The University of San Francisco
USF Scholarship: a digital repository @ Gleeson Library | Geschke Center

Doctor of Nursing Practice (DNP) Projects | Theses, Dissertations, Capstones and Projects

Spring 5-17-2018

Manager Leadership: Beginning at Novice

Kathy Bay
kathywbay@comcast.net

Follow this and additional works at: https://repository.usfca.edu/dnp

 Part of the Nursing Administration Commons, and the Other Nursing Commons

Recommended Citation
Bay, Kathy, "Manager Leadership: Beginning at Novice" (2018). *Doctor of Nursing Practice (DNP) Projects*. 125.
https://repository.usfca.edu/dnp/125

This Project is brought to you for free and open access by the Theses, Dissertations, Capstones and Projects at USF Scholarship: a digital repository @ Gleeson Library | Geschke Center. It has been accepted for inclusion in Doctor of Nursing Practice (DNP) Projects by an authorized administrator of USF Scholarship: a digital repository @ Gleeson Library | Geschke Center. For more information, please contact repository@usfca.edu.

Manager Leadership: Beginning at Novice

Kathy W. Bay DNPc, RN, CENP

University of San Francisco

DNP Comprehensive Project

Committee Members:

Dr. Elena Capella, Chair

Dr. KT Waxman, Member

Dr. Gregory DeBourgh, Member

Acknowledgements

"Each of us has cause to think with deep graditude for those who have lighted the flame within us" (Schweitzer, n.d). I indeed have deep graditude to everyone who helped me on the journey, lighting the pathway, and helping me to navigate the course. First and most importantly, Steve, my husband, and Victoria, our daughter who have been editors, supporters, and at times cheerleaders to encourage me on this journey. Other family members including my sister, Ginger, my brother-in-law, Michael, and finally in memorium, my father-in-law, Dr. Ernie Bay who specifically encouraged me to "go for it". All of the faculty and support staff at the University of San Francisco were knowledgeable and supportive, but I'd specifically like to thank Dr. K. T. Waxman and Dr. Elena Capella who both served as my committee chair at different intervals and spent hours helping me brainstorm, connect with resources, and develop the project concepts as well as Dr. DeBourgh for his time and insight regarding barriers and the writing of my project report. A special thank you to the Northwest Organiation of Nurse Executives who supported this Doctor of Nursing evidenced-based change in practice project through their members. To my cohort/class members, I have truly appreciated the opportunity to learn with you and benefit from your knowledge and support. Lastly, a special thank you to peers and friends who repeatedly asked how things were going, what they could do to help, and kept the flame within me from burning out.

Table of Contents

Abstract

To meet the current and anticipated nursing leadership gaps, there is a critical need for tools and programs to develop of future leaders. Unfortunately, there is a deficiency related to the preparation and readiness of novice nurse managers which impacts turnover, burnout, and the quality, safety and cost of care for patients. The aim of this Doctor of Nursing evidence-based change in practice project was to create an online training program that integrated two national nursing leadership competencies to assist the development of novice nurse managers as they transition to a formal leadership role.

A video-based module system with active learning objectives established on adult learning principles was created for sixteen participants in healthcare organizations in Washington and Oregon recruited through a nursing leadership organization. Although limited results from program participants impacted the overall program, survey outcomes indicated seventy-five percent of respondents strongly agreed the program improved their knowledge and reparation as a nursing leader indicating the program can provide an effective, efficient process for novice leader development that is not cost or time prohibitive.

Keywords: *Leadership development, nurse manager, novice manager development, online learning.*

Section II. Introduction

Problem Description

In 1999, the Institute of Medicine (IOM) stunned the medical community, government, and consumers when they reported that as many as 98,000 people each year die from preventable medical errors (2011). Further analyses from other sources lead to the possibility that deaths related to medical errors are significantly underestimated and would more accurately be reported near 400,000 annually (Classen et al., 2011). Moreover, the U.S. has the highest per capita costs for healthcare service of any developed nation in the world and lags behind in many quality and safety measures compared to other developed nations including, but not limited to infant mortality, chronic disease management and projected length of life (Squires & Anderson, 2015).

In 2014 the U.S. spent $9,086 per-capita or 17% of the gross domestic product (GPD) on healthcare which has increased 3,600 percent since 1970, from $74 billion to $3.205 trillion in 2015 (Levitt, Claxton, Cox, Gonzales & Kamal, 2014). If healthcare costs are not reduced by 2020, the U.S. will be spending $0.40 per dollar made on healthcare (Levitt, Claxton, Cox, Gonzales & Kamal, 2014). Although there are some signs that healthcare quality is improving based on reductions in potential years of life lost/mortality per 100,000 population, continued diligence to revise and improve approaches is essential (Levitt et al., 2014). Due to the presence of nursing personnel in the acute care setting, it is well recognized that they have a key role in the healthcare quality and outcomes for patients that lasts well beyond transition from the hospital (Warshawsky, Rayens, Stefaniak & Rahman, 2013). Beyond the hospital walls, nurses in ambulatory, home health, and advanced practice, and other areas have a significant impact on quality and patient safety (Malloch & Porter-O'Grady, 2009).

Based on anticipated retirements, current vacancies, and registered nurses (RNs) leaving practice due to dissatisfaction, it is estimated that the U.S. will need more than one million additional RNs by 2025 (National Council of State Boards of Nursing, 2013). Furthermore, the relationship with their manager is the most commonly reported reason a staff member leaves an organization (Collini, Guidroz & Perez, 2015; Duffield, Roche, Blay & Stasa, 2010). Given the essential changes in healthcare that are in progress, an appropriately prepared nurse manager can have a tremendous positive impact and is the linchpin for organizational success (Baxter & Warshawsky, 2014; Cowden, Cummings & McGrath, 2011).

Both Pathways to Excellence and Magnet programs coordinated by American Nurses Credentialing Center (ANCC) (2018) include manager competence, accountability, and leadership as essential tenets for designation. Unfortunately, there is a deficiency related to the preparation and readiness of novice nurse managers which negatively impacts patient quality, safety, and the cost of care. Many are selected for their position based on their clinical excellence (Gallo, 2007; Korth, 2016). The skills that make a successful bedside nurse are not the same as needed for the manager/leader position (Gallo, 2007). Furthermore, "the transition from independent contributor to a role in which one contributes through others can be daunting" (Gallo, 2007, p. 28). Research has shown the informal and often unstructured leadership development program used in many organizations have not been successful (Doria, 2015; Gallo, 2007). Validation of performance competency for the manager differs from validation of performance for a staff member in regards to orientation, training, and verification of performance. Verification of performance is needed to reduce risk for our patients, staff, and the organization as well as the reputation of the professional nursing leadership role. There are multiple tools available, but many organizations are unable or unwilling to pay the cost of

focused nursing leadership training due to the time commitment or inability to facilitate with external organizations. Lastly, a gap in leadership coverage impacts the quality of healthcare provided in the hospital (Baxter & Warshawsky, 2014). In consideration of the current healthcare evolution, nursing leaders must be visible and capable of supporting the changing environment.

Available Knowledge

A literature search was conducted focusing on the following PICO question: What impact does nurse manager leadership training have on the quality of care provided to patients in the clinical setting? Utilizing Cumulative Index to Nursing and Allied Health Literature (CINAHL), PubMed, and OVID with key search words of nursing, leadership, novice, and leadership training identified 454 articles. Further review with inclusion criteria were English language articles published in peer-reviewed magazines in years 2010 to present. Articles were excluded based on programs in socialized or government sponsored health systems, those with a primary focus on clinical knowledge development and unique department areas, for example, the Emergency Department or Operating Room. Also excluded were articles recommending what should be included in a manager training rather than the actual program. Abstracts were reviewed for the 22 remaining articles for possible inclusion. Lastly, several articles provided historical information regarding the preparation of the nurse manager and were reviewed in their entirety. A total of seven articles were selected for discussion in this paper. Articles were reviewed utilizing the using the Johns Hopkins Evidence-Based Practice Research Appraisal (Dang & Dearholt, 2017), organized approach to appraise, synthesize and translate evidence for research and non-research based review. Although there is a wealth of evidence on the impact of the nurse manager on quality and safety, much of the focus is on the overall lack or ineffective preparation process versus a successful transition. No randomized control trials or comparison

data for managers who had completed specific orientation programs were found. Research does indicate nurse managers receive little or no training or support when transitioning to the formal leadership position leaving them "ill-equipped" for the position (Keys, 2014, p. 103).

In a longitudinal, quasi-experimental study of 23 nursing units in two hospitals, Warshawsky, Rayens, Stefaniak, and Rahman (2013) reviewed hospital-acquired pressure ulcers (HAPU) and patient fall rates in hospital units during a gapped leadership position to those with stable leadership. They found that patients in medical-surgical units with nurse manager turnover were more likely to fall (odds ratio: 3.16; 95% confidence interval: 1.49-6.70) (Warshawsky et al, 2013). Furthermore, in the intensive care unit, the patients were more likely to develop HAPU (odds ratio: 2.70; 95% confidence interval: 1.33-5.49) (Warshawsky et al., 2013). Utilizing complexity science theory as a framework, they subsequently associated the adaptive leadership unique to the nurse manager position as an enabling level between the administrative/executive and the line staff (Warshawsky et al., 2013).

Complexity science theory proposes that in the new knowledge era, leaders must evolve from an authority basis to organize and motivate knowledge workers (Schnieder & Somers, 2006; Uhl-Bien, Marion & McKelvey, 2007). The leader's skills must include knowledge and competency for change management as a component of adaptive leadership skills. As knowledge workers, frontline nurses may have greater awareness and skill to perform the needed tasks than their manager (Uhl-Bien & Marion, 2009). To enhance quality patient outcomes, identifying how them manager can develop the knowledge and skills to motivate employees to achieve the desired results.

The nurse manager is a crucial organization element to achieve the strategic plan as well as critical in communicating information from the frontline, bedside staff to senior leadership (Uhl-

Bien, Marion. & McKelvey, 2007; Uhl-Bien & Marion, 2009). The nurse manager is also a conduit and translator in the highly complex healthcare organization (Uhl-Bien, Marion. & McKelvey, 2007; Uhl-Bien & Marion, 2009). The staff-manager relationship impacts patient outcomes including, but not limited to, medication errors, patient mortality, hospital acquired-conditions, as well as patient perception/satisfaction scores (Collini, Guidroz & Perez, 2015; Portoghese, Galletta, Battistellli & Leiter, 2015; Wong, Cummings & Ducharme, 2013). Moreover, the nurse manager is the bridge between senior leadership and staff serving to translate the strategic plan into operations. Conversely, as the immediate supervisor to frontline staff, the nurse manager is the most direct link to communicate information to senior leadership (Baxter & Warshawsky, 2014; Cowden, Cummings & McGrath, 2011; Cummings, et al., 2010; Duffield, Roche, Blay & Stasa, 2010; Gallo, 2007; Hudgins, 2016; Hunt, 2014; Kirby, 2008; Warshawsky & Havens, 2014; Warshawsky, Rayens, Stefaniak & Rahman, 2013; Wong, Cummings & Ducharme, 2013).

Effective communication is a key leadership characteristic, and research has shown this to be a crucial component for resolution of barriers and translate organizational strategy (Baxter & Warshawsky, 2014; Coomber & Barribal, 2007; Cowden, Cummings, & McGrath, 2011). Furthermore, the nurse manager provides accountability for practice standards on the unit (Baxter & Warshawsky, 2014; Coomber & Barribal, 2007; Cowden, Cummings, & McGrath, 2011). The unit culture and environment are influenced by the manager's approach and communication techniques either directly or by the expectations that are established. Given the relationship of managers and the frontline staff, they have a tremendous impact on the organizational success and more importantly quality of care and patient/staff safety (Duffield, Roche, Blay & Stasa, 2010; Maragh, 2011; Portoghese, Gallentta, Battistell & Leiter, 2015).

Not limited to the specific unit, the nurse manager and their staff facilitate "improvement throughout the organization in addition to enabling the work in their assigned patient care areas" (Warshwsky et al., p. 726).

In the calendar year (CY) 2015, U.S. registered nurse (RN) turnover rate rose to 17.2% from 11.2% in CY 2011; and the RN vacancy rate has risen steadily from less than 5% in 2012 to 8.5% in 2015 (Nursing Solutions Inc., 2016). As the human resource or personnel costs represent 54.2% of operating revenue in many healthcare organizations, this is a vulnerable area for cost reductions (Herman, 2013). Even more so, nursing personnel represents a large portion of the overall personnel costs (Spetz, 2013). Turnover rates are increasing, and personnel replacement is not only expensive, but it disrupts organizational operations (Yin & Jones, 2013). Replacement of a manager position is estimated to cost more than $150,000 and bedside RNs $116,845, a significant non-reimbursed organizational cost (Arnold, 2012). The financial impact of turnover adds up, for example, consider a hospital that employs 100 nurses. Based on the current national RN turnover rate of 17.2%, this represents a $2,009,734 in expense that if avoided, could be redirected for other operational expenses (NSI, 2016).

Some organizations provide business training, but little in the way of leadership development for the novice nurse manager (Moore, Sublett & Leahy, 2016). Not only is nurse turnover increasing, but North Carolina NMs surveyed by Warshawsky and Havens (2014) indicated that 62% (n=181) planned to leave their current position in the ensuing five years. The study, based on the secondary analysis of a survey distributed to 1,225 NMs (response rate of 24%, n=291) assessed job satisfaction and anticipated turnover (Warshawsky & Havens, 2014). Analysis revealed the primary reasons for planned departures were job stress or burnout 30% (n=63), a career change 27% (n=56) and retirement 22% (n=47); only 15% (n=32) planned a job change

related to promotion (Warshawsky & Havens, 2014). Other research has confirmed the findings that burnout and work stress, as well as planned retirement, are the reasons for most planned transitions (Hudgins, 2016; Taylor, Roberts, Smyth & Tulloch, 2015).

Baxter and Warshawsky (2014) reported that the average nurse manager career is five years. Unfortunately, proficiency development, level IV of V on Benner's competency continuum (Benner, 1984) takes approximately six years (Warshawsky & Havens, 2014). Given that a shortage already exists and is anticipated to worsen, it is unfortunate that many nurse managers never reach their full leadership potential (Doria, 2015; Gallo, 2007; Uhl-Bien, Marion & McKelvey, 2007). As knowledge workers, there is concern that retirements and turnover of the nurse managers will lead to loss of expertise and unsafe conditions for patients (Doria, 2015; Gallo, 2007). Furthermore, there are some indications that Generation X nurses (birth years 1961-1981) may not be willing to take on the nurse manager role (Keys, 2014; Kirby & DeCampli, 2008). Additionally, as resources continue to tighten, hiring replacement nurses for staff or manager positions will become even more difficult. Hiring employees, including leaders, with the necessary skill who have potential and commitment to work within the organization is critical to achieving organizational safety and success. Solutions to the anticipated critical staffing deficits reside in changing practice to support the essential knowledge development in our nursing leaders as well as creating a healthy and supportive culture for succession planning. The review of evidence can be examined in Appendix A. Specifics of RN vacancy rates, healthcare turnover rates, and forecasting for Oregon- and Washington-specific nursing deficits and Oregon leadership data are available in Appendices B, C, D, and E. Appendix F depicts some of the barriers identified by the Oregon Nursing Workforce Center recruiting nursing leaders.

