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Nurses' Experience of Leadership in Assisted Living: A Situational Analysis

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NURSES' EXPERIENCE OF LEADERSHIP IN ASSISTED LIVING: A SITUATIONAL ANALYSIS

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Dedicated to the nurses who contributed to this study. Every day, these nurses bring their deep experience and gentle caring to the service of elders. Like their nursing forbearers, they put themselves in unfamiliar surroundings and courageously re-define the field of care.

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Abstract

This study concentrates on the voice of registered nurses as they describe their experiences of leadership within the nontraditional, non-institutional, non-hospital environment of assisted living. It further expounds upon regulatory and corporate information as context for the nurses' leadership experiences. The desire to hear nurses describe their personal experiences of leadership influenced the decision to use grounded theory as a methodological process. The belief that voice requires context to be most effectively understood influenced, in turn, the addition of a situational analysis approach to the grounded theory methodology. As a result, interviews and scrutiny of contextual elements form the core of this study. The expectation that registered nurses will assume a leaderly presence has increased during the past 20 years as significant changes in the overall climate of health care have taken place. The study identifies many of the factors included in this change, specifically an alteration in the locus of care from hospitals exclusively to more diverse settings. Because of the limited presence of physicians in the extra-hospital world, nurses and administrators now form a leadership dyad in these settings and are charged with managing organizations delivering complex chronic patient care. Assisted living is a creative residential option that has been developed for elders who prefer individual choice in addition to physical care support. This study analyzes the themes and overriding influences explicated in personal interviews with nursing leaders in a variety of assisted living communities in one state. It also describes the contributing elements inherent in the healthcare and assisted living environments for their contextual implications. One important aspect of this study is its separation of nurse and physician leadership elements. It seeks to highlight those factors that emerge as supporting or denigrating nursing leadership experiences in an environment that is not itself mired in the conventional role expectations of the traditional

healthcare world. It is anticipated that this study will bring to light the pressure that nurses feel as they are caught between the inherent value of patient advocacy and the corporate and regulatory requirements of assisted living communities

TABLE OF CONTENTS

List of Tables

List of Figures

Foreword

Two Motions

It is not enough to be willing to come out of the dark
and stand in the light,
all hidden things brought into sight, the damp
black spaces,
where fear, arms over its head, trembles into blindness,
invaded by truth-seeking light:
it is not enough to desire radiance, to be struck by
radiance: external light
throws darkness behind its brilliance, the division
nearly half and half:
it is only enough when the inner light
kindles to a source, radiates from its sphere to all
points outwardly: then, though
surrounding things are half and half with
light and darkness, all that is visible from the source
is light:
it is not enough to wish to cast light: as much
darkness as light is made that way: it is only
enough to touch the inner light of each surrounding thing
and hope it will itself be stirred to radiance,
eliminating the shadows that all lights give it,
and realizing its own full sphere:
it is only enough to radiate the sufficient light
within, the
constant source, the light beyond all possibility of night.

However;

in separating light from darkness
have we cast into death;
in attaining the luminous,
made, capable self,
have we
brought error
to perfection:

in naming have we divided what
unnaming will not undivided:

in coming so far,
synthesizing, enlarging, incorporating, completing
(all the way to a finished Fragment)
have we foundered into arrival:

in tarring, caulking, timbering,
have we kept our ship afloat
only to satisfy all destinations
by no departures;
only to abandon helm,
sailcloth, hemp, spar;
only to turn charts
to weather, compass to salt, sextant to sea:

as far as words will let us go, we have
voyaged: now
we disperse the ruin of our gains
to a different kind of going
that will
become less and
less
voyaging

as arrival approaches nowhere-everywhere
in gain of nothing-everything.

(Ammons, 1972, p. 143)

CHAPTER I: BACKGROUND OF THE STUDY

Rationale for the Study

The purpose of this study is to examine the leadership experiences of registered nurses within the assisted living setting as they manage the competing priorities of resource allocation and goal achievement in the absence of the familiar though often controlling influence of physicians. Research on nursing leadership has taken place predominantly within the hospital environment or, much less often, in skilled nursing facilities. The residential nature of assisted living, coupled with the increasing need for critical thinking, clinical judgment, and staff supervision in the absence of physicians in that setting creates a unique space for leadership qualities of nurses to be identified, described, and understood.

Brief History of Nursing

Nursing is an art and a science (Watson, 1995). It requires a controlled orientation with a connected purpose, a factual focus with a relational sense, and a technological facility with a trust in the mystery of personal presence as interpersonal instrument (Benner, 1984, 2000; Tarlier, 2004; Watson, 1995, 2002). Nursing's history has been fraught with issues related to the politics of gender, accomplishment, and *otherness,* and the question of its inherent right to exist as a unique profession. In order to seek acceptance within the healthcare environment of the 1970s and 1980s, nursing focused on its scientific origins, resulting in the achievement of levels of competence with technology and science that Florence Nightingale would have found curious (Benner, 1984; Gordon, 2005). In an attempt to balance itself and give credence to the esthetic, personal, and connected nature of nursing, the profession later identified its more intuitive character and both cultivated and articulated its caring ideology (Bone, 2002; Mayeroff, 1971;

Noddings, 1984; Watson, 2003). Born and raised in the shadow of medicine, nursing has had to struggle to be seen and heard for its own unique contribution: Medical and scientific outcomes generally accrue to the physician, whereas the intelligent, intuitive, caring activities of the nurse that fortify a healing environment for patients remain invisible (Billing & Alvesson, 2000; Bone, 2002; Jacques, 1993).

Ammons' poem asks us to rethink ideas and movements that can have paradoxical consequences. That is wise counsel as nursing attempts to reconsider itself in the light of modern values, expectations, and experiences. The guidance that is needed for this courageous voyage emanates from within the profession and is steered by the belief that nursing will succeed in "realizing its own full sphere" only when it champions itself to be "stirred to radiance" (Ammons, 1972).

This guidance will be achieved through solid nursing leadership, despite the fact that the history of nursing leadership has been filled with the reciprocal issues of seeking and suppressing, discovering and doubting, valuing and trivializing, and utilizing and exploiting (Heller, Drenkard, Esposito-Herr, Romano,& Valentine, 2004). Nursing's inextricable association with the social constructs of women's work, duty, and caring created a unique situation in which the actions associated with nursing work were simultaneously mandated and minimized (Reverby, 1987). Nursing has long suffered from a lack of definition regarding what actually constituted its unique contributions. Susan Reverby (1987) identifies this conundrum as "being ordered to care in a society that refuses to value caring" (p. 36). As nursing leadership sought to stir itself into visibility and acknowledgment, the frequent result has been misinterpretation, increased external control over clinical practice, and greater fragmentation of

the nurses affected by this process (Gordon, 2005; Reverby, 1987). The direction of the nursing profession has generally been shaped by the political issues of the day. The reform ideas of the mid-nineteenth century and the attendant focus on “scientific” medicine were the first of these influences. This reform era produced the creation of formal training programs, which were intertwined with inpatient hospital care. Florence Nightingale was the prime mover behind this trend, believing that properly trained nurses were essential to patient survival (Nightingale, 1915). The nursing students in the schools dedicated to these training programs received infrequent lectures from physicians while they cared for hospitalized patients in exchange for room and board. The presence of an unpaid cadre of nurses enabled the expansion of the voluntary hospital system within the United States. The training schools, simultaneously, improved the public’s impression of nurses from that of almshouse inhabitants and women of low moral character to one of self-sacrificing care providers. However, from the beginning nurses found themselves caught in the triple crossfire of the priorities of medicine to be directed by physicians; the expectation of administrations that the nurses provide tireless, uncomplaining, free labor; and the needs and preferences of their patients (Ogren in Hein, 2001; Reverby, 1987).

Over the years, societal changes have continued to have an important impact on the direction of nursing as a profession. The development of public health nursing, military nursing, standards of practice and licensure, and the ongoing and vocal debate over educational preparation appropriate for entry into practice are a few of the major influences. The women’s movement in the 1960s and 1970s inevitably collided with nursing’s traditional identification with “women’s work, passivity,” and oppression. (Friedman, 2001)

Nursing Leadership

The concept of nursing leadership, including both clinical and administrative roles, is relatively new within the nursing profession. The definition of what constitutes a clinical leader has yet to be identified in a universally accepted manner. The term “administrative leadership” is generally used in health care to distinguish a level of supervision that is removed from clinical practice and is part of a managerial hierarchy within an institutional setting (Porter, 1991). Expecting nurses to display leadership has, historically, been rather insignificant or nonexistent, although the identification of clinically expert nurses has achieved recognition within the profession (Benner, 1984). Even nurses who have attained the status of chief nurse executive often discover that they have “considerable power in making decisions related to nursing [but have far] less influence in strategic and financial planning” (Harrison & Roth, 1987, p. 75). However, medical and executive leaders, who are the counterparts of the chief nurse, generally exercise leadership over all facets of organizational decision-making, often including nursing (Harrison & Roth, 1987).

The changes that have taken place recently in all healthcare settings amend the status quo of nursing’s professional identity as clinician to include that of clinical and administrative leader (Pesut, 1999; Ulrich, 2004). These changes require that nurses understand their role as leaders on the healthcare team and function competently and authoritatively within that context. The advent of a market-driven healthcare system and the alterations that it demands in practice compel registered nurses at all levels to exercise critical thinking and problem-resolution skills. Nurses must be prepared to authoritatively assert their decisions and recommendations within the context of both administrative and clinical operational arenas. Additionally, they must direct and

oversee the practice of care providers with different preparation and practice expectations. These nurses must translate operational and clinical guidelines that influence practice into applicable plans of care that take into account patients' personal preferences, unique activities, and specific responses. All these functions demand an understanding of and facility with leadership skills (Heller et al., 2004; Stanley, 2006).

Changes in Healthcare Focus

The focus of health care is no longer exclusively the costs hospital. As healthcare have escalated over the years and the corporate philosophy of managed care has assumed predominance, out-patient diagnostic centers, surgical centers, free-standing acute rehabilitation centers, subacute rehabilitation centers, and skilled nursing centers have all been created to provide healthcare diagnosis and treatment. Historically, these activities were accomplished within the acute care hospital. When health care was dispensed in a central location, nursing support to patients reflected the patriarchal attitude that physicians and hospital executives maintained. This accepted point of view held that nursing support was provided exclusively to the physician, who was solely responsible for any and all interventions involving the patient. Now that health care is offered in widely diverse locations and settings, nurses have assumed a more autonomous role. As Benner's (1984) landmark study has shown, many nurses have reinforced this responsibility with advanced education in addition to significant clinical experience, both of which have allowed them to become experts in their fields.

Additionally, the aging of the population has vastly increased the need for healthcare services to manage chronic medical conditions (Gordon, 2005; Wagner, Austin, Davis, Hindmarsh, Schaefer, & Bonomi, 2001). In general, allopathic medicine views itself as a curative

model, using diagnostic tests, medication, and surgery as tools. The management of chronic conditions often requires exquisite medication adjustment after a spate of diagnostic tests highlight the issue at hand. However, chronic conditions are, by definition, not amenable to curing. The clinical strategies that nurses bring to bear on chronic conditions (i.e., astute observational skills, careful monitoring of subtle changes in condition and sharp intervention abilities, to name a few) that do not require physician intervention or oversight are modalities that benefit people with these chronic health conditions. The caring orientation of nursing creates a space for relationships to develop that can help the patient achieve maximum benefit from the management strategies and interventions that are employed. The complexity of managing chronic medical conditions, especially in the presence of multiple co-morbidities that often affect elderly patients, demands a collaborative relationship between medicine and nursing.

The Pressure of Competing Priorities for Nurses

The "squeeze" that registered nurses have always experienced within the healthcare environment was recognized in studies by Bone (2002) and Erlen & Frost (1991) and Spreen Parker (1990). The pressure emerges from the competing priorities of the physician whose orders the nurse is carrying out; the patient for whom the nurse is both a care provider and advocate; and institutional executives who manage the structure, compensation, and benefits under which the nurses work. The pressures continue regardless of the change in the locus of health care from hospitals to other settings (Gordon, 2005). As frustrating as this squeeze has been, it has also served to protect the nurse from having to assume a forceful leadership position when conflicting goals, priorities, or ideologies consumed the physician and executive factions of the healthcare leadership triangle. Nurses often held this state of affairs in disdain while they simultaneously

benefited from the safety of the situation's distance from the fray. The new healthcare landscape renders this non-acceptance of their leadership function a more problematic position. In distanced settings that provide care for frail elders, physicians have a much abbreviated and decidedly episodic presence. Their involvement in patient management is most often limited and generally characterized by sparse institutional influence. This leaves the registered nurse as the primary clinical presence in settings providing chronic care to the rapidly growing elder population. In these less medically focused settings, the lessening of physician control within the leadership triangle could allow the space for nursing advancement in leadership skills to occur.

The Assisted Living Environment

The setting with the most limited physician involvement is assisted living. Assisted living (AL) is the fastest-growing residential option for seniors who need physical and/or cognitive support that cannot safely be met in settings such as private homes, independent living environments, or retirement communities (Mitty, 2003; Stearns & Morgan, 2001). The elder citizens for whom this option was originally designed prefer the non-institutional, homelike settings of assisted living communities and do not require the 24-hour skilled nursing interventions that characterize the care provided in either hospitals or long-term care settings termed skilled nursing facilities (SNF). However, the aging of the population at large and the "aging in place" of residents in assisted living communities has created a situation in which the initial parameters of the healthcare component of these communities (wellness education and monitoring) have been superseded by escalating medical care needs, identification and intervention of acute conditions, as well as management of exacerbations of chronic conditions for the increasingly frail residents (Chapin & Dobbs-Kepper, 2001; Redfoot, 2006).

Whereas licensed nursing oversight and involvement was not integral to the original development of the assisted living concept, it has become more customary (Wallace, 2003) in light of the burgeoning need to accurately identify situations in which sophisticated medical care must be secured and follow-up assessment and intervention developed. This significant alteration in intent has resulted in the absolute expectation of astute clinical judgment and effective nursing leadership. Additionally, it has highlighted the traditional squeeze that nurses experience between the medical profession and facility administration, but in a somewhat altered way. Unlike other institutional settings, in assisted living the registered nurse is typically the only healthcare professional who can accurately execute the assessment function that ultimately secures an effective intervention for the resident. In this setting, the nurse must determine care priorities and make clinical judgments, sometimes in opposition to family preferences and administrative/marketing goals. Additionally, the registered nurse must directly supervise the activities of licensed practical nurses (LPNs) and certified nurses' aides (CNAs) or home health aides (HHAs), who also have a role in providing care for the residents. The requirements for exacting judgment, flexibility, and leadership contributes to the realization that registered nurse's position, in its singularity of influence within the healthcare environment, accords the nurse an opportunity to exercise capabilities either unvalued or unwelcome in other settings.

Overview of the Research Approach

This study utilizes situational analysis, a form of grounded theory, to describe the entire array of influences present within the assisted living setting and then focus specifically on the motivation, behavior, practices, and experience of leadership that the registered nurses who took part in the study describe. This methodology fosters the explication of coexisting and competing

forces within the environment that, if overlooked, would decontextualize the situation and serve to promote a superficial understanding of it. Employing situational analysis causes all forces affecting a given situation to be identified and acknowledged. Additionally, it compels highlighting relationships that exist between and among the existing forces. Finally, it allows the silences or voids within the discourse to be recognized for the potential influence they might have on the situation as a whole. Ultimately, it allows the voice of the nurse to be heard within the complex context that contains it (Clarke, 2005). (See Appendix A—Traditional Vs. Constructivist Grounded Theory).

As a result of their inherent philosophy and recently promulgated regulations in all states, assisted living environments are established very generally in either a social or a medical model context. Because assisted living is a residential and not fundamentally a healthcare setting, familiar clinical accoutrements (hospital beds, overhead paging systems, crash carts, etc.) are generally nonexistent. The setting anticipates that the nurse will operate "below the radar," evaluating and influencing quality of life and wellness (the social model) rather than focusing on diagnosis and healthcare interventions (the medical model).

As a result of the impact of aging in place (Frank, 1994) and the increasing complexity of managing residents with diagnoses of dementia in assisted living communities, many states are in the process of evaluating their regulatory stance (Mollica, 2005, 2006) to include a more comprehensive approach to the healthcare component of assisted living. Therefore, the researcher has selected Connecticut, a state that employs a medical model regulatory framework as the best container for the observation and scrutiny of nurses' leadership roles, abilities, and feelings. This environment allows the registered nurse to practice both the tasks (medication

administration) and the executive functions (clinical assessment, care plan development, evaluation of interventions, supervision of licensed practical nurses and certified nursing assistants) allowed within the registered nurse license parameters. It further affords a clinical environment in which physicians are not available for leadership roles at the community level—they generally provide primary care to their specific patients only. As a result, clinical leadership responsibilities fall to the registered nurse in the assisted living setting, with state regulations identifying the accountability this role carries. Finally, information gleaned from interviews with nurses leads to a need for input from additional sources. As a result a theoretical sampling of interviewees from other related fields—assisted living administrators and regional operations executives-- is included. Geographical proximity is an important factor when considering access to emergent data via theoretical sampling and additional interviews. The overall intent of the study was to observe and interview nurses fulfilling leadership roles so that the supports for their efforts, the particulars of the milieu, the relational configuration, and the existing power dynamics could all be explicated and examined in a positive and contributory manner.

Situating the Researcher

I have held a license as a registered nurse for 41 years. I am a graduate of a diploma school of nursing, which was typical educational preparation for my generation. My clinical working experiences have included medical-surgical nursing, pediatrics, labor and delivery, premature and observation nursery (an area that would now be classified as neonatal ICU), physical rehabilitation, public health nursing, geriatrics, and insurance nursing and workers' compensation consultation. Relatively early in my career, I decided that acute care clinical nursing was not an area that I enjoyed or found fulfilling. Hospital politics within the hierarchical

and patriarchal milieu at the bedside or unit level were stifling, frustrating and unrewarding. I used the leadership skills that I had developed through many baptisms of fire over the years and assumed increasing leadership roles as team leader, head nurse, nursing supervisor, and the creative force behind the development and direction of various programs. I ultimately chose to leave the hospital environment altogether for long-term care.

Within the long-term care setting, I filled various mid-level leadership positions initially, finally assuming directorship functions in which I developed programs. Later, I became a licensed nursing home administrator, but I found that position to be more political and less satisfying than I had hoped, with far less ability to affect positive change than I had imagined. Ultimately, I assumed positions as vice president of clinical services with several long-term care companies, did organization development consultation in my own business, and did new business development for several companies that were tangential to health care. In due course, my career took me rather far afield from my nursing roots but I always remained within the general realm of health care.

Recently, I have worked in the somewhat fledgling field of assisted living. Although this work placed me back amidst the patriarchal mindset and hegemony that characterized the hospitals of my youth, I have experienced it as a surprisingly creative environment. It is through this experience that I have come to see assisted living as a fertile and worthy setting for registered nurses to exercise leadership. The relative absence of physicians makes the nurses' clinical leadership critical. The expectation of managing both clinical and regulatory compliance, multi-level staff oversight and supervision, and care coordination makes the role of chief nurse in this setting one with unique potential for a leaderly presence.

Conclusion

This study looks beyond nursing's desire to "come out of the dark and stand in the light" (Ammons, 1972). It seeks to explicate qualities of leadership and requisite environmental supports that positively influence nurses' experiences of leadership. It seeks to identify ways in which nursing "radiates from its sphere to all points outwardly" to reach "the light beyond all possibility of night" (Ammons, 1972).

CHAPTER II: LITERATURE REVIEW

It is not possible in this research project to discuss all the factors that influence the role of nurses and their leadership functions within the exceedingly complex healthcare system. As a result, specific issues that reason and experience call to the foreground are highlighted and their impact on nursing in general and nursing leadership in particular are considered in greater depth. The constellation of relevant issues presented here incorporates a diverse collection of related influences that Clarke identifies as 'sensitizing concepts' (2005, p. 28). Clarke identifies that these concepts provide perspectivity that fosters the examination of the ". . . salient elements in [the] (that) situation and their relations" (p. 29). This process will assist in "opening up" the data (Clarke, 2005) and will allow the researcher to question them in ways that bring new eyes to the situation and assist in placing assumptions, information, perspectives, and silences on the table. In Chapter II, I identify those areas that present for me the greatest influence and impact on nursing leadership in health care. I identify confounding elements that I believe have contributed to the existence of the situation at hand and explore their origins as they have been studied in the literature. I describe, also via the existing literature, factors that have materially contributed to the state of affairs that is nursing and nursing leadership today.

My initial analysis causes me to believe that there are both (a) contextual elements and (b) factors that are intrinsic to nursing that currently and historically influence the exercise of nursing leadership. I discuss those elements that I see as belonging to each category in a separate section of this literature review and end with a discussion of (c) the environment of assisted living communities, their genesis, and their current state in order to provide a thorough context. As the chosen research methodology for this study—grounded theory situational analysis—requires, additional influencers may be identified through the iterative process of interviewing.

Contextual Factors

Forty-one years of nursing practice in diverse surroundings within and peripheral to traditional healthcare settings have caused me to identify concepts that fundamentally influence the profession of nursing in the United States. These elements include professional identity formation in nursing, nurses' relational experience of leadership within a system of care, and general issues of leadership within the professions. This in-depth didactic and practical experience has caused me to identify the following factors as contextually relevant to the current status of nursing leadership: (a) patriarchy related to nursing, (b) power related to nursing, (c) gendered healthcare, and (d) the aging of the population in general. These are factors that are outside of the personal purview of the nurse, but that exert substantial control over the historical environment within which nursing was born and over which the current and future possibilities for the profession and the individuals who work within it operate. These elements are intricately interrelated and create powerful influence relationships within the context of healthcare in general and nursing in particular. These highlighted sensitizing concepts reflect Clarke's belief that ". . . perspective dominates the interpretation upon which action is based" (2005,p. 21).

Patriarchy Related to Nursing

While much has changed in recent years regarding the underlying assumptions that guide behavior in modern society, we are still greatly influenced by the assumed appropriateness of a traditional division of labor. This division assigned circumscribed roles that were defined sexually and carried with them particular social value. Within this context, male dominance was assumed (Hearn & Parkin, 1988). The social values that accrued to paid work done outside the home were materially different from those assigned to domestic labor. Work within the home, in support of husband and family, was socially constructed as women's work and included all the

homely domestic chores of cooking, cleaning, and care-giving for children and infirm family members and friends. As time progressed and domestic work was done outside the home, this work was still considered women's work and received a wage that reflected society's perspective of it as lesser in importance and value. As Reverby's study (1987) has demonstrated, Western capitalist society has profited immensely from this arrangement.

Historically, the physician-nurse relationship has emulated this patriarchal division of labor. The relationship was also greatly influenced by the Victorian values not only of women's role but of women's demeanor as well. Nurses were expected to be passive, courteous, neat, kindly, and self-sacrificing (Nightingale, 1915). Nursing was idealized as a calling for which women were uniquely qualified because of their personal attributes. It was further viewed as womanly duty because it was part of the societal expectations that the woman's role carried. There was no sense of women's rights within this caring context, only that women had an obligation to care for the ill and infirm. Society valued paid labor, and the role of nursing was considered of lesser importance because it mirrored women's domestic responsibilities and was performed by members of society who were of secondary stature to men.

This conundrum, that women were "ordered to care in a society that refuses to value caring" (Reverby, 1987, p. 36), remains the defining description of nursing today. Hughes (2001) comments on the conflicting nature of the ideology of domesticity and the ideology of professionalism, which afforded men social prestige and autonomy, with respect to these ideologies' inherent and powerful shaping of the evolution of nursing. She notes that the attempt to merge the opposing ideologies has historically created constraints for nursing and confusion for the public, which accepts the premise of a duty to care but rejects the concept of a right to

care, refusing the inclusion of choice that the latter entails. Early nurses were effectively schooled not to go *to work* but rather to go *on duty*, terminology that reinforced the dedication that their contribution demanded but caused remuneration, appreciation, acknowledgement, and value for their work to be silent and therefore nonexistent within the ideology of professionalism. The "virtue script" that Buresh & Gordon (2006, p. 17) reference connotes the long-held belief that nurses were women with exacting religious sensibilities who believed they were called to do God's work and received their rewards as a result of intrinsic acts of ministering and caring. Nowhere in this script is there room for recognition of the economic as well as societal benefits that nurses' work produces. In her exhaustive 1987 work *Ordered to Care,* Reverby argues that paternalism and patriarchy have continued to create barriers to the professionalization of nursing as they have successfully associated nursing with the domestic sphere alone. This correlation to domesticity and femininity fortifies the view that nurses' work as women's work is simple and homely and therefore does not entail the specialized expertise that typifies the work of professionals. As we shall see in future sections, contemporary expectations of nurses' knowledge and performance have increased exponentially and the belief in a professional practice, controlled by the profession, has returned as a focus (Steinbrook, 2002).

