Strongly Disagree	Don't Know	Refused
1. I provide clear instructions when assigning work						
2. I treat all nursing assistants equally						
3. I deal with the complaints and concerns of nursing assistants						
4. I am open to new and different ideas, such as new or better ways of dealing with resident care						
5. I am supportive of progress in a CNA's career, such as further training						
6. I help the CNAs with their job tasks when help is needed						
7. I listen to CNAs when they are worried about a resident's care						
8. I support CNAs working in groups or teams with other health care workers such as physical therapists, dieticians, RNs, LVNs, or other nurses						
9. I discipline or remove CNAs who do not do their job well or share of their work						
10. I tell CNAs when they are doing a good job						
11. I intervene when there is conflict between staff.						

IV. Leadership Support

The term "Management" refers to the Administrator, Director of Nursing Services/Assistant Director of Nursing Services and other Department heads in your organization. Please check the column that best reflects your feelings about each statement.

	Strongly Disagree	Disagree	Neither Disagree or Agree	Agree	Strongly agree	Don't know
1. Management responds to staff concerns.						
2. Staff respects the facility's management.						
3. Staff receives praise from management when they do their job well.						
4. Management is clear about what they expect from staff.						
5. Management values the work done by staff at all levels.						
6. Management thinks staff should be given the authority to do more things and make more decisions on their own.						
7. Management support staff and work with them to learn new things.						
8. Management encourages teamwork among staff.						

V. Staff Communication in Your Organization

Please check the column that best describes how you feel about each statement.

	Strongly disagree	Disagree	Neither agree or disagree	Agree	Strongly Agree
1. Communication among staff is very open.					
2. All levels of staff communicate effectively about efforts to improve care.					
3. The information passed among staff is generally correct.					
4. I am generally well informed about what is happening during other shifts.					
5. It is easy for staff to get information they need to solve problems on the job.					
6. Some staff members have a hard time doing their jobs (for example, reading charts and notes) because they speak a different language or have difficulty reading.					
7. I have a good understanding of the goals for each resident.					
8. I have a chance to gain new skills and knowledge on the job.					

V. Cultural Competency

Please check the column that best describes how you feel about each statement.

	Strongly disagree	Disagree	Neither agree or disagree	Agree	Strongly Agree
1. This facility is a comfortable place for staff of different races/cultures to work.					
2. Not enough of the facility's supervisors are from different races or cultures.					
3. Sometimes there are problems between staff of different races and cultures.					
4. Some staff has problems communicating with other staff members who speak a different language.					
5. I understand why some cultures or races do their jobs in a certain way.					

Appendix G: Post Training Session Satisfaction Survey

1. Facility in which you currently work _____

2. How long have you worked as a nurse?

3. What is your overall evaluation of today's training workshop?

   Poor Fair Good Very Good Excellent

4. How would you rate the workshop in terms of how the information was presented?

   Poor Fair Good Very Good Excellent

5. Was there enough opportunity for you to interact with others and ask questions?

   Yes No

6. Please rate the usefulness of each topic presented.

	Not useful	Somewhat useful	Very useful
Critical Thinking			
Communication			
Coaching CNAs			
Conflict Resolution			
Diversity			

7. Please rate the amount of information you received on each topic.

	Too much information	About the right amount of information	Not enough information
Critical Thinking			
Communication			
Coaching CNAs			
Conflict Resolution			
Diversity			

8. Are there topics you would like to receive education/training/practice on that were not presented today?

9. Did you feel like the topics and scenarios presented today captured the types of issues you deal with in your job? If not, what else could have been addressed?

10. Please list two examples of how you think you will apply what you learned today in your job.

11. Do you feel you there will be any barriers to you implementing the new skills and ideas you learned today? If so, what are they?

12. How could the workshop be improved to make it more useful to nurses like you?

Appendix H: Nurse Participant Interview Protocols

Telephone Interviews Approximately One-Month Post Full-Day Training Session

1) What did you think about the training session?