Rationale

Florence Nightingale said, "Let whoever is in charge keep this simple question in her head; not, how can I always do this right thing myself, but how can I provide for this right thing to be always done?" (Nightingale, n.d.). Healthcare organizations are complex, knowledge-oriented organizations that require adaptive leaders to meet challenges with agility (Uhl-Bien, Marion, & McKelvey, 2007). As the U.S. healthcare evolution continues, developing and hardwiring the skills of our novice nursing leaders to ensure consistency of approach, safety, and quality will be critical. McAlearney's (2006) qualitative research in the healthcare field illustrated vulnerabilities with the primary focus on actual healthcare tasks with leadership development "lagging 15 years behind" other industries (p. 973). The quote "Insanity: doing the same thing over and over again and expecting different results" is attributed to Albert Einstein (n.d.) and is representative of hospital systems that do not address this issue. Lastly, numerous articles and research have documented the ineffective nurse manager training and development methods currently in use (Baxter & Warshawsky, 2014; Cummings et al., 2010; Cziraki, McKey, Peachey, Baxter & Flaherty, 2014; Havaei, Dahinten, & MacPhee, 2015; Moore, Sublett & Leahy, 2015).

In addressing the IOM Future of Nursing (FON) recommendations, the Robert Woods Johnson Foundation (RWJF) convened an advisory committee of nursing leaders who recommended revisions in the preparation and education of nurses and created Quality, Safety Education for Nurses (QSEN) competencies (American Association of Colleges of Nursing [AACN], 2012). Initially, at the pre-licensure level with subsequent work focused on graduate education, the QSEN competencies identified the knowledge, skills, and attitudes (KSA) needed for practice outcomes focused on quality and safety. Additionally, the American Organization

of Nurse Executives (AONE) has categorized three competency areas for the nurse manager: The Science, The Art and The Leader Within. Unfortunately, there is an inability to support the training either due to financial concerns, inconvenience, or for other reasons makes it hard to have dedicated training for novice nurse managers. Utilizing Benner's framework and the defined standards, nursing can change the course and outcomes by providing leadership with the right tools to improve care for the patients and the community, the true intent behind's Nightingale's philosophy.

Specific Aims

The goal of this project was to create a training program that integrates the AONE nurse manager competencies (2015) with the QSEN curriculum (2012) to assist in the competency development of novice nurse managers as they transition to a formal leadership role. Through an online video-based module system and active learning objectives established on adult learning principles, the *Beginning at Novice* program will provide an effective, efficient process for novice leader development that is not cost or time prohibitive. The overall project goal was for the manager to enhance their self-assessment, self-confidence in skills, knowledge sets, and abilities. Benner's Novice to Expert Learning Domain Framework (1984) demonstrates the impact of a structured platform for competency continuum development and provides the framework for this training program. Although the training will not immediately move the manager from the novice to competent or proficient level, the tools provided will assist to expedite preparation and knowledge needed to assist in skills development. The aim statement for the project: By January 30, 2018, Northwest Organization of Nurse Executives (NWone) will have a training program based on nationally recognized education tenets for nursing

leadership in place via their web-based platform for novice nurse managers with at least two participants completing the modules.

Section III Methods

Context

The primary stakeholders are novice nurse leaders, healthcare organizations, and professional nurse leader organizations. These individuals/groups are similar in the need for the manager to perform their oversight successfully. Although not a direct stakeholder in the performance of novice nurse managers, professional nursing leadership organizations benefit if they can help manager development needs to help support member healthcare organizations. Additionally, the patients and the community are impacted by the leadership provided by the nurse manager but are silent and somewhat uninformed stakeholders. In the local environment, NWone was identified as a partner because they identified a need to develop a new method for nurse manager education. Past NWone educational offerings for nurse managers had been provided through a series of in-person classes. The NWone Executive Director, reported reduced participation making the program cost prohibitive (personal communication, September 22, 2016). The Executive Director wanted to partner to develop the online program to expand training while reducing the cost and supported exploration of this innovative concept. The NWone letter of support for participation is available in Appendix G.

A Qualtrics survey link was sent to Chief Nursing Officers (CNOs) (N=178) members in Washington and Oregon to obtain feedback about their organizations' orientation and preparation of new nurse managers through the NWone list-serve. After exclusion of inactive email addresses, approximately fifteen percent of participants responded (N=25). Only four percent (n=1) of the respondents were extremely satisfied with the orientation offered for

new/inexperienced nurse managers. Fifty-eight percent (n=14) of the respondents reported they were somewhat or extremely dissatisfied. Other information collected through the survey included a) are nurses hired directly after school graduation; b) whether the orientation program is evidence-based; c) the type of orientation provided; and d) if they felt their nurse managers would be interested in an online program lasting 5-10 hours to increase their knowledge and competency. Furthermore, none of the organizations sponsored AONE training. Lastly, the CNOs were asked to identify novice nurse manager or frontline leaders who might be interested in participating in the pilot program. Detailed survey results are available in Appendix H for review.

Based on recruiting by the CNOs, sixteen nurse managers volunteered to participate in the module pilot. Although not planned or controlled, the participants (N=16) were evenly divided managers working in Washington (n=8) and Oregon (n=8). Only one of the participants worked outside of the acute care setting. A pre-training survey link was distributed to all participants and was completed by one-third (n=5) of the participants. Responders reported leadership experience that ranged from less than one year (n=1), two to three years (n=1), and more than five years (n=3). Respondents reported a range of training from none (n=1), conferences (n=1), and leadership training within their organization (n=2). Other survey results are available in Appendix I for review. Additional information assessed through the survey included: a) highest level of nursing education/degree; b) number of staff reporting to the manager; c) size of facility; d) if the hospital has a certification/designation; e) if the manager was hired from the unit where they lead; f) certified in area of practice; g) prioritization of learning needs; and h) type of leadership/nursing training completed.

In addition to utilizing recommendations from the CNO and participant surveys, one of the first steps prior to module development was to create a crosswalk of AONE and QSEN competencies. As nationally recognized standards, the competencies provide guidelines for material that should be incorporated. Most of the competencies were represented by both AONE and QSEN. Of note, financial education was identified by both the CNO survey as well as AONE competencies but is not a specific QSEN competency. Utilizing the identified competencies and the surveys as a foundation, an outline of specific topics for modules was developed for review by the NWone Education Committee. A gap analysis identifying where sources of input that assisted with awareness of need is available in Appendix J.

Intervention

The program, named *Beginning at Novice*, is an innovative online program which includes comprehensive modules, sample tools, and resources for managers based on nationally recognized standards for nursing leadership competencies. *Beginning at Novice* was developed using of adult learning principles and reinforces the participant's need and utilize their organization's guiding principles including the mission, vision, values, and strategic plan, as well as key policies, procedures, and programs. This approach provided a focused and unique learning experience. Furthermore, utilizing the Benner (1984) defined learning domains, with an emphasis on self-reflection to guide learner development, *Beginning at Novice* embraces the learner's self-awareness and development with targeted instruction to resolve knowledge gaps. The modules were created independent of each other, but to compliment and progress over time with ongoing knowledge development. For example, Module 1 on leadership established foundational theory with tools and resources but also referred to other modules and how details and knowledge would be expanded in future modules. Other module themes included: human

resources, healthcare finances, change management and quality, and safety in healthcare. All of the modules were created to address knowledge gaps based on the national competencies previously identified. Specific module outlines and links to the video modules are available in Appendix K.

Project Timeline

The developed plan for the intervention was created on a Gantt chart to streamline efficiencies. The Gantt chart reflects timing, but one factor not incorporated into the initial timeline was the NWone review time prior to posting for participants. Due to the timing of turnaround and publishing modules, the modules were completed approximately three weeks behind schedule. The Gantt chart and Work Breakdown Structure with actual versus projected completion dates are available in Appendices L and M for review.

Strength, Weakness, Opportunities, and Threats (SWOT) Analysis

Due to the need for a change of practice to improve nursing leader education, there is strength in the plan. Some of the common weaknesses and threats were common for new initiatives such as participant or development costs and technology demands. Although no project or program is without hazards, there are limited threats to an initiative like *Beginning at Novice*. A noteworthy threat could be lack of engagement by senior nursing leaders who mentor and develop less experienced nurses. Furthermore, global support by the healthcare organization is important to support knowledge and competency development gained by interviews with Human Resources, Risk Management, Quality and Safety leaders. Engagement by the learners is also a threat unless the training is mandatory and completion can be validated. For this program, participants volunteered and there was no mechanism to validate module completion except with the post-training survey feedback. As noted earlier, the participants voluntarily enrolled for the

training after notification by their CNOs. It is unknown how much the CNOs may have coerced or encouraged the nurse managers to participant. The program timeline should include ample time for development of training curriculum as well as completion by the participants as demands on nursing managers may already be overwhelming (Doria, 2015). Consideration of program fees for participants would impact the number of participants. In addition to the novice nurse manager education, other topics could be identified to expand offerings. Lastly, there are multiple programs available that provide leadership development, but the efficient methods and ease of access for this project make this a more effective tool to utilize due to online distance learning as the main modality. Additional details on the strengths, weaknesses, opportunities, and threats can be viewed in Appendix N.

Return on Investment Plan

Spetz (2013) reported the principles of economics are impacted by preferences driven by comparisons between marginal costs and marginal benefits. Since the focus of *Beginning at Novice* was the development of knowledge and skills to enhance manager performance, financial outcomes were focused on cost avoidance, not increased revenue. After the initial program development, program costs are limited to participant time and updates based on evidence changes or review of material. For this program, the training was provided free of charge, and participants' perceptions of learning define the marginal benefits gained from the program. A true assessment of the financial impact would be based on reductions of hospital-acquired conditions (HACs) and turnover of managers and staff, but these elements will not be directly assessed for this initiative cycle. For large scale, broad program expansion, the plan could include data collection of pre- and post-training data for analysis of impact such as: (a) reduction of manager turnover; (b) reduction of staff turnover and safety events; and (c) reduction of HACs

and patient safety events. The budget, cost-benefit avoidance, and return on investment data is available for review in Appendices O and P.

Communication Matrix Plan

The project communication plan includes not only routine updates to advisory faculty but also communication with the NWone Education Committee and Executive Director. Monthly updates were planned as part of the project timeline and incorporated into the Gantt chart. Additionally, when unexpected delays impacted the timeline, updating both NWone as a stakeholder and the advisory faculty. Lastly, the module participants were key stakeholders who should be updated routinely as the timeline impacts their schedule as well. Overall, the goal of communication is to provide an update to stakeholders, but also to identify a mechanism to get back on schedule or, if unavoidable, adjust the timeline. The detailed communication matrix plan is in Appendix Q.

Cost-Benefit Avoidance

As previously noted, turnover rates are increasing, and personnel replacement is not only expensive, but it disrupts organizational operations (Yin & Jones, 2013). Healthcare organizations are focused on cost reduction. Given the cost and the difficulty of replacing staff and managers, addressing turnover will have a critical impact (NSI, 2016). *Beginning at Novice* may not reduce all RN staff or manager turnover, but even a small reduction could have a significant impact on healthcare organizations given the current economic challenges experienced in healthcare.

In addition to the impact on turnover, the Joint Commission (TJC) Sentinel Event #57 identifies the leadership responsibility for a culture of safety and may represent even more impact on quality and outcomes (TJC, 2017). As noted, research has demonstrated lack of

manager oversight due to turnover results in higher patient falls, and catheter-acquired urinary tract infections (Warshawsky, Rayens, Stefaniak & Rahman, 2013). Paige (2010) reported the average hospital spends an estimated $1,614,500 annually on HACs that are generally within the realm of nursing to prevent including, decubitus ulcers, post-operative pressure ulcers, post-operative respiratory failure, and infections. As noted with turnover, participation in this training will not completely prevent all HACs, but if effective leadership can reduce the impact by even 10%, it will represent a positive financial change and even more so, a benefit for patients. The potential cost avoidance impact and value chain analysis are available in Appendices O and R respectively.

Study of Interventions

While outcomes metrics related to improved patient safety and the reduction of staff and manager turnover would validate the effectiveness of the modules, this option was not feasible due to time limitations. Therefore, short-term indicators chosen to assess the intervention included: a) review of the modules by NWone; b) completion of a pre- and post-survey by participants; and c) use of a focus group with the participant CNOs to provide feedback on the modules.

Measures

There were several measures identified to assess the effectiveness of the intervention: a) feedback from NWone Education Committee; b) percentage AONE/QSEN competencies incorporated into the modules; and c) feedback from participants. Beginning with the NWone Education Committee feedback, the committee had the opportunity to preview the modules and provide feedback. For Module 1, feedback from the committee was incorporated into the slides and script to improve the overall product prior to recording. The following four modules were

viewed only after the module was recorded by the committee to reduce turnaround delays and improve efficiency. The second measure utilized to monitor the effectiveness of the intervention was review and update of the AONE/QSEN crosswalk tracking for covered elements. The crosswalk is available in Appendix S for review.

The third measure, participant input, was obtained prior to beginning the training, through a survey. Unfortunately, only five of the sixteen participants completed the survey. In the first module, the participants were also encouraged to complete the AONE manager competencies self-assessment to improve awareness of knowledge gaps. Although this program was not endorsed by AONE, the training is based on the AONE competencies. Due to limited feedback from participants during the project and in the post-training survey, input was also requested from cohort members and experienced managers to validate module effectiveness. The survey was created specifically for this project and provided general information. None of the selected metrics would provide information restricted only to the *Beginning at Novice* intervention, but when combined give directed feedback about its effectiveness. Lastly, assessing completion of the AONE/QSEN crosswalk elements will assist with outcome achievement.

Analysis

Several limitations were identified that might impact the program and data including enrolling sufficient participants who complete the entire program, obtaining feedback from the participants. Lack of support from the participant's organization for the interviews and other action steps identified for the modules could also hinder the leader's competency and knowledge development. Primary data from participant responses were analyzed with the goal to expand the program in the future with that would include secondary data related to pre- and post-training

nurse-sensitive indicators. There may be some maturity/development that occurs within the organization that influences the participant's learning that cannot be qualified or validated as unrelated to the program. Of course, there could also be barriers from a work standpoint that would impact the self-assessment negatively as well. Furthermore, responses from all participants were collected as aggregate data to protect confidentiality. It was important that the nurse managers felt comfortable giving true unbiased and accurate responses for program feedback. Lastly, the turnaround time for approval of the modules created unexpected delays that slowed efficiency of the program.

For the initial pilot, data were collected utilizing an online survey created using Qualtrics. Although the data points, participant group, and data analysis was limited, qualitative feedback provided by email from participants and the NWone Education Committee provided input regarding the program. The pre- and post-training survey results with questions are available in Appendices I and T for review.

Ethical Considerations

Grace (2018) states "ethical principles are useful in helping Advance Practice Nurse's (APNs) identify salient issues, … and affirm appropriate actions (p. 17). The American Nurses Association (ANA) Ethical Standards defines ethical considerations within the boundaries of clinical practice, but cites the need for a utilitarian approach supporting "what is best for the most people." Although *Beginning at Novice* is an online program and the participants did not meet in the physical sense of training, knowledge gaps and online communities can be very threatening. Ground rules were established to protect participant privacy and electronic communication was done through blinded email messages. Participants were invited to give input through threaded discussions, but limited communication from participants occurred.

Anonymous, aggregate data on the effectiveness of the training will be collected using an online Likert-scale survey as well as a post-training focus group for evaluation and impact of training. The original plan included assessment of participant learning by obtaining feedback of the nurse manager's learning through focus groups that would include both the participants and their CNOs. Given the limited feedback from participants during the program, this option was not performed with the concern that nurse manager might feel intimidated if the training had not been completed. Throughout the training, participants were encouraged to contact the developer for any concerns and provide program feedback.

The overall the program goal of enhancing the preparedness of nursing managers meets both ANA and Jesuit ethical principles improving not only the manager's readiness but also through improving health outcomes by reduction of HACs. Lastly, the statement of determination, available in Appendix U, was approved by the University of San Francisco Doctor of Nursing Practice Department as a non-research process improvement project.

Section IV Results

Results

Although the education of the novice nurse manager participants was the focus of the project, the entire intervention was more than the actual training provided. The intervention included all of the steps related to the development of a training program for use by NWone for nurse manager development. As a healthcare leadership organization, NWone wanted to offer healthcare organizations a training program for nursing managers.