Nursing has always had to respond to more than one master. In the hierarchy of the healthcare system, the nurse plays a triple role: first in relation to the patient, second in relation to the physician, and finally in relation to auxiliary personnel and institutional administration. The late 1800s mark the beginning of modern nursing. Florence Nightingale is credited with establishing the first schools for training nurses in England and her influence was soon seen in similar schools in the United States. Nightingale's concept of nursing was as an autonomous,

dignified profession, aligned with medicine but not subordinate to it. In 1867, Nightingale wrote "the whole reform in nursing both at home and abroad has consisted in this: to take all power over nursing out of the hands of men and put it in the hands of one female trained head and make her responsible for everything" (in Partridge, 1984, p. 51). This concept, brought to the United States, created enormous advantages for hospitals, which could become the site of nursing education while benefiting from the free labor the students provided. This apprenticeship model soon became the approved method of educating nurses.

However, around the turn of the twentieth century, nurses began lobbying for the registration of trained nurses in the belief that such regulatory requirements would serve to better institutionalize both the quality of nursing education and the standards of the profession. Physicians objected to both registration and to elevating nursing to an established profession under the belief that this would eventually lead to a shortage of nurses. Oddly enough, once registration became the accepted standard, it did not concurrently result in a definition of the scope of nursing practice. This oversight led to the convoluted and less-than-clear definitions of nursing practice that have evolved over the years. It also allowed forces outside of the profession, namely physicians, to continue to constrain the limits of nursing practice. Patriarchal perceptions and their influence on public opinion have persisted in defining nurses' roles even after the advent of monumental changes in health care and the alteration of women's roles in society (Morrow, 1988). Nursing leaders face the dilemma of having to synthesize the apparently conflicting strategies of the domestic and professional heritage of nursing (Hearn & Parkin, 1988; Reverby, 1987), the nurturing elements (Watson, 2002), and the need for critical thinking

(Benner, 1984), along with the expectations regarding feminine and masculine performance as they seek to keep “our ship afloat” while working to “satisfy all destinations” (Ammons, 1972).

Power Related to Nursing

Nursing, like most things, both contains and is controlled by power. The healthcare environment is filled with examples of powerful influences and characters, all of which converge around the subject of human health and illness in some way. Additionally, nursing’s uniquely situated position within the healthcare system fosters the imposition of power upon it from forces external to it, as nurses have been expected to don or have willingly assumed the socially constructed mantle of womanliness, passivity, acceptance, and virtue (Reverby, 1987)

Power is relational—more than one person is needed for power to be exercised, whether it appears in the form of “power over” or “power with” (Miller, 1976). Power usually operates reciprocally, though not always with equal reciprocity. Power influences the creation of reactions. Because power operates both relationally and reciprocally, there is interest in the balance-of-power dynamic in situations. The patient, who is at the nucleus of the practice of health care, is often the entity with the least power. Nurses, who are the professional group closest to the patient, have elusive power within the organization but this is often controlled by the formal authority of their employers, the informal influence of physicians, and the nurses’ own preference for invisibility, working behind the scenes, with deference. As a group, nurses lack what Suzanne Gordon calls “the voice of agency” (Buresh & Gordon, 2006, p. 5). The medical profession has long been accustomed to controlling the practice of nursing, despite nursing’s recent, real attempts to alter this reality, according to a study by DuPlat-Jones (1999). The voice of agency contains a formidable ability to recognize the importance of the work

nurses do and the expectation that this work will be respected and rewarded (Buresh & Gordon, 2006). It further relies on the belief that the doers of that work know that their contribution is important within the context of health care—and that the work is worthy of their own respect and encouragement.

The paradox of nursing in the United States is that it is the largest of all the healthcare professions, with more than 2 million registered nurses alone, but has repeatedly endured cycles of shortages and oversupply, with extreme shortage being the current and anticipated future reality. Additionally, the hospital model for training nurses that made possible the development of modern hospitals as well as modern medicine has continued to keep nursing as a relatively powerless component of the healthcare world (Friedman, 2001).

Rosabeth Moss Kanter (1977) developed her Theory of Structural Power in Organizations after reviewing workplace conditions, including those that applied to women. In Kanter's model, power evolves from structural conditions, not personal characteristics or the effects of careful socialization. Rather than considering power as coercion or dominance, Kanter's research caused her to define power as the ability to get things done in a work environment. This definition is reinforced and supported by nurse theorist Imogene King (1981) who defined power as the capacity to achieve goals, or as *power to*. In Kanter's concept, power derives principally from a person's capacity to gain access to resources, information, and support and secondarily from access to opportunities for cooperation to get work done within the formal and informal systems of organizations (Kanter, 1977). Individuals lacking control over the conditions that make their positive actions possible will essentially be accountable for

an outcome without the power to achieve it. This reality will lead to frustration and failure as they experience organizational demotivation, job dissatisfaction, and burnout (Kanter, 1979).

Most nursing ventures are organizationally designed and institutionally situated. This reality has not allowed independent access either to formal power or to informal organizational factors that significantly influence the perception that nurses have power as a group. Nor has it created a milieu within which nurses readily build upon their personal or professional agency to achieve outcomes. The issue of nursing empowerment is addressed in a future section of this paper, but for now it is important simply to acknowledge the impact that Kanter's theory has had on the creation of empowering situations that foster satisfaction and achievement at work. Laschinger, in her role as professor of nursing and nursing researcher in Canada, has been a primary researcher in many studies that use Kanter's theory in the context of nursing and healthcare (Laschinger, 1996; Laschinger, Sabiston, & Kutszcher, 1997; Laschinger & Sabiston, 2000; Laschinger, Almost, & Tuer-Hodes, 2003).

Foucault (1991) believed in a shared relationship between power and knowledge. Those who can lay claim to legitimate knowledge posses the power to shape the form of enquiries around it and decide what the discussion will be and who will be included in it. This notable definition of power has relevance to the ongoing control that medicine has had over nursing because physicians have the ultimate decision-making authority regarding who becomes a patient and what interventions will be ordered for that patient (Reinhardt, 2004). One of nursing's roles is to carry out physicians' orders and physicians' ability to generate orders places them in a position of commandeering nursing time, expertise, and attention. Additionally, the caring role of nurses presents a conflict of power. Caring for people is an important though not a

valued activity within our society. Oakley's study (1993) points out that caring is not considered a skill that requires special knowledge or expertise, a perspective that again relegates the caring perspective of nurses to a "lesser" position within the healthcare arena.

Nurses report, in the recent study by Laschinger and Sabiston (2000), that they often feel helpless to make changes in their organization or profession, reflecting Gordon's comment on the need for nursing to encourage nurses' agency of voice. The literature suggests that feelings of powerlessness expressed by nurses demonstrate oppressed group behaviors (Farrell, 2001; Roberts, 2000). This conclusion is also supported in professional practice situations and reflects the belief that nurses have been oppressed by hospitals, physicians, and administrators (Kuokkanen & Leino-Kilpi, 2000; Reverby, 1987; Trossman, 2003). The discussion of patriarchy above explored the issue of nurses responding to many masters. The oppression of nursing by the same entities further reinforces the profession's lack of autonomy and poor sense of itself. In this context, when nursing is viewed through the perspective of medicine, it is seen as a lesser intervention rather than as a different though still valued one (Stein, Watts, & Howell, 1990).

Nurses have power, despite the fact that they typically do not consider themselves powerful, according to Sieloff's 2004 study. The healthcare environment is one that attempts to contain the energy of related and competing groups, all of whom are essential to ultimate success but most of whom find sharing power uncomfortable. Nursing is a unique and consistent presence among all related and competing entities. Thus, it is imperative that nursing realize its inherent power and understand how to utilize it for common purposes. Competent nursing leadership that is capable of maintaining a relational perspective (Cummings, 2004), facilitating

the reduction of collusion with oppressive activities (Gordon, 2005; Hedin, 1992; Roberts, 2000), and garnering cooperation to clearly identify nursing practice that is understandable in its uniqueness (Hegyvary, 2003) will go a long way toward claiming the necessary authority that will allow the profession to endure.

Gendered Healthcare

The concept of *gendered organizations* has emerged over the years as feminist views and research designs have called into question the assumptions that underlie and support the way work is conducted in the Western world (Fletcher, 1999). This concept also is an outgrowth of studies conducted separately by Jean Baker Miller (1976) and Carol Gilligan (1982) regarding the ways in which women develop and are socialized to a "way of being" in the world. Relational cultural theory is a more expanded and culturally associated iteration of the "self-in-connection" or "self-in-relation" theory developed by Miller (1976). The fundamental elements of these theories emerged as women were studied and as their natural developmental and operating styles were explicated. Miller's work identified developmental processes that were the opposite of the individuation and separation process that historical studies of men had assumed to be "the way it was" for all humanity. Both Miller (1976) and Gilligan (1982) observed women developing a preference for connection, mutual empathy, and relationship rather than seeking individuation or separation. Gilligan (1982) observed the detrimental effects of the prevalent assumptions about individuation on adolescent girls who gradually altered their sense of themselves as the subject of their lives into a sense of increased objectivity. Adolescent girls' social success became determined by their ability to morph into characterizations of subordinate women whose role was to care for and assist but not to actually be prominent.

The further evolution of self-in-relation and relational culture theory illuminated the "notion that our understanding of all of life has been underdeveloped and distorted because our past explanations have been created by only one half of the human species" (Miller, 1986, p. xi). Once concepts contrary to culturally accepted truths were identified, it was natural to consider the ways in which *difference* had been treated within that cultural context. Accepted norms, viewed as the only way to be, are inherently valued as superior, crucial, and important while their opposite are considered inferior, marginal, and less than worthy. The feminine relational construction, which includes space for emotion, feeling, and mutuality, is viewed by Western society as appropriate to the woman's role of family nurturer and supporter. This style is considered subordinate in the workplace to the stereotypically masculine style that revolves around a take-charge, directive, and more detached way of being. Dominant groups perceive their opposites as subordinate, defective, or substandard. Dominant groups employ labels and actions that are descriptive of the major group and thus reflect detrimentally on their perceived subordinates. Fletcher's 1999 study has identified that the public sphere of men's activity and the perspective that this is where real and valued work occurs reinforce the inherent power and superiority of this group while allowing the socially colluded nurturing, coordinating, and supporting private-sphere work of women to be dismissed as unimportant, though socially necessary.

Western society has both influenced and benefited from this gender-defined, dominant-subordinate dichotomy that fosters the accepted superiority of men, that falsely describes women's contribution "in terms derived from [men's] own systems of thought" (Miller, 1986, p. xix), and that renders women's activity as therefore nonexistent or inherently inadequate and trivial.

Fletcher (1999) was influenced by the relational work of Miller and colleagues that identified an *other* way of development that takes place within the context of relational connection with and to other people. She was intrigued by the notion that the traits of empathy, vulnerability, and connection could be conceptualized as strengths rather than simply as feminine traits associated with women's greater emotional needs. Because men are acculturated to remain aloof and separate from their emotions, women

> become the 'carriers' of relational strengths in society, responsible for creating relational connections for others and meeting basic relational needs without calling attention to the needs themselves. Rather than strengths, these relational attributes are commonly described as deficiencies (e.g., emotional dependence, weakness, vulnerability). This allows society to perpetuate the myth of self-reliance and independence, even though most people have a [largely female] network of people supporting their "individual" achievement (Fletcher, 1999, pp. 9-10).

Fletcher (1999) studied women in the workplace and described the ways in which the relational activity they contributed, in addition to their competence with the identified work skills, supported and advanced the collective work while it simultaneously rendered them invisible within the work environment. Kanter's study (1977) had already presented a nuanced view of organizational life that explicated gender differences in the workplace as a reflection of natural strategies that were used in the exercise of power dynamics and not as inherently gender-defined. In a growing environment of increased consideration for the benefits of caring, helping, teamwork, and building consensus and webs of connection in the workplace (Fletcher, 1999; Helgesen, 1990; Wheatley, 1992) sought to explicate traditional workplace dynamics by utilizing a poststructuralist perspective that challenged common assumptions. These assumptions had heretofore silenced possible alternative truths as they privileged the conventional wisdom that supported the status quo. This poststructuralist perspective moved the focus from individual

intentions to the systems of common assumptions that formed the collective reality. To be clear, the relational practices that Fletcher observed were not personal attributes or idiosyncrasies, but rather were actions that "reflect[ed] a relational logic of effectiveness." They included the skills of "empathy, mutuality, reciprocity, and a sensitivity to emotional contexts" (Fletcher, 1999, p. 84). In this study, Fletcher found that activity that was foreign to the collectively constructed acceptable workplace practices was rendered invisible by three major descriptive categories (a) the misattribution of motive, (b) the limits of language, and (c) the social construction of gender.

The misattribution of motive caused relational practice to be dismissed as a personal idiosyncrasy rather than a desire to make a more effective contribution to the work. The mental construction of this misinterpretation assumes that a desire to be liked or a need for emotional dependence, rather than a desire for effectiveness, growth, or enhanced achievement, motivates relational practice. The ultimate result is to leave the traditional logic of effectiveness intact.

Regarding the limits of language, Fletcher identified the conundrum that occurs when an available descriptive language has been created to portray and ultimately sustain the status quo in which relational activity is dismissed and devalued. Many of the words that more effectively describe the relational practices (helping, nurturing, nice, polite) were more commonly associated with the lesser-valued private sphere and femininity. This reality renders the behavior from a gendered perspective, weakening its organizational relevance and its possible perception as real work. Fletcher's study further identified that the terminology of relational practices described activity that did not have a separate conclusion. Rather, the relational activity was used as a support for the general outcome of the project (creating the experience of team, enabling

others to perform their work effectively), and was considered not tangible, measurable and quantifiable and therefore not real work.

The social construction of gender is related to the ways in which relational activities become misconstrued with images of femininity and motherhood and therefore become invisible in the workplace. As we have seen, women are expected to function within the confines of the feminine role that anticipates relational practices, benefits from these, but devalues both the doing of this work and the doers. Women's activities that are commonly considered the natural expression of their gender (e.g., helping, listening, and teaching) unwittingly reinforce the patriarchal notions of the dominant group that they are entitled to these ministrations in support of their performance of "real work."

> The two, contradictory sides of the social construction of gender . . . —being expected and even relied upon to enact relational practice, while being dismissed or devalued for acting that way—embody a more general contradiction that plays itself out in our larger societal systems. Indeed, it is a contradiction inherent in the public/private split that the power-knowledge system of patriarchy works to suppress: *relational activity is not needed and women must provide it* (Fletcher, 1999, p. 112)

Relational activity that supports real work in the public sphere but that is discounted within that sphere because it carries with it the stigma of activity appropriate only to the private sphere, once explicated, forms the basis for the belief that organizations are not gender-neutral. Although it is still universally prevalent, male domination within organizations is seldom questioned, analyzed, or explained (Hearn & Parkin, 1988). Until recently, men have viewed their behavior and perspectives as representing the human; and organizational structures and processes have been theorized to be gender-neutral (Acker, 1990). When a single perspective such as patriarchy or a non-relational approach predominates, it is difficult to *see* its opposite.

Recent feminist scholarship has resulted in an elaboration of gender as a concept and secured the search for the explanation of the persistent subordination of women. New approaches to the study of waged work see organizations as inherently gendered and highlight the intertwined concepts of gender and class as confounding elements (Acker, 1990). To say that organizations or other units are gendered means "that advantage and disadvantage, exploitation and control, action and emotion, meaning and identity, are patterned in terms of a distinction between male and female, masculine and feminine" (Connell, 1995, p. 45). Acker (1990) posits that gendering occurs in five interacting processes that may appear analytically separate but are, in fact, part of the same reality. These distinctions will be presented here with identifiers that reflect their relevance to the world of nurses and health care. The first of these identified processes is the construction of divisions along the lines of gender. Kanter (1977) observed in her study that men are almost always in the highest positions of organizational power and that even additions to the workplace, such as increased technology, generally require reorganization but not the elimination of traditional gendered divisions of labor. Healthcare decision-makers are predominantly male while nurses, a faction that is 97 percent female and represents the largest professional healthcare group, wield minimal power within the healthcare context and seldom find themselves in positions that exert decision-making influence across the entire organization (Gordon, 2005; Weinberg, 2003).

The second gendering process is the construction of symbols and images that explain or reinforce these divisions. This includes, but is not limited to, modes of dress, language, and media exposure. While women have made significant inroads in this area, the prevailing image of a business leader is one of successful, forceful masculinity. Physicians dress in business suits

or professional lab coats whereas nurses' attire was historically starched white uniforms and caps and currently includes scrubs that are simultaneously worn by nurses' aides, janitors, and other nonprofessionals (Hughes, 2001; Kalisch & Kalisch, 1987). Additionally, while nurses comprise the largest professional healthcare group, their representation in media stories as knowledgeable and authoritative professionals is almost nonexistent (Buresh & Gordon, 2006; Kalisch & Kalisch, 1987).

The third set of processes that form gendered social structures are interactions between all combinations of genders that recreate dominance and submission. Physicians write "orders" that nurses have been acculturated to follow, formerly reflecting an acquiescence that bordered on mindlessness (Gordon, 2005). Nurses have been schooled in a deferential attitude toward physicians and have become adept at "doctor-nurse games" of information-sharing and diagnosis-generating that are passive and understated (Stein, et al, 1990). Fourth is the effect of these interrelated processes on the social construction of self-concept and the reinforced representation of the self as a gendered member of an organization. In health care, the gender divisions are traditionally established and societally reinforced, despite alterations in roles that have added women to the medical and administrative ranks and men and advanced practice nurses to the nursing ranks (Gordon, 2005). The final component in the process of reinforcing the gendered nature of organizations is the composite reality that gender is implicated in all actions that contribute to the creation of social structures (Acker, 1990). Gender is a constitutive element in organizational logic that is reinforced daily in the written work rules and other systems used for running large organizations. These elements both create and respond to the concept of hierarchy that was historically taken for granted in organizational life. Despite

modern networks and matrix models of operating, healthcare environments continue to reflect the patriarchal, hierarchical, bureaucratic models of a bygone age (Pretzer, 2001; Zimmerman & Hill, 2000). Additionally, traditional organizational logic holds that two jobs at different hierarchical levels cannot be responsible for the same outcomes (Acker, 1990). As a consequence, nursing care given in support of patients is translated as effort in support of the medical treatment plan. This reality ensures that all patient outcomes accrue to the efforts of medicine alone, and that nursing assessment, intervention, and surveillance remains invisible (Fletcher, 1999; Jacques, 1993).

The gendered nature of healthcare organizations perpetuates the superior/subordinate dichotomy that mirrors the Cartesian separation of mind and body so prevalent in the twentieth century. It reinforces the lack of congruence and cohesion that individual actors on the healthcare stage contribute to the brokenness of the system. This reality plays out most detrimentally in the increasing need for chronic care management that requires the involvement of knowledgeable teams rather than discrete heroes. The portrayal of women as either self-actualized actors or as passive victims of a patriarchal system presents a duality that is universally delimiting and lacking in honesty. Among other components of the healthcare system that are seriously flawed and that contribute to its ineffectiveness is the gendered nature of this structure, which insists on buttressing historical models despite their proven inadequacy while failing to seek alternatives that could better inspire successful change. “As far as words will let us go, we have voyaged” (Ammons, 1972). Unexamined and embedded assumptions that privilege one group over another stifle possibility and cause innovative alternatives to be overlooked as old answers are

repackaged with shiny new names. To overturn this reality, all parties must open themselves to growth and potential.

Aging of the Population

The result of improved medical science, healthier lifestyles, better nutrition, and enhanced public health has been an increase in expected life span of American citizens. The average life expectancy is currently 75 years, with prospects for ever-increasing longevity improving all the time. The aging of the population, especially the anticipated overload as the Baby Boomers reach retirement age, is the result of societal successes and the improvements and progress noted above and has become an increasing issue. The number of people aged 65 and older is increasing by about 6 million per year and people 85 and older represent the fastest-growing segment of that population. Elsner, Quinn, Fleming, Gueldner, & Poon (in Hein, 2001) report that in 1996 the United States Census Bureau (1996) identified eight states (Arizona, Arkansas, California, Colorado, Georgia, Nevada, Utah, and Washington) in which the population over age 65 is anticipated to more than double within the next few years. Additionally, the number of people who have reached the age of 100 is increasing substantially. The Census Bureau (1998) further reported that these “expert survivors” (Elsner, Quinn, Fleming, Gueldner, & Poon in Hein 2001) numbered 36,000 in 1990 and 61,000 in 1998, making centenarians the fastest-growing segment in the United States. Demographers predict that between 2010 and 2030, the number of people 65 and older will rise from 39 to 69 million. Forecasts also anticipate that by the year 2030 there will be significantly fewer people under age 18 than over age 65.

The effect that this age wave will have on the healthcare system will be powerful and long lasting. According to Shur Bilchik (in Hein, 2001), PricewaterhouseCoopers data show that older Americans currently use four to five times more healthcare services than younger people. And whereas people over age 85 represent only 11% of non-disabled Medicare beneficiaries, they account for a much larger relative portion of healthcare resource usage (Shur Bilchik, in Hein, 2001).

Shur Bilchik (in Hein, 2001) references Daniel Perry, Executive Director of the Alliance for Aging Research in asserting that the medical conditions that affect elderly citizens and that greatly impact the healthcare system are not the "big killer diseases such as cancer and heart attacks" (p. 367). Rather, the issues surround unrecognized and undertreated chronic conditions associated with aging. This reality signifies a need for a rapid alteration in the healthcare concentration of the United States, moving the focus from an orientation on exciting cures of acute conditions toward the management of complicated and interrelated conditions that are the purview of chronic and long-term care. Alan Lazaroff, MD, of Denver's Geriatric Medical Association comments that the current healthcare " . . system is geared to rescue the elderly from the complications of chronic diseases, [but that] we need to learn to help people live, not just stop them from dying. In the future, our central principle will need to be to prevent or minimize disability" (Shur Bilchik, in Hein, 2001, p. 367).

The prevalence of Alzheimer's disease and other dementias increases markedly with age. In the United States, the cost of treating people with this disease ranks slightly behind that of the combined costs of treating people with heart disease and cancer. However, the cost of Alzheimer's treatment increased twofold in less than a decade, signaling an upward spiral of

need in the immediate future (Howe & Lettieri, in Hein, 2001). In the United States, business ethics are coming into conflict with medical ethics as a result of managed care practices and the economic implications of an aging population. Howe and Lettieri (in Hein, 2001), assert that in 1993, the Medicare system spent $154 billion dollars for the care and treatment of its elder and disabled citizens. In all countries, questions about allocation of resources for elderly citizens are being debated, not simply from an economic perspective but, more importantly for the spirit of the countries involved, for the humane considerations that these discussions raise. Age-based healthcare rationing might result in substantial fiscal savings, but is that the most effective and humane approach to consider?

Many researchers and healthcare professionals have indicated a need to make a rapid but significant alteration in treatment models because chronic conditions are currently being dealt with using an acute care model. While this is the familiar approach, it will not result in either people-successful or cost-acceptable outcomes (Shur Bilchik in Hein, 2001). The medical model concentration on diagnosis and cure presents an option that misses the point of the chronic needs of long-term residents who require care focused on sustaining functioning and preventing further complications (Elsner et al., in Hein, 2001). This assessment and intervention process entails additional time to accurately evaluate the patient's ability to live independently and will need to include measures to enhance and support optimal functioning, not merely survival.

As a result of the change in demographics discussed above, discourse on the subject of aging became more prevalent after the turn of the twenty-first century. Many older Americans have demonstrated not only an ability to survive into later years, but a penchant for learning how to thrive. The concurrent debates over intergenerational equity in shrinking healthcare and

welfare structures and the newfound elder search for meaning in old age have created an interesting and somewhat paradoxical soup. The ongoing angst over the viability of Social Security and Medicare needs to be re-examined from both an economic and a moral and existential position (Cole & Stevenson, in Hein 2001). Dovetailed to this discussion is the consideration of the deeply embedded belief that physical treatment leading to cure is the most appropriate and valued utilization of healthcare resources. An aging population appears, at this juncture, to be both a present and future reality. Philosophies and methods spawned in a time of youthful predominance cannot apply relevantly when growth and youth are no longer the standard. “In coming so far . . . have we foundered into arrival” (Ammons, 1972) at the place where we have “satisfy[ied] all destinations by no departures”? (Ammons, 1972) The world we have is configured as it is because of the successes of our past as well as the decisions and inclinations that led the way. Strategies to address these new issues will require rethinking of our beliefs and values as a people as well as reformatting the priorities this reconsideration presents.