2) We talked a lot about conflict resolution, communication and other things. Have you had a chance to use any of that yet? What are some specific examples?

3) If you haven't been able to apply anything yet, was there anything that you thought might be good to do, but you didn't know how or you didn't feel comfortable?

4) What about your nursing home should change in order to make doing the things you learned easier?

5) How could we have prepared you to go back to your facility? (Examples might include more explicit information or providing someone you could have called.)

In-Person Interviews Approximately 6 months Post Full-Day Training Session

1. Which training sessions did you attend (May/June) (June/October)

2. How long have you been a nurse?

3. How long have you worked at this facility?

Pre-Training Experience and Expectations

4. Had you attended any other leadership or supervision training sessions prior to this one? If so, what was it? How did you use it when you got back to your facility? (Mercy (Masonic?) nurses went to LEAP training)

5. Did you feel you needed leadership and supervisory training prior to attending this training? If so, what areas did you think you needed to strengthen?

6. What is your biggest challenge area as a leader/supervisor, if any?

7. What expectations does your nursing home set for you in terms of your supervisory role?

8. Did the management in your facility discuss the training project with you before you attended the sessions? Did they set any sort of expectations for you?

9. Before you attended the first training session, what were you hoping to get out of the program?

Content/Quality of Training Program

10. Were your expectations of the training program met?

11. Which topics covered in the session did you find most relevant to your every day job, if any? (coaching, critical thinking, communication, conflict resolution, diversity)

12. Are there any that you didn't find relevant? If so, why not?

13. Do you feel like you need on-going or more in-depth training in any of the topic areas to feel more comfortable with them? If so, in what areas and what would be the most beneficial way to conduct additional training?

14. What did you like/not like about the training sessions (full-day and booster)?

15. Are there any changes you think that would have made the training sessions better and more useful to you? (both in the training day itself or outside of it?)

Post-Training Program Experience

16. Have you been using any of the skills you learned in the training session on the floor, either with CNAs or management? Can you give any specific examples?

17. Have you faced any barriers to trying to use the skills and techniques discussed in the training? From management, other nurses, CNAs, yourself?

18. Do you feel like the training program had any impact on your leadership and supervisory skills? If so, can you give specific examples? If not, can you say why? (the training wasn't effective, you didn't need to improve your skills, you face barriers to trying to execute them, etc.)

19. Did the management in your facility discuss what you learned with you after you attended either session? (individually, in a staff meeting, etc.)

20. Did the expectations your facility management has of you as a supervisor/leader change over the course of this project?

21. Do you notice any differences facility wide because of this project? Differences in the nurses as a whole, such as better communication, more confidence, etc? Differences in the interaction between CNAs and nurses? In the interaction between management and nurses?

22. What type of training does your facility's director of staff development conduct with nurses? If the DSD does not conduct training with nurses, who does?

23. Do you feel that your DSD could conduct training on the types of topics that were discussed in our training session?

Appendix I: CNA Interview Protocols

1. How long have you been a CNA? How long have you worked here as a CNA?

2. What is your general impression of your charge nurse or the charge nurses here? (distinguish whether they work with one regularly or rotate)

3. Were they aware that the nurses were participating in the training program?

4. Have you noticed any difference in how your charge nurse interacts with you and your fellow CNAs since they attended the training (or the last few months if weren't aware of it)?

5. Do you feel that your charge nurse needs any training in any management or supervisory areas?

6. Do you feel that your charge nurse listens to your input and concerns? Respects your input and concerns? Responds?

7. Does your charge nurse give you the information you believe you need about residents to do your job effectively?

8. Does your charge nurse teach you new skills or help you improve your skills for caring for residents?

9. Is your charge nurse good at acknowledging and addressing conflicts?

10. Do you feel there is good teamwork between CNAs and charge nurses?

11. Is there anything the organization needs to do to improve/change the interaction between charge nurses and CNAs?