Facilitating the creation of the modules with NWone was the initial step of the intervention. The voice-over PowerPoint slides were recorded individually and converted to an mP3 file for review by NWone. Following review by the NWone Education Committee, the

presentation link, module resources, and references were then forwarded to the participants for training. Throughout the development of the training, process improvements were made to improve the efficiency of the process, although no changes were made to the actual training modules.

In addition to the modules, references, and resources disseminated to the participants, email prompts were sent asking for program feedback, questions, and ideas to share on the topic. As previously noted, minimal feedback was received from participants. One participant left the program before the first module due to a job change. A second participant sent a message three months into the pilot during data collection stating due to time conflicts none of the modules had been completed. When the final module link was sent, participants were reminded of the goal for completion and notified of the reminder for the survey to be sent. One week later the survey was distributed via email. Two reminders were sent for feedback, but only two participants completed the post-training survey. After discussion with the faculty advisor, additional participants were enrolled to provide program feedback. Due to time limitations, some of the participants were unable to complete the full series or active learning objectives. A total of 12 respondents completed the survey with 58.3% (n=7) completing only the first module, 8.3% (n=1) completing two modules, and 33.3% (n=4) finishing the entire series. Sixty-six percent (n=8) of the participants cited too busy with other tasks to complete the series. None of the participants used the feedback selection of dislike of the module and/or format. Positive implications for *Beginning at Novice* included: 75% of respondents (n=9) strongly agreed, and the remaining 25% (n=3) somewhat agreed the modules helped improve knowledge and preparation as a nursing leader. Furthermore, 75% of respondents (n=9) had no suggestions for

improvement of the modules while 16% (n=2) reporting using a live format would enhance learning. Consolidated results from the survey are available in Appendix S for review.

Section V Discussion

Summary

The project aim was to create a program for use with novice nurse managers to support the development of leadership knowledge and skills. Although there was limited feedback and participation from the initial cohort group, the program has received positive feedback from NWone Education Committee, Executive Director, and participants via the survey. Other learnings from the project included both efficiencies related to the complexity of the overall development of the modules and complexity of the overall goal. Although the competencies from AONE and QSEN defined the elements that should be included for the training, curriculum development was time intensive due to the need for research for appropriate topics, development of resource and references, and the actual recording of the modules. Following the feedback provided by NWone on the first module prior to recording, the process was streamlined by proving the modules for review after recording which improved development efficiency.

Strengths of the project included the development of a series of modules that meets the established aim of enhancing the development of nursing leaders. It is anticipated that the modules will continue to be used by NWone for members with no additional time commitment for program development. Unfortunately, the method selected for the initial rollout of the program was not as successful as intended. An implication for advanced nursing practice is consideration of how to engage participants in personal development initiatives. The literature is rich with barriers to training implementation including the required time commitment of participants (Keys, 2014). One consideration currently in discussion to improve the program is

to reduce module length thus reducing time commitment for the participant. Other ideas include identification of a method to validate completion of the module in combination with offering continuing education units for participants. Furthermore, offering audio-only versions of the module to ease access for learners for example during a commute or other times when traditional access to PowerPoint slides would not be feasible. Lastly, using the modules with a mentoring or organizationally mandated training program where the manager is required to complete the modules and activities would support higher completion. It could assist with dedicated time that could be incorporated into the trainee's workload. The continuous quality improvement cycle is displayed in Appendix V.

Interpretation

In developing the project, it was anticipated that there would be more feedback from participants. As noted previously, the manager role can be overwhelming and time consuming leaving very little time for training. Nonetheless, a key responsibility for professionals is the development of knowledge and skills. In comparison to a live, classroom setting, this program is a cost-effective alternative. The Executive Director, NWone stated they plan to offer the training to member organizations who will have the opportunity to provide it and potentially require managers to complete the training (personal communication, March 7, 2018). For future professional and staff development purposes, anticipate a significant amount of time for development of the teaching materials, even with defined standards.

Limitations

The use of non-novice managers for the training, adding participants late in the program to increase feedback, and lack of ongoing communication and feedback from participants is a project limitation. The addition of participants after the initial program launch was a mitigating

factor to increase overall program feedback. Earlier intervention with the participants to continue their involvement or voluntary enrollment through an advertisement where the manager had self-enrollment in the training would have been beneficial. Although all of the participants were nursing leaders, some had significant leadership experience which might have impacted their learnings from the modules.

Conclusions

The purpose of this project was to create an online training program that integrates the AONE nurse manager competencies (2015) with the QSEN curriculum (2012) to assist in the competency development of novice nurse managers. As previously noted, the traditional in-person training method is expensive for both the participant to attend and also for the sponsoring organization. The *Beginning at Novice* program has confirmed that a video-based, module system and active learning objectives established on adult learning principles, can provide an effective, efficient process for novice leader development that is not cost or time prohibitive. Since the program design supported the training goals, NWone plans to continue use of the modules offering them for use in all member hospitals in Washington and Oregon. Future program planning will incorporate continuing education units for participants using an attestation of completion by the participant. Given the participant's organization will assign the training and ensure completion through direct observation, future participation is anticipated to increase. Furthermore, *Beginning at Novice* offers an incentive as a NWone member benefit. Although limited feedback was obtained on this project, it is clear that the development of nursing managers and leaders remains essential to improve healthcare quality and meet Nightingale's (n.d.) goal for "the right thing to always be done."

Section VI Other information

Funding

The program was developed as a scholarly project by a doctoral candidate free of charge. NWone hosted *Beginning at Novice* for no charge for all participants with no restrictions or requirements of membership. Participant time was estimated at ten hours for module and learning objective completion, but this time was considered professional development. NWone will determine the ongoing program development as a membership benefit. A project budget is available in Appendix N for review if the program is implemented. Although not realized for this pilot program, a potential cost avoidance and value chain impact is available in Appendices O and R respectively.

Section VII

References

American Association of Colleges of Nursing. (2012). Graduate-Level QSEN Competencies Knowledge, Skills and Attitudes. Retrieved from: http://qsen.org/competencies/graduate-ksas/.

American Organization of Nurse Executive. (2015). AONE Nurse Manager Competencies. Chicago, IL: Author. Accessed at www.aone.org.

American Nurse Credentialing Center. (2017). Standards for Pathways to Excellence and Magnet Designation. Retrieved from: http://www.nursecredentialing.org/Certification.

Arnold, J. (2012). Cost of hiring new nurses. Nurses' World Blog. Retrieved from: http://nursing.advanceweb.com/Features/Articles/Cost-of-Hiring-New-Nurses.aspx.

Baxter, C., & Warshawsky, N. (2014). Exploring the acquisition of nurse manager competence. *Nurse Leader*, February 2014; 46-59.

Benner, P. E. (1984). *From novice to expert: Excellence and power in clinical nursing practice.* Menlo Park, CA: Addison-Wesley Publishing, Nursing Division.

Budden, J. S., Zhong, E. H., Moulton, P., & Cimiotti, J. P. (2013). Highlights of the national workforce survey of registered nurses. *Journal of Nursing Regulation* 4(2), 5-14.

Classen, D. C., Resar, R., Griffin, F, Federico, F., Frankel, T., Kimmel, N., Whittington, J. C., Frankel, A., Seger, A., & James, B. C. (2011). Global trigger tool shows that adverse events in hospitals may be ten times greater than previously measured. *Health Affairs Today,* April 2011, 30(4) 581-589. doi: 10.1377hlthaff.2011.0190

Covelli, B. J. (2017) Online Discussion Boards: The Practice of Building Community for Adult Learners. *The Journal of Continuing Higher Education*, 65:2, 139-145, doi: 10.1080/07377363.2017.1274616

Collini, S. A. Guidroz, A. M., & Perez, L. M. (2015). Turnover in health care: The mediating effects of employee engagement. *Journal of Nursing Management*, 2015, 23, 169-178. doi: 10.1111/jonm.12109

Cox, C., Dunn, A. Rittmueller, L., & Whitmire, B. (2016). A new way of measuring health costs sheds light on recent health spending. Retrieved from: http://www.healthsystemtracker.org/brief/a-new-way-of-measuring-health-costs-sheds-light-on-recent-health-spending-trends/?_sft_category=spending.

Cummings, G. G., MacGregor, T., Davey, M., Lee, H., Wong, C. A., Lo, E., Muise, M., & Stafford, E. (2010). Leadership styles and outcome patterns for the nursing workforce and work environment: A systematic review. *International Journal of Nursing Studies*, 47, 3630385. doi: 10.1016/j.ijnurstu.2009.08.006

Cziraki, K., McKey, C., Peachey, G., Baxter, P., & Flaherty, B. (2014). Factors that facilitate registered nurses in their first-line nurse manager role. *Journal of Nursing Management*, 2014, 22, 1005-1014. doi: 10.1111/jonm.12093

Dang, D., & Dearholt, S. L. (2017). *Johns Hopkins Nursing Evidence-Based Practice Module and Guidelines*. 3rd ed. Indianapolis, IN: Sigma Theta Tau International.

Doria, J. (2015). Successful transition from staff nurse to nurse manager. *Nurse Leader*, February 2015, 78-81. doi.org/10.1016/j.mnl.2014.07.013

Duffield, C. M., Roche, M. A., Blay, N., & Stasa, H. (2010). Nursing unit managers, staff retention and the work environment. *Journal of Clinical Nursing*, 20, 23-33. doi: 10.1111/j1365-2702.2010.03478.x

Gallo, K. (2007). The new nurse manager: A leadership development program paves the road to success. *Nurse Leader*, 2007, August, 28-32. doi: 10.1016/jmnl.2007.05.004

Grace, P. J. (2018). *Nursing Ethics and Personal Responsibility in Advanced Practice*, 3rd ed. Burlington, MA: Jones & Bartlett Learning.

Hampton, D., & Keys, Y. (2016) Generation Z: Emerging force in the workplace. *Voice of Nursing Leadership*, November, 14-16.

Havaei, F., Dahinten, V. S., & MacPhee, M. (2015). The effects of perceived organisational support and span of control on the organisational commitment of novice leaders. *Journal of Nursing Management*, 2015, **23**, 307-314. doi: 10.1111/jonm.12131

Herman, B. (2013). 10 statistics on hospital labor costs as a percentage of operating revenue. *Becker's Report*, December 10, 2013. Retrieved from: http://www.beckershospitalreview.com/finance/10-statistics-on-hospital-labor-costs-as-a-percentage-of-operating-revenue.html.

Hudgins, T. A. (2016) Resilience, job satisfaction and anticipated turnover in nurse leaders. *Journal of Nursing Management*, 2016, 24, E620E69. doi: 10.1111/jonm.12289

Institute of Medicine (IOM). 2011. *The future of nursing: Leading change, advancing health*. Washington, DC: The National Academies Press. Retrieved from: http://www.nationalacademies.org/hmd/Reports/2010/The-Future-of-Nursing-Leading-Change-Advancing-Health.aspx.

Joint Commission, The. (2017). Sentinel event alert #57: Leadership responsibilities for a culture of safety. Retrieved from: https://www.jointcommission.org/assets/1/18/SEA_57_Safety_Culture_Leadership_0317.pdf

Keys, Y. (2014). Looking ahead to our next generation of nurse leaders: Generation X nurse managers. *Journal of Nursing Management*, 2014, 22, 97-105. doi: 10.111/jonm.12198

Kirby, K., & DeCampli, P. (2008). Nurse manager development beyond the classroom. *Nurse Leader*, April, 2008, 44-47. doi: 10.1016/j.mnl.2008.02.005

Korth, J. (2016). Communication and coaching: Keys to developing future nurse leaders. *Nurse Leader* 2016, 207-211. http://dx.doi.org/10/1016/j.mnl.2015.04.004

Levitt, L., Claxton, G., Cox, C., Gonzales, S., & Kamal, R. (2014). Assessing the performance of the U.S. health system. Retrieved from: http://www.healthsystemtracker.org/insight/assessing-the-cost-and-performance-of-the-u-s-health-system/.

Malloch, K. & Porter-O'Grady, T. (2009). *The quantum leader applications for the new world of work*. Sudbury, MA: Jones and Bartlett.

Maragh, K. A. (2011). The nurse leader as change agent and role model: Thoughts of a new nurse manager. *Nurse Leader*, 2011, 39-42. doi. 10.1016/j.mnl/2010.09.007

McAlearney, A. S. (2006). Leadership development in healthcare: A qualitative study. *Journal of Organizational Behavior*, 2006, 27, 968-982. doi: 10.1002/job.417

Miltner, R. S., & Dawson, M. A. (2015). Professional development needs of nurse managers. *The Journal of Continuing Education in Nursing*, 2015, 46(6), 252-258. doi: 10.3928/00220124-20150518-01

Moore, L. W., Sublett, C., & Leahy, C. (2016). Nurse managers' insights regarding their role highlight the need for practice change. *Applied Nursing Research*, 30 (2016) 98-103. http://dx.doi.org/10.1016/j.aprn.2015.11.006

National Council of State Boards of Nursing. (2013). The 2013 National RN Workforce Survey. Retrieved from: https://www.ncsbn.org/workforce.htm.

Nightingale, Florence. (n.d.). BrainyQuote.com. Retrieved from BrainyQuote.com Web site: https://www.brainyquote.com/quotes/quotes/f/florenceni752509.htl.

Nursing Solutions, Inc. (2016). National healthcare retention & RN staffing report. Retrieved from: www.nsinursingsolutions.com.

Oregon Center for Nursing. (2014). Oregon's research initiative on the organization of nursing: Initial finding. Retrieved from: https://www.oregon.gov/oha/analytics/HealthCareWorkforceReporting/Nurses-Wanted-Demand-Report.pdf.

Pabio, C., & Cadmus, E. (2016). Using the Pathway to Excellence framework to create a culture of sustained organizational engagement. *Nurse Leader*, June, 2016, 203-206. http://dx.doi.org/10/1016/j.mnl.2016.01.005

Paige, L. (2010). 5 most common hospital acquired conditions based on total costs. *Becker's Hospital Review*, September 16, 2010. Retrieved from: http://www.beckershospitalreview.com/hospital-management-administration/5-most-common-hospital-acquired-conditions-based-on-total-costs.html.

Porter-O'Grady, P. (2014). From tradition to transformation: A revolutionary moment for nursing in the age of reform. *Nurse Leader*, 2014; February, 65-69. http://dx.doi.org/10.1016/j.mnl.2013.08.006

Portoghese, I., Galletta, M., Battistelli, A., & Leiter, M.P. (2015). A multilevel investigation on nursing turnover intention: The cross-level role of leader-member exchange. *Journal of Nursing Management*, 2015, **23**, 754-764. doi: 10.1111/jonm.12205

Robert Wood Johnson Foundation. (2009). Evaluation of the Robert Wood Johnson Foundation Wisdom at Work Initiative. Retrieved from: http://www.rwjf.org/content/dam/files/legacy-files/article-files/2/revlewinevalrnturnover.pdf.

Schneider, M., & Somers, M. (2006). Organizations as complex adaptive systems: Implications of Complexity Theory for leadership research. *The Leadership Quarterly* 17 (2006), 351-365. doi: 10.1016/j.leaqua.2006.04.006

Spetz, J. (2013). The economic context of nursing practice in the United States. In K. T. Waxman (Ed.). Financial and business management for the doctor of nursing practice (pp. 22-37). New York, NY: Springer Publishing Company.

Squires, D., & Anderson, C. (2015). U.S. health care from a global perspective: Spending, use of services, prices, and health in 13 countries. Retrieved from: http://www.commonwealthfund.org/publications/issue-briefs/2015/oct/us-health-care-from-a-global-perspective.

Sylvia, M. L., & Terhaar, M. F. (2014). *Clinical analytics and data management for the DNP*. New York, New York: Springer Publishing Company.