Factors Intrinsic to Nursing

This process now brings me to a discussion of the more intrinsic factors that emanate from and directly influence the attitudes, satisfaction, and performance of registered nurses within this changing healthcare environment. I have identified those factors as (a) identity and knowledge in nursing, (b) empowerment in nursing, (c) the nursing shortage, and (d) the future of nursing leadership.

Identity and Knowledge in Nursing

The historical antecedents of modern nursing have contributed to the persistent belief in the trustworthiness, honesty, and ethical attributes of nurses but have done little to explain or

reinforce the knowledge and skill that nurses' work requires. The public perception of nurses centers on who they are as people, not what they do as professionals (Buresh & Gordon, 2006). Nurses have historically had difficulty articulating their specific and unique contribution to health care, partly because the available vocabulary has revolved around a script of virtue and perceived feminine characteristics such as caring. The virtue script (nurses are angels of mercy) reinforces personal attributes but leaves silent the nuance and subtlety of the nurse's caring work as well as the knowledge and experience necessary to expertly perform that work. The frequently self-denigrating nature of nurses depicts caring as simple intuition, thus relegating it to a commonplace activity not worthy of note. Additionally, Benner's comprehensive research (1984, 2000) has identified that the methods nurses use to assess patient situations are often seen as mere chatting rather than as purposeful actions accompanied by astute clinical evaluation and knowledge that collectively serve to identify errors in treatment, prevent potentially lethal complications, and thus *rescue* patients.

Personal agency is defined as the capacity for acting or the condition of acting or exerting power. Beyond this instrumental description, a more reflective illustration is that an agent is "someone who acts and brings about change, and whose achievements can be judged in terms of her own values and objectives, whether or not we assess them in terms of some external criteria as well" (Sen, 2000, p. 19). Writing about the multiple inequities that women suffer in many countries, Sen further distinguishes the more dynamic nature of women's *agency* from the state of women's *well-being.* For nurses, developing and reinforcing a sense of agency depends on their recognizing the importance of the work of nursing and of their own value in doing that work. Effective nursing assessment and intervention demands knowledge and experience that

lead to mastery of multiple skills and techniques, none of which accrue to simply being a good person. Florence Nightingale saw the importance of agency, although the word in its current connotation did not exist in her time; and she held in disdain attitudes that trivialized the qualifications necessary for nursing. In *Notes on Nursing* (1969), she wrote:

> It seems a commonly received idea among men and even some women themselves that it requires nothing but a disappointment in love, the want of an object, a general disgust, or incapacity for other things to turn a woman into a good nurse. This reminds one of the parish where a stupid old man was set to be a schoolmaster because he was "past keeping the pigs" . . . .
>
> The everyday management of a large ward, let alone of a hospital—the knowing what are the laws of life and death for men, and what the laws of health for wards—(and wards are healthy or unhealthy, mainly according to the knowledge or ignorance of the nurse)—are not these matters of sufficient importance and difficulty to require learning by experience and careful inquiry, just as much as any other art? They do not come by inspiration to the lady disappointed in love, nor to the poor workhouse drudge hard up for a livelihood. (pp. 133-134).

Knowing in Nursing—Nursing Theory and Practice

Although nursing is a profession that has, over years, highlighted and reinforced its scientific and theoretical underpinnings, the fact remains that it is by definition a discipline defined and described by practice. Since Florence Nightingale, nursing practice has been concerned with placing the human body in the best condition to access the body's own recuperative and restorative capacities. The human body of Nightingale's description is the embodied person who responds to fresh air, walks, and clean, warm, well-lighted environments (1969). This person simultaneously lives in a collective human world of relationships, concerns, and meanings. Illness disrupts access to this world (Merleau-Ponty, 1962). Benner's study (2000) illuminated that nursing is in a unique position to further convey "this social, sentient, skillful body that dwells in a physical and social world and in temporality (p. 78)." Nursing is

also a platform upon which scientific knowledge comes into contact with the human experiences of illness, recovery, and health as it also affords a space for exploration of perceptual capacities that facilitate ways of thinking and acting as moral agents in particular lifeworlds. Finally, nursing correlates practice with theory in supporting the vision of holism that links recuperative powers of the body and the functions of lifeworld to recovery and healing (Meleis, 1997). Technical cure and restorative care need not be considered as oppositional forces, and this reality reinforces the requirement for nurses to be clearly conversant with anatomy and physiology, microbiology, pathophysiology, and a broad spectrum of therapeutic interventions.

The training schools of Nightingale's design have slowly given way to those with increasing interest in academic preparation, although nursing's entry into practice remains multiply defined. Over recent years, theory advancement specific to nursing and related to the developing academic environment has consumed a great deal of attention and research effort. Carper's seminal study in 1978 identified, for the first time, a way of knowing that serves as the underlying rationale for nursing practice. This work distinguished four fundamental, interrelated patterns of knowing that were differentiated by their logical type of meaning. These patterns are (a) empirics, the science of nursing; (b) esthetics, the art of nursing; (c) the component of a personal knowledge in nursing; and (d) ethics, the component of moral knowledge in nursing (Carper, 1978). This work has been so important to the advancement of the profession that it bears further exploration, especially as it relates to practices of caring, ethical considerations in relation to medicine, and theories of intentionality within the profession.

Empirics: The Science of Nursing

Because of the historically accepted training or apprenticeship model of nursing preparation, the concept of a science of nursing was rarely considered until the late 1950s. Since then, there has been a significantly increased emphasis on developing a body of empirical knowledge that is nursing-specific. This strong desire for validation of an empirical foundation for nursing practice may have been associated with an appeal for legitimizing the profession (Pierson, 1999). However, the pattern of knowing that is designated as *nursing science* does not present with the same degree of integration of abstract and systematic explanations of the natural world as do more mature sciences. It does create a conceptual structure within which to consider the familiar phenomena of health and illness in relation to human life processes. It also presents a more descriptive classification and an increasingly analytical perspective that is directed at explaining observed empirical facts identified by praxis. Carper's model represents health as a dynamic process that varies according to circumstances, making it much more than the absence of disease (Carper, 1978). The model has been extended and carried on by Benner (1984), Meleis (1997), and Merleau-Ponty (1962). Carper's interpretation of empiricism in nursing, with its focus on objectivity and context-free replicability, has been adjusted over the years to reflect less positivistic research-based knowing, specifically by including grounded theory and ethnographic research designs (White, 1995). These newer designs require interpretation that is more subjective in nature and not inherently generalizable, replicable, or "publicly verifiable," criteria Carper (1978, p. 15) identified in her initial description of nursing empirics.

Historically, Cartesian philosophy, with its emphasis on separation of mind and body, caused nurses and other practitioners to seek a level of mental clarity that could isolate certain

truth. Efforts were generated toward creating a measurable reality that could combine clear and exact reasoning with a systematic, mathematical questioning of empirically derived data. This philosophical premise caused practitioners to distrust sense perception and to see as suspect all nonintellectual components of rational thought, including emotion and imagination (Pierson, 1999). Because nursing was developing its empirical basis during a time when Cartesian thought processes were considered universal, the theories and frameworks created sought to describe, explain, predict, and control the central issues of professional nursing practice. The nursing process developed at this time espoused a deliberate, systematic, and neutral approach to client care. In this process, discrete empirical data (i.e., general appearance of the individual, vital signs, and diagnostic test results, among others) were used to formulate nursing diagnoses that characterized client care deficits that then served to inform nursing priorities and interventions. This process was intended to create a nursing approach that was appropriate, effective, and uniform and that would prevent inconsistencies in care that resulted from the use of individual intuitive approaches (Pierson, 1999). The ultimate intent was to aggregate the efforts of practitioners and researchers in nursing and develop a universal database and outcome classification system that would direct nurses' actions within particular situations toward "controlling human responses" (Nagle & Mitchell, 1991, p. 22).

While this view did not demand the exclusion of patients' personal experiences as important considerations, it did obscure these findings through efforts made toward achieving objectivity and predictability contained within the professional parameters of nursing practice. Patients' personal experiences were generally considered within the context of their

commonality with similar situations, and not regarded for their unique contribution to the given issue.

Esthetics: The Art of Nursing

The second pattern of knowing in nursing that Carper identified was esthetics—the art of nursing. This designation materially extended the traditional interpretation of knowledge creation, which depended almost exclusively on empirical investigation. An esthetic experience, as envisioned for this pattern, involves knowledge gained by "subjective acquaintance" (Carper, 1978) and incorporates the direct feeling of the experience. According to Carper, "the art of nursing involves the active transformation of the patient's behavior into a perception of what is significant in it—that is, what need is being expressed by the behavior" (Carper, 1978, p. 17). Carper considered empathy as an important component in the esthetic pattern of knowing, describing empathy as the ability to gain knowledge of another's felt experience via effective and authentic interpersonal engagement. Jacobs-Kramer and Chinn (1988) contributed that esthetic knowledge is expressed in the "art-act" of nursing and posited that this knowledge pattern functions simultaneously as a separate entity that fully integrates context into the subject of nursing and as the synthesis of the knowledge patterns that assimilates with practice. Further, White (1995) reinforces that Jacobs-Kramer and Chinn (1988) consider experience as a necessary condition of esthetic practice that includes "engaging, interpreting, and envisioning."

Johns (1995) debates the interpretation of empathy as the core skill within this pattern. He argues that a more accurate description of this core skill is intuition. Both Jacobs-Kramer and Chinn (1988) and Johns (1995) associate components of the pattern of esthetic knowing in nursing with Benner's (1984) work regarding expert clinicians. Jacobs-Kramer and Chinn's view

is that experience is context-specific and cumulative, thus aligning with Benner's (1984) position that expertise is not a transferable skill. Johns (1995) adds the gestalt nature of intuition, which supports Benner's (1984) assertion that skilled practitioners transcend linear processes in perceiving situations and making decisions. Carper (1978) notes that appropriate skilled responses involve the ability to envision the desired and anticipated outcomes of the specific intervention. Orem's concepts of nursing practice (1980) reflect this process which also requires an effective "interpretation of the whole situation and an analysis of the interdependence of the parts within the latter" (Johns, 1995, p. 228). This component adds further detail to the construction of Benner's (1984) work related to expertise in nursing. Benner proposed that the expert nurse perceives the situation "as a whole" and, using past experience, "moves to the accurate region of the problem without wasteful consideration of a large number of irrelevant options" (1984, p. 3).

The construct of the ethics of nursing corroborates Benner's distinction between novice or advanced beginner practitioners and experts. In Benner's (1984) research, the former utilized rule-governed behavior, and this caused them to employ classroom-learned principles and theories that were universally applied and not appropriately context-dependent. The latter group, experts, did not rely on analytic principles to provide connection between their understanding of the situation and appropriate, immediate action. Rather, the experts just knew how to proceed. The novices were successful when they could recognize the depth of the situation and take into account the appropriate theoretical considerations and guide their performance accordingly. Benner's work, based on Dreyfus & Dreyfus (1986), identified that following rules legislated against successful performance by expert practitioners because the rules could not identify the

most uniquely relevant tasks to perform in a specific, actual situation. For this reason, experts bypassed the rules as they moved directly and perceptively to an understanding of the whole situation and initiated interventions even as they were completing their assessment. In interpreting the work of the expert, knowledge embedded in actual practice must be explicated, along with the contexts and meanings intrinsic to particular clinical situations.

Benner's (1984) important study highlighted the difficulty inherent in identifying and naming subtle inner workings that result in accurate perception and understanding but that bypass readily observable linear methodologies. According to Carper (1978) the esthetic pattern of knowing in nursing "involves the perception of abstracted particulars as distinguished from the recognition of abstracted universals. It is the knowing of a unique particular rather than an exemplary class" (p. 18).

A Component of Personal Knowledge

The third pattern of knowing in nursing is a component of personal knowledge. Carper (1978) identifies this as the most difficult component to master and to teach because it involves the practitioner knowing himself or herself and actualizing "an authentic personal relationship between two persons" (p. 19). This knowing reflects an I-thou (Buber, 1970) encounter in which the nurse seeks to know the patient by means of an authentic interpersonal relationship that promotes wholeness and integrity, and the achievement of engagement rather than detachment. Carper considers this pattern to be "most essential in understanding the meaning of health in terms of individual wellbeing" (1978, p. 18), and reflects Mayeroff's notion of reciprocity in interpersonal relationships, with his belief that this construct allows a person to be "able to understand [another person] and his world as if I were inside it" (Mayeroff, 1971, p. 42). This

concept further highlights the disparity between the historically preferred type of knowledge (theoretical understanding) and clinical knowledge (practical understanding) that has been viewed as lesser as it has been assumed to be a mere application of theory (SmithBattle, Drake, & Diekemper, 1997). It also underlies the concept of the "therapeutic use of self" within the context of the nurse-patient relationship, which has been the focus of significant nursing research studies (Schoenhofer, 2002; SmithBattle et al., 1997; Watson, 2002). Clinical narratives that serve to explain actual practice resist the conceptual clarity so prized in the world of abstract theory-building. The richness of these narratives, however, is to "preserve the *messy* complexities of the practice world, the significance of relationships, the importance of timing and context, and the crucial role of experience for acting skillfully in complex situations" (SmithBattle et al., 1997, p. 76).

Whereas Benner's work explicated the discovery of excellent nursing practice in acute care settings, SmithBattle et al. (1997) conducted a similar study with home care nurses and identified that the nurses' responsive use of self underscored their unique ability to "create common ground" (1997, p. 76) within which they could work successfully with families and patients. This ability to appropriately respond to their patients and families enabled the home care nurses to gain a *situated understanding* of their clients' life that fostered the development of trust relationships so crucial to successful treatment regimens. These nurses learned the benefits of deeply listening to the clients' concerns, beliefs, and values; of decreasing social distance and disparities of power; of identifying problems collaboratively with their clients; and of learning the multiple webs of meaning that shape and constrain clients' choices and their experience of health and illness.

Personal knowledge also reflects the interpretation of authentic therapeutic relationships that involves interpersonal connection and empathy, as described by Jean Baker Miller and her colleagues (Miller, Jordan, Stiver, Walker, Surrey, & Eldridge in Jordan, Walker & Harting, 2004) at the Stone Center at Wellesley College. Within Miller's construct, empathic, mutual relationships are the goal, with the intent of creating a mutual exchange in which one is affecting the other while being affected by the other. As the home care nurses' study described, mutuality of relationship changes both parties. Fundamental to an established sense of mutuality is an "appreciation of the wholeness of the other person, with special awareness of the other's subjective experience" (Jordan et al., 1991, p. 82). Johns (1995) posits that, in order to authentically engage in mutual relationship, nurses need to have an honest and accurate concept of themselves that involves three interrelated factors: "1) the perception of the self's feelings and prejudices within the situation; 2) the management of the self's feelings and prejudices in order to respond appropriately; and 3) managing anxiety and sustaining the self" (p. 229). With this personal knowledge, nurses can achieve a level of therapeutic connection with the patient and bring into the encounter an "intention to nurse" (Locsin, 2002, p. 1) that can substantially enhance the mutual benefits of the relationship. This espoused intentionality causes nurses to consciously seek meaningful practice parameters that allow the knowing of the whole person. Several conceptual models for nursing, (e.g. Orem's Self Care Theory, 1980; Newman's Interactive-Integrative Paradigm, 1986; Peplau's Interpersonal Relations in Nursing, 1952; Rogers's Science of Unitary Human Beings, 1990) along with Krieger's work on Therapeutic Touch (1979) identify that intentionality, heightened self-awareness, and mutuality for nurses means growth, expansion, and wholeness. In addition, these attributes create a "healing

environment" (Quinn, 1992, p. 26) that enhances "the intent of presence and connectedness" (Lowe, 2002, p. 10) within the nurse/patient relationship.

Munhall (1993) added an additional pattern of knowing that she titled *unknowing*. This pattern extends Carper's personal ways of knowing and adds the emphasis of openness to the picture, as unknowing demands introspection that can enhance the understanding of intersubjectivity and perspective. This construct demands that nurses seek to really understand themselves and their patients as two distinct human beings, one of whom the nurse does not know. With the initial meeting, two separate perspectives or worldviews come together, resulting in the intersubjective space wherein the organized world of one person meets the organized world of another. This space is viewed as the fertile ground upon which will be enacted caring, understanding, empathy, and conflict as the nurse is motivated by her intent to come to know the patient's world.

Intersubjectivity has been considered from the established perspective of Cartesian philosophy within the traditional scientific academy and, more recently, from the human science standpoint. Within the traditional scientific paradigm, nursing models were developed that drew on natural science and general systems interpretations of individuals as the total sum of parts. These initial frameworks sought to remove nursing from medically directed practice by identifying and substantiating the unique role of nurses within the healthcare environment. The intersubjectivity script in these models identified nursing as an interactive process that was based on the initiative, the approaches, and the knowledge of the nurse (Chinn & Jacobs, 1987, p. 42). This script fostered the development of the nursing process as a simulation of the traditional

scientific method and, later, the creation of nursing diagnoses (Pierson, 1999) that aimed to reduce clients' experiences to "a single, objectively identifiable element" (Gadow, 1996, p. 29).

The objectively scientific models of nursing were not universally accepted within the profession because they influenced a nursing practice that involved the use of standardized algorithmic or automatic responses to complex physical problems via the performance of instrumental tasks. As a result, other models of nursing developed that drew on a human science perspective, reflecting a postmodern standpoint and suggesting that individuals are more than the sum of their parts and are capable of interacting with their environment in an exchange centered on human experience. In this paradigm, nursing activities focused on promoting health (Lindsey & Hartrick, 1996), and these activities are generally taken to be interactive processes that derive from the "enabling characteristics of the nursing action and the will and behavior of the client" (Chinn & Jacobs, 1987, p. 41). Reflecting Miller (1976, 1986) and Carper's (1978) work, the fundamental way of being and knowing and helping people in these models is through relationship and connection. Watson's Caring Science paradigm (1985) replicates these models that accentuate "understanding the significance and meaning of human experience within the context of the 'human health-illness experience'" (Pierson, 1999, p. 297). Within this process, meaning is contextual and personal; therefore, it cannot be generalized. Meaning, not truth, is constructed through the nurses' active engagement with others. As a result, the concept of intersubjectivity becomes paramount within this construct. It engages nurses and clients in an intense relationship and causes the subject of caring to re-emerge within the nursing vocabulary as "dynamic, thoughtful, deliberate activity based on human interaction" . . . that represents an "ethical ideal, deeply grounded in our sense of humanness" (Pierson, 1999, p. 297). Within the

nursing framework, caring relationships consist of an active sense of engagement, genuine responsiveness, presence, reciprocity, and a commitment to foster the well-being of another (Benner & Wrubel, 1989; Noddings, 1984; Watson, 1995, 2003).

Ethical Ways of Knowing

The last of Carper's patterns of knowing in nursing involves ethical ways of knowing. The moral code that informs nursing practice is based on the primary principles of service to people and respect for human life. This pattern of knowing does not relate to rules of conduct or performance. It does address the notion of obligation (what ought to be done) but anticipates that moral choices must be considered in terms of specific actions to be taken in particular, concrete situations. Merely applying ethical principles is not sufficient because these principles serve simply to inform the situation. This interpretation represents early commentary on the situational and relational importance of moral decision-making, which reflects Gilligan's (1982) conception of moral development as arising from conflicting problems rather than a model of competing rights such as that put forth by Kohlberg (1981). Gilligan's conception of morality as concerned with the activity of care centers moral development around an understanding of responsibility and relationships in opposition to Kohlberg's view, which revolves around fairness and therefore links moral development to the understanding of rights and rules.

Carper points out that there are no rulebooks that provide acceptable answers to the moral choices nurses are faced with daily. Jacobs-Kramer & Chinn (1988) offer the comment that nurses must continually process the societal questions of the meaning of life in relation to a quality of living. The former reflects the prevailing values of the healthcare system, which are currently in transition in many places and have incorporated a conceptualization of life that is

more than physical existence. The latter represents recent thoughts on a service intervention that is not likely to result in resumption of a desired quality of living. As patient advocates, nurses often find themselves being asked to translate these nuances to an uneducated public. As nurses face the obligation of determining an ethical course of action, they must consider conflicts of values within themselves and between themselves and others (Carper, 1978). The ability to be an ethical practitioner is embodied in the moral imagination and skills of a good clinical practitioner and leader (Benner, 2000). It must also be based on the concept of responsive relationships, which is founded on three essential elements: respect, trust, and mutuality (Tarlier, 2004), elements that reciprocally inform the development of ethical nursing knowledge in practice.

Sociopolitical Knowing

In addition to Carper's four patterns of knowing in nursing, Munhall has added the fifth pattern of unknowing, discussed previously. White in 1995 added a sixth pattern of knowing in nursing named sociopolitical knowing. This pattern, White notes, addresses the issue of *wherein*, suggesting that nursing is not exclusively about the nurse-patient relationship, but is, rather, inclusive of the broader context within which nursing and health care take place. This pattern purports to question the assumptions that underlie nursing practice, the nursing profession, and health policies. This pattern fundamentally concerns the cultural identity ascribed to, defining and constraining nursing. This pattern posits a journey beyond Carper (1978) and Mayeroff's (1971) description of personal knowing and relates to deeply entrenched historical issues of connection and dislocation. It identifies that nursing is present and involved in the care and treatment of people whose major infirmity may be poverty, unemployment, undernutrition, isolation, or alienation—all precipitated through societal structures. It further asks that an

analysis of domination within social, economic, and political arenas be critiqued with regard to the impact these institutions have on health. And finally, it demands that nurses understand their role in translating their specific healthcare contribution in language that the public can hear and understand in order to better educate the public and more effectively secure support for nursing intervention.

This pattern returns us to prior discussions in this paper on power and its impact on whose voice is heard and whose is silenced within social systems. It challenges nurses to involve themselves beyond their comfort places in the work of the larger world and to seek to make a deeper impression on that world.

Reflection

The patterns of knowing in nursing, whether viewed as four, five, or six in number, require consideration and reflection to be integrated within practice parameters that enable their power to inform and transform.

Conducting research during the 1980s, Belenky, Clinchy, Goldberger, & Tarule (1986) identified differences in ways that women come to know and understand their world—ways they learn—that represent fundamental alterations in that which was heretofore inferred based on studies of their male counterparts. In this landmark study, *Women's Ways of Knowing*, the authors asserted that when women achieve a level of knowing called *connected knowing*, they "learn through empathy" (Belenky et al., 1986, p. 115), a word that Gilligan (1982) and Miller (1976) also use frequently in their research, and that Benner (1984) employs in her study of expert nurses. Other attributes of connected knowing were (a) having an attitude of trust, (b) assuming the other person has something good to say, and (c) recognizing that the purpose of

conversation is not to judge but to understand "[C]onnected knowing involves feeling, because it is rooted in relationship; but it also involves thought" (Belenky et al., 1986, p. 121).

Both Gilligan (1982) and Belenky et al. (1986) use the metaphors of webs and nets to describe the ways in which women conceptualize their connections in relationship. The mental imagery is one of both safeguarding and entrapment, but the metaphor also conveys the message that movement in one part of the system will be felt in all parts of the system, thus reinforcing the interrelatedness that women experience *in relation*. This metaphor is also useful for describing the relational leadership style that has the leader as a central figure, which allows open portals where participants can observe each other in their interactions and where the sensitivity of the organizational tension creates positive energy for growth and change. In contrast, the historical male metaphor of the hierarchical pyramid speaks of elusiveness, distance, the need for intermediaries to carry messages, and control from afar (Baack, Carr-Ruffina, & Pelletier, 1993; Belenky et al., 1986).

The importance of the self-in-relation theory and the understanding of a new way of learning that is common among women is crucial to appreciating the significant differences that women bring to the workplace as well as to the world at large (Grant, 1988). Understanding the patterns of knowing in nursing includes these learning and leadership styles. Because of the persistent view of dominance that certain perspectives hold in the culture—strong is good, leadership is male, my way or the highway, lead, follow, or get out of the way—alternate ways of seeing, doing, and acting have consistently been viewed as *lesser* (Applebaum & Shapiro, 1993). However, this can also be seen as the logical destination in a trip conducted "as far as words will let us go" (Ammons, 1972). The scholarly research that has been done on these topics

may gradually begin to shed light on the *rightness* of either perspective or, indeed, of many other approaches until other viewpoints begin to be incorporated into the universal lexicon of what is the *norm* (Dobbins & Platz, 1986; Fuchs-Epstein, 1991; Rosener, 1990) and the distance that the acceptable words let us travel is extended.