Uhl-Bien, M., Marion, R., & McKelvey, B. (2007). Complexity leadership theory: Shifting leadership from the industrial age to the knowledge ear. T*he Leadership Quarterly* 18 (2007), 299-318. doi: 10.1016/jleaqua.2007.04.002

U.S. Department of Labor, Bureau of Labor Statistics. (2016). Occupations with most job

growth 2014-2024. Retrieved from: http://www.bls.gov/news.release/ecopro.t06.htm.

Warshawsky, N. E., & Havens, D. S. (2014). Nurse manager job satisfaction and intent to leave. *Nursing Economics*, 32(1). 32-39.

Warshawsky, N., Rayens, M. K., Stefaniak, K., & Rahman, R. (2013). The effect of nurse manager turnover on fall and pressure ulcer rates. *Journal of Nursing Management*, 2013, 21, 725-732. doi: 10.1111/jonm.12101

Washington Center for Nursing. (2015). Estimated Washington State RN supply and demand. Retrieved from: https://www.wcnursing.org/data-resources/other-wa-health-and-workforce-organizations/.

Westcott, L. (2016). How coaching can play a key role in the development of nurse managers. *Journal of Clinical Nursing*, 25, 2669-2677. doi: 10.111/jocn.13315

Witges, K., & Scanlan, J. M. (2014). Understanding the role of the nurse manager: The full-range leadership theory perspective. *Nurse Leader*, December, 2014. http://dx.doi.org/10/1016/j.mnl.2014.02.007

Wong, C. A., Spence Laschinger, H. K., & Cummings., G. G. (2010) Authentic leadership and nurses' voice behaviour and perceptions of care quality. *Journal of Nursing Management*, 2010, 18, 889-900.

Wong, C. A., Cummings, G. G., & Ducharme, L. (2013). The relationship between nursing leadership and patient outcomes: A systematic review update. *Journal of Nursing Management*, 2013, 21, 709-724. doi: 10.111/jonm.12116

Yin, L, & Jones, C. B. (2013). A literature review of nursing turnover costs. *Journal of Nursing Management*, 2013, 21, 405-418. doi: 10.1111/j.1365-2834.2012.01411.x

Section VIII

Appendix A

Table 1: Evidence Review

Citation	Type of Research	Design/Method and Sample	Other data/factors	Outcomes/Limitations	CI/Odds ratio	Level/Quality Appraisal to Practice:
Baxter and Warshawsky (2014)	Non-experimental; non-randomized electronic survey of nurse managers working at two organizations that was completed by 37 nurses.	The Nurse Manager Skills Inventory Tool was used to assess 15 competencies in the 3 domains where managers self-assessed on Benner 1-5 scale.	One organization provided detailed descriptions of the skills. Item scores were averaged by individual then averaged to create a mean score for each competency category.	**Outcomes:** The only managers identifying themselves as "expert" was for clinical practice after 6-10 years of experience. With the exception of clinical practice, it took 6 years for managers to reach "proficient". Lowest scores for all respondents were for the science domain in financial management. **Limitations:** Some variation of how the questionnaires and explanations were given to participants. Overall a small sample given the size of the organizations.	N/A	Level III B Appraisal: Small sample, good information.
Cowden, Cummings, Profetto-McGrath (2011)	A systematic review of published English language	Data was extracted from 23 articles to understand the relationship	The nursing shortage is impacting safety and quality of care. "Relational	**Outcomes:** A positive relationship between transformational leadership, supportive work environments and staff	N/A	Level III A Appraisal to practice: Great

	articles on leadership practices and staff nurses' intent to stay.	between nurses' intent to stay and manager leadership practices.	leadership styles attentive to the individual needs of the nurse promote staff nurses' intention to stay" (p.472).	nurses' intentions to remain in their current position. **Limitations:** Clarifying concepts intent to stay and intent to leave is needed for establishment of theoretical foundation and research.		analysis of information.
Cummings, MacGregor, Davey, Lee, Wong, Lo, Muise and Stafford (2010)	A systematic review	Review identified 34,664 titles, 53 included in study.	Categories identified: -Staff satisfaction -Staff relationship with work -Staff health and wellbeing -Work environment factors -Productivity and effectiveness	**Outcomes:** 24 studies reported that leadership styles focused on people and relationships associated with higher nurse satisfaction. 10 studies showed transactional styles were associated with lower satisfaction. **Limitations:** Potential for reporting bias. No RCTs and limited control for extraneous variables	NA	Level III A Appraisal to practice: Great analysis of information.
Keys (2014)	A qualitative survey of Generation X nurse managers for perspectives on professional success, fulfilment and environment conducive for loyalty.	Perspectives of 16 Generation X nurse managers were obtained through questionnaires and telephone interviews by the primary investigator. Interviews were recorded for	During the interview, 13 questions were asked. Directed content analysis was utilized for interpretation and results were verified by another researcher with "no vested interest" (p. 100).	**Outcomes:** Professional success based on staff providing quality patient care as well as meeting defined metrics. They noted the lack of training/preparation for the position. Barriers to fulfillment included workload, training/preparation and lack of work/life balance.	N/A	Level III B Appraisal to practice: Although small sample size, it was good information for practice.

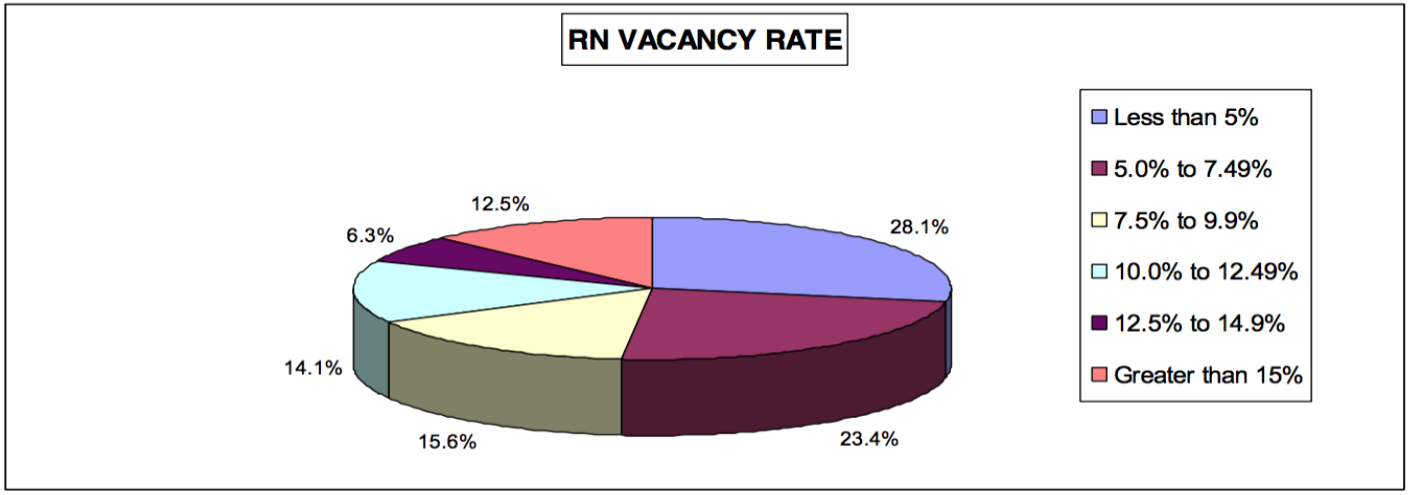
		review and validation.		**Limitations:** Sampling methods as well as limited ability to transfer findings from a Magnet facility to general hospitals.		
Moore, Sublett, Leahy (2016)	A descriptive, qualitative study to understand the insights of nurse managers regarding their role	Content analysis was done to analyze data. Participants must have been in position at least one year; 13 participated from 5 organizations of the original 18 recruited.	Nurse manager vacancies are increasing. Identifying ways to improve the nurse manager role and preparation. Two feedback themes: "Someone to walk along side" and "a stronger foundational knowledge" (p. 100).	**Outcomes:** 75% of participants reported minimal to no preparation/support when orienting to position. Findings document need to change manager preparation. **Limitations:** Small participant group, but similar findings to other studies.	N/A	Level III A Appraisal to practice: Great analysis of information.
Portoghese, Galletta, Battistelli, Leiter (2015)	Non-experimental, non-randomized, self-administered survey.	Aggregated data of 935 nurse from 4 Italian hospitals	Hierarchal linear modelling showed job satisfaction mediated the relationship between job characteristics and intention to leave. Leader-staff interaction impacted intent to leave.	**Outcomes:** Work environments impacted job satisfaction and intent to change positions. **Limitations:** Review of data delayed; convenience sample limits generalizability.		Level III B Appraisal to practice: Good analysis of information.

Warshawsky, Rayens, Stefaniak, & Rahman (2013)	Longitudinal quasi-experimental study used to determine whether unit characteristics including manager turnover have an effect on pt falls or HAPU	A convenience sample of 23 nursing units in two hospitals, a large 569-bed academic medical center (37%) and a 222-bed community hospital (63%).	Assessed comparable MedSurg and ICU units with NM turnover and those with consistent leadership over nine- quarters of pt outcome data ranging from October 2009-December 2011. Of the 23 units, 13 had experienced interim nurse management (which was classified as turnover) and 10 had stable leadership. Interim leadership average was 19.5 weeks with range of 0-63 weeks in length.	**Outcomes:** Nurse manager turnover and intensive care status were associated with more pressure ulcers; MedSurg units with more falls. **Limitations:** The researchers reported small sample size. Additionally, qualifications of interim leadership as well as the stable unit leadership are not assessed.	MedSurg pt falls compared to ICU ($F1,11=15.9$, $P = 0.002$). Pts with NM turnover [OR: 3.16; 95% CI: 1.49-6.70] and ICU (OR: 2.70; CI 95%:1.33-5.49) more likely to develop pressure ulcers.	Level IIA Appraisal to practice: Important information for practice and consideration.

Appendix B

Figure 1: RN Vacancy Rate

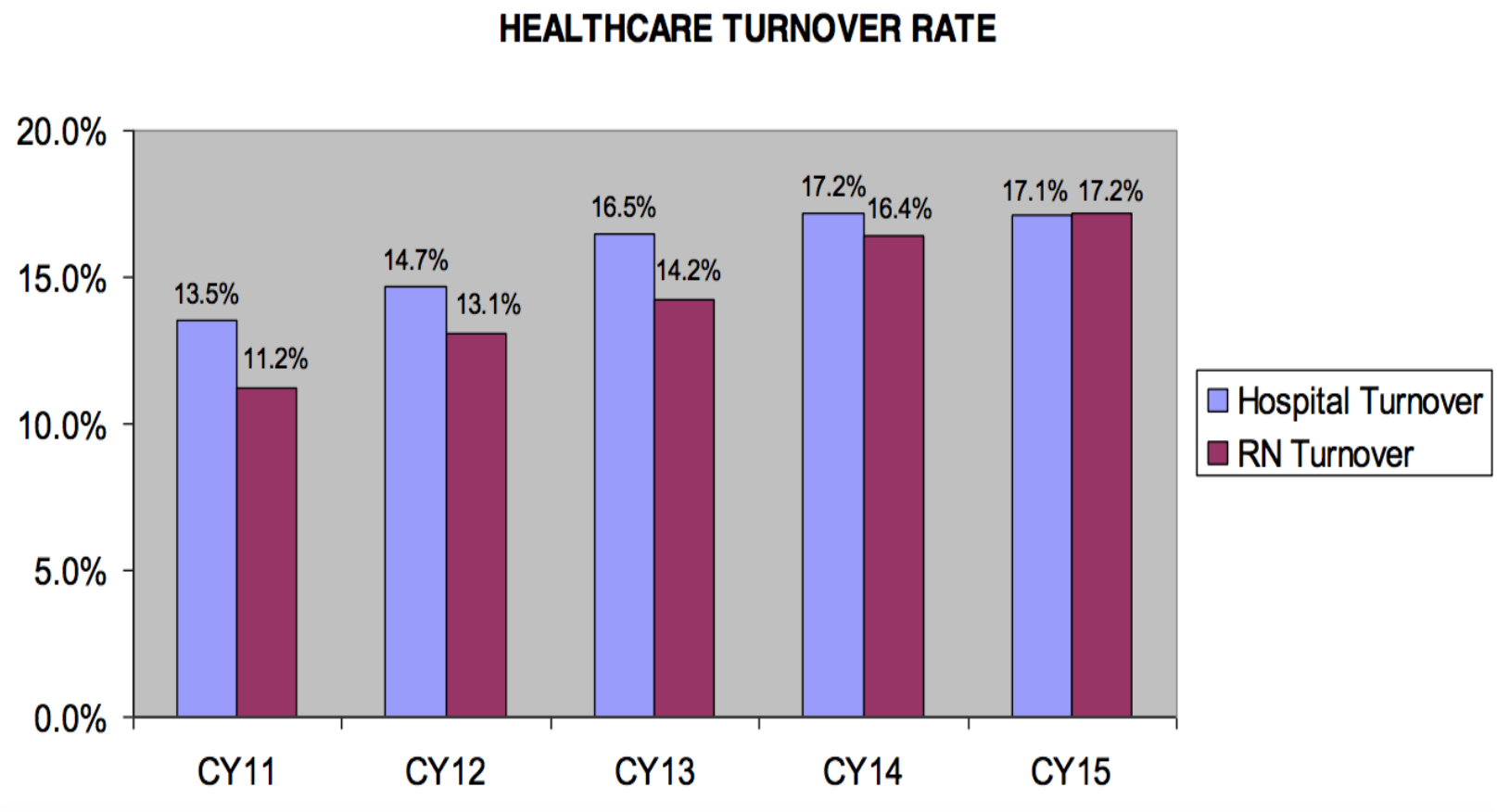
RN VACANCY RATE	2012	2013	2014	2015	2016
Less than 5%	59.5%	48.3%	41.0%	34.3%	28.1%
5.0% to 7.49%	23.8%	14.7%	20.5%	25.7%	23.4%
7.5% to 9.9%	11.9%	18.9%	17.9%	15.7%	15.6%
10.0% to 12.49%	2.4%	11.2%	10.3%	10.0%	14.1%
Greater than 12.5%	2.4%	7.0%	10.3%	14.2%	18.8%



Source: Nursing Solutions, Inc. (2016). National healthcare retention & RN staffing report. Retrieved from: www.nsinursingsolutions.com.

Appendix C

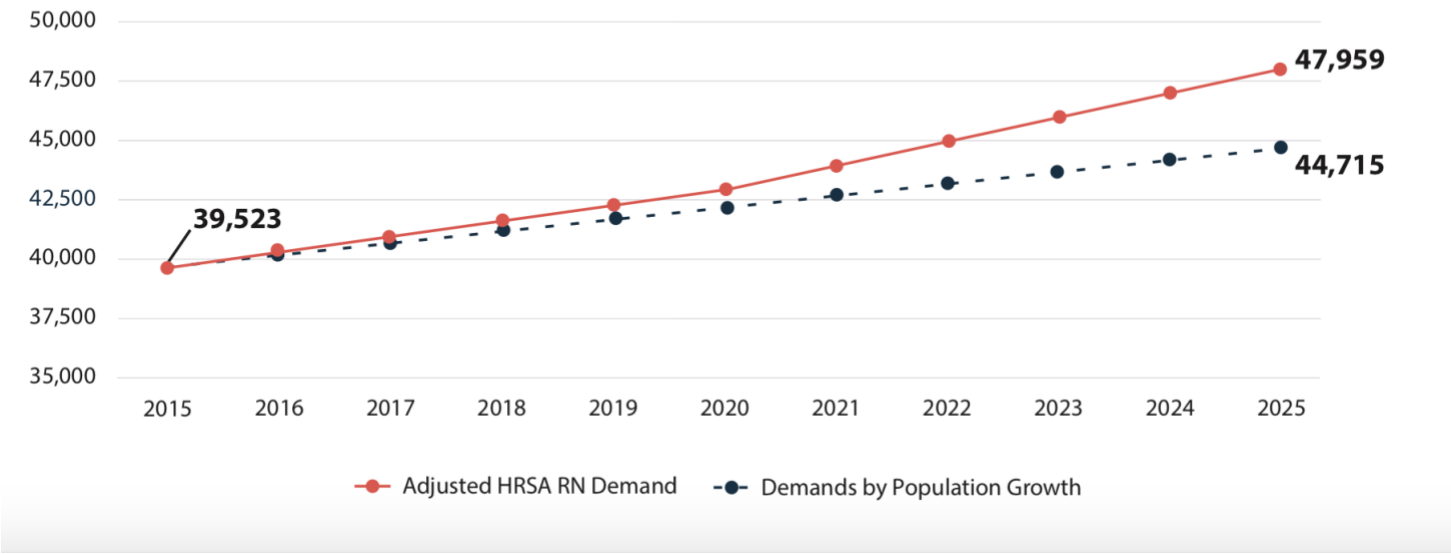
Table 2: Nursing Healthcare Turnover Rate



Source: Nursing Solutions, Inc. (2016). National healthcare retention & RN staffing report. Retrieved from: www.nsinursingsolutions.com.

Appendix D

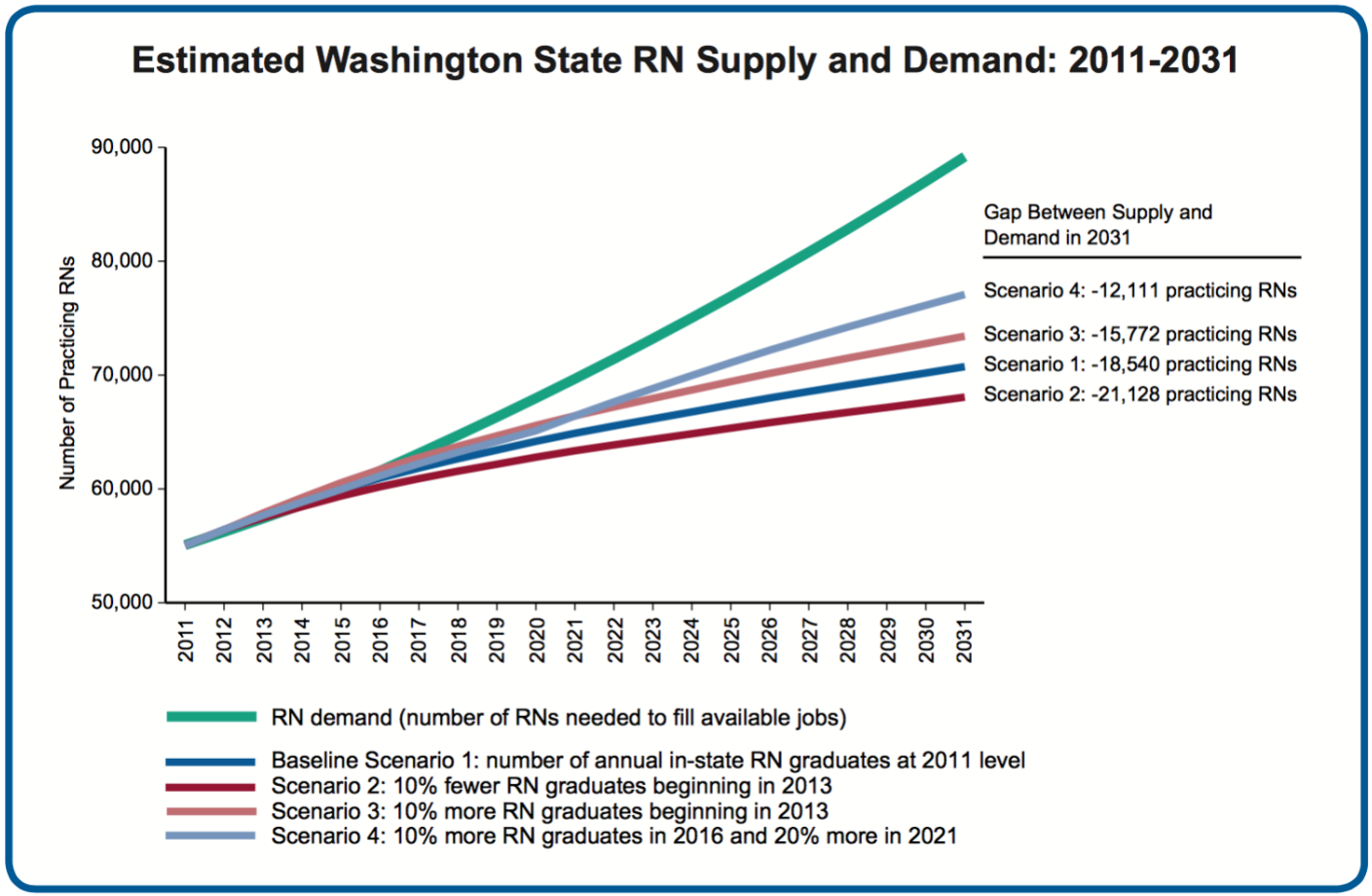
Table 3: Forecast of Oregon RN Supply and Demand



Source: Oregon Center for Nursing

Appendix E

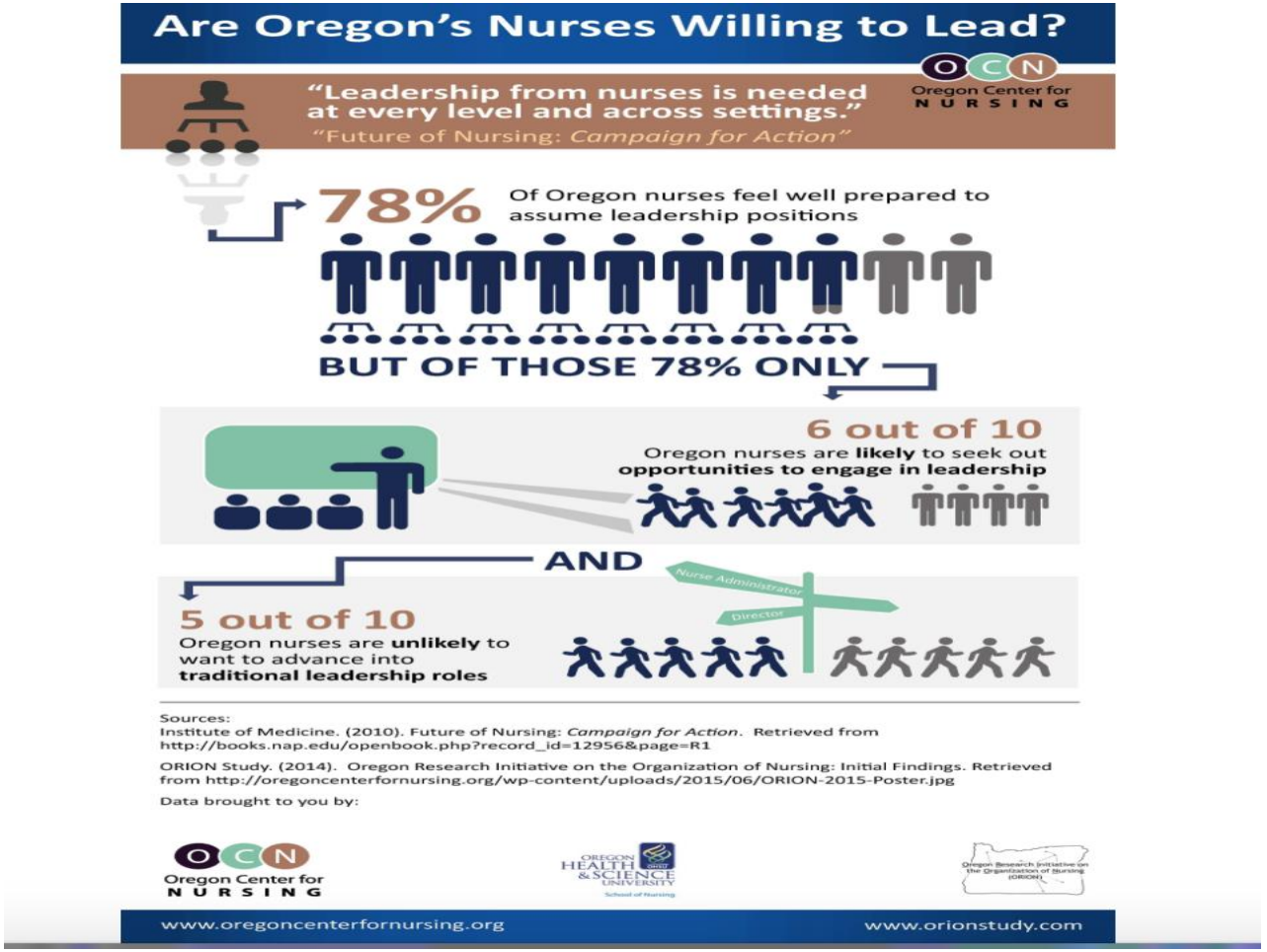
Figure 2: Forecast of Washington State RN Supply and Demand



Source: Washington Center for Nursing

Appendix F

Figure 3: Oregon Nursing Willingness to Leader



Source: Oregon Center for Nursing.

Appendix G

Organizational Letter of Support

Letter of Support

This letter outlines the agreement between Northwest Organization of Nurse Executives (NWONE) and Kathy Bay, Doctor of Nursing Practice Program, University of San Francisco. In support of her doctoral project, Kathy will create an online training program that will be posted on the NWONE training portal.

1. An online questionnaire for Nurse Executives will be created by Kathy and sent out to NWONE Chief Nursing Officer (CNO) list serve based on Quality and Safety Education for Nurses (QSEN) and the American Organization of Nurse Executive (AONE) competencies for the nurse manager.
2. Kathy will tabulate results of survey and share with NWONE.
3. The NWONE list serve will be utilized to identify potential participants for the novice nurse manager training program
4. Based on review of evidence and CNO feedback, Kathy will create a training module that will serve as a beta-test for nurse managers
5. Based on feedback from the beta-test, Kathy will create five to ten additional modules focused on the highest priority topics identified through literature review and survey feedback.
6. At the conclusion of the training, NWONE will maintain control of the training for organizational purposes at no cost.
7. Kathy will seek feedback from participants though a survey and focus group. Participation in the training and evaluator feedback is voluntary.

Signing below indicates agreement with the above information:

NWONE Jane M. Hutcheson 4/25/2017 Date

University of San Francisco K T Waxman Date 5/1/17

Appendix H

Table 4: Chief Nursing Officer Survey Results

Q1 - How does your organization train/orient new nurse managers?				
Succession planning 17.07% (n=7)	General orientation given by Human Resources Department 29.27% (n=12)	Through AONE competency development program (n=0)	Peer or preceptor assignment39.02% (n=16)	No specific training program 14.63% (n=6)
Q2 - How satisfied are you with the orientation program offered to new or inexperienced nurse managers?				
Extremely satisfied 4.17% (n=1)	Somewhat satisfied 29.17% (n=7)	Neither satisfied or dissatisfied 8.33% (n=2)	Somewhat dissatisfied 50% (n=12)	Extremely dissatisfied 8.33% (n=2)
Q3 - Is the orientation program for novice nurses evidence based?				
Definitely Yes 25% (n=6)	Probably Yes 20.83% (n=5)	Might or might not 20.83% (n=5)	Probably not 29.17% (n=7)	
Q4 - Are you familiar with the AONE Nurse Manager Competency program?				
Definitely yes 41.67% (n=10)	Probably yes 12.5% (n=3)	Might or might not 12.5% (n=3)	Probably not 12.5% (n=3)	Definitely not 20.83% (n=5)
Q5 - Has your organization sponsored nurse managers to complete the AONE program?				
Yes 16.67% (n=4)				No 83.33% (n=20)
Q6 - Do you think novice nurse managers at your organization are familiar with the American Association of Colleges of Nurses (AACN) Quality and Safety Education for Nurses (QSEN) training standards?				
Definitely yes (n=0)	Probably yes 4.17% (n=1)	Might or might not 29.17% (n=7)	Probably not 54.17% (n=13)	Definitely not 12.50% (n=3)
Q7 - Do you hire nurses directly after graduating from nursing school?				
Yes 95.83% (n=23)				No 4.17% (n=1)
Q8 - Do you think novice nurse managers in your organization would be interested in completing a 5-10 hour online training program based on national standards to increase their knowledge and competency?				
Definitely yes 33.3% (n=8)	Probably yes 50% (n=12)	Might or might not 16.67% (n=4)	Probably not 0% (n=0)	Definitely not 0% (n=0)
Q9 - If it were included in the program, would you or someone in your organization be available to provide coaching based on specific learning modules for your nurse manager if s/he participated in the program?				
Definitely yes 58.33% (n=14)	Probably yes 25% (n=6)	Might or might not 16.67% (n=4)	Probably not 0% (n=0)	Definitely not 0% (n=0)

Q10/Q11 - There is a significant amount of material to cover for training a training program. What specific areas of focus do you feel are important to include in the training? Is there anything else you think should be considered for education of novice nurse managers?

Priorities (General)	Frequency Reported
Finance, budget	10 Cost=1 Zero-based budget=1
Interpersonal Management	Conflict management=6 Communication=1 Difficult conversation=1 Tools=1
Human Resources	Coaching=6 Accountability=6 Union Contracts/Management=3 Discipline=2 Management=2 Evaluations=1 Recruiting=1 Diversity=1 Employee Relations=1
Professional Development	Coaching=6 Developing others=4 Succession Planning=2 Peer to boss=1
Time Management	Time Management=5 Self-Care=4 Work-Life Balance=2
Leadership	Transformational=3 Leadership=2 Motivation=2 Change Management=2 Creating vision=1
Quality/Safety	Quality/Safety=6 Regulatory=1 Legal=1 Quality Improvement=1
Patient Experience	Patient Experience=1 Service Recovery=1

Appendix I

Table 5: Participant Pre-Training Survey Results

Q1 - Please select your length of experience as a nurse manager.				
No experience, I'm not a manager 0% (n=0)	0-1 years 33.3% (n=2)	2-3 years 16.67% (n=1)	4-5 years 0% (n=0)	More than 5 years 50% (n=3)
Q2 - How many staff (employees) report to you?				
Less than 10 0% (n=0)	11-20: 20% (n=1)	21-30: 20% (n=1)	31-50: 20% (n=1)	More than 50: 20% (n=1)
Q3 - Please select the hospital size that most closely relates to your facility.				
Critical Access 40% (n=2)	25-50 beds 0% (n=0)	51-100 beds 20% (n=1)	101-150 beds 20% (n=1)	More than 150 beds 20% (n=1)
Q4 - Please check any of the below designations applicable for your hospital.				
Pathways to Excellence 33.33% (n=1)	Magnet Recognition 33.33% (n=1)	Baldridge Award 33.33% (n=1)		
Q5 - Were you hired from the unit where you are or will be the manager?				
Yes 33.33% (n=2)	No 66.67% (n=4)			
Q6 - Please select your highest nursing education or college degree.				
Diploma 0% (n=0)	Associates Degree 16.67% (n=1)	Bachelor's Degree 33.33% (n=2)	Master's Degree 50% (n=3)	
Q7 - Are you certified in your area of practice?				
Yes 33.33% (n=2)	No 66.67% (n=4)			
Q8 - Training Priorities: Consolidated Training Prioritized by Participants.		**Q9 - Training Completed**		
Managing Change Time Management, Work-Life Balance, Preventing Burnout Delegation Human Resources including discipline, contracts, hiring, and evaluations Quality and Safe Patient Care Interpersonal Management Finance including budgeting/budget building, variance writing Leadership		AONE Essentials of NM Orientation 0% (n-0) Nurse leadership training within organization 40% (n=2) Nurse leadership fellowship through national org. 0% (n=0) None 40% (n=2) Other: Conferences 20% (n=1)		

Appendix J

Figure 4: *Beginning at Novice* Gap Analysis

"Let whoever is in charge keep this simple question in her head not, how can I always do the right thing myself, but how can I provide for this right thing to be always done?" (Nightingale, n.d.). The design of *Beginning at Novice* started with an awareness of the knowledge gaps and lack of tools readily available for development of nursing leaders.