Empowerment in Nursing

Early in 1983, Roberts identified nurses as an oppressed group historically controlled by societal forces that ultimately determined the leadership style of the profession. Friere's work (1971) with non-nursing groups in Brazil highlighted the system by which the oppression that allowed a dominant group to categorize societal norms and values was maintained. As a result of this dominant influence, characteristics that did not reflect those of the dominant group would take on negative values. Despite the fact that the valued characteristics are the ones most prevalent and comfortable in the subordinate groups, the tendency is to internalize the identified hierarchy of values and to conclude that the subordinate group will have more power if its members espouse the distinctiveness of their oppressors. The subtle though persistent reinforcement of these beliefs maintains the dominant and subordinate relationship of the two groups until ultimately all parties see the oppressed group as inherently inferior. Members of the subordinate group who support the views of the dominant group also assist in maintaining the system and the status quo. Often, the leaders of the subordinate group seek increased status by currying favor with the dominant group. This results in imbalance and disequilibrium within the subordinate group, as its members are then oppressed by their leaders, who become ineffective members of both groups. In this process, the subordinate group leadership becomes marginalized by their ambiguous position (Friere, 1971).

Clifford (1992) saw nursing leadership as marginalized, and therefore a difficult fit with the subordinate group of professional nurses, while not being accepted as a full member of the dominant group by hospital administrators or physicians.

Methods and strategies have been devised to help people move beyond oppression. These mechanisms threaten the status of the dominant group and of the unbalanced equilibrium between both groups. Clifford (1992) comments on her view of the myth of empowerment as she notes that

> empowerment is a process, not a thing to be eaten or worn. It is a process which grows from the grass roots up. It is not a program initiated by a nurse executive. It is a way of thinking and behaving which, at best, can be enabled by nursing management (p. 1).

The road beyond marginalization and oppression involves a genuine commitment to a shared vision by senior management. However, the nursing leader is in an awkward position to effect this change. Having been promoted through the healthcare hierarchy overshadowed by the dominant group, the nurse executive can be torn by conflicting responsibilities. The nurse executive is primarily a nurse and therefore focused on providing quality patient care. In a management position, her stewardship responsibilities cause her to respond to cost reductions and other corporate mandates that could result in a dilution of that same patient care. A solid personal and professional identity could assist the nurse manager to traverse this difficult terrain and establish mechanisms for enhanced utilization of her positional power within the organization. This would also facilitate the creation of environments that support empowerment for staff nurses.

Discussions of empowerment in nursing over the past decades have originated from theoretical pursuits that view this concept primarily from management and social psychological

perspectives. The *American Heritage Dictionary* identifies that to empower is to invest. To invest is to spend or devote time or effort for future benefit, to endow with authority or power. Empowerment is frequently included in dialogues around motivation of subordinates as a means to increase the tasks delegated to them. It is often seen as something that is given to another, bestowed on another. In this context, it is a top-down approach that more clearly reflects a power differential in a superior and subordinate than a sharing of power to achieve mutual benefit.

The researchers from the Stone Center at Wellesley (Miller & Stiver, 1997) share a basis for their understanding of empowerment with Rogers (1975) and Maslow (1954) in that they view personal power as inner strength and self-determination rather than dominance, control, or mastery. They have extended these initial concepts to one that supports power within connection or relational power and have thus viewed empowerment as a mutual process in which both parties derive benefit. Referring again to Rogers (1975), the researchers at the Stone Center focused "on the characteristic aspects of mutually empathic relationships to facilitate psychological growth and empowerment" (Surrey, in Jordan, Kaplan, Miller, Stiver, & Surrey, 1991, p.166). Theirs is a model that anticipates the reciprocal and empathic connection of individuals that result in feelings of enhanced communal engagement, attention, and interest, which ultimately leads to mutual empowerment.

Laschinger (1996); Laschinger et al. (1997); and Chandler (1991) have used Kanter's (1977) model of Structural Power in Organizations as a framework for examining nursing work environments that influence nurses' responses to work experiences. The studies that Laschinger has been involved with consistently support Kanter's (1977) theory that access to opportunity, information, support, and resources correlates positively with work effectiveness, specifically

influencing organizational commitment, job autonomy, and involvement in organizational decision making. Other areas that were associated with work effectiveness for nurses in these studies included increased visibility within the system, flexibility in job activities, and formation of strong organizational alliances. These studies have served to highlight the various ways in which alterations can be made in work dynamics that assist nurses to feel more valued and therefore more empowered. Examples of how these results can be put into practice include shared governance models, decentralized nursing decision-making, commitment to ending nurses floating to other units to cover shifts, and fostering of formal and informal cross-departmental influence relationships within the healthcare setting.

Chandler's study (1991) undertook to explicate the critical variables that nurses perceived in their work environments that facilitated their empowerment. This study identified that many research efforts to that date had devoted attention to nurses' relationship with power. These studies assumed that power emanated from the individual and, in this context, described nurses as being ignorant or fearful or as isolated from power. Chandler's research used Kanter's model (1979) to gain information regarding nurses' perceptions of their practice environments relative to their capacity to empower the people who function within those environments. The results again reflected Kanter's theory and identified that if the requisite support, information, and opportunity were available, the response of the nurses would be an increase in motivation, risk-taking, and career aspirations. The study further identified that nurses understand clearly that they do not have positional power within the current healthcare environment. However, the results of these studies indicate that the nurses' lack of empowerment may be related to a lack of support, information, and opportunity rather than to an unprofessional attitude. The general

conclusion of these studies and many others is that an increased awareness of organizational change is necessary to enhance nurses' feelings of empowerment and their resultant commitment to the organization. The problem with this supposition is that the organization needs to initiate the change within itself, thereby threatening established power relationships (Chandler, 1991). Achieving this will require that nurse managers share their positional power and learn to become catalysts rather than controllers of work environments that include the information, support, and resources necessary to practice professional nursing. "The paradigm shift is from 'power over' the staff nurse to 'empowerment of' the staff nurse" (Chandler, 1991 p. 22).

It is interesting that Chandler published a different research study (1992) that sought to gain insight into the source and process of staff nurse empowerment and powerlessness. Heretofore, many studies assumed that empowerment was the same process as delegating or sharing power. Chandler designed her study to query this assumption. Additionally, she called into question the further conjecture that the supervisory structure in nursing was the same as that in other fields. In this regard, the belief is that the supervisor is the person who holds the ability to delegate or provide resources. The reality is that in the specific work environments that most nurses experience, "the staff nurse is held accountable by many more individuals than the traditional supervisor-subordinate dyad" (Chandler, 1992, p. 66).

Chandler used an exploratory, descriptive design process, employing a survey method and interviews for this research effort. Staff nurses described situations in which they experienced feeling empowered, then described situations in which they experienced feeling powerless. The results indicated that 57 percent of the respondents felt empowered by interactions with patients and families. The activities in these encounters were typically

described as comforting, supporting, and teaching. The second largest empowerment category (23 percent) was nurse-physician interactions that involved the physicians seeking nursing input, collaborating in making patient care decisions, and acknowledging nurses' value to the process. The largest response of experiencing powerlessness came as a consequence of negative nurse-physician interaction in which nurses were ignored, verbally abused, or otherwise treated with disrespect. The second category of powerlessness was identified when something untoward and unanticipated happened with a patient despite all the efforts the nurse had put forth in technical expertise and compassionate caring (Chandler, 1992). The results of this study are important for their identification that empowerment is not exclusively a factor that emanates from external sources; in these situations, empowerment came from the nurses themselves. Furthermore, empowerment in this study was defined as experienced in relation to patients, the family, and physicians. Empowerment originated in interaction, replicating the findings of the Stone Center (Jordan et al., 1991) researchers. Chandler's 1992 research effort highlighted a significant difference in activities that nurses identified as empowering. Nowhere in this study did feelings of empowerment emanate from supervisors or from organizational committee work. Although these results were small in scope, they have significant implications for nursing leadership because they reflect the caring orientation and the relational propensity of most nurses. Further, these results and those identified using Kanter's model (1979) have important information for addressing the nursing shortage in North America because they highlight areas of preference and dissatisfaction that nurses have been expressing for several decades.

Nursing Shortage

Episodic nursing shortages have characterized the nursing profession in the United States at least since the inception of the hospital-focused system of the 1940s. There have been multiple reasons for these shortages, with the majority of explanations being (a) fluxes in inpatient census at hospitals resulting in either reduction in the nursing workforce or the enthusiastic wooing of nurses back to the bedside when an upturn in clinical need occurred, (b) increasing specialization of nursing within institutional settings, (c) nurses' dissatisfaction with personnel issues, especially related to mandated overtime and floating from a primary work site to any other area of the hospital, (d) nurses' dissatisfaction with administrative support related to poor communication with nursing supervisors, corporate mandates that were not nurse friendly, and feelings of being undervalued in the system, and (e) nurses' dissatisfaction with relationships with the medical profession resulting in poor communication and coordination of patient care issues, physical and verbal abuse that was weakly addressed by hospital administration, and overall disrespectful treatment, (f) inadequate financial compensation.

Nurses bring a relational competence to their work in the healthcare arena. The gendered nature of this environment simultaneously requires, denigrates, and *disappears* (Fletcher, 1999) in this work while creating an atmosphere in which the work is considered to be affect-based rather than an essential structural practice that benefits the whole. One important example of this reality is contained in Jacques's (1993) study of nurses' dimensions of caring work. In this study, Jacques observed an activity he termed *information-passing* in which the nurse acted as the intermediary for essential patient information among medical and allied personnel on an average of 87 times per day. Jacques reflected that despite the valuable effect of this work on

organizational competence, the subject of information-passing was not included in job descriptions or reward structures in any way. “[Information passing] was, instead, left to happenstance, its presence assumed and the costs of its absence ignored” (Jacques, 1993, p. 12).

Jacques’ initial study further delineated categories of working that consumed nursing time. He divided these categories into visible and invisible work. Visible work included (a) feeding the patient; (b) moving the patient and physical comfort; (c) medications, IVs, and taking specimens; (d) giving treatments; (e) performing patient personal hygiene; and (f) administrative items, forms, etc. Invisible work included (a) getting clinical information; (b) giving information, education, and instructions for home care; (c) communicating information to the patient from others and vice-versa; (d) “rapport talk,” communication designed to establish a relationship; and (e) “above and beyond,” work neither required nor expected. Jacques discovered that categories of invisible work were most often performed concurrently with activities listed in visible work categories. He further ascertained that if the invisible, coordinating, and communicating activities were completely removed from the activities of the nurse, 96 percent of the nurse’s time would still be accounted for (Jacques, 1993, p. 4).

Contemporaneous with these discoveries, managed care had appeared on the healthcare horizon. Health maintenance organizations (HMOs) were initially viewed as feasible and fiscally sound market-generated answers to rapidly escalating healthcare costs. It was expected that the HMOs would result in affordable services while still providing quality care. Over time, this bright beginning declined into a weak shadow of its original promise. Profit-making became more common and cost reductions were secured in whatever manner possible (Friedman in Hein, 2001). This reality caused hospitals to engage in restructuring and realigning strategies to reduce

their costs and jockey for a more viable place in the healthcare arena. Registered nurses were sacrificial lambs in this scenario. One of the most telling descriptions of this phenomenon was the dismantling of Beth Israel Hospital and its merger with New England Deaconess Hospital; this was chronicled by Weinberg (2003) and Gordon (2005). The primary message in Weinberg and Gordon's work is that "when profit and institutional survival are the motives that guide administrative action and behavior, nursing suffers" (Gordon, 2003, p. xii). The decimation of nursing departments all over the country resulting from hospitals adopting the values of corporate rationality in the managed care world has today become the legacy of HMOs and concurrent hospital restructuring. And today's nursing shortage owes much of its virulence to the reduction in force that managed care initiated as well as the manner in which these mandates were carried out. Chambliss (1996) reports that hospital restructuring of the late 1990s devalued the caring aspects of nursing work and damaged nurses' ability to act professionally because of the increased demands made on them, while reinforcing their subordination to institutions that saw fit to select margin over mission. The work of nursing became less attractive to women just as greater entrée into historically male professions became a reality.

Any reduction in a nursing workforce would result in higher nurse-patient ratios and greater responsibility required of the nurse. However, the nursing shortage that is currently being experienced is occurring simultaneously with a significant decrease in supply of nurses being educated and a dramatic increase in an elderly population that consumes a greater proportion of healthcare resources than any other group. The present scarcity of nurses will not have the episodic nature of prior shortages. The statistics indicate that the average age of nurses is 45, with many planning to retire within the next few years (Bednash, 2000). Nursing school

admissions decrease annually, and there are few RNs in the 20- to 27-year-old age range (Buerhaus, Staiger, & Auerbach, 2000). Unfilled nursing positions comprise 75 percent of hospital vacancies and an alarming number of nurses are leaving the profession. A recent study done in Pennsylvania identified that 22 percent of the 43,329 nurses questioned planned to leave nursing altogether (Aiken, Clarke, Sloane, Sochalski, Busse, Clarke H, Giovanetti, Hunt, Rafferty & Shamian, 2001).

The current nursing shortage has been fueled by the issues identified above, but contains the same basic problems as the experiences of limited nursing supplies that have preceded it. The very structure of the profession and the contextual boundaries within which it is practiced have historically resulted in periodic episodes of scarcity. The squeeze that nurses experience within these structural boundaries—between care for the patient, support to physicians, and their employment by administration—often causes decreased satisfaction and increased frustration. The structure of the workplace and the nature of the work environment emerge as major contributors to dissatisfaction and burnout, resulting in an ever-deepening shortage of qualified nurses. The structural conflicts inherent in nursing practice include implicit directives to "be caring and yet be professional, be subordinate and yet responsible, be diffusely accountable for a patient's well-being and yet oriented to the hospital as an economic employer" (Chambliss, 1996, p. 62).

While this is the historical description of nursing, the consequences of increased nurse-patient ratios and more complex acutely ill patients requiring care compounds the problems that nurses face daily. The technical expertise that nurses have had to gain over the years has radically impacted how they function within the healthcare environment. They remain the

consistent, clinically astute presence that provides “surveillance, early detection, and timely interventions that save lives” (Aiken, Clarke, & Sloane, 2002, p. 7), while they also create relationships with patients that allow for treating their illness not merely their disease, and facilitating wellness and recovery. Their absence has resulted in negative outcomes for the very sick patients depending on them, according to studies conducted recently (Aiken, Clarke, Sloane, Sochalski, & Silber, 2002). The ratio of registered nurses per hospital bed was 0.651 in 1983, 0.857 in 1990, 1.048 in 1994, and 1.115 in 1996 (Buerhaus & Staiger, in Hein, 2001) This fact contributes to the statistic that 40 percent of hospital nurses have burnout levels that exceed the norms for healthcare workers, and job dissatisfaction among hospital nurses is four times greater than the average for all United States workers (Aiken et al., 2001).

Additionally, the subject of nursing wages has contributed to the negative feelings of many in the profession. While most practicing nurses entered the profession to make a difference for people and not to realize wealth, the least nurses should be able to expect is that their wages surpass the rate of inflation. Since 1992, this has not been the case. During the early to mid-1990s, when managed care and hospital restructuring characterized the healthcare arena, wages remained stagnant. Sochalski’s 2002 study demonstrated that as the demand for nurses increased after the year 2000, bedside nurses, regardless of their level or expertise, received wages that rose at rates that decreased with experience. The message sent by this reality was that bedside nursing was of less value than administration, despite the need for expert clinicians caring for increasingly ill and complicated patients. All these significant changes, coupled with the nursing workforce assessment of inadequate support from management in the form of insufficient

resources and information, has materially resulted in the shortage that is impacting all of healthcare.

Studies on nurse empowerment have indicated that nurses respond best to work settings that promote autonomy and control over practice environments and that foster a cooperative nurse-physician relationship (Laschinger et al., 2003) and reduce dissatisfaction and burnout. As far back as 1998, a report of the Secretary of Health and Human Services Commission on Nursing made recommendations for alleviating the prevailing nursing shortage. These recommendations included (a) appropriately utilize scarce nursing resources (reduce use of nurses in non-clinical capacities), (b) create incentive plans to recognize and reward levels of education and expertise, (c) ensure that staff nurses have opportunities to participate in shared governance and the management of healthcare units, and (d) create mechanisms to develop nursing resources and demonstrate the value that organizations place on nurses (Maraldo, 1991). In most institutions, these recommendations have not been acted upon to date.

Much prior research has outlined areas that are important to nurses and relevant to their work effectiveness and that, if addressed, could have a significant impact on the future of nursing and the wellbeing of patients cared for within institutional settings. Disregarding this research in favor of inactivity or poorly directed activity that makes no relevant improvements will cause a national and regional response that resembles “fear, arms over its head, tremble[ing] into blindness, invaded by truth-seeking light” (Ammons, 1972). The comments that nurses have made relative to their preferences and dissatisfactions, if really heard and creatively addressed, could change the face of nursing and healthcare for the better. The target of much of the nurses’ criticism of these issues has been institutional administration and nursing management. The next

section will review issues of nursing leadership as they exist, are changing, and have an impact on the issues delineated thus far.

Nursing Leadership

The squeeze that nurses experience within the healthcare environment between their obligation to care and advocate for patients, their responsibility to work collaboratively with physicians while carrying out *doctors' orders,* and their obligations to administration as employees of institutions within the healthcare arena, create enormous conflict that is intensified by the pressures of managed care and corporate mandates to reduce costs and work with less resources. This squeeze impacts staff nurses and nursing leaders alike. The dynamics of this reality have been discussed in this paper and reflect the conundrum that inflexible organizational structure and the need to develop creative responses reflects.

Business literature over the past decades has been saturated with studies and commentary on management theories. Health care somehow is not included in the vast majority of managerial research and has maintained its hierarchical, autocratic, centralized managerial process. The hierarchical structure attempts to control the conflicting though interrelated goals of physicians, nurses, and administrators who exist to provide treatment, care, and service to patients. Until recently, this balancing act has been sustained rather successfully, even if it is not in line with more modern concepts of management theory. The recent increases in scrutiny on medical practice, administrative functions (documentation and billing), patient outcomes, safety, and information generation and dissemination have exposed the weaknesses in the monolith of healthcare. No longer is central control achieving the uniformity of actions and outcomes that have been acceptable in the past. No longer can nurses be thought of as worker bees that can

function effectively in any environment or specialty; technology and the need for decision-making close to the patient have upset that accepted premise. And no longer is it possible to tolerate nursing leadership that does not, in fact, lead. This last statement applies to all registered nurses who adhere to the American Nurses Association Standards of Professional Performance in which *leadership* was added as a requisite in the 2004 iteration. It is no longer appropriate for anyone to believe that leadership in nursing applies only to managers, administrators, and executives. “In fact, all RNs assume the mantle and responsibility of leadership when they sign their first nursing licenses” (Ulrich, 2004, p. 364).

In the research on empowerment, nurses have been vocal in their desire for the creation of work environments that support autonomy, decision-making, relationships across departmental lines, and nurses’ control of their own professional practice. Recently, there have been several theories and models devised to consider how this rather significant change in healthcare environments could be facilitated. A few of those models are discussed here.

In 1997, Porter-O’Grady reviewed options and presented a concept of leadership at the point of service. Referencing Ackoff (1994), Porter-O’Grady noted that the focus of health care was moving from a hierarchical institutional perspective to one in which the meeting of the provider and patient became the major area of concern. This change would allow a confluence of resources, supports, and systems at the point when they were most essential to the provider-patient relationship. This convergence at the unit or bedside level would create conditions for efficiency and effectiveness and generate best outcomes by supporting those responsible for both the necessary knowledge and the provision of service. This discussion generates the expectation

that managers will alter their former patterns of behavior in favor of those that reinforce a new role as process leaders.

Drucker (1997) described that the primary role of managers in the past was related to the transfer of information from within the various levels of the system to other areas within the organization. Managing, controlling, directing, and implementing were significant activities that managers were expected to perform. More recent developments in health care require that these functions be replaced by the work of integrating information and generating knowledge in order to support the provider (the nurse) closest to the customer (the patient) in preparing to make effective decisions and accomplish the tasks at hand. This model ensures that assessments and interventions can occur in real time, as the customer requires. While this change in focus appears reasonable on its face, and has been incorporated by many other areas of the business world, the long history of a specific organizational structure within the healthcare environment could make any alterations extremely difficult to achieve. Despite this difficulty, hospitals are changing the way they do business and think about the services they provide. A major impetus for these changes is related to the rise of magnet hospitals as premier providers of care as well as desirable places for nurses to work.

The American Nurse Credentialing Center (ANCC) Magnet Recognition Program for Excellence in Nursing Services has been measuring nursing indicators and patient outcomes and designating hospitals with magnet status since the early 1990s. The initial impetus for this designation was a study conducted by the American Academy of Nurses (AAN) to “identify a national sample of what will henceforth be referred to as ‘magnet hospitals’—that is, those which attract and retain professional nurses in their employment—and to identify the factors that

seem to be associated with their success in doing so" (American Nurses Association, 1983, p. 2). This report made several recommendations that are relevant today and reflect the desires of nurses to be empowered to perform their technologically competent caring work. Some of these recommendations were (a) a philosophy of caring from top management that pervades the patient care environment; (b) leaders who are visible and accessible; (c) participatory management with practicing nurses engaged in decision-making at the unit, departmental, and hospital levels; (d) facilities that contribute to better care for patients; (e) directors who interact frequently with nursing staff one-on-one; (f) extensive involvement of nursing in planning for new services and technology selection; (g) quality assurance programs that identify and resolve problem situations; (h) nursing administration that recognizes the autonomy of the professional nurse; (i) leadership that encourages the nurses in their continuing self-development (American Nurses Association, 1983).

Ten years later, this program was updated to recognize not only environments that attract nurses but also nursing excellence and the role that professional nursing plays in the delivery of quality patient care. In 2003, Laschinger and colleagues studied nurses' perceptions of workplace empowerment, magnet hospital characteristics, and job satisfaction and learned that there was a positive correlation among all three factors. Magnet hospital characteristics of nursing autonomy, nursing control over their practice environment, and positive nurse-physician relationships resulted in the nurses' increased feelings of empowerment. These outcomes were also predictive of nurses' job satisfaction. Laschinger identified implications for nursing managers (a) to identify barriers to staff nurses' access to the qualities identified in the study and create ways to remove the barriers, (b) to identify systems and structures that maximize the utilization of the

clinical expertise of the nurses and reinforce these, (c) to ensure that nurses have significant input in the design of their work environments, (d) to reinforce point-of-care decision-making with the necessary structures to support this, and (e) to fortify the status of alliances with other healthcare professionals and team members. The role of nursing leaders in this study then becomes twofold. Staff nurses are reinforced for their clinical leadership activities and patient outcomes, and nurse managers assume a role that supports the staff nurses receiving the resources they need to accomplish the tasks and clinical judgments that present themselves. In this way, recruitment and retention will be enhanced along with professional practice and clinical excellence (Laschinger et al., 2003). In fact, many magnet hospitals today outpace their competitors with lower turnover rates and higher staff morale.

Professional practice models are another method for addressing the leadership and clinical excellence needs of an increasingly complex healthcare population. A professional practice model (PPM) is a mechanism of care designed to utilize the professionalism of the care delivery *team* to improve patient outcomes. “Attributes of the PPM include (a) solid nurse/patient relationships, (b) nursing autonomy and control over the practice environment, (c) positive nurse-physician relationships, and (d) constructive work collaboration, and personal responsibility” (Rusch, 2004, p. 61). Many magnet hospitals have included PPMs in their environmental change initiatives and there is evidence that PPMs are effective in associating professional nursing practice with positive patient, staff, and organizational outcomes (Havens & Aiken, 1999).

A significant component of PPMs is the clinical nurse leader role, which includes such functions as expert clinician, educator, systems analyst and risk anticipator, team manager, and

information manager (Rusch, 2004). This role is differentiated from the advanced practice and clinical nurse specialist roles in that the clinical nurse leader is primarily an expert clinician and nursing team leader who orchestrates, manages, and delivers hands-on care. A pilot study of the development of a PPM that incorporated a clinical nurse leader role was described by Smith, Manfredi, Hagos, Drummond-Huth, and Moore (2006). This pilot study produced improved nurse satisfaction scores; patient satisfaction ratings trended positively in all nursing care-related areas and were consistently above the industry national average; physician satisfaction with nursing care reached a 95 percent rating; nurse-physician collaboration markedly improved; patient length of stay (LOS) was reduced by 9 percent, representing a savings of $416,150.00 to the hospital; and agency nurse utilization was reduced over the life of the pilot study, representing a cost savings of $120,165 (Smith et al., 2006). Unanticipated positive outcomes of this project that resulted from the clinical nurse leader's timely interventions included a 38 percent reduction in patient restraint use and a decrease in patient falls in comparison to the overall hospital statistics. This study and the development of the clinical nurse leader role highlight the concept of nursing leadership at the bedside, with nurses prepared to plan, deliver, and monitor quality patient care professionally, autonomously, and with superb patient outcomes.

The Robert Wood Johnson Foundation, among other philanthropic organizations, has committed to working toward a positive impact on the nursing shortage by focusing efforts on identifying "underlying issues that could make the hospital a more appealing and functional workplace and foster leadership and partnership opportunities to address nursing issues more broadly" (Robert Wood Johnson Foundation, 2006). Toward that end, their focus is on nursing at

the bedside. As a result, the Robert Wood Johnson Foundation has entered into a collaborative relationship with the Institute for Healthcare Improvement, involving 13 hospitals in a pilot project named Transforming Care at the Bedside. Additionally, the foundation has established a Fellowship in Nursing Policy and Philanthropy and has an existing Executive Nurse Fellows program, the purpose of which is to foster nursing leadership at all levels.

While the Robert Wood Johnson Foundation has opted to focus on retention of nurses in the workplace, other entities have chosen to direct their attention to nurse education, recruitment, and facilitating the public's interest in nursing as a profession. An interesting study conducted in 2002 concentrated on gathering information regarding the leadership qualities and expectations of a younger workforce. Based on the new work being done on leadership at all levels of nursing, it is imperative that students recruited to nursing education understand that leadership is a major expectation. This study identified the assumptions and preferences of the emerging workforce in light of their expectations of teachers and nursing leaders. Based on Tulgan's *Managing Generation X* (1995), the personal attributes and expectations that these individuals bring to their education and to the workplace include that (a) leaders will be effective and intelligent; (b) leaders will provide mentoring and skills training; (c) leaders will give frequent feedback; (d) leaders will trust and respect them for the work they do; (e) as employees, they want flexibility and money; (f) Generation Xers often lack people skills or an understanding of team-player attitudes; and (g) balance in work and personal life is important; job longevity is not. This is a profile of individuals very different from the dedicated, self-sacrificing labor force of nurses that has historically cared for the patients in the healthcare system in the United States. Regardless of the difficulties, it is imperative that new nurses understand and experience a leadership trajectory

in a systematic manner such that continuing leadership can be maintained and, ideally, reinforced.

Studies done on leadership in magnet hospitals between 1983 and 1991 have isolated a variety of leadership qualities that nurses want in their leaders. They want someone who (a) is visionary and enthusiastic, (b) is supportive and knowledgeable, (c) has high standards and high staff expectations, (d) values education and professional development, (e) upholds position power and status within the organization, (f) is highly visible to nurses, (g) is responsive and maintains open lines of communication, and (h) is actively involved in nursing organizations (Scott, Sochalski, & Aiken, 1999). Younger nurses, when queried, specified that they shared many of these feelings. They also reinforced the notion that younger workers want to be led, not managed. All this information will be critical to developing leadership qualities for the future, if members of the emerging workforce choose to enter nursing at all. The fear is that the emphasis younger workers place on entrepreneurship, short-term employment, and balance in their lives will make careers in a highly structured, chaotic, and challenging healthcare environment unattractive, especially in the field of leadership in healthcare, with its inherent stressors and frustrations (Rudan, 2002).

Regardless of creative models being used or piloted, nursing leadership emerges as the essential and elemental driver of all options. Bennis and Townsend (1995) articulated the characteristics of post-modern healthcare leaders as they described the death of bureaucracy and the dawn of a new era of leadership in their important work, *Reinventing Leadership: Strategies to Empower the Organization*. In this book, the authors stressed the need for leaders (a) to blend

art and science in their leadership practices, (b) to lead with a strong set of convictions that are consistently demonstrated, not merely parroted in speeches, (c) to understand that leadership is about character and the fostering of trust relationships, (d) to appreciate that leadership trust is equated to demonstrating caring for people in the organization, (e) to realize that leadership success is related to the leaders' ability to give up power and truly empower everyone else in the organization, (f) to understand that the leadership role must change from one of managing and controlling to one of coaching and facilitating the staff's redesign of their own work, and (g) to recognize that effective leaders in chaotic environments such as healthcare must demonstrate creative thinking and a mindset willing to take risks.

Many of these qualities are inherent in transformational leaders as opposed to those with a more familiar transactional leadership style. Transactional leadership is focused on contingent reward for followers. In this style, leaders emphasize process in goal-setting and they seek to compromise, manipulate, and control situations and followers. The rewards that transactional leaders give to followers, according to Bass (1985), entail praise, recognition, and merit increases that can be given or withheld based on the supervisor's assessment of employee performance. This style results in compliance and often goal achievement, with maintenance of the status quo and minimal job satisfaction. Transformational leadership, alternatively, uses inspiration, ideals, intellectual stimulation, and individual consideration to influence the behavior and attitudes of others (Bass & Avolio, 2000). Researching this approach, Hater and Bass (1988) learned that transformational leaders were able to move followers beyond their focus on self interests and excite their allegiance to a shared vision and goals. Additionally, Bass's 1985 research identified that the transformational perspective increased followers' feelings of self-

worth and self-esteem, fostered their involvement in challenging and meaningful work, and enhanced their perception of being valued through coaching and mentoring relationships.

The emergence of chronic care as a focus in the United States raises the subject of the more direct involvement of registered nurses in leadership roles. Many of the sites where chronic care services are provided—skilled nursing facilities, hospice, and home care—are areas in which traditional medicine has only episodic presence and influence. Additionally, these are often areas that are highly regulated, most specifically the skilled nursing settings. While reimbursement structures such as Medicare and Medicaid continue to reflect the physician-centric model, they do so with the full knowledge that (a) physician involvement is rather limited, (b) essential coordination of care among multiple specialties is the norm, and (c) allopathic medicine is predicated on a philosophy of curing acute conditions. Much of the industrialized world is grappling with the complexity of managing the care of people with chronic illnesses. An article in the *British Medical Journal* enumerated the multiple studies that had been conducted regarding the benefits of nurse management over physician management of people with diabetes. “In focus groups, patients preferred nurse led shared care for managing diabetes over doctor led care by a ratio of nearly 6:1” (Bodenheimer, MacGregor & Stothart, 2005, p 613.). The authors identified that although nurses could play a pivotal role in improving chronic care, the barriers to this occurring include (a) a nursing shortage that makes recruitment difficult, (b) few insurance plans pay for this level of care, and (c) United States nursing education does not emphasize this role for nurses.

A recent study of nursing leadership in long-term care settings (Scott-Cawiezell, Schenkman, Moore, Vojir, Connolly, Pratt, & Palmer, 2004) recognized the need for improved

communication between nursing leaders and staff, acknowledging that the work in nursing homes is accomplished in ways unique to that setting. This study identified the discrepancy in perceived communication effectiveness between leaders and staff, pointing out the importance of validation of the accuracy of mutual understandings.

Laschinger has conducted many studies using Kanter's Theory of Power in Organizations. In 1996, she focused on public health nurses in a Canadian province (Battle Haugh & Spence Laschinger, 1996) that was undergoing significant practice changes related to new reimbursement and care priorities. Similar changes have occurred in the United States. This study identified that employment of the strategies for communication and empowerment that Kanter's theory enumerates could be helpful as "both management and staff will need to feel empowered in their work environments to develop the expertise necessary to ensure success of this new focus of community health care" (Battle Haugh & Spence Laschinger, 1996, p. 44). Moiden (2003) acknowledges that leadership studies in elder home care settings are scarce. Moiden used a case study approach to focus on the impact of leadership with staff who work at the bedside. This study pointed to the need to attend to the wishes of direct care staff, recognizing that nursing leadership will "fail to promote a personal and work life balance unless its style is more democratic in a way that staff like, and the concept of "followership" is understood better" (p. 24).

Moulton (2000) and Williamson (2005) have both studied issues of empowerment related to home care nurses. These studies identified the perceived autonomy of nurses who worked in environments in which empowerment and collaborative practice opportunities were presented. In

addition, Williamson's study acknowledged the empowerment that nurses perceived in their interactions with patients and other health providers , reflecting Chandler's 1992 study.

Nurses working in hospice programs function, as with most long-term care settings, in a team environment. Koshuta's 1997 study examined the nurse executive role in hospice programs, identifying the perception that hospice administrators had a great deal of autonomy. Writing an editorial piece in 2003, Mula recognized that "integration of leadership qualities into clinical practice will significantly improve palliative care services" (p. 48).

Research on nursing leadership in long-term care has not historically garnered significant interest. In 2003 the American Health Care Association (AHCA) developed a process for assessing and improving competencies for senior nurse leaders in Long Term Care. This comprehensive document identified the multiplicity of roles that nurse leaders fill in long-term care settings, from human resources to clinical care. Studies have shown that the nursing leadership roles in long-term care entail many of the same issues that nurses' experience in more acute settings related to autonomy, empowerment, and control of practice. While these roles compel a certain amount of independence, the nurses filling them do not always experience a heightened sense of autonomy and professional stature.

The role of the nursing leader demands a comfort level with transactional processes such as budgets, productivity, staffing, and quality monitoring while simultaneously remaining focused on the essential transformational characteristics of coaching, mentoring, facilitating, and leading. As we have heard in the research on nurse empowerment, nurses will follow leadership that can inspire and motivate performance beyond expectations if it can also engender a sense of team spirit, shared goals, and a common vision. With an emphasis on coaching rather than

controlling, nurse managers create a supportive climate that is sensitive to individual differences and also values real listening within the broad boundary of effective communication. In nursing parlance, the environment that supports these outcomes is some form of shared governance. Magnet hospitals, as well as other settings, embody this way of being as they simultaneously make visible the actual work of nursing so that it can be benchmarked, appreciated, and valued (Pinkerton, 2006) along with the people doing the work.

With current projections estimating the existence of more than 100,000 staff nurse vacancies and future shortages assessed to reach above 800,000 by the year 2020 (Martin, 2003), it is essential that the demonstrated preferences of working nurses be taken into account. The literature (Aiken et al., 2002; Taunton, Boyle, Woods, Hansen & Bott, 1997; Upenieks, 2000) supports the position that effective nursing leadership has been demonstrated to be an integral component of retention of existing staff and must be an important part of any recruitment and/or retention strategy. The current turbulent healthcare environment demands that front-line nurse managers as well as nurse executives exercise an enhanced level of leadership. The impetus for this mandate includes high staff turnover rates, frequent staff vacancies, patients with higher levels of acuity, limited financial resources, and the utilization of increasingly complex technology along with a vast array of reporting requirements. There is a dire need for nursing education to include studies and practice in leadership strategies and approaches in addition to the clinical knowledge historically included in nursing curricula (Russell & Scoble, 2003; Scoble & Russell, 2003). Incorporating and expanding leadership competency in the profession will be activated as nursing programs reconsider the manner in which professional nurses are integrated into the healthcare system.

As a result of this review, nursing programs will develop innovative educational programming that addresses these contemporary needs. The inclusion of leadership to nursing curricula will also reinforce the expectation that registered nurses must learn to embrace authority and accountability as they simultaneously assume responsibility for the care of patients. Nurses, accustomed to bedside decision-making, often feel unprepared to participate in decisions that have an organizational impact. Nurses often demonstrate that they are uncomfortable or unsure about their ability to lead (McGoldrick, Menschner, & Pollock, 2001). The process of education and reinforced practices that facilitate nurses' personal growth as leaders and the alteration in their self-perception that allows this change in attitude creates a circumstance that causes nursing to "realize its own full sphere" (Ammons, 1972) in a world sorely needing this attention.

The Assisted Living Environment

The assisted living component of elder care services in the United States did not exist 25 years ago. The concept was initiated almost simultaneously on both coasts. In Oregon the model developed as a public policy initiative that creatively utilized Medicaid waivers to establish assisted living as another option within the long term care continuum (Kane & Wilson, 2001). In the east, the model developed by entrepreneurial providers created an extension of the board-and-care homes that were run in private residences with no medical intervention and very limited personal care support. The new model took many of its values and structures from existing eldercare options in the Netherlands and Scandinavia. The entrepreneurs' vision included attractive congregate living arrangements with private apartments and supportive services based

on individual need, provided on an unscheduled basis and delivered with a great deal of consumer choice and control. Ten years later, the entrepreneurial, proprietary concept had become a rapidly expanding residential choice for elderly consumers who sought the homelike ambiance and appreciated the independence that the assisted living communities afforded. At this point, investors saw the merit of these proprietary options and, as a result, assisted living communities were constructed in affluent markets at great speed. Assisted living communities are the fastest growing sector of senior housing in the United States (Citro & Hermanson, 1999). In 2001, the United States had 36,399 licensed assisted living facilities with 910,486 units, representing a 14.5% increase in capacity since the year 2000 (Mollica, 2002). A recent national study found that (a) more than half of assisted living residents were 85 years of age or older; (b) 25% had moderate to severe cognitive impairment; (c) 33% experienced urinary incontinence; (d) 51% received assistance with bathing; and (e) 77% received assistance with medications (Hawes, Phillips, & Rose, Holan & Sherman, 2000).

Initially, the assisted living communities had difficulty translating their model into language that the public could comprehend and be able to differentiate from skilled nursing centers. Assisted living had no legislative or regulatory mandates at that time, and the various proprietary organizations sought to distinguish themselves through their philosophies of support and service. This philosophical basis generally included a well-appointed and comfortable residential environment and concepts such as independence, privacy, ability to make personal choices, and dignity. As time progressed, an additional concept was added. That concept was identified as *aging in place*. This concept has had many definitions, but it essentially relates to the ability of residents to grow older in the specific residence and remain there despite increasing

frailty due to aging and the effects of chronic conditions (Chapin & Dobbs-Kepper, 2001; Mitty, 2003). Recent research has indicated that ". . .central to a resident's ability to age in place was ultimately the 'fit' between the capacity of both the facility and the resident to manage resident decline"(Ball, Perkins, Whittington, Connell, Hollingsworth, King, Elrod, & Combs, 2004, p. S205).

To this day there is still no singular, universally accepted definition of assisted living. However, most providers and related groups agree on the definition contained in the Assisted Living Workgroup Final Report to the Senate Special Committee on Aging. This definition states that Assisted Living is "a state-regulated and monitored residential long-term care option . . . [that] provides or coordinates oversight and services to meet the residents' individual scheduled needs, based on the residents' assessments and service plans, and their unscheduled needs as they may arise" (Assisted Living Working Group, 2003). Conceptually, assisted living communities have been built on a social model of care that provides a safe, homelike environment in which residents receive personal and social support as opposed to a medical model of care, in which the "resident is a patient, being cared for according to an institutional schedule" (Chapin & Dobbs-Kepper, 2001).

Over the course of 25 years, states have promulgated regulations to address the public's questions and concerns regarding this new model of elder care. Initially, nursing oversight and supervision was nonexistent. As time progressed, the nursing presence became episodic, and often on a contractual basis. A study published in 2003 indicated that 71% of assisted living communities nationwide had a licensed nurse, either registered nurse (RN) or licensed vocational nurse (LVN), working on staff full or part time. 55% of assisted living communities reported

having an RN on staff full or part time, while 40 % of the communities responded that they had a full time RN on staff (Hawes et al., 2003). The advent of the aging in place philosophy (Mollica, 2005) brought to the foreground the need for a more consistent and sophisticated nursing presence. Focusing on the assisted living setting's ability to retain residents and prevent departures to other settings, a 2003 study found that the community's ability to retain residents was substantially increased if there was a full-time registered nurse on staff (Phillips, Munoz, Sherman, Rose, et al). Another study identified that "as a resident's clinical condition declines, privacy and autonomy become more difficult to uphold. . . and physical and mental decline precipitate greater concern for an individual's safety" (Kissam, Gifford, Mor, & Patry, 2003, p. 1652). Hawes et al. (2003) found that communities have rather idiosyncratic policies regarding resident admission and retention guidelines, contributing to the confusion in description of the services anticipated in an assisted living setting. Despite this confusion, Phillips et al. (2003) found that the odds of a resident being discharged to a nursing home were 50% less if there was a full-time registered nurse on staff.

Although state regulations differ, the responsibilities that registered nurses are expected to fulfill within the assisted living environment include (a) pre-admission and periodic resident assessments; (b) review of medication regimens; (c) screening and assessing of any resident who experiences a change of condition, from physical to cognitive to functional to behavioral changes; (d) development of a plan of care that meets the residents' healthcare needs; (e) observation and supervision of staff performance related to resident care; and (f) recommendation and/or oversight of in-service educational requirements based on residents' needs (Mitty, 2003). In addition to these responsibilities, registered nurses in assisted living

environments must exercise leadership in partnering with administration and physician colleagues. In general, the physician presence in assisted living settings is significantly reduced from that which is required in other long-term care settings. There is no systematic role for a medical director; each resident has his or her own physician who may not visit the home to see their patient. This reality essentially leaves the physician absent from the power dynamic that typically manages healthcare environments.

The fact that assisted living is not considered a health care environment at all is both its advantage and its deficit. It is advantageous in that the model has evolved to one that is significantly more resident focused and supportive of resident choice and autonomy than any institutional environment would be. It is a problem in that increasingly frail elders are being supported and cared for in these environments and their safety is of paramount concern. As Mitty (2003) reflects,

> The social aspects of assisted living—closeness, minimal conflict, social activities, and family interaction and visitation, to the degree that can be achieved—are strongly and positively correlated with a high quality of life and lower levels of depression. But when a resident's well-being or health falters, residents and families are likely to value supportive and health-related services more than social and recreational ones. One study suggests that new or exacerbated health conditions among assisted living residents who are aging in place might put them at risk for depression and a reduction in the quality of their lives (p. 40).

The issue of nursing delegation (the empowerment of aides or other unlicensed personnel to act in the place of the nurse by performing certain skilled nursing tasks in the care of a particular resident), especially with respect to medication administration to frail elders, is one that concerns nurses in many states. Often it is the assisted living regulations and not the Nurse Practice Act that permit nurse delegation. This reality is worrisome in that it leaves

accountability unclear because authorization for such delegation is vague. Nevertheless, studies related to nursing delegation and medication management highlight the increasing focus on this practice in assisted living settings (Munroe, 2003; Reinhard, Young, Kane & Quinn, 2006). Residents, nursing practitioners and the health care system all experience the tensions of balancing resident choice with safety regarding the issue of medication management (Sikma & Young, 2001). Munroe advises that ". . .it is imperative that nursing have a major voice in the development of the delegation role in these settings to avoid pressure from assisted living administration to 'delegate or else'" (2003, p. 103).

In a future forum held by the Assisted Living Federation of America (ALFA) in 2006, leaders in the assisted living business shared their perspectives on future growth and challenges of the field. Growth opportunities were predominantly related to the aging of the population with an expectation that there would need to be a proliferation of services for residents with dementia. Participants anticipated dealing with more educated consumers who knew what services they wanted and expected their *designer care* needs to be met. Concerns or challenges that the participants identified included (a) a perceived industry-wide shift causing independent living to look more like assisted living and assisted living to look more like skilled nursing, (b) fears related to an increasingly scarce workforce with the right competencies and values, and (c) anticipated regulatory changes causing infringements on residents' choices and quality of care (ALFA, 2006). These concerns signal the direction that the assisted living field will take in the future as it seeks to capture the market share of elders appropriate to its services; manage within the confines of the new regulations and state initiatives, whether or not they are ultimately

constraining; and address the ongoing issue of consistent and prepared staff to provide increasingly complex care to the residents.

With the continued growth of the assisted living model, resident/family satisfaction has emerged as a significant issue. Studies related to quality of life factors such as independence, privacy, autonomy and normalization have been identified as important (Hawes, Phillips, & Rose, 2000). Satisfaction survey tools have been developed to assist assisted living communities to gain a better understanding of measures their primary consumers consider important. Edelman, Guihan, Bryant, and Munroe (2006) posit that findings from satisfaction surveys may help administrators describe available services and the context of aging in place in language the consumer can better understand. Quality of care concerns in assisted living communities has also increased. A tool for measuring the quality of care has been developed by members of the Minimum Data Set (MDS) and Quality Research Team at the University of Missouri-Columbia. The tool, entitled Observable Indicators of Quality-Assisted Living is currently being field tested (Aud, Rantz, Zwygart-Stauffacher, & Flesner, 2007).

The paradox is that assisted living is a creative option for seniors that is appreciated and valued by them, while it is an environment that is not easily conducive to the level of supportive care that very frail elders require

By all reports, assisted living is a model of elder care that will continue to grow and evolve. There will be an increased need for medical and nursing intervention, not merely the wellness focus that was envisioned 25 years ago. Because of resident needs and projected staffing constraints, ALFA envisions the existence of organizational cultures characterized by teamwork, respect, and empowerment. If this is so, registered nurses who can tolerate the

ambiguity of an evolving model of care may find a welcome vehicle for creativity, advancement, professional growth, and esteem.

Conclusions

All the socially defined role requirements that have characterized nursing in the acute care setting have also colored its practice in the long-term care environment. Entrepreneurial settings, especially ones that focus on a proprietary model, enhance the squeeze that nurses always experience between their dual responsibilities as patient care providers/advocates and institutional employees (Duhigg, 2007; Woolhandler & Himmelstein, 2004). Census-driven administrative decisions often exert pressure on clinical judgments relative to appropriate levels of care and services for residents. This is especially true in the assisted living setting, where there may be an absence of specific regulations, creating a situation in which resident choice and aging in place become competing factors, with professional clinical assessment and administrative persuasion regarding occupancy and census goals.

Most assisted living settings have one registered nurse who functions as the chief nursing leader; indeed, the chief clinical leader. As has been noted, physician presence is severely limited in this setting. Residents in assisted living in Connecticut suffer from all the predictable chronic conditions that would be anticipated with an elderly population. They also require support for medication administration, either from an unlicensed aide operating under the guidance of the registered nurse or directly from a nurse. The chronic conditions that require clinical management are complex and interrelated and demand expert nursing oversight, observation, and, in the absence of physician presence, intervention. Preventing further complications is a

major goal and resident safety is a significant focus; all the while understanding that residents have the right to exercise choice and enjoy privacy.

Residents with dementia represent a large population that requires enormous efforts to maintain safety, prevent complications, and monitor disease progression and intervene appropriately. The home-like environment of assisted living settings creates pleasant surroundings but also provides a challenge for nurses to care for very frail elders as they age in place. The single nurse leader in each setting is generally able to manage the clinical complications as a result of her expert professional abilities. However, the market-driven, real estate focus of the business model creates pressures that are unique to assisted living. These pressures create a conflictual situation for the nurse that is similar to the squeeze (Erlen & Frost, 1991; Reverby, 1987) that nurses have always experienced, but is potentially more stressful because the assisted living nurse is a professional with no other readily available clinical partner with whom to consult or share the burden.

CHAPTER III: METHODOLOGY

Situational analysis is a relatively recent methodological support and therefore warrants deeper discussion relative to its origins and utilization in this study. Thus, this chapter is divided into two major conceptual areas. The first addresses the philosophical underpinnings and methodological fit of the constructivist approach to this research. The second addresses the specific methodological procedures employed in the study. The research question in this study involves a qualitative examination of registered nurses' experience of leadership within the assisted living environment. As has been previously discussed, there are multiple influences present in this situation related to the nurses themselves, the expectation of both the profession and the public regarding the nurses' role and performance, the overall healthcare environment, and the specific conditions of the assisted living setting. This study explicates the voice of nurses who fill a primary leadership role within a nontraditional, non-hospital, generally unstructured setting while it also highlights the complex situation that comprises the assisted living environment. The influences that have been identified in the previous chapter appear to be pivotal in the professional experience of the researcher. The choice of methodology, therefore, reflects the researcher's desire to listen intently and present the resultant data in a manner that highlights the beliefs, feelings, and experiences of the nurses being interviewed, while simultaneously making visible the social phenomena that create the context within which the nurses work, and the relationships between and among the nurses and the situational elements.

Grounded Theory and Situational Analysis: Methodological Fit

The desire to uncover data from experiences lived by real nurses engaging in the day-to-day challenges of nursing leadership resulted in the decision to utilize grounded theory as a methodological approach. The belief that context informs behavior and practice resulted in the

researcher's decision to employ situational analysis as a form of grounded theory and a mechanism for presenting a picture of the engaged whole, with relevant influences identified, characterized, and documented.

In utilizing situational analysis, this study describes the range of influencers present within the multi-site settings that constitute "the situation" of the study. The singular nurse leader in each selected setting was interviewed in conjunction with analyzing the components of the situation. This methodology fosters the explication of coexisting and competing forces within the environment that, if overlooked, would have decontextualized the situation. Employing situational analysis causes all forces affecting a given situation to be identified and acknowledged. Additionally, it compels the highlighting of relationships that exist between and among the existing forces. Finally, it allows the silences or voids within the discourse to be recognized for the potential influence they might have. Ultimately, it allows the voice of the nurse to be heard within the complex context that contains it.