Appendix K

Table 6: *Beginning at Novice* Module Outline

Module 1: Leadership
- Introduction, admin processes for program
- Future of Nursing Campaign
- Institute of Medicine: To Err is Human
- Quality of Care
- Culture of Safety
  - TeamStepps
  - Just Culture
- Leadership Styles
  - Empowerment
  - Shared governance
  - Visiblity
  - Renters versus owners
- Self-Care
  - Meditation and journaling
  - Boundary setting
Module 1 Leadership:
https://youtu.be/60nmGm-M9o0.
	Module 2: Human Resources
	- Labor law
	- State guidelines
	- Human Resources policies
	- Discipline
	- Just Culture
	- Nurse Practice Act
	- Staffing Ratios
	- National Council State Boards of Nursing training
	- Documentation
	- Hiring
	- Termination
	- Safety
	- Grievance process
	- Contract/Unions
	
	Module 2 Human Resources:
	https://m.youtube.com/watch?v=cPHPBOeIV0M&feature=youtu.be.

- Module 3: Change Management - Lean - 6 Sigma - IHI training - PDSA cycle - Project management - Small tests of change	Module 4: Healthcare Finance - Budget - HPPD - Variance - Revenue - Expenses - Capital/Non-capital planning and expenses - Patient days

<table>
<tr>
<td>
 Unit culture
 Journaling
Module 3 Change Management:
https://youtu.be/U3ZPG9SSPc4.
</td>
<td>
 Journaling
Module 4 Healthcare Finance:
https://youtu.be/KzNPmn81NPk.
</td>
</tr>
<tr>
<td colspan="2">
Module 5: Quality and Safety
 Healthgrades
 Pay for performance
 Regulatory/Accreditation
 Magnet/Pathway for Excellence
 Culture of Safety
 Patient Grievance
 RCA, FMEA, Risk Management
 Swiss cheese model
 TeamStepps
 Journaling
Module 5 Quality and Safety: https://youtu.be/ppFN5gCCDXI.
</td>
</tr>
</table>

Appendix L

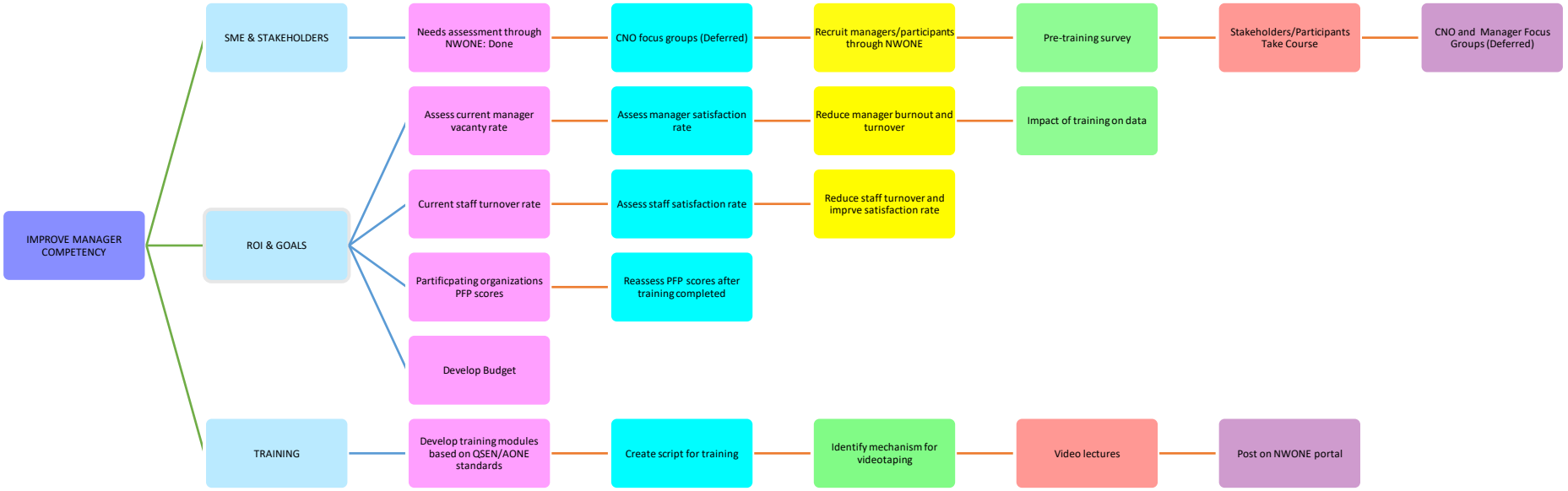
Figure 5: Gantt Chart

Task	2017										2018		
	1/1-4/1	5/1	6/1	7/1	8/1	9/1	10/1	11/1	11/15	12/15	1/15	2/15	3/15 -5/15
Literature research for module content	X	X	X					X					
Consider ROI and project timeline	X	X											
Venture concept development (Module)	X	X		X	X	X	X	X	X	**Completed 12/8**			
Stakeholder analysis/Niche identification	X	X											
Outreach to stakeholders with marketing campaign		X	X	X	X								
Identification of local resources for partnering			X	X	X								
Stakeholder focused advertising/recruiting		X	X	X									
Enroll participants for initial program				X							**X**		
Pre-training survey for managers and CNOs				X									
Training begins					8/15								
Committee chair update				X	X	X	X	X	X	X	X	X	
Check in with participants for feedback, prompts, and status (plan monthly)				X	X	X	X	X	X	X			
Updates to NWone (Stakeholder)				X	X	X	X	X	X	**X**	**X**		
Course completion reminder for module completion								X	X	**X**			
First participant group completes course									X	**X**			
Post course assessment/focus group or surveys									X	**X**			
Preliminary data analysis complete										X	**X**		
Follow-up data assessment at 3 and 6 month points											**In progress**		
Further development of program						X				X			X

Actual completion dates in blue.
Additional recruitment due to initial participant group dropout.

Appendix M

Figure 6: Work Break Down Structure



Appendix N

Table 7: SWOT Analysis

Strengths	Weaknesses
• Literature search demonstrates need for organized training. • Modules have the potential to reach a large population of participants. • Use of adult learning principles make the course a good resource for nurse managers. • Ease of access online makes easy availability for participants when time is available. • The pilot program is free for participants and their organizations.	• Use of an external resource (Northwest Organization of Nurse Executives [NWone]) who may not want to continue or allow the program to be fully actualized. • Use of online modality does not allow for direct contact with participants. • Dependency on NWone platform and approval for training modules. • The participants are voluntarily involved in the program and their completion of the training, including self-development through reflection and action items which is outside the control of the project may not be completed. • More work is needed to show modules address learning/educational gap. • Drop out of participants might reduce effectiveness of pilot program.
Opportunities	**Threats**
• Networking with a nursing leadership organization in the community supporting professional nursing development. • Future growth could include other nursing leadership organizations as well as large healthcare organizations. • Enhance patient safety related to reduction in hospital acquired conditions. • Reduce healthcare costs through oversight improvements through appropriately prepared managers.	• Other programs available online including the new American Organization of Nurse Executives (AONE) training program. • Changes in healthcare reimbursement have reduced the operating margins for organizations leading to reduced optional spending. This program might be considered by some as an optional cost that can be avoided.

Appendix O

Table 8: *Beginning at Novice* Budget/ROI

Year 1: Development of Novice Nurse Manager Program	Budget
REVENUE	No revenue for year 1
Donation of time (program development). 0.1 FTE	$10,400
Cost avoidance (see assumptions below) Reduction manager turnover: 1 of the 18 of the participants Reduction of staff turnover: 1/participation/organization	 $37,500 $29,211
Cost avoidance	$66,711
EXPENSES donation of time	$10,400
Cost-avoidance	$56,311

Assumptions:

- Average hourly rate of $50/hour donated to NWone for program development. In the future, this might be possible through committee work.
- Cost of manager turn-over: $150,000 with an impact of 25% reduction related to training. Total: $37,500 per manager retained.
- Cost of staff turnover: $116,845 with an impact of 25% reduction related to training. Total: $29,211.
- Year one budget does not include reduction of HACs or additional NWone membership.

Year 2

Year 2: Development of Novice Nurse Manager Program	Budget
REVENUE: Ten additional NWone members	$2500
Cost avoidance: Manager turnover avoidance Staff turnover avoidance	 $75,000 $58,422
Total revenue	$135,922
EXPENSES	
Salaries and Wages:	$10,400
Subtotal S/W	$10,400
Supplies Expense	N/A
Total revenue/cost-avoidance	$135,922
Total expenses	$10,400
Total revenue or cost-avoidance– expenses (profit)	$125,522

Assumptions:

- NWone membership attributed to program at $250/membership.
- 36 participants in next series of the leadership program.
- Total of 36 participants would double reduction of managers leaving/turnover to (1:18 doubled to 2:36 due to larger group of manager participants).
- Reduced staff turnover of one per manager unit (total 36).
- There will a reduction of hospital-acquired conditions (HAC), but deferred calculation due to the ability to monitor through program. The benefits are being attributed to the increased NWone membership which will continue to increase over time.
- 0.1 FTE to update training and manage coaching/group discussion. Continued assumption of salary at $50/hr., no benefits.
- Supplies/equipment are provided by the contractor providing module updates at no additional cost.

Appendix P

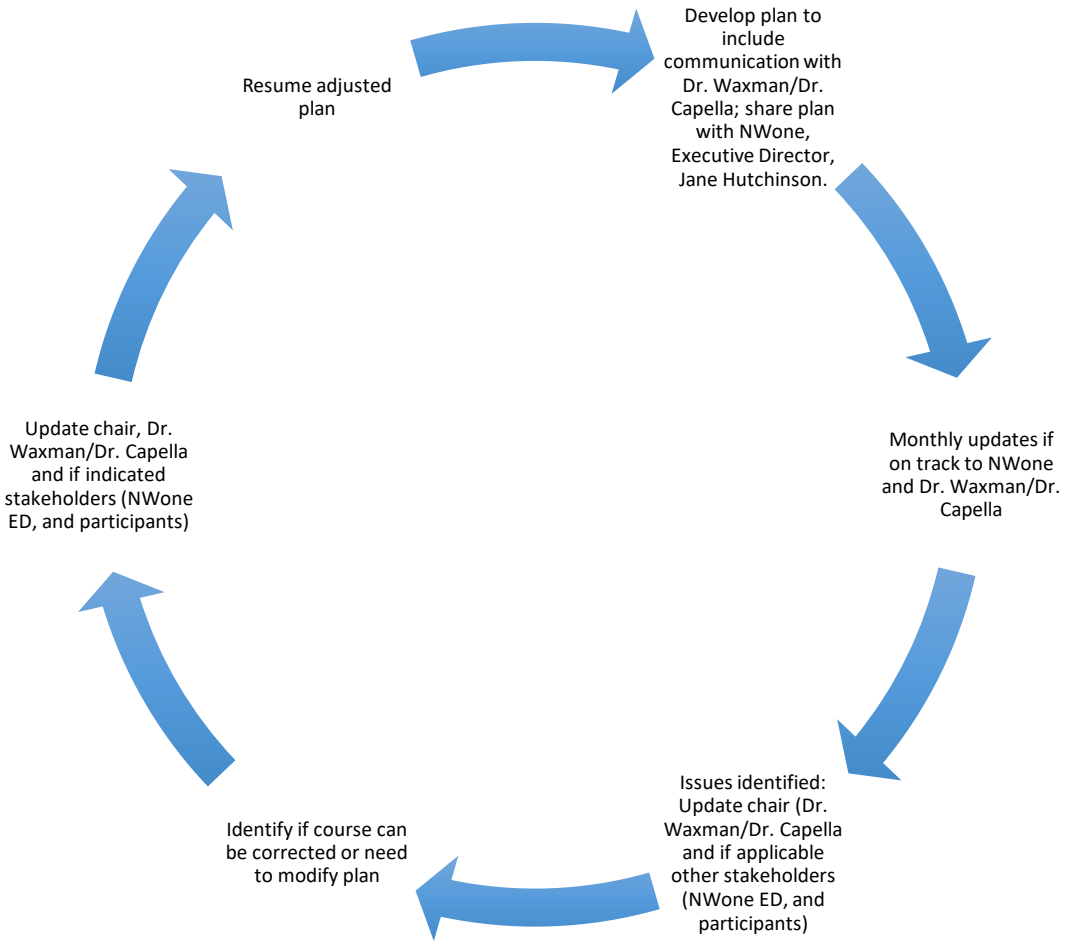
Table 9: Cost Avoidance Projections

Turnover Reduction	Cost	Attributed Share	Amount/Retained	2 Retained	3 Retained	5 Retained
Manager replacement $150,000	$150,000	25%	$37,500	$75,000	$112,500	$187,500
Staff turnover	$116,845	25%	$29,211	$58,422	$87,633	$146,055
Nurse Driven Hospital Acquired Conditions	Hospital	Cost/Event	10% Reduction Savings	20% Reduction Savings	30% Reduction Savings	50% Reduction Savings
Decubitus ulcers	$536,900	$9,200	$53,360	$106,720	$160,080	$$266,800
Post-Op Pulmonary Embolus	$564,000	$15,500	$56,400	$112,800	$169,200	$225,600
Post-Op Respirator Failure	$261,000	$21,900	$26,100	$52,200	$78,300	$130,500
Infections	$252,600	$24,500	$25,260	$50,520	$75,780	$126,300

Based on 2009 average hospital cost and number of events reported in Becker's Hospital Review, September 16, 2010 by Paige, L.