Functionalist Theory

The roots of grounded theory can be found collectively within the Chicago School of Sociology, its utilization of symbolic interactionism as a research perspective, and its eschewing of the pervasive influences of functionalist theory as the dominant viewpoint of its time. Functionalist theory is important to review and understand because it has historically informed many nursing theories and practices. Functionalist theory refers to the Cartesian belief that all things are comprised of interrelated, functioning parts that are only important in their ability to serve the whole—individually, the parts lack real value. This reductionist, utilitarian concept allows research efforts to spotlight individual actions, roles, and social entities only to the extent

that they serve to benefit or result in identifiable consequences to the larger collective. People are not intrinsically important, but assume a measure of value based on their acculturation into roles that foster the systematic advancement of the society. An inability to fit into socially prescribed roles results in labeling of behaviors as deviant, dysfunctional, and ultimately a threat to the stability of the whole. The function of society is to *socialize* individuals into their prescribed roles and functions.

One of the effects of functionalism on the study of health care is the delineation of a *sick role*, as elaborated by Parsons in 1951. This concept identifies conditions under which individuals are relieved of their socially assigned roles, but only as long as these individuals carry out the expectations of their interim role. Failure to do so results in the description of deviant, noncompliant behavior, with attendant societal consequences accruing along with the label. The functionalist perspective draws on beliefs in an evolutionary process of social change, one that does not envision accommodating to rapid social change and that ultimately prefers homeostasis to any change at all (Bowers, 1988).

Nursing practices formed by a functionalist perspective include the specific role of the nurse as a reflection of Victorian womanly values and of a place in society that reinforces and actually demands that women quietly support the more important work of others. Additionally, the development of the scientific emphasis on medicine results in natural conditions such as pregnancy, childbirth, and menopause being *medicalized* and rendered as states of illness for which treatment, directed and managed by a physician but assisted by nurses, is required. As specific nursing theories developed, starting in the 1950s, concepts related to “role, system,

equilibrium, adaptation, and homeostasis . . . attest to the comprehensive integration of functionalism" (Bowers, 1988, p. 35) within the overall notion of nursing work.

Symbolic Interactionism

Symbolic interactionism is a response to the functionalist concept of a well-ordered, integrated, and stable-to-slowly adjusting whole. This theory, articulated most comprehensively by Herbert Blumer, focuses on the individual rather than the social system. Symbolic interactionism is based on three simple premises: a) human beings act on things based on the meanings that those things have for them; b) the meanings of those things derive from the social interaction that people have with each other; and c) the meanings are understood as an interpretative process that the person uses in his everyday encounters (Blumer, 1969). In symbolic interactionism, meaning arises through the process of interactions between and among people engaged in doing something. Although for interactionists the self is comprised of Me (the object of self-reflection) and I (the reflector), the most important site of symbolic interaction occurs in human group life as people operate in association with one another and seek to make meaning and achieve understanding within that formative environment. The self is socially constructed within this framework, and reflects the interpretative nature of the "I" as well as the active nature of the "Me". In this context, individuals relate via objects, which the symbolic interactionists describe as "anything that can be referred to or indicated" (Blumer, 1969, p. 11). Objects are classified in three ways: (a) physical (chairs, trees); (b) social (a friend, a mother); and (c) abstract objects (moral principles, ideas such as justice, love). These objects derive their meaning from the ways in which people act toward them. As a result, reality is uniquely defined by each individual. In the process of doing research based on a symbolic interactionist

philosophy, the researcher seeks to uncover the nature of the objects contained in each individual's world and understand how the individual defines and experiences his/her distinctive circumstance (Bowers, 1988).

As individuals interact with each other, their observations and interpretations of the meanings of objects that others impose influence their understanding of objects in their world. Thomas & Thomas (1929) argued that "[I]if men define situations as real they are real in their consequences" (p. 572). This interpretation identifies the mechanism by which society constructs its norms and perpetuates the reality that, once social norms become objectified (experienced as inflexible realities), they simultaneously become internalized by individuals who reinforce their reification. Issues of women's subservient place in society and of women's intellectual subordination, previously discussed in this study as they relate to nursing, are created and enhanced by institutionalized social constructions that then ascribe to women a lesser position in the world. This socially constructed reality is real in its consequences and has enormously impacted the ways in which women interpret themselves within the social milieu, on their roles and value within the society, and on their ultimate conception of themselves as individual actors in the world (Bowers, 1988).

Grounded Theory

Grounded theory (GT) is a method of analysis and interpretation of data that is identified from or *grounded in* information systematically gathered from interactions with people involved in the doing of the phenomena of interest. It is a general methodology for developing theory that evolves "through continuous interplay between analysis and data collection" (Strauss & Corbin, 1998, p. 161).

> The practice of GT research incorporates the investigator's use of key intellectual strategies: (a) constant comparative method of analysis, (b) theoretical sampling and use of multiple comparison groups (Glaser & Strauss, 1967). The areas of interest for investigation are social problems to which people must adapt. The investigators are oriented to discovering the basic social processes that people use to deal with the situations in which they find themselves and that, generally speaking, are not understood by them at the conscious level. (Benoliel, 1996, p. 408)

Glaser & Strauss discovered grounded theory in the process of conducting a sociological field investigation in the 1960s in which multiple analytical perspectives emerged. The grounded theory methodology allows researchers to generate theory that incorporates the various interrelated influencers into a formalized process that addresses the rigor required of scholarly endeavors while remaining removed from the traditional hypothesis-testing modalities then in vogue in social science research. It also seeks to produce theory that is conceptually dense and is inclusive of data associated with multiple conceptual, plausible relationships that emerge as a result of the data sources being utilized. Although grounded theory researchers focus on individual involvement in their interviews and descriptive elements, they concern themselves predominantly with themes, processes, and patterns of action and interaction among the various entities involved in the study. They are also fascinated by the effects of either internally generated or externally generated alterations in action that result in reciprocal changes in the relationship under review (Denzin & Lincoln, 1998).

Because grounded theory is instrumental in allowing constructivist researchers to explicate complex social phenomena, it has become a useful and important methodology for nursing researchers who intend to move beyond the controlled, positivistic notion of traditionally accepted knowledge creation to one that recognizes multiple realities and various legitimate ways of thinking about situations. Benoliel's review of grounded theory studies in nursing from 1980 to 1995 demonstrates a significant increase in the utilization of grounded theory. Multiple

interpretations of grounded theory appear in research studies and philosophical and methodological commentary both within nursing and external to it. Suffice it to say that just as socially constructed theories emerge from collected data, so does the further development of the post-positivist approach to knowledge creation evolve with increased utilization of and facilitation with the conceptual framework of grounded theory.

Situational Analysis

While grounded theory provides a framework for discerning some of the influences of the social situation around nursing leadership within assisted living environments, it does so as a consequence of its focus on a specific core issue. It includes attention to the issue of perspective around the situation, but it does not give full weight to the constructed nature of context as that element greatly influences the issue under investigation. Situational analysis, as a form of grounded theory, provides the comprehensive structure by which the complex issues inherent in a study of nursing and healthcare in a restricted setting can be seen and examined. Situational analysis, as developed by Adele Clarke (2005), utilizes basic grounded theory analyses that highlight the salient social processes. Clarke then adds supplementary analytical approaches that focus on illuminating the "key elements, materialities, discourses, structures, and conditions that characterize the situation under inquiry" (p. xxii).

These additional situational analysis approaches are configured as three types of mapping techniques: (a) situational maps—identifying the major elements in the situation, human, non-human, discursive—and prompting analysis of the relationships among them; (b) social worlds or arenas maps—identifying the participants and the dimensions within which their interrelated discourses and negotiations take place; and (c) positional maps—identifying the foremost

positions taken and not taken in the data to explicate areas of difference, controversy, and question contained within the situation of inquiry. In this way, “the situation itself becomes the ultimate unit of analysis” (Clarke, 2005, p. xxii), leading to a facilitated process of addressing both the integral elements and their relationship to each other. In this manner, situational analysis fosters the inclusion of more extended though relevant data while offering a broader framework within which to analyze this information. As a result, situational analysis enhances the researcher’s ability to study “differences of perspective, . . .highly complex situations of action and positionality . . . heterogeneous discourses . . . and . . . situated knowledges of life itself” (Clarke, 2005, p. xxiii). Clarke further states that her purpose in describing this methodology is to explicate “approaches that can simultaneously address voice and discourse, texts and the consequential materialities and symbolisms of the nonhuman, the dynamics of historical change, and, last but far from least, power in both its more solid and fluid forms” (2005, p. xxiii). The outcome of this process is the creation of *thick analyses*, which assertively consider the entirety of elements present and influential in the issue as well as their obvious and nuanced interrelationships with each other.

Clarke views situational analysis as a logical extension and evolution of grounded theory that encompasses data of a contextual nature for the significant influences upon the research question that it creates. It seeks to be more open to inclusion of complexity, difference, and heterogeneity related to the situation being researched, which becomes the site of the analytic grounding. Situational analysis professes to “embrace the limitations of analyzing a particular situation rather than attempt to overcome them through the generation of formal theory” (Clarke, 2005, p. 22). Through the use of this methodology, one-dimensional, normal curves of data

representation are replaced by multidimensional visual mappings that embody the components and associated or influencing relationships that more clearly ferret out the intricacies of real, lived situations. Situational analysis exhibits an increased congruency with the postmodern reality of social complexity, chaos, diversity, and the desire to elucidate the origins of assumptions and the sites of their demonstration. This preference seeks to aggressively explicate the areas of historical silence, reinforcing the postmodern value that all knowledge is situated within a framework of perspective, reflecting the belief that all situations are real in their consequences. Postmodernism eschews claims of the universality of knowledge, believing that this point of view is generally naïve, but more importantly, reflects a hegemonic strategy designed to silence oppositional forces and other less powerful perceptions.

In relation to the issue of nursing leadership within assisted living environments, the depth and breadth of data assembly and analysis, from a situational analysis standpoint, takes into consideration the nuanced areas that continue to influence and impact the exercise of this function. This method "intentionally aim[s] at capturing complexities rather than aiming at simplifications . . . elucidate[s] processes of change in situations as well as . . . elucidate[ing] patterns and stabilities . . . [and] detangle[s] agents and positions sufficiently to make contradictions, ambivalences, and irrelevancies clear" (Clarke, 2005, p. xxix). If we have learned anything from the literature, it is that nursing and the entire healthcare environment are inherently complex, convoluted, and confusing. The situational analysis framework affords a model within which to address these issues in an organized and systematic manner. It also assists in identifying the reality that researching leadership within health care does not occur in a linear fashion, with findings leading to results in a compliant or methodical manner. The world of

actual practice within changing environments calls for the consideration of a linear approach impossible and unenlightening. Situational analysis and its grounded theory antecedents structuralize the processes of discovery and identification that this effort demands and allows the fluid framework to create boundaries that may become more permeable if the emerging data warrant.

Study Design

This section outlines the design of the study. It includes (a) the situation—assisted living environments in Connecticut; (b) the site—the geographical location for the study; (c) the participants—volunteer registered nurse participants who fill a specific role in assisted living communities in Connecticut, and additional participants who represent a purposive theoretical sample of informed professionals; and (d) the processes involved in the study—inviting participation, discourse analysis, and data management.

This section will be written in the first person as a follow-up to the positioning of the researcher with regard to the study. The use of the first person addresses and honors the journey of this research process.

The Situation

The “situation” that forms the basis for this study is the social phenomenon in health care currently and specifically in assisted living environments related to the role of the registered nurse. The “setting” comprised a variety of assisted living environments within an identified geographic area. The reason that setting and situation are different is that there are limited numbers of registered nurses in each assisted living environment, with only one person filling the role of nurse leader in each setting. As a result, the collective description of the influencers

present in assisted living environments creates the situation being studied. It is this unique reality that establishes the context for the exercise of leadership that the interviews with the registered nurses highlighted. The situational analysis established the broad context, or landscape; and the grounded theory-based coding of the interviews with the nurses created the thick description. The "tacking back and forth" that Clarke recommends (2005, p. 186) established a rhythm that balanced context and detail, thus guarding against the one being sacrificed to the other. The ability to manage the heterogeneity of multiple-site research is addressed by Clarke (2005) and reinforces the inherent "tension between density and chaos that characterizes multisite work" (pp. 166-167).

The Site

I selected the state of Connecticut as the site of this research for the following reasons: (a) the existence of nurse-affirming regulations (the Department of Health Regulations for Assisted Living allow registered nurses to perform all the functions allowable by their license and acceptable in the assisted living environment, including such nursing tasks as administering medications, as well as the executive functions of performing clinical assessments and developing comprehensive patient care plans); (b) an appropriate sample size—the number of assisted living communities within the state created a potential sample size of nurse participants large enough to secure the commitment of 20 to 30 individuals willing to contribute their time to the interviewing process; and (c) geographic convenience that enhanced the ease of travel for repeat interviews to further explicate emergent data either with registered nurses or other sources—i.e., assisted living administrators, state regulators, or other individuals from the business realm—in the theoretical sampling.

There is great variety in the assisted living regulatory environment from state to state. Because the core question in this study relates to nurses' experience of leadership, I chose a state with a nurse-supportive regulatory environment, thereby creating a perspective that could be empowering and enhancing of nursing activities and removing concerns related to nursing-neutralizing or nursing-oppositional regulations. A variety of written materials may have a significant impact on this research process. Among these materials are the nurse-oriented assisted living regulations within the state (See Appendix B—Department of Public Health Assisted Living Regulations). Connecticut has a regulatory environment that supports the professional practice of nursing despite the enactment of those regulations in the non-traditional environment of a communal residential setting. The following table highlights the sources of documents and written discourses and artifacts cited in this study. Detail of these sources is included in Appendices as identified in the table.

DOCUMENT	SOURCE	APPENDICES
Department of Public Health Assisted Living Regulations	Connecticut Public Health Code 19-13-D105 (a) through (m)	Appendix B
Marketing Materials from Assisted Living Companies	Copied randomly from company websites---all available in the public domain	Appendix C
Assisted Living Regulations Advisory Committee	Membership list Minutes of 1-24-07 meeting	Appendix E
Assisted Living Legislation in Connecticut	Public Act 07-2 Effective 10/1/07	Appendix F
Connecticut Nurse Practice Act	Chapter 378, Section 20-87a	Appendix G
Declaratory Ruling related to Licensed Practical Nurses	Connecticut Board of Nurse Examiners for Nursing 2-7-89	Appendix G

Declaratory Ruling regarding Unlicensed Personnel	Connecticut Board of Nurse Examiners for Nursing 4-5-95	Appendix G

Table 1: Sources of Documents, Written Discourses and Artifacts

The Participants

This study involves interviews with registered nurses filling leadership roles within assisted living environments as supervisors of assisted living services agencies (SALSAs). These participants volunteered to participate in the study as individuals, not as representatives of specific assisted living settings or companies. The theoretical sample was secured as a result of analyzing the salient issues raised by the SALSA interviewees and identifying knowledgeable, non-SALSA professionals who would provide commentary from a broader perspective. While the SALSA participants volunteered for this study, the members of the theoretical sample were strategically sought out and selected. The following tables identify the demographic information related to the SALSA group and the theoretical sample.

SALSA	AGE RANGE	ED BACKGROUND	NSG SUPV EXP	YEARS OF NSG	SNF	HC	AL
#1 S#5	55-65	MSRN	Y	30	Y	Y	N
#2 S#6	45-55	DIP	Y	25	Y	Y	N
#3 S#7	55-65	MSRN	Y	41	Y	Y	N
#4 S#8	35-45	MS, MBA	Y	22	Y	N	N
#5 S#9	35-45	AA	Y	20	Y	Y	Y
#6 S#10	55-65	BSN	Y	35	Y	Y	N
#7 S#11	45-55	BSN	Y	35	Y	Y	Y
#8 S#12	35-45	BSN, DN	Y	20	Y	Y	Y

#9 S#13	45-55	BSN	Y	30	Y	Y	N
#10 S#14	35-45	AA	Y	22	Y	Y	N
#11 S#15	35-45	Dip to BSN	Y	22	N	Y	Y
#12 S#16	55-65	Dip	N	46	N	N	N
#13 S#17	45-55	BSN	Y	31	N	Y	N

LEGEND:
NSG SUPV EXP--Prior experience as a nursing supervisor
SNF experience---Skilled Nursing experience
HC experience--Home Care experience
AL experience--Assisted Living experience
Dip--Diploma in Nursing
AA--Associates Degree in Nursing
BSN--Bachelor of Science in Nursing
MSN--Master of Science in Nursing
MBA--Masters in Business Administration
DN--Doctorate in related field

Table 2: SALSA Demographics

Theoretical Sample	**Age range**	**Educational background**	**Years in healthcare**
#1 T#5B	35-45	MPH	8
#2 T#6N	45-55	BSN	20
#3 T#7B	55-65	MS	35
#4 T#8B	45-55	MS	25
#5 T#9N	55-65	MSN	37
#6 T#10N	45-55	RN/MBA	27
#7 T#11B	55-65	MPA	33
#8 T#12B	55-65	MS	30+
#9 T#13B	55-65	JD	20
#10 T#14N	35-45	MSN	20

#11 T#15B	45-55	MBA	30

LEGEND:
T---member of Theoretical Sample
B---business background
N---nursing background
MPH--Masters of Public Health
BSN--Bachelor of Science in Nursing
MS--Masters of Science
MSN--Masters of Science in Nursing
RN/MBA--Registered Nurse/Masters of Business Administration
MPA--Masters of Public Administration
JD--Juris Doctorate

Table 3: Theoretical Sample Demographic

Processes

Inviting and Interviewing Nurse Participation

Connecticut Assisted Living Association (CALA), the state's assisted living trade association, has a subcommittee comprised exclusively of the nurses who perform the chief nurse functions within the state's assisted Living communities. At three consecutive monthly meetings of this CALA SALSA group, I provided information regarding this research project and invited voluntary participation. Interested nurses contacted me or provided their contact information for me to communicate with them privately

I explained the study to the nurses who communicated their interest. Individuals who chose to participate signed an Antioch University Institutional Review Board-approved Informed Consent document prior to the interview (See Appendix D, Antioch University Informed Consent). Potential interviewees were informed that there was no financial remuneration for participation in this study and that participation was voluntary and could be discontinued at any time at the discretion of the participant.

I safeguarded the participants' privacy and confidentiality by creating an alphanumeric code to identify each individual. This code was used on all occasions to identify comments made by a specific participant. The legend explaining the codes has been maintained under lock and key exclusively within my personal access.

All interviews were conducted at a comfortable site of the nurse's choosing. Three interviews were conducted over the telephone; the remaining 21 were conducted in person. The outline was an iterative one for both the SALSA group and the members of the theoretical sample. The initial question was: "Talk to me about your experience as a chief nurse in an assisted living environment." The word "leadership" was not used as a prompt. Follow-up questions were based on the flow of information as it emerged in the conversation. I focused the interview carefully enough to address the issues at hand but loosely enough to allow the nurse participants to initiate the issues that were most or salient to them. Interviews were tape recorded by me with the full knowledge and understanding of the interviewee. All interviews were transcribed by a contracted entity; the tapes included the coded identification of the participants. Exchange of tapes between the researcher and the transcriptionist occurred within the confines of accepted Internet security practices. I reviewed all transcriptions for accuracy, and compared the transcribed words to the actual tape-recorded interviews

Members of the theoretical sample were sought based on their knowledge of assisted living in Connecticut and beyond, and their ability to contribute to the " . . theoretically interesting facets of the emergent analysis" (Clarke, 2005, p xxxi) Members of the purposive theoretical sample were interviewed in a similar manner as the SALSA group, with an exception that the initial iterative question was "What is your experience of chief nurses' leadership in

assisted nursing?" This question was followed up based on the flow of the conversation. I safeguarded the participants' privacy and confidentiality by creating an alphanumeric code to identify each individual. This code was used on all occasions to identify comments made by a specific participant. The legend explaining the codes has been maintained under lock and key exclusively within my personal access.

Because assisted living companies have historically differentiated themselves both from each other and from skilled nursing settings on the basis of their philosophical orientation, I questioned whether the philosophy of various organizations could also have an impact on leadership performance. As a result, I reviewed and analyzed the contextual influence of readily available written materials that are in the public domain. I reviewed these materials using the constant comparative coding method of grounded theory and the mapping structure of situational analysis (See Appendix C—Assisted living companies excerpts from marketing materials in the public domain).

Data Management

In this section I will separately address the coding of both the interviews and the written documents. While the constant comparative process was used for both sets of data, analysis of the written documents required scrutiny of agreements and conflicts within and between the documents as well as within and between the interviews.

Coding of Interviews

Analytic coding of the transcribed interviews was done based on the constant comparative model This involved the utilization of *open coding* initially as I reviewed the material and developed codes after a line-by-line, section-by-section examination. During this

initial process, I created temporary labels for the data under review, initiating the constant comparison of comments that appeared to be similar both between participants and within individual participants' comments. This step created an environment of deep respect for the actual words of the participants; the *in vivo* origins thus ensuring accuracy and relevance of terminology. As the data were subjected to deeper analysis and comparative scrutiny, themes within the data became evident. I created memos related to the themes that were emerging, searching for interconnections, misconnections, processes, and implications. As a result of this process, a deeper understanding of the complexity of nursing leadership within the arena of assisted living communities did emerge.

It is important to stress that the data collection process based on grounded theory was an open process. There was no attempt to exclude any elements present in the data—the goal was to identify all relevant data bits and allow them to attain their rightful place in the total picture as it was emerging. As time progressed and data analysis continued, some categories appeared as more significant and others faded into the background. Core categories thus rose to prominence in the data. These represented groupings of data that were more central to the description and ultimate understanding of the situation being scrutinized.

The examination of data required that individual data elements be further dissected to ascertain deep-seated assumptions, predilections, challenges, influences, oppositional forces, or reinforcers. Upon completion of this initial analytical process, I engaged in axial coding, which is designed to bring back together, in a reconstructed format, the data bits that had formed themselves into larger themes of influence within the topic. This method of breaking down and reconstructing took place throughout the course of the research until I heard only repeats of

information already collected and ascertained that all essential elements had been brought forward and saturation had been reached.

Coding of Documents

Documents and web based materials related to this study were coded using the constant comparative process (Boeije, 2002; Strauss, 1987), as described above. This involved the use of *open coding,* with line by line, section by section examination. I created temporary labels for the data under review, identifying specific words within the texts that were similar both between documents/web based materials and within them. With deeper analysis and comparative scrutiny, themes within the documents/web based materials became evident. I created memos related to the themes that were emerging, searching for agreement, conflicting statements, and silences. As a result of this process, a deeper understanding of the complexity of the written and imaged assisted living environment emerged. The process proceeded to axial coding in which issues of thematic coherence were formed into categories. These categories were then scrutinized for their relationship to each other and to the interview categories.

Research Team

As described in Chapter I, I have a deep background in nursing and in assisted living. My research team of non-nurses facilitated the explication of any personal preconceived notions I might have had and assisted in maintaining a sense of balance regarding the data analysis. Blind coding with two non-nurse research partners was the initial safeguard against the unwitting intrusion of researcher bias. Six interviews were simultaneously blind coded, with accompanying fruitful discussion of both codes and category development. This served to ensure accurate reflection of the meaning intended by the interviewees. From this point onward, I reviewed and

coded the interviews myself. However, my primary research partner remained closely involved throughout, raising questions regarding coding, categories, assumptions, and interpretations.

NVivo, a qualitative software package developed by Qualitative Solutions and Research International (QSR) was used as an adjunct to my coding and the research team's participation. This automated software package helped to manage the volume and iterations of codes and categories more functionally than a strictly manual method. I had prior experience with NVivo software and found it helpful in handling volumes of data.

Data Analysis

Examination of all discourses formed the foundation of the data analysis. The situational and interview analyses were conducted in a synergistic fashion, with the initial emphasis on the situational descriptors. The interrelatedness of the codes and ultimate categories made discrete separation not only impractical but not helpful. Boeije's belief that " . . .comparisons go hand-in-hand with interpretation" (2002, p. 409) further describes the analytic process that defined this study. Initial data analysis created the broad landscape that describes the assisted living situation in Connecticut from the perspective of the SALSA. The theoretical sample provided a purposive, non-SALSA sampling of assisted living related professionals to offer commentary related to the various theoretical issues that had been identified in the SALSA interviews. Interviews with these professionals were coded and analyzed using the constant comparative method of simultaneous coding, interpreting and theorizing (Clarke, 2005). Grounded theory interview analysis created an opportunity to again use the constant comparison method to identify the key social processes or themes that were present in the overall situation and ". . . distinguish categories of data, [that leads to] (to the) the conceptualization of the field under study and to the

patterning of the data that ultimately provides an answer to the research questions that are examined in a particular study" (Boeije, 2002, p. 408).