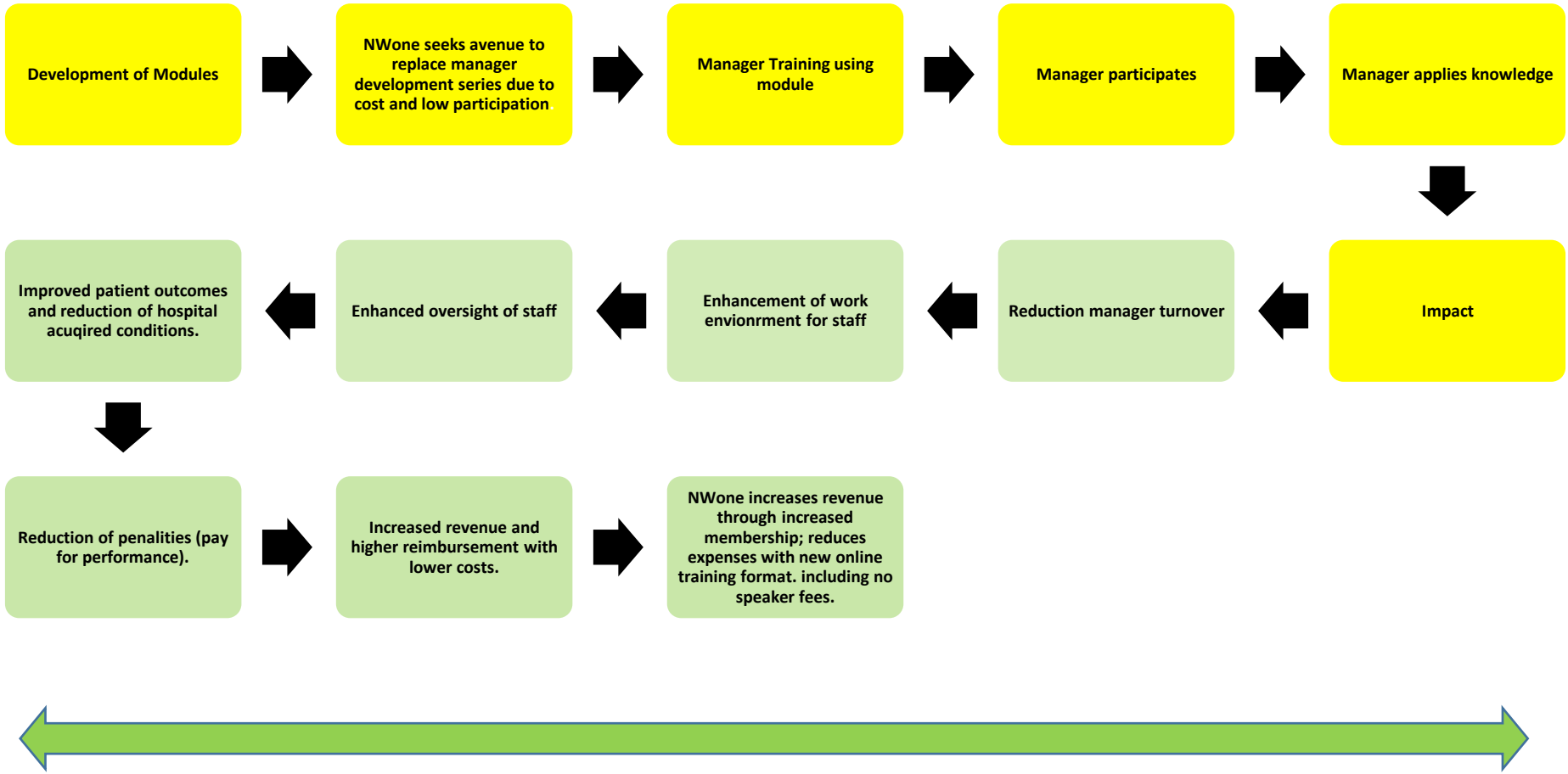
Appendix Q

Figure 7: Communication Matrix



Appendix R

Figure 8: Value Chain Analysis



Appendix S

Table 9: Crosswalk *Beginning at Novice,* AONE Manager Competencies, and ACCN QSEN Curriculum

Patient-Centered Care: Recognize the patient or designee as the source of control and full partner in providing compassionate and coordinated care based on respect for patient's preferences, values, and needs.				**Updated December 31, 2017**
Knowledge	**Skills**	**Attitudes**	**AONE Domain/Focus**	**Module Content**
Analyze multiple dimensions of patient-centered care: • patient/family/community preferences, values • coordination and integration of care • information, communication, and education • physical comfort and emotional support • involvement of family and friends • transition and continuity Analyze how diverse cultural, ethnic, spiritual and social backgrounds function as sources of patient, family, and community values Analyze social, political, economic, and historical dimensions of patient care processes and the implications for patient-centered care Integrate knowledge of psychological, spiritual, social, developmental and	Elicit patient values, preferences and expressed needs as part of clinical interview, diagnosis, implementation of care plan and evaluation of care Communicate patient values, preferences and expressed needs to other members of health care team Provide patient-centered care with sensitivity, empathy and respect for the diversity of human experience Ensure that the systems within which one practices support patient-centered care for individuals and groups whose values differ from the majority or one's own. Assess and treat pain and suffering in light of patient values, preferences, and expressed needs	Elicit patient values, preferences and expressed needs as part of clinical interview, diagnosis, implementation of care plan and evaluation of care Communicate patient values, preferences and expressed needs to other members of health care team Provide patient-centered care with sensitivity, empathy and respect for the diversity of human experience Ensure that the systems within which one practices support patient-centered care for individuals and groups whose values differ from the majority or one's own. Assess and treat pain and suffering in light of patient values, preferences, and expressed needs	*Performance Improvement* Customer and patient engagement *Assess customer and patient satisfaction *Develop strategies to address satisfaction issues *Patient safety* *Monitor and report sentinel events *Participate in root cause analysis *Promote evidence-based practices *Manage incident reporting *Foundational Thinking Skills* 1. Apply systems thinking knowledge as an approach to analysis and decision-making 2. Understand complex adaptive systems definitions and applications *Relationship Management and Influencing Behaviors* 1. Management conflict	Module 1 review of purpose of mission, vision and values; strategic plan. Discussion of RCA, sentinel events and event reporting and interview with risk manager or quality leader.

physiological models of pain and suffering			2. Situation management *Identify issues that require immediate attention *Apply principles of crisis management to handle situation as necessary	Review of *Just Culture* and TeamSTEPPS Reporting priorities. Interview with legal/risk management and quality leaders.
Analyze ethical and legal implications of patient-centered care Describe the limits and boundaries of therapeutic patient-centered care	Respect the boundaries of therapeutic relationships Acknowledge the tension that may exist between patient preferences and organizational and professional responsibilities for ethical care Facilitate informed patient consent for care	Value shared decision-making with empowered patients and families, even when conflicts occur		IHI resources and training.
Analyze strategies that empower patients or families in all aspects of the health care process Analyze features of physical facilities that support or pose barriers to patient-centered care Analyze reasons for common barriers to active involvement of patients and families in their own health care processes	Engage patients or designated surrogates in active partnerships along the health-illness continuum Create or change organizational cultures so that patient and family preferences are assessed and supported Assess level of patient's decisional conflict and provide access to resources Eliminate barriers to presence of families and other designated surrogates based on patient preferences	Respect patient preferences for degree of active engagement in care process Honor active partnerships with patients or designated surrogates in planning, implementation, and evaluation of care Respect patient's right to access to personal health records Value system changes that support patient-centered care		
Integrate principles of effective communication	Continuously analyze and improve own level of communication skill in	Value continuous improvement of own		Self-reflection/journaling with improved

with knowledge of quality and safety competencies Analyze principles of consensus building and conflict resolution Analyze advanced practice nursing roles in assuring coordination, integration, and continuity of care Describe process of reflective practice	encounters with patients, families, and teams Provide leadership in building consensus or resolving conflict in the context of patient care Communicate care provided and needed at each transition in care Incorporate reflective practices into own repertoire	communication and conflict resolution skills Value consensus Value the process of reflective practice		emotional intelligence as the goal.
TEAMWORK AND COLLABORATION: Function effectively within nursing and inter-professional teams, fostering open communication, mutual respect, and shared decision-making to achieve quality patient care.				
Analyze own strengths, limitations and values as a member of a team Analyze impact of own advanced practice role and its contributions to team functioning	Demonstrate awareness of own strengths and limitations as a team member Continuously plan for improvement in use of self in effective team development and functioning Act with integrity, consistency and respect for differing views	Acknowledge own contributions to effective or ineffective team functioning	*Personal growth and development*: *Manage through education advancement, continuing education, career planning and annual self-assessment. *Influencing others: Role model professional behavior. *Encourage participation in professional action.	-Suggestion or recommendation to use the AONE self-assessment.
Describe scopes of practice and roles of all healthcare team members Analyze strategies for identifying and managing overlaps in team member roles and accountabilities	Function competently within own scope of practice as a member of the healthcare team Assume role of team member or leader based on the situation Guide the team in managing areas of overlap in team member functioning	Respect the unique attributes that members bring to a team, including variation in professional orientations, competencies and accountabilities Respect the centrality of the patient/family as core members of any health care team	*Strategic Management:* 1. Facilitate change *Assess readiness for change *Involve staff in change process *Communicate changes *Evaluate outcomes 2. Project management *Identify roles	-Module on change management with SWOT analysis project management. -Shared governance or staff engagement/frontline involvement; owners versus renters.

	Solicit input from other team members to improve individual, as well as team, performance Empower contributions of others who play a role in helping patients/families achieve health goals		*Establish timelines and milestones *Allocate resources *Management project plans 3. Contingency plans *Manage internal disaster or emergency planning and execution *Manage external disaster or emergency planning and execution 4. Demonstrate written and oral presentation skills 5. Manage meetings effectively 6. Demonstrate negotiation skills 7. Influence the practice of nursing through participation in professional organizations 8. Collaborate with other service lines 9. Shared decision-making *Establish vision statement *Facilitate a structure of shared governance *Implement structures and processes *Support a just culture	Change and project management. Review of Lean and 6 Sigma, PDSA, cycle of change.
Analyze strategies that influence the ability to initiate and sustain effective partnerships with members of nursing and inter-professional teams Analyze impact of cultural diversity on team functioning	Initiate and sustain effective healthcare teams Communicate with team members, adapting own style of communicating to needs of the team and situation	Appreciate importance of inter-professional collaboration Value collaboration with nurses and other members of the nursing team		
Analyze differences in communication style preferences among patients and families, advanced practice nurses and other members of the health team Describe impact of own communication style on others	Communicate respect for team member competence in communication Initiate actions to resolve conflict	Value different styles of communication		Review of communication styles, journaling and self-reflection.
Describe examples of the impact of team functioning on safety and quality of care Analyze authority gradients and their influence on teamwork and patient safety	Follow communication practices that minimize risks associated with handoffs among providers, and across transitions in care Choose communication styles that diminish the risks associated with authority gradients among team members	Appreciate the risks associated with handoffs among providers and across transitions in care Value the solutions obtained through systematic, inter-professional collaborative efforts		-Inter-disciplinary work. -Shared governance. -*Just Culture* -Swiss Cheese model

	Assert own position/perspective and supporting evidence in discussions about patient care		10. Support a culture of innovation	
Identify system barriers and facilitators of effective team functioning Examine strategies for improving systems to support team functioning	Lead or participate in the design and implementation of systems that support effective teamwork Engage in state and national policy initiatives aimed at improving teamwork and collaboration	Value the influence of system solutions in achieving team functioning	*Relationship Management and Influencing Behaviors* Relationship management: *Promote team dynamics *Mentor and coach staff and colleagues *Apply communication principles	Observing/assess unit culture.
EVIDENCE-BASED PRACTICE (EBP): Integrate best current evidence with clinical expertise and patient/family preferences and values for delivery of optimal health care.				
Demonstrate knowledge of health research methods and processes Describe evidence-based practice to include the components of research evidence, clinical expertise and patient/family values	Use health research methods and processes, alone or in partnership with scientists, to generate new knowledge for practice Adhere to Institutional Review Board guidelines Role model clinical decision making based on evidence, clinical expertise and patient/family preferences and values	Appreciate strengths and weaknesses of scientific bases for practice Value the need for ethical conduct of research and quality improvement Value all components of evidence-based practice	The Science: Patient Safety *Strategic Management* Influence others: *Encourage participation in professional action *Role model professional behavior *Apply motivational theory *Act as a change agent *Assist others in developing problem-solving skills *Foster a healthy work environment *Promote professional development **Promote stress management **Apply principles of self-awareness	-Discussion of motivational theory, increasing emotional intelligence and healthy work environment.
Identify efficient and effective search strategies to locate reliable sources of evidence	Employ efficient and effective search strategies to answer focused clinical questions	Value development of search skills for locating evidence for best practice		Unit observations
Identify principles that comprise the critical appraisal of research evidence	Critically appraise original research and evidence summaries related to area of practice	Value knowing the evidence base for practice specialty		*Just Culture*

Summarize current evidence regarding major diagnostic and treatment actions within the practice specialty Determine evidence gaps within the practice specialty	Exhibit contemporary knowledge of best evidence related to practice specialty Promote research agenda for evidence that is needed in practice specialty Initiate changes in approaches to care when new evidence warrants evaluation of other options for improving outcomes or decreasing adverse events	Value public policies that support evidence-based practice	*Diversity:* 1. Cultural competence *Understand the components of cultural competency as they apply to the workforce 2. Social justice *Maintain an environment of fairness and processes to support it 3. Generational diversity *Capitalize on differences to foster highly effective work groups *Appropriate Clinical Practice Knowledge* 1. Each role and institution has expectations regarding the clinical knowledge and skill required of the role. These expectations should be established for the specific individual based on organizational requirements.	
Analyze how the strength of available evidence influences the provision of care (assessment, diagnosis, treatment and evaluation) Evaluate organizational cultures and structures that promote evidence-based practice	Develop guidelines for clinical decision making regarding departure from established protocols/standards of care Participate in designing systems that support evidence-based practice	Acknowledge own limitations in knowledge and clinical expertise before determining when to deviate from evidence-based best practices Value the need for continuous improvement in clinical practice based on new knowledge		-Review of job descriptions and staff observations. -Interview HR leader -Review unit and organizational staff satisfaction surveys. -Review patient experience scores.
QUALITY IMPROVEMENT (QI): Use data to monitor the outcomes of care processes and use improvement methods to design and test changes to continuously improve the quality and safety of health care systems.				
Describe strategies for improving outcomes of care in the setting in which one is engaged in clinical practice Analyze the impact of context (such as, access, cost or team functioning) on improvement efforts	Use a variety of sources of information to review outcomes of care and identify potential areas for improvement Propose appropriate aims for quality improvement efforts Assert leadership in shaping the dialogue about and	Appreciate that continuous quality improvement is an essential part of the daily work of all health professionals	*Performance Improvement:* Identify key performance indicators. Establish data collection methodology. Evaluate performance data. Respond to outcome measurement findings.	-Review of quality and safety/performance improvement. –Interview risk/quality manager. –Discussion of near miss/good catch.

	providing leadership for the introduction of best practices		Comply with documentation requirements. *Foundational Thinking Skills:* *Apply systems thinking knowledge as an approach to analysis and decision-making. *Understand complex adaptive systems definitions and applications.	
Analyze ethical issues associated with quality improvement Describe features of quality improvement projects that overlap sufficiently with research, thereby requiring IRB oversight	Assure ethical oversight of quality improvement projects Maintain confidentiality of any patient information used to determine outcomes of quality improvement efforts	Value the need for ethical conduct of quality improvement		
Describe the benefits and limitations of quality improvement data sources, and measurement and data analysis strategies	Design and use databases as sources of information for improving patient care Select and use relevant benchmarks	Appreciate the importance of data that allows one to estimate the quality of local care	*Financial Management* 1. Recognize the impact of reimbursement on revenue 2. Anticipate the effects of changes on reimbursement programs for patient care 3. Maximize care efficiency and throughput 4. Understand the relationship between value-based purchasing and quality outcomes with revenue and reimbursement 5. Create a budget 6. Monitor a budget 7. Analyze a budget and explain variance 8. Conduct ongoing evaluation of productivity 9. Forecast future revenue and expenses 10. Capital budgeting *Justification *Cost benefit analysis	-Review of CMS reimbursement. -Review of VBP -HAC -ACA
Explain common causes of variation in outcomes of care in the practice specialty	Select and use tools (such as control charts and run charts) that are helpful for understanding variation Identify gaps between local and best practice	Appreciate how unwanted variation affects outcomes of care processes		-Review of CMS reimbursement. -Review of VBP –HAC -ACA
Describe common quality measures in the practice specialty	Use findings from root cause analyses to design and implement system improvements Select and use quality measures to understand performance	Value measurement and its role in good patient care		-Review of CMS reimbursement. -Review of VBP –HAC -ACA
Analyze the differences between micro-system and macro-system change Understand principles of change management Analyze the strengths and limitations of common	Use principles of change management to implement and evaluate care processes at the micro-system level Design, implement and evaluate tests of change in daily work (using an	Appreciate the value of what individuals and teams can to do to improve care Value local systems improvement (in individual practice, team		

quality improvement methods	experiential learning method such as Plan-Do-Study-Act) Align the aims, measures and changes involved in improving care Use measures to evaluate the effect of change	practice on a unit, or in the macro-system) and its role in professional job satisfaction Appreciate that all improvement is change but not all change is improvement		
SAFETY: Minimizes risk of harm to patients and providers through both system effectiveness and individual performances.				
Describe human factors and other basic safety design principles as well as commonly used unsafe practices (such as workarounds and dangerous abbreviations) Describe the benefits and limitations of selected safety-enhancing technologies (such as barcodes, Computer Provider Order Entry, and electronic prescribing) Evaluate effective strategies to reduce reliance on memory	Participate as a team member to design, promote and model effective use of technology and standardized practices that support safety and quality Participate as a team member to design, promote and model effective use of strategies to reduce risk of harm to self and others. Promote a practice culture conducive to highly reliable processes built on human factors research Use appropriate strategies to reduce reliance on memory (such as forcing functions, checklists)	Value the contributions of standardization and reliability to safety Appreciate the importance of being a safety mentor and role model Appreciate the cognitive and physical limits of human performance	*Human Resources:* *Staffing needs* *Evaluate staffing patterns/needs. *Match staff competency with patient acuity. a. Manage human resources within the scope of the labor laws. b. Apply recruitment techniques. c. Staff selection: *Apply individual interview techniques *Apply team interview techniques. * Select and hire qualified applicants.	–Staffing discussion –FTEs –HR module and staff selection/interviews –Action item to interview HR leader.
Delineate general categories of errors and hazards in care Identify best practices for organizational responses to error	Communicate observations or concerns related to hazards and errors to patients, families and the health care team.	Value own role in reporting and preventing errors Value systems approaches to improving patient safety	Scope of practice *Develop role definitions for staff consistent with scope of practice.	Review Nurse Practice Act; scope of practice and responsibility to monitor and report.

Describe factors that create a just culture and culture of safety Describe best practices that promote patient and provider safety in the practice specialty	Identify and correct system failures and hazards in care Design and implement micro-system changes in response to identified hazards and errors Engage in a systems focus rather than blaming individuals when errors or near misses occur Report errors and support members of the healthcare team to be forthcoming about errors and near misses	in lieu of blaming individuals Value the use of organizational error reporting systems	*Implement changes in role consistent with scope of practice. Orientation *Develop orientation program *Oversee orientation process *Evaluate effectiveness of orientation. Patient safety *Monitor and report sentinel events *Participate in root cause analysis *Promote evidence-based practices *Manage incident reporting *Human Resources: Leadership Skills* 1. Performance management *Conduct staff evaluations *Assist staff with goal-setting *Implement continual performance development *Monitor staff for fitness for duty *Initiate corrective actions *Terminate staff 2. Staff development *Facilitate staff education and needs assessment *Ensure competency validation	Awareness of impact on performance, accountability and monitoring. Staff orientation purpose and function.
Describe processes used to analyze causes of error and allocation of responsibility and accountability (such as root cause analysis and failure mode effects analysis)	Participate appropriately in analyzing errors and designing, implementing and evaluating system improvements	Value vigilance and monitoring of care, including one's own performance, by patients, families and other members of the health care team		Avoidance of blame-finding culture; review of incident process.
Describe methods of identifying and preventing verbal, physical and psychological harm to patients and staff	Prevent escalation of conflict Respond appropriately to aggressive behavior	Value prevention of assaults and loss of dignity for patients, staff, and aggressors		SMART goals
Analyze potential and actual impact of national patient safety resources, initiatives and regulations	Use national patient safety resources: • for own professional development • to focus attention on safety in care settings • to design and implement improvements in practice	Value relationship between national patient safety campaigns and implementation in local practices and practice settings		-HR module -NPA -Management of diversion

			*Identify and develop staff as part of a succession planning program 3. Staff retention *Assess staff satisfaction *Develop and implement strategies to address satisfaction issues *Promote retention *Develop methods to reward and recognize staff ??? Maintain survey and regulatory readiness. Monitor and promote workplace safety requirements. Promote intra/interdepartmental communication. *Career Planning* 1. Know your role *Understand current job description/requirements and compare those to current level of practice 2. Know your future *Plan a career path 3. Position yourself *Develop a career/plan that provides direction while offering flexibility and capacity to adapt to future scenarios	-Action item: review of PCA/staff satisfaction results. -Developing action plan for results Review of preparation and continual readiness. -Observations on unit/culture of safety and monitoring/healthy environment. -Action item to review job description.

			Personal Journey Disciplines 1. Apply action learning *Apply techniques of "action learning" to problem solve and personally reflect on decisions 2. Engage in reflective practice *Includes knowledge of, and active practice of reflection as a leadership behavior a. Holding the truth: The presence of integrity as a key value of leadership b. Appreciation of ambiguity: Learning to function comfortably amid the ambiguity of our environments c. Diversity as a vehicle to wholeness: The appreciation of diversity in all its forms: race, gender, religion, sexual orientation, generational, the dissenting voice and differences of all kinds d. Holding multiple perspectives without judgment: Creation and holding a space so that multiple perspectives are entertained before decisions are rendered e. Discovery of potential: The ability to search for and find the potential in ourselves and in others	Modules use objectives/action learning items to enhance learning based on adult principles. Professional development.

			f. Quest for adventure towards knowing: Creating a constant state of learning for the self, as well as an organization g. Knowing something of life: The use of reflective learning and translation of that learning to the work at hand h. Nurturing the intellectual and emotional self: Constantly increasing one's knowledge of the world and the development of the emotional self i. Keeping commitments to oneself: Creating the balance that regenerates and renews the spirit and body so that it can continue to grow	
INFORMATICS: Use information and technology to communicate, manage knowledge, mitigate error, and support decision-making.				
Contrast benefits and limitations of common information technology strategies used in the delivery of patient care Evaluate the strengths and weaknesses of information systems used in patient care	Participate in the selection, design, implementation and evaluation of information systems Communicate the integral role of information technology in nurses' work Model behaviors that support implementation and appropriate use of electronic health records Assist team members to adopt information technology by piloting and evaluating proposed technologies	Value the use of information and communication technologies in patient care	*Information technology:* Understand the effect of IT on patient care and delivery systems to reduce work load. *Ability to integrate technology into patient care processes. *Use information systems to support business decisions.	

Formulate essential information that must be available in a common database to support patient care in the practice specialty Evaluate benefits and limitations of different communication technologies and their impact on safety and quality	Promote access to patient care information for all professionals who provide care to patients Serve as a resource for how to document nursing care at basic and advanced levels Develop safeguards for protected health information Champion communication technologies that support clinical decision-making, error prevention, care coordination, and protection of patient privacy	Appreciate the need for consensus and collaboration in developing systems to manage information for patient care Value the confidentiality and security of all patient records		
Describe and critique taxonomic and terminology systems used in national efforts to enhance interoperability of information systems and knowledge management systems	Access and evaluate high quality electronic sources of healthcare information Participate in the design of clinical decision-making supports and alerts Search, retrieve, and manage data to make decisions using information and knowledge management systems Anticipate unintended consequences of new technology	Value the importance of standardized terminologies in conducting searches for patient information Appreciate the contribution of technological alert systems Appreciate the time, effort, and skill required for computers, databases and other technologies to become reliable and effective tools for patient care		
Describe and critique taxonomic and terminology systems used in national efforts to enhance interoperability of information systems and	Access and evaluate high-quality electronic sources of healthcare information Participate in the design of clinical decision-making supports and alerts	Value the importance of standardized terminologies in conducting searches for patient information Appreciate the contribution of technological alert systems		

knowledge management systems	Search, retrieve, and manage data to make decisions using information and knowledge management systems Anticipate unintended consequences of new technology	Appreciate the time, effort, and skill required for computers, databases and other technologies to become reliable and effective tools for patient care		

References

Institute of Medicine. Health professions education: A bridge to quality. *Washington DC: National Academics Press*, 2003.

Cronenwett, L., Sherwood, G., Pohl, J., Barnsteiner, J., Moore, S., Sullivan, D., Ward, D., Warren, J. (2009). Quality and safety education for advanced nursing practice. *Nursing Outlook*, 57(6), 338-348.

Appendix S

Table 10: Post-Module Participant Survey Results

Question	1	2	3	4	5
How many modules did you complete?	58.3% (n=7)	8.3% (n=1)	0	0	33.3% (n=4)
Estimate how many of the action items you were able to complete?	58.3% (n=7)	0	16.6% (n=2)	25% (n=3)	0
Approximately how long did the action items from each module take to complete? (Results in hours)	25% (n=3)	8.3% (n=1)	0	8.3% (n=1)	58.3% (n=7)

- Having shorter modules would make it easier to do them.
  - Yes= 50% (n=6)
  - No=41.2% (n=5)
  - Maybe=8.3% (n=1)

- The module would be better if…
  - No suggestions for improvement: 75% (n=9)
  - It was audio only with references and resources available to download: None
  - It was a live format: 16.7% (n=2)
  - The PowerPoint slides were sent out with the module link: None
  - The PowerPoint slides with the script was provided with the module link: None
  - Other: Send out references via email for each module for downloading: 8.3% (n=1)
- Specific feedback received:
  - “I like all of the modules. You sound very knowledgeable and professional.”
  - “Module 4 was a good overview-it is very broad, but the staffing considerations is pretty basic but if you’ve never done that-pretty important. Nothing confusing and you bring up good points.”
  - “You are on track!”
  - “This is very well-done- I do a lot of reading about leadership (and of course try to implement good principles!)- you have captured a ton of current, relevant concepts into a very nice format. I often tune out during webinars but am actually to stay engaged with yours. I am a moderately experienced manager working in a local health department, have worked as

an associate dean in an ADN program as well and this is applicable to environments outside of acute care, probably even outside of health care. Looking forward to more."

- "Good work. This is a hard concept for many newer managers to grasp. You gave good examples and I liked the emphasis on doing small tests of change."
- "Really important information for nurse managers. Really well done."

Appendix T

Statement of Determination

UNIVERSITY OF SAN FRANCISCO | School of Nursing and Health Professions

DNP Project Approval Form: Statement of Determination

Student Name: Kathy Bay

Title of Project: Manager Development Leadership Program, Beginning at Novice

Brief Description of the Project:

A) Aim Statement: By January 30, 2018, the North West Organization of Nurse Executives will have a complete training program in place via their web-based platform for novice nurse managers with at least two participants completing the training.
B) Description of Intervention: Working with North West Organization of Nurse Executives (NWONE), I will create a nurse manager training program that can be utilized for new managers to assist with their transition into a formal leadership role. The training will be based on AONE and QSEN competencies as well as evidence-based practice and input from the Chief Nursing Officers in NWONE. Utilizing NWONE's web-based platform, members and member organizations to access the training on-line. My project would begin with the assessment from NWONE and literature and finish with reassessment of participants after training completion.
C) How will this intervention change practice: There is clear evidence that the relationship with the manager has the most impact on nurses. Both Pathways to Excellence and Magnet designation programs coordinated by American Nurses Credentialing Center (ANCC) include manager competence, accountability and leadership as tenets. Given the relationship of managers and the frontline staff, they have tremendous impact on organizational success and more importantly quality of care and patient/staff safety.
D) Outcome measurements: Utilizing focus groups from participants, synthesize common threads of feedback from their participation. The overall project goal is for the manager to assess themselves are better prepared for their role.

To qualify as an Evidence-based Change in Practice Project, rather than a Research Project, the criteria outlined in federal guidelines will be used: (http://answers.hhs.gov/ohrp/categories/1569)

☒ This project meets the guidelines for an Evidence-based Change in Practice Project as outlined in the Project Checklist (attached). Student may proceed with implementation.

☐ This project involves research with human subjects and must be submitted for IRB approval before project can commence.

Comments:

UNIVERSITY OF SAN FRANCISCO | School of Nursing and Health Professions

EVIDENCE-BASED CHANGE OF PRACTICE PROJECT CHECKLIST *

Instructions: Answer YES or NO to each of the following statements:

Project Title:	**YES**	**NO**
The aim of the project is to improve the process or delivery of care with established/ accepted standards, or to implement evidence-based change. There is no intention of using the data for research purposes.	X	
The specific aim is to improve performance on a specific service or program and **is a part of usual care**. ALL participants will receive standard of care.	X	
The project is **NOT** designed to follow a research design, e.g., hypothesis testing or group comparison, randomization, control groups, prospective comparison groups, cross-sectional, case control). The project does **NOT** follow a protocol that [illegible] clinical decision making.	X	
The project involves implementation of established and tested quality standards and/or systematic monitoring, assessment or evaluation of the organization to ensure that existing quality standards are being met. The project does **NOT** develop paradigms or untested methods or new untested standards.	X	
The project involves implementation of care practices and interventions that are consensus-based or evidence-based. The project does **NOT** seek to test an intervention that is beyond current science and experience.	X	
The project is conducted by staff where the project will take place and involves staff who are working at an agency that has an agreement with USF SONHP.	X	
The project has **NO** funding from federal agencies or research-focused organizations and is not receiving funding for implementation research.	X	
The agency or clinical practice unit agrees that this is a project that will be implemented to improve the process or delivery of care, i.e., **not** a personal research project that is dependent upon the voluntary participation of colleagues, students and/or patients.	X	
If there is an intent to, or possibility of publishing your work, you and supervising faculty and the agency oversight committee are comfortable with the following statement in your methods section: *"This project was undertaken as an Evidence-based change of practice project at X hospital or agency and as such was not* [illegible]	X	

ANSWER KEY: If the answer to **ALL** of these items is yes, the project can be considered an Evidence-based activity that does NOT meet the definition of research. **IRB review is not required. Keep a copy of this checklist in your files.** If the answer to ANY of these questions is **NO**, you must submit for IRB approval.

*Adapted with permission of Elizabeth L. Hohmann, MD, Director and Chair, Partners Human Research Committee, Partners Health System, Boston, MA.

UNIVERSITY OF SAN FRANCISCO | School of Nursing and Health Professions

not be able to do their presentation that semester and will defer their presentation until the next semester.

I look forward to working with you during this important and exciting phase of your DNP program. You should also access the *DNP Handbook*, the N749 and the N789 syllabi and the DNP Portal for additional and supplementary information on the Qualifying Project and the Comprehensive Project. Please feel free to contact me with any questions or concerns you might have.

Please sign and return a copy of this memo to me.

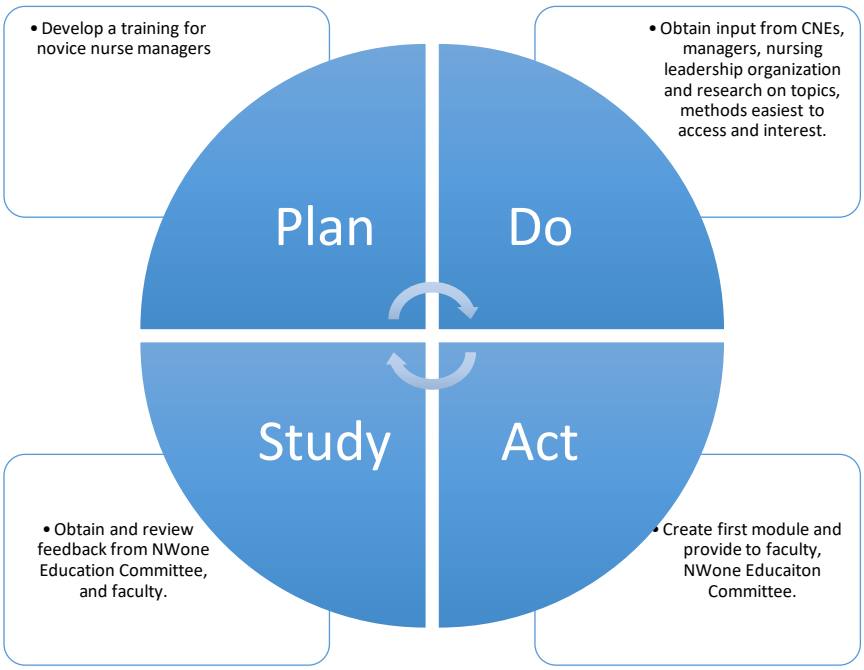
Student signature _____ Date 20 Nov 2016

Chair signature _____ Date 22/NOV/16

Appendix U

Figure 9: Continuous Quality Improvement, PDSA Cycle

Phase One



Phase Two