The purpose of the situational analysis coding was to refine the broadest description of the situation into its more overarching categories, under which the related codes were subsumed. Once the situation was described, the grounded theory/interview analysis proceeded to look deeper within the categories for essential themes. The visual maps that were created throughout the situational analysis process were used concurrently with a frequent return to the source data---interview transcripts, state regulations, related state legislation, state Nurse Practice Act, and publicly available information related to assisted living settings—to both reinforce grounding in the data and to challenge the researcher to see relationships, disagreements, variances and other influences present but not readily apparent.

Interview data involved analysis of transcripted interviews with the volunteer sample of SALSAs, all of whom filled a position within the assisted living environment in Connecticut that experienced uniformity in regulation. External data that were not created exclusively for the purpose of this study but that were highly relevant to it were also analyzed, with the clear understanding that input from the interviews was dynamic and iterative while the regulations, legislation, and publicly available assisted living information were static. Initially, the open coding of discourses was conducted to identify all issues present within the data. This process, and the memo creation that accompanied it, forced a broad outline to be drawn around the social phenomenon of nursing leadership in assisted living. The coding was developed from the words of the interviewees as much as possible. As analysis of the created codes developed, the process involved elaborating on the properties of the more enduring codes. Ultimately, the more

densified groupings evolved into categories that afforded a rich description of phenomena of interest---both the data related to the assisted living environment and that related to nursing leadership within it. This process of comparison and interpretation proceeded to axial coding, during which the groupings of codes that had been created were further analyzed for their more categorical definition. The purpose of the situational analysis coding was to refine the broadest description of the situation into its more overarching categories, under which the related codes were subsumed. Once the situation was described, the grounded theory/interview analysis proceeded to look deeper within the categories for essential themes. This analysis was conducted at the conclusion of the situation analysis process, not simultaneous with it. The visual maps that were created throughout the situational analysis process were used concurrently with a frequent return to the source data---interview transcripts, state regulations, related state legislation, state Nurse Practice Act, and publicly available information related to assisted living settings—to both reinforce grounding in the data and to challenge the researcher to see relationships, disagreements, variances and other influences present but not readily apparent.

Institutional Review Board Requirements

I complied with all requirements of the Institutional Review Board of Antioch University in the conduct of this research project. All participants in this study were adults who were fully informed of the scope and purpose of the project prior to agreeing to become involved. The subject matter of this study was considered to be of a type that would not pose a risk to the participants. The written materials that the study included were all publicly available documents that contained relevant information but were not sensitive in any way.

Each participant received the following information relative to the research project: (a) an explanation of the project, including a statement that the study involved research; (b) an explanation of what was expected of participants; and (c) a description of any foreseeable risks or discomforts that the participant might experience; as well as (d) a description of the anticipated benefits of the study to the participants and others; (e) a statement of the voluntary nature of participation in the study and a disclosure that participants could withdraw at any time without penalty; (f) assurances that all responses would be maintained in a confidential manner; (g) my identification and contact numbers; and finally (h) a statement of the Institutional Review Board contact person at Antioch University.

The informed consent form that participants signed (See Appendix D, Antioch University Institutional Review Board Informed Consent) was brief though comprehensive in describing the scope of information relative to the project. The form was succinct, logical, and readable and did not contain technical language or jargon. It had a visual presentation that assisted potential participants to easily comprehend the key points of the project as well as all contact information that participants might need going forward, and it provided a script for me to utilize during initial discussions with potential participants.

This research project did not involve the specific institutions within which the participants worked. The focus of the project was the individuals themselves and their constructed experiences of leadership. All employing organizations were completely anonymous for the purposes of this study; their related, publicly available, printed materials were used only for context and discernible themes. Pictures of assisted living buildings and individuals contained in this dissertation were obtained from the Internet. These pictures reflect information

that is in the public domain, but is not a representation of any specific assisted living organizations in Connecticut.

CHAPTER IV: FINDINGS

The aim of this study is to gain greater insight into a specific situation of assisted living. It is also to respectfully listen to the voice of the registered nurse who fills the solitary role of the supervisor of an assisted living services agency (SALSA) in the Connecticut model of assisted living. This SALSA role represents the singular clinical authority within the assisted living setting according to the Connecticut regulations governing assisted living facilities. The role includes the total responsibility for managing, coordinating, supervising, intervening, and providing clinical support in the assisted living service agency (ALSA) that is required by an increasingly frail elder population.

The findings in this study are based on situational analysis mapping and grounded theory interview analysis. Situational Analysis, as developed by Clarke (2005), is an extension of the Grounded Theory method and utilizes similar analytical tools with the addition, in situational analysis, of visual mapping strategies. The source data for this study consists primarily of interviews conducted with a volunteer sample of SALSAs and a purposeful theoretical sample of non-SALSA professionals related to the assisted living field. Additional data were gathered from field observation and analysis of extant discourses of documents related to the assisted living setting. The purpose of utilizing situational analysis as the methodology for discerning the potential social, economic and political forces present in the situation of nurses within an assisted living environment is to "understand the situation of inquiry broadly conceived" (Clarke, 2005, p. xxxv).

The first section of this chapter presents the findings of the situational analysis and provides the broad geographical framework within which the findings of the grounded theory

interview analysis are located. The situational analysis incorporates direct quotes from the interviews and all related discourses as data sources, along with field observations and other related experiences. The second section of this chapter presents the thematic analysis that emerged from the grounded theory analytic process of the interviews conducted for this study. The grounded theory interview analysis incorporates quotes from the SALSAs who volunteered to participate in this study and the purposive theoretical sample of professionals knowledgeable about the field of assisted living in Connecticut. Because the focus of this study is the SALSAs' experiences of leadership within a defined situation, the predominant perspective is that of the nurse. The interpretation of the interview analysis is placed within the broader frame of contextual understanding provided by the situational analysis. By systematically contextualizing the nurses' experiences through the situational analysis, it is believed that a deeper and more richly detailed interpretation of nurses in the assisted living situation can be made.

The following convention has been established to accurately and consistently reflect the source of comments integral to this study. All direct quotes are presented in single space and indented. Interviews have been given an alpha-numeric combination that is unrelated to the sequence with which the interviews were conducted. The SALSA interviews contain the letter S; the theoretical sample contains the letter T. To further delineate the appropriate perspective from which the members of the theoretical sample speak, an additional alpha designation of N identifies a person with nursing background; the designation of B identifies a person with business background. Process and issue reflections that form the infrastructure of my analysis are presented in *italics,* are double-spaced and are indented. Information related to extant discourses is indented, with their source specified.

Situational Analysis—Primary Situational Areas

Pursuant to the requirements of the situational analysis methodological design, the coding process led to the development of visual depictions of the data. These maps are constructed to illustrate the variety and complexity of data identified as part of the situation under study. Initial maps were created manually and included codes that originated from all sources of data. Because of the volume of codes that this process identified (842), and the inability of software to represent these data cartographically, they are presented in Appendix H as a list of early codes. The messy map (Figure1) contains codes that are representational of those that emerged from the initial process. Continual refinement and comparison resulted in the merging of codes with similar essence. The Social Arenas Map (see Figure 2) was created after further synthesis of these data to ". . . make *collective* sociological sense" (Clarke, 2005, p. 110) of the situation. This map identifies representative characteristics of discourses within the social phenomena of the situation, using data from interviews, and related documents (see Appendices B, C, E, F, and G). This is the beginning of the re-gathering process, as differences and commonalities are identified along with overlapping boundaries. This map is important to the following results as it creates a picture of the primary forces of influence in assisted living in Connecticut. Figure 2 shows the emergence of larger areas to which many categories contribute meaning, for example, clinical expert, resident/family, levels to support care, grouping/forming, and company. The words included in the map derive directly from the coding process. Their placement on the Social Arenas Map (Figure 2) depicts the presence of shared descriptive terminology across the three primary situational areas. For example, "clinical expert" is overlapped by seven categories and each of these categories is further connected to others in the map. In this way the coding process and analysis of their relationships to one another creates a

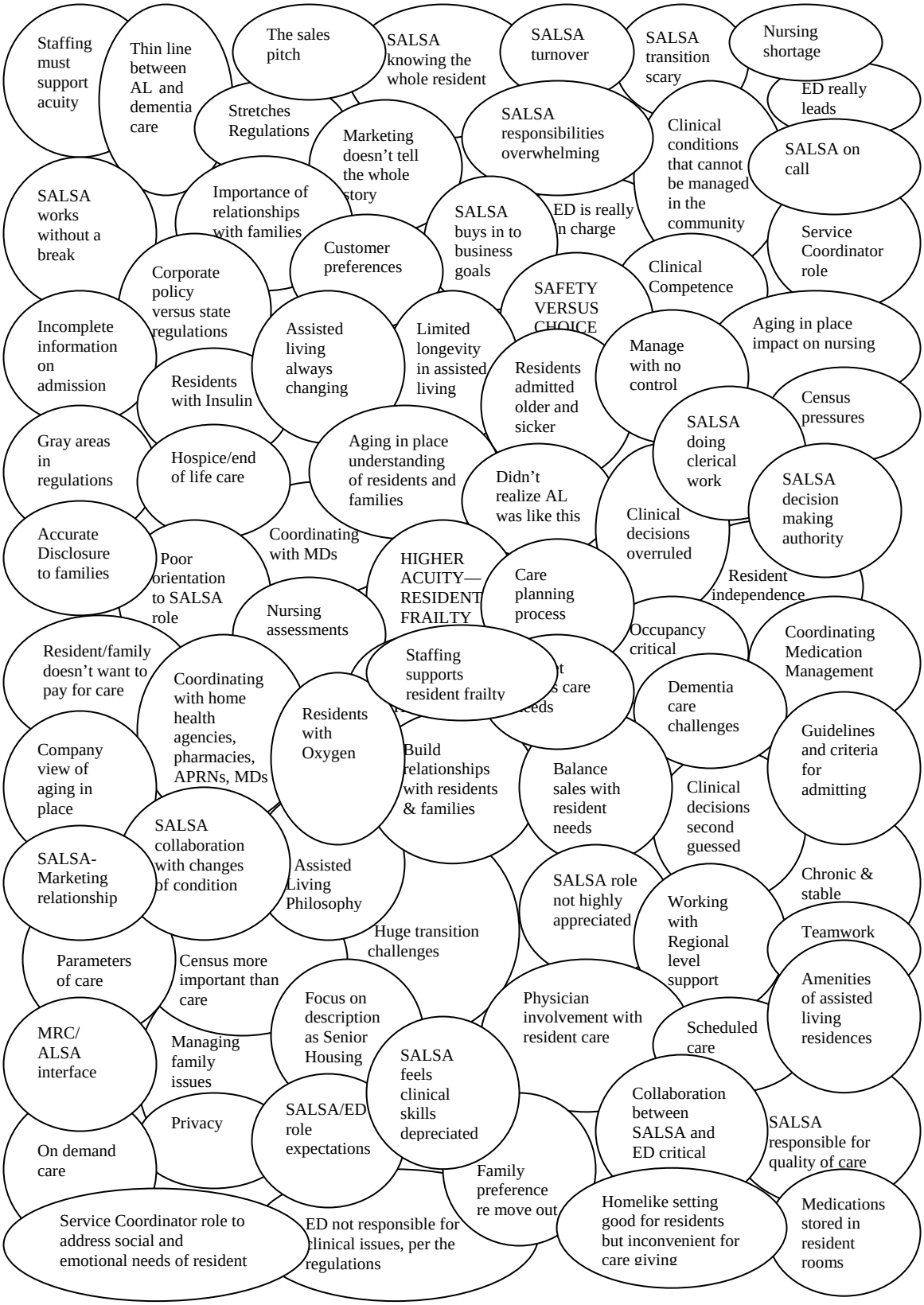
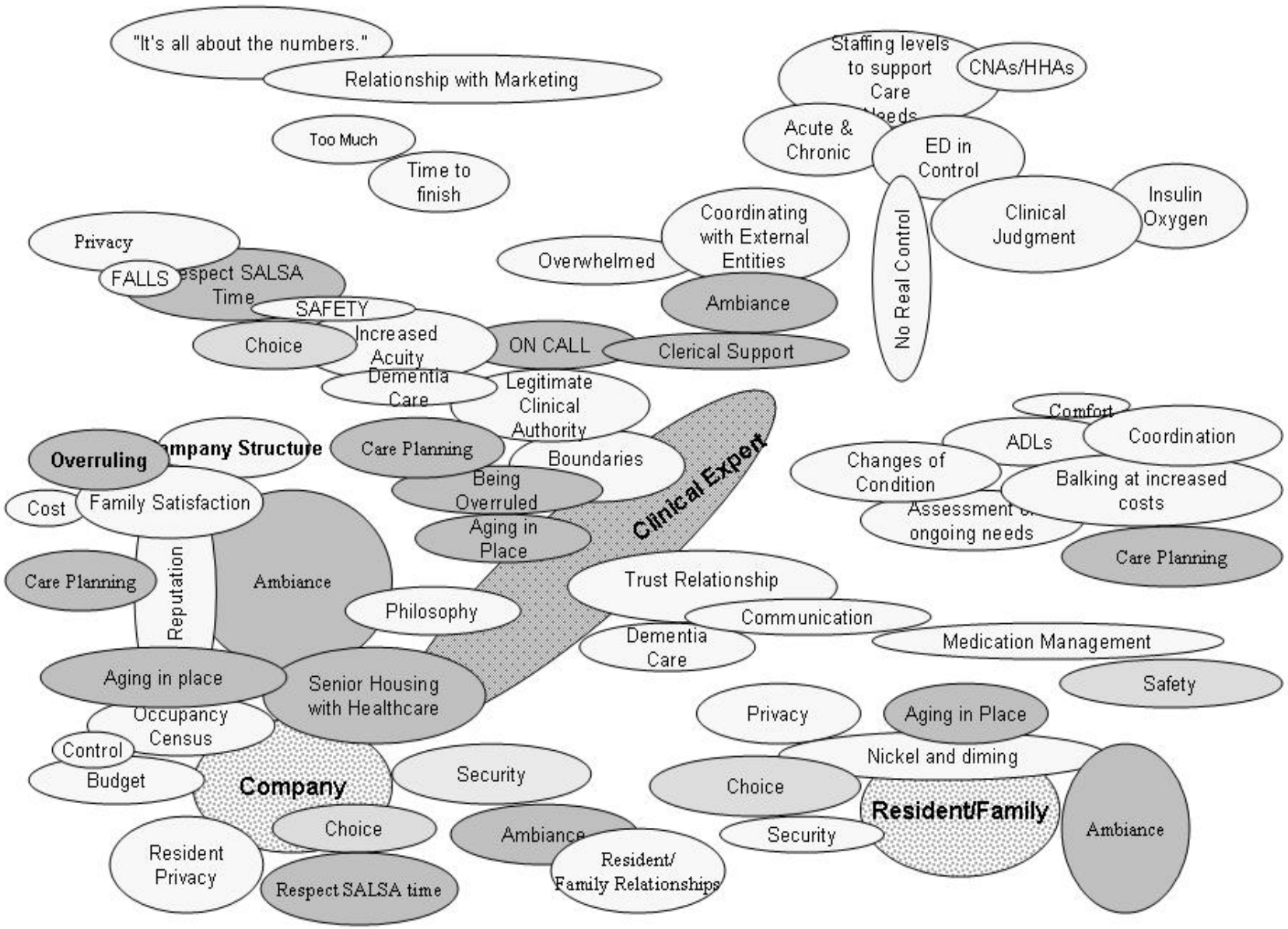


Figure 1. Situational Analysis: Messy Map



Social Arenas Map

winnowing process that finally determines primary situational arenas in which considerable social, political and economic forces are represented.

The primary situational areas identified in this analysis were the *company*, the *customer*, and the *clinical expert*. The designation of the *company* represents both proprietary and not for profit entities that own or manage assisted living communities in Connecticut. The *customer* represents residents and their families who avail themselves of assisted living services. The *clinical expert* represents the registered nurse who fills the solitary role of Supervisor of the Assisted Living Services Agency. To visually depict the final result of the situational analysis, Figure 3 includes each of the primary areas with the major code categories that contribute to it. The reader will note that in *the Primary Situational Areas F*igure (Figure 3), there are several codes that are repeated in the primary arenas (for example, ambiance, aging in place, safety). In the earlier map (Figure 2) the presence of the same categories across more than one social arena was depicted by overlapping circles. It should also be pointed out that each of the primary situational areas is irrevocably interconnected to the others and thus the overlapping circles that represent them in Figure 2.

Significant in the interpretation of the same or similar categories within the primary situational areas, is the comparison of the meaning of these categories from the positional perspective of each respective area. To highlight the similarities and differences that emerge

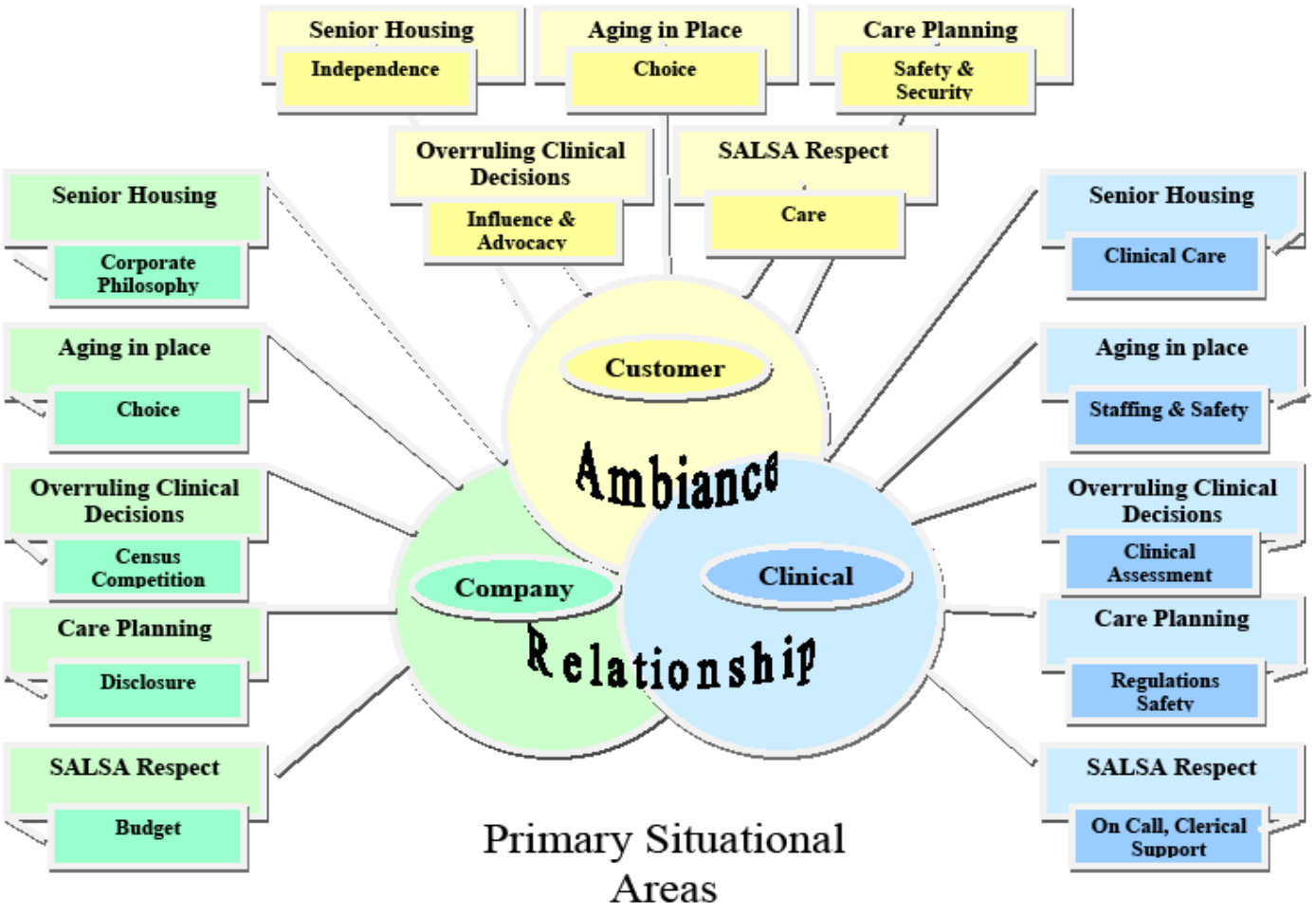


Figure 3. Primary Situational Map

across these situational areas, I will discuss them with respect to issues of alignment and conflict. This prism will assist in viewing the complexity of the interrelatedness of the central areas in this situation, allowing areas of commonality and distinction among these three situational areas of Company, Customer and Clinical Expert to become visible. To further aid in clarification, the categories in Figure 3 have been patterned to depict an alignment or conflict of position across the three primary situational areas. Presentation of the findings for the Situational Analysis will be organized around categories of alignment and conflict in relation to each of the primary areas of *Company, Customer* and *Clinical Expert.* Verbatim quotes from interviewees, regulatory and legislative data, and field memos will be used to illustrate the source for the situational findings.

Alignments across Three Situational Areas

There are a number of subjects in which the positions represented by the primary situational areas find common ground. The *community ambiance* and the opportunity to *establish relationships* with residents are two such areas. Figure 3 shows that these two categories fall under all three situational areas and are represented in the center of the overlapping circles. It must be noted that *positionality* of each of these areas has been derived from the perspective of the nurses and the theoretical sample that includes both a business and administrative nursing perspective All the members of the theoretical sample included professionals who have a deep background in the operations of assisted living communities in Connecticut as well as regionally and nationally. Members of the theoretical sample fill positions of Regional Operations Management, Regional Nursing Resource, and Operations Consultant to assisted living environments, Regulators, Healthcare Attorneys, Executive Directors, and National nursing leadership in assisted living. Public relations materials published by the Connecticut assisted

living corporations (see Appendix K for examples) provide extant source data. Although residents and families were not interviewed for this study, their preference for a homelike setting that supports independence and choice was emphasized by nursing, corporate and administrative perspectives and is corroborated by previous research (Dobbs & Montgomery, 2005; Frank 1994).

Community Ambiance

As an entrepreneurial venture conceived as high-end senior housing, the assisted living setting in Connecticut has been one in which innovative service options, including restaurant style dining and a variety of social activities, are the rule. With the addition of nursing oversight and the change in caregivers from kindly individuals to more highly trained certified nursing assistants (CNAs) and home health aides (HHAs), the setting has incorporated more coordinated clinical supports but still retained its homelike feel. Resident quality of life remains a fundamental tenet of this setting. Clinical care has historically been delivered in an "under the radar" fashion, maintaining the focus on resident involvement and individuality and enjoyment.

A review of readily available written materials describing assisted living settings includes terms such as "privacy," "choice," "independence," and "dignity" with the frequent addition of "luxurious", "elegant", "well-appointed", and "spacious".

The physical attractiveness of the assisted living environment reflects the fundamental philosophy related to a homelike ambiance (see Appendix J). These characteristics are identified in coding categories ambiance, choice, independence, and safety/security (see Figure 2, Social Arenas Map).

. The SALSAs interviewed for this study have been universally supportive of the attractive, non-institutional, not overly regulated ambiance that the residents so enjoy.

> assisted living? It's a wonderful environment for the—the residents. I love the environment; I love this (S#9)

> I've seen people really 'come back' (improve in quality of life and health) coming to us. (S#17)

Mrs. M had had a bad time in the hospital. She was discouraged and needed a lot of personal help. When she came to the assisted living community, she did not want to participate in activities or even come to the dining room for meals. The staff was sensitive to her preferences but continued to invite her to venture out. She gradually accepted their attentions—she liked having her hair combed in a certain way, and enjoyed a session in the beauty parlor. She liked a little makeup on when she went to one of the social hours in the afternoon. She enjoyed talking to one of the other residents. Mrs. M. gradually started participating in the life of the community and enjoying it. Her family was thrilled.

Nonetheless, working in a congregate, homelike environment has also presented a great deal more inconvenience for the SALSAs in their care of the residents.

> You have to go into their individual rooms to get their medications. We don't have centrally stored medications. We don't have a cart to push around. They could be at dinner, they could be getting their hair done, they could be at Bingo; you have to chase them down". (S#14)

However, the SALSAs have learned to accommodate for this somewhat unconventional setting for delivering care and within the limits that each assisted living setting establishes, the nurses have generally been able to adjust. The benefits that accrue to the residents as a result of this setting have generally been seen as outweighing the inconveniences for the SALSAs.

> I really just want to do right by the residents here at the end of their days. (S#7)

> I wish I'd moved here sooner. I enjoy life so much more and feel healthier than I have in years. (Testimonial from assisted living website)

> "I was one of the first to move into this beautiful new building. I love it here! Everyone is so friendly." (Testimonial from assisted living website)

Establishing Relationship

A second area of alignment is over the issue of relationship formation. All positions in the Primary Situational Area—the Customer, the Clinical Expert, and the Company—agree that trust relationships are essential. While residents may choose to enter assisted living settings for socialization and ease of securing related services such as dining, housekeeping, and laundry, the increasing entry age of many residents indicates that the decision is more motivated by needs for support in activities of daily living (ADLs) and healthcare management (Mitty, 2003). The healthcare component is an area that requires the establishment of a trust relationship between the resident/family and the community, namely the SALSA and clinical staff. Adult children who live at geographical distances from their elder parents depend on local professionals to assuage their concerns by assertively communicating and providing needed care.

> . . . no matter how much you prepare people I think it's very hard for somebody to see their mom or dad in a nonfunctioning way and cognitive impairment is so illusive sometimes. (T#12B)

> It is just tremendously important to have that relationship or sooner or later inevitably something goes wrong and it all comes apart. (T#8B)

This relationship is essential as residents age in place and may require additional support or perhaps relocation to a secured unit within the assisted living environment or a discharge to a skilled nursing setting.

> . . . if the nurse hasn't really developed a relationship with a family member even if they have a positive one with a resident, this should begin to change when we needed that relationship, we needed to contact those family members and let them know there was a hospital admission or rehab admission or maybe even a move-out notice probably was in their best interest to go to a skilled facility. If the nurse didn't have that positive relationship with that family it was really a challenge. If that was the first time they are contacting them or they only contact them every few months as kind of formality rather

> than a true communication, then we struggle with those residents and those family members and potential move-out and that is where our headaches really begin to mount up. (T#8B)

The resident/family has entered into a contract with the community to provide whatever services have been described in the facility's disclosure statement. There are reciprocal expectations that contract for care will be provided at mutually agreed-upon levels, and paid for. These expectations must be clearly understood at the outset if disagreements are to be avoided in the future.

> A lot of people don't want to pay for services. (S#6)

> Well, sometimes the families think it's one-stop shopping and once they bring Mom or Dad here, they're here for the rest of their lives and the average stay at assisted living is 2-1/2 years. So, that would be pushing it nowadays depending on what their diagnosis is. (S#9)

When the relationships have been formed and there is alignment regarding expectations, the changing care needs of an aging population can be managed with dignity. This situation demands that there be truth-telling from the outset—that the marketing arm of the facility performs their function professionally . . .

> It did feel like a bait and switch because they said to the family the director of marketing told them (the family) that we have nurses 24 hours a day . . . whatever they needed would be taken care of. (T#6N)

> They sell them a bill of goods that they can't necessarily deliver in the long term. All customer service is really important. (S#15)

and that nursing forms their essential relationship, communicates frequently, and performs accurate assessments and creates personalized care plans.

> . . . no one should be coming into a community that the nurse did not agree is appropriate. Most physicians will certify 'chronic and stable,' but no one was ever admitted to our community without an assessment. (T#7B)

> There is a lot of gray areas in assisted living since it's not as regulated as any other part of health care; but it allows you do to a lot more for the residents as far as caring for their needs. (S#9)

Although there are subtle differences in the role of *establishing relationship* across the three situational areas, essentially there is support and benefit in establishing a positive, contractually clear and advocacy relationship that maintains the dignity and individuality of the residents.

Conflicts Across Three Situational Areas

The specific areas of conflict that the Situational Analysis identifies include (a) senior housing with healthcare, (b) aging in place, (c) overruling clinical decisions, (d) care planning, and (e) respecting SALSA's time. These areas are represented in Figure 3, The Primary Situational Areas map with the associated categories. The complexity within the overall situation is brought to light as the differing positions of *company, customer and clinical expert* come into conflict around significant decisions related to the customer's care and the SALSA's responsibilities. These conflictual positions and subsequent decision-making processes within the situation appeared to exert considerable influence on the assisted living community. The textual illustrations from all sources of data in this study detail the meaning of these conflictual areas from each of the primary situational positions.

Senior Housing with Health Care

The *Company*, in general, sees itself as a senior housing business, that includes the provision of healthcare. In this study, the Company is represented by executive directors, regional operations officers, regional clinical officers, and various other titles that are included in the theoretical sample.

> . . . owners are about the bricks and mortar that keep money coming in. (T#10N)

> . . . one of the major problems for assisted living is that so many of the providers, at least the owners or key corporate people, view it as a housing industry. . . . I don't think that's out of any malicious intent. It's simply that's the way that assisted living was originally conceived. That is what investors generally understand it to be. And care is secondary. (T#13B)

This perspective creates a conflict for the *Clinical Expert*, whose role is exclusively directed at the clinical care of the residents. A business that does not even minimally consider the inclusion of a healthcare component is unlikely to value or even recognize the people charged with managing that area. From the theoretical sample the following views were expressed.

> Senior living executives seem to have remained blissfully if not deliberately ignorant of any care component from what they are doing. (T#13B)

> . . . in assisted living that care component just isn't at the table somehow in some very significant way yet. (T#13B)

Aging in Place

The operating philosophy in assisted living communities is one that provides a shared basis for acting across family, business administrators and clinical experts. However, as residents *age in place* and their physical condition deteriorates, the belief that residents have the right to remain in their "home" is not consistently supported across all three positions. It is often the *Clinical Expert* position that is at loggerheads with the *Customer* and *Company*. The factors that contribute to this conflict are (a) being admitted older and sicker, (b) staffing to support increased acuity, (c) needing increased ADL (Activities of Daily Living) support, (d) communicating with families for changes in condition and (e) care planning to manage increased acuity. These quotes reflect the Clinical Expert dilemma in this situation.

> . . . my biggest concern is, do they have the staffing that's appropriate to meet the needs? (S#16)

> . . . really needy residents . . . they can be there, they are chronic and stable. They just require very heavy, heavy care; very heavy care. (T#10N)

> . . . if you're going to do it you'd better have enough staff to do it, and you better be able to have other great programming that people see beyond somebody sitting in a wheelchair all day and not talking and needing to be fed and all of that. (T#10N)

While the nurses agreed with and supported the aging in place philosophy, they were often torn between their advocacy of residents' right to choose and concern over adequacy of clinical support to keep these residents safe.

> . . . if the residents request is to stay in the home, we'll do everything that we can to support them in that. (S#7)

> The number of physical conditions that they're dealing with—just the complex medical stuff, multiple diagnoses, diabetes. I would say in probably 60 percent of those residents, congestive heart failure and people are living with hospice care. Much more clinically and emotionally demanding. (T#12B)

> We have family where there's a very frail woman in her mid-90's who needs extra support services and the family is saying, "No." (S#5)

Overruling Clinical Decisions

An element related to the aging in place experience is a pattern of non-clinical managers overruling the judgments of the clinician (the SALSA). In the majority of my interviews with SALSAs, I was told that they actually had experience of having their clinical decisions overruled by a non-clinical manager, knew of at least one SALSA colleague who had had that experience, or feared that being personally overruled was a distinct possibility at any time. Many members of the theoretical sample corroborated these statements. The confounding issues play out in admission approvals; especially if the community is "census-challenged" (see Figure 3 for the sub-categories that contribute to conflict).

> You wouldn't believe the residents we are moving into our communities. Because we need occupancy. Occupancy is at one of the lowest levels it has been in a long time in our industry. And so people are just moving people in who are interested. We don't even determine if they are appropriate on the front end. We just automatically send the nurse out to assess every one. (T#14N).

> Part of my role was to do assessments, whether or not an individual was appropriate to be able to come into this community, and on, sadly enough, a number of occasions, my decision was overruled and the individuals came to this community. (S#8)

or when a resident's condition has deteriorated and the SALSA evaluates that they can no longer be cared for *safely* in an assisted living environment.

> . . . a nurse says to their executive director. . .no, that person is not appropriate for this setting anymore But I think it's a rare case, it's the very strong SALSA who will take somebody off the service and against their ED's [Executive Director's] advice. (T#10N)

> But for those families who don't want the resident to move but they really are at a point where they're not safe in the environment, that's where a lot of the communities are sitting right now. They have really the nursing home level resident; they may or may not have the staffing to meet those needs without a private caregiver. (S#16)

If a resident has skilled nursing needs round the clock, this is generally a situation that does not garner such pressure because it can be clearly established that 24-hour registered nurse assessment and potential intervention is beyond the scope of the "chronic and stable" parameters of assisted living in Connecticut. The more difficult decision-making occurs when residents who begin to fall frequently or experience increased cognitive decline present a risk of fractures or wandering/elopement. Another example are those residents who have been managing their oxygen administration or insulin injections but have experienced a physical or cognitive decline and can no longer assume this responsibility. In the Connecticut regulations (see Appendix B), nurses' aides may "assist" with medications, under the direction of a registered nurse, if the resident needs reminders and minor help. These resident situations present a significant problem for the nurse to manage safely and professionally in an environment that stresses individual choice.

> . . . if you can't develop a care plan to meet their needs then corporations tend to look at you and say, "Well, you're not being—you're not working with the team. (S#15)

(h) Nursing Services provided by an assisted living services agency

> (3) A registered nurse shall be responsible for the following which shall be documented in the client's service record:
> (G) referral to appropriate professionals or agencies, whenever the client's condition necessitates, including the provision of current clinical information ensuring that if the client's condition is no longer chronic and stable, services of a licensed home health care agency are engaged or other appropriate arrangements are made;
> (H) planning for clients who shall no longer receive or require the services of the assisted living services agency (See Appendix B--CT DPH Public Health Code, 19-13-D105(h)(3)(G)(H)).

The conflict in these situations appears as one between the census/marketing interests of the community and the regulatory and resident-centered mandate to provide safe, coordinated care (see Figue 3).

> There is a lot of competition out there. And it's tough to get beds filled.
> And yeah, I do feel the pressure is put on the SALSA to accept people they feel aren't appropriate. (T#9B)

> . . . they tend to be ruled by that marketing phone call. (S#8)

Below are comments regarding the pressures of census/marketing priorities and the situation of SALSAs having their clinical decisions questioned, second-guessed, and often overruled by non-clinical management. Reflecting the force of the company, from the perspective of the SALSA and the theoretical sample:

> There is always a push from a marketing standpoint to move that resident in and that is generally where the company is interested no matter what they say. It's all about the move-in. (T#8B)

> . . . it's based on business practices—our community has been pretty full; if they're not they'll make you take anyone. There will be a lot of heat to take any kind of resident. (S#17)

Reflecting the force of the clinical area, all from members of the theoretical sample with nursing background:

> . . . Sales has their priority—filling the beds; ED has their priority—keeping the building functioning and filling the beds; and nursing has their priority—just trying to keep people

> healthy. The priorities are not the same, and we don't incentivize the same things either. (T#10N)

> SALSAs saying that . . . I can't make the final decision—even though I knew this client was going to be inappropriate, and going to be a problem—I had to admit them (T#9N)

> I would say that probably in only one-quarter of the cases that I know of, the nurse would have the final say. (#10N)

A comment reflecting a measure of agreement between the business and the clinical areas is:

> Acuity is held in check to a certain extent when either the ED or other administrators, or other non-clinical people are aware of the negative impact of higher acuity on marketing; or the nurse has been able to create a position for herself in that triad—nursing, marketing, administration—where she is believed and her opinion is held in high regard. It flows through to the money that if we take these people it may be good on the short term, but it's not going to be good on the long term. (T#6N)

Families often find themselves in the midst of this conflict as they make decisions about living arrangements and support services for a loved one without accurate understanding of the parameters of care appropriate to assisted living or provided by a specific community.

> We have cases where we have to bring in Protective Services because nobody else is taking responsibility…we feel that the person is really a danger to themselves. (T#12B)

Legislation passed in Connecticut at the close of the last General Assembly session, Public Act 07-2 Sections 30-38 (See Appendix F), addresses the protection of the family's rights by specifically directing the manner in which services must be described and disclosed to families prior to admission. This legislation also identifies the responsibility of the managed residential community (MRC), under the direction of the executive director, if certain expectations are articulated for a safe admission and those expectations are not upheld by the family (See Appendix F).

> (NEW) (*Effective October 1, 2007*) No managed residential community shall enter into a written residency agreement with any individual who requires twenty-four hour skilled nursing care, unless such individual establishes to the satisfaction of both the managed residential community and the assisted living services agency that the individual has, or has arranged for, such twenty-four hour care and maintains such care as a condition of

residency if an assisted living services agency determines that such care is necessary. (Section 35)

(NEW) (*Effective October 1, 2007*) A managed residential community shall enter into a written residency agreement with each resident that clearly sets forth the rights and responsibilities of the resident and the managed residential community, including the duties set forth in section 19a-562 of the general statutes. The residency agreement shall be set forth in plain language and printed in not less than fourteen-point type. The residency agreement shall be signed by the managed residential community's authorized agent and by the resident, or the resident's legal representative, prior to the resident taking possession of a private residential unit and shall include, at a minimum:
(1) An itemization of assisted living services, transportation services, recreation services and any other services and goods, lodging and meals to be provided on behalf of the resident by the managed residential community;
(2) A full and fair disclosure of all charges, fees, expenses and costs to be borne by the resident;
(3) A schedule of payments and disclosure of all late fees or potential penalties;
(4) The grievance procedure with respect to enforcement of the terms of the residency agreement;
(5) The managed residential community's covenant to comply with all municipal, state and federal laws and regulations regarding consumer protection and protection from financial exploitation;
(6) The managed residential community's covenant to afford residents all rights and privileges afforded under title 47a of the general statutes;
(7) The conditions under which the agreement can be terminated by either party;
(8) Full disclosure of the rights and responsibilities of the resident and the managed residential community in situations involving serious deterioration in the health of the resident, hospitalization of the resident or death of the resident, including a provision that specifies that in the event that a resident of the community dies, the estate or family of such resident shall only be responsible for further payment to the community for a period of time not to exceed fifteen days following the date of death of such resident as long as the private residential unit formerly occupied by the resident has been vacated; and
(9) Any adopted rules of the managed residential community reasonably designed to promote the health, safety and welfare of residents. (Section 37).

Persistent issues related to aging in place have caused the Department of Public Health in Connecticut to consider adjusting their assisted living regulations to reflect the increased acuity and frailty of residents. In 1994 when the original assisted living regulations were enacted in Connecticut, there was no realization that residents with dementia would be cared for in this setting. In the interim, communities have not only cared for residents with this challenge, but many communities have developed secured units for residents with significant dementia. Some

communities support residents' end of life needs with Hospice services. As a result of the changing needs of residents in assisted living settings, a regulations advisory committee has been established to review existing Department of Public Health regulations and make recommendations to the department regarding changes, additions and updates (See Appendix E). The researcher is a member of that committee. As part of its role, this committee will recommend to the Department of Public Health that these legislative initiatives be included in the regulations. Additionally, one of the work groups on the regulations advisory committee is charged with recommending the disclosure requirements to be added to any new regulations. This workgroup has not yet made its report to the full committee. The work group addressing the issue of dementia care has already made its initial recommendations regarding disclosure related to dementia care.

> Disclosure: (As indicated in DRAFT Recommendation #1) Any Assisted Living Residence which offers to provide or provides services to residents with Alzheimer's Disease or other dementias by means of an Alzheimer's Dementia Care Unit/Program shall be required to disclose the type of services provided, in addition to those services required by rules and regulations herein. This Disclosure will be contained in appropriate statements separate from that used for the non-secured unit of the community. (Work Group #4 related to Dementia Care Units—work in process)

Several consequences can accrue to the customer—resident and/or family members—as a result of either improper promises made prior to admission or second-guessing and overruling of clinical decisions. These consequences are related to (a) the family's refusal to engage in the process, an infrequent but unsettling situation; (b) an inability for the nurse to develop the trust relationship that is so essential to effective functioning as partners in this venture; or (c) the family's dissatisfaction with care and services due to inaccurate expectations.

> I can give you a million examples of when a family member was so distant and then the condition of the resident changes that's when we contact the family and say this is what's in the best interest, say it's your mother, and the families are like no, not going to do it. (T#8B)

> . . . a lot of the challenge today is the communication with families and helping them understand the changes that their loved one will probably ultimately experience and what that means to altering service plans, or maybe that their loved one is no longer appropriate for assisted living and just really communicating that on an ongoing basis so if and when something needs to change, they may be more accepting. (T#8B)

> Lots of times the families are in denial that there's enough of a change and the challenge is always when the family is out-of-state and only see their parent three or four times a year, and they are not realizing what the day-to-day scenario is like. (S#5)

These situations can also have a deleterious effect on census, reputation, and profits, producing the exact opposite result to that intended by a focused pressure on marketing and admissions.

Legislative initiatives (see Appendix F), coupled with an increase in family complaints made to the Department of Public Health (DPH) related to assisted living communities, discussed in the regulations advisory meeting, have prompted DPH to establish the committee mechanism to review regulations. Assisted living providers have altered their service packages to respond to residents' increased frailty and desire to age in place. However, the relationship between aging in place and overruling of clinical decisions by non-clinical managers underscores a situation in which political demands, assisted living clinical practice parameters and business pressures conflict.

Care Planning

Care Planning is a significant influence in the situational analysis and presents conflictual processes among the positions of *Company, Customer and Clinical Expert.* In Figure 3 the sub-categories that further define this category of *Care Planning* are named. The actual inability for clinical staff to plan for and provide the care for a resident on an on-going basis may largely be the result of increasingly complex medical or cognitive impairments that emerge after the resident was accepted into the residence. In all communities, residents' healthcare conditions change as a natural function of the aging process. The regulatory expectation of the role the

SALSA plays is to assess care needs, create a plan for the safe delivery of that care, reassess as needed, intervene whenever plan alterations are necessary, and ultimately coordinate the healthcare needs of all residents who are part of the assisted living services agency (ALSA). The coordination requirement involves caregivers within the community, other nurses and nurses' aides, as well as entities external to the community. Depending on the boundaries within which individual assisted living communities and companies describe the services they provide, the external entities can include physicians, private caregivers, home care agencies, pharmacies, hospice, labs, x-ray, and other ancillary healthcare services.

The state regulations that address the care planning requirement stress the importance of planning, documentation (in the medical record, called the client service record in Connecticut regulatory parlance) and coordination.

Client service record

> (2) The complete client service record shall include, but not necessarily be limited to:
>
> (K) documentation of coordination of services with the client, family, and others involved in the client service program;
>
> (3) Upon a client's referral to a home health care agency, the name of the agency to which the client was referred and a summary of the reason(s) for the referral shall be documented in the client record including the staff person contacted and the date of contact with the agency.
>
> (4) Upon a client's resumption of services by an assisted living services agency, a summary of the care and services provided to the client by the home health care agency shall be documented in the client record. (See Appendix B--CT Public Health Code, Section 19-13-D105(k)(2)(K)(3)(4)

As evident from the *Aging in Place* analyses presented earlier, there is support for residents remaining in their familiar surroundings, but concurrently this position significantly alters the evaluation, coordination, communication and intervention demands placed on the clinical staff. Managing these increasingly complex and dynamic care needs, however, remains

the sole responsibility of the SALSA, who may be the only registered nurse in the community directing a staff with few other nurses (licensed practical nurses) composed predominantly of nurses' aides.

> *Three years ago, when I began working as a regional nurse resource in an assisted living company, residents who were taking Coumadin (a frequently prescribed blood thinner) and needed management of their blood levels so that correct dosing could be prescribed, received that level of support from their families or their MD. A year and a half ago, the SALSAs in the assisted living communities I oversaw made individual decisions to manage that parameter themselves, on the belief that if they were administering this medication that required such careful titration, they needed to ensure that the blood levels were being checked and evaluated. This would be considered an appropriate standard of practice for a nurse in Connecticut. Nurses administering insulin felt similarly obligated to ensure that the insulin dose was given with parameters of blood sugar levels. This change indicated a significant alteration in the level of responsibility and oversight that the SALSAs were managing. It was a decision that is readily supportable by standards of nursing practice, but one that others were overseeing when residents were healthier and were more capable themselves or experienced less frequent alterations in these critical parameters.*

The SALSAs I interviewed value the non-medical, non-institutional belief system of assisted living and support the residents' desire to experience a quality of life beyond mere existence. Many SALSAs engage in educational or recreational activities with the residents, as time permits, and experience deep relationships with the elders as one of the most worthwhile consequences of their work.

> My heart sings to nursing. I love the resident contact. (S#16)

> I get to build a lot more relationships—closer relationships to residents and families here. (S#9)

> I like the privilege of working with the seniors. (S#12)

The SALSAs' responsibility for assessing resident situations with regard to safety, and developing plans to support safety, becomes enormously conflictual if families do not feel the need to cooperate in the decision-making process and if non-clinical managers repeatedly question their clinical expertise. Having said that, the related expectation is for the SALSA to be

open to creative care planning with an eye to developing innovative structures that afford safety but that also respect, wherever possible, the residents' desire to remain in their assisted living home.

> Safety means—are they a wander risk? If they are a risk to wander, we have [a major highway] right out our front door and [another major transportation line] out our back door and we have 18 doors in the building. So, it doesn't take a rocket scientist to understand that if your family member is at risk to walk out the door thinking they're going to go home, and they don't know how to get there, that unless they have a 24-hour live-in and are compliant with that person, they can't move in. (S#16)

Recently promulgated legislation in Connecticut states:

> (NEW) (*Effective October 1, 2007*) (a) All managed residential communities operating in the state shall: Provide a formally established security program for the protection and safety of residents that is designed to protect residents from intruders (See Appendix F--Public Act 07-2, Sec 31 (4).)

The managed residential community's (MRC) responsibility for ensuring safety is a new addition to the assisted living landscape in Connecticut. Prior to enactment of this law, which took effect October 2007, the SALSA bore the entire burden. Given the degree of conflict between the primary situational areas around the issues of *care planning,* this legislation appears to be a significant and timely change.

Respecting SALSA Time

A final area of conflict within the three interrelated areas of *Company, Customer*, and *Clinical Expert*, occurred when the nurse, the SALSA, experiences being treated disrespectfully and not as a valued professional. The areas of specific concern that were enumerated in the interviews are: a) being on call, and b) the lack of clerical support.

The term "on call" signifies the SALSAs' regulatory responsibility to be available for decision-making within the assisted living services agency at all times, and includes a responsibility to be present at the community whenever needed. It is considered appropriate for

the SALSA to contract for on-call services from another health care agency, the only stipulation in the regulations being that the nurse assuming the responsibilities be a registered nurse licensed to practice in Connecticut.

In most assisted living communities in Connecticut, the customary model of staffing predominantly by nurses' aides prevails. Assisted living regulations require the SALSA to be onsite a certain number of hours per week based on the number of full time equivalent licensed nurses or nurses' aides on staff.

> (1) The agency shall employ a supervisor of assisted living services to be on site as follows:
> (A) at least twenty (20) hours per week for each ten (10) or less full time or full time equivalent licensed nurses or assisted living aides; or
> (B) at least forty (40) hours per week for each twenty (20) or less full time or full time equivalent licensed nurses or assisted living aides.
> (2) In addition to the supervisor of assisted living services, the agency shall be staffed with licensed nurses at least ten (10) hours per week for each additional ten (10) or less full time or full time equivalent assisted living aides. (Department of Public Health Assisted Living Regulations 19-130D105 (j)(2)(3)(A)(B)(4))

As a result, there is seldom a nursing presence on the overnight shift in the assisted living communities. To address the need for oversight required by the regulations, the SALSA can assume the responsibility for being on call, delegate that responsibility to another registered nurse, if there is another registered nurse on staff, or refer that task to an external agency under a contractual arrangement, as described in assisted living regulations

> An assisted living services agency may contract for on-call registered nurse services with a licensed home health care agency. The on-call nurse shall be reachable by telephone and shall be available to make an on-site visit (Department of Public Health Assisted Living Regulations 19-13-D105 (j)(8))

In many of the communities, there is not another registered nurse who is willing to accept the responsibility or the interruptions of being on call, even if they receive additional compensation. (Most SALSAs are not compensated with additional pay for being on call). Contracting with

home care agencies can be workable if there are consistent nurses who carry out this function for a specific assisted living community. Without that, many of the SALSAs believe that they would have less-successful resident decisions being made and they (the SALSA) would still be in the position of having to make corrections as a follow-up. The additional reality is that many home care agencies do not accept contracts that include on-call responsibilities because they are experiencing the crunch of the nursing shortage themselves and feel the need to make decisions regarding utilization of the RNs on their staff to support their own caseloads. These conflictual issues leave the SALSA with less than optimal choices for handling the on-call responsibilities that are exclusively their own, per the regulations.

> An assisted living services agency shall designate a registered nurse to be on call twenty-four (24) hours a day. The on-call registered nurse shall have two (2) years of full time or full time equivalent clinical experience in nursing, at least one (1) year of which shall be in a home health care agency or community health program that included care of the sick at home. The on-call registered nurse may be the supervisor of assisted living services or another registered nurse as specified in this section. (Department of Public Health Assisted Living Regulations 19-13-D105 (j)(8))

> *I had a conversation with a SALSA at a recent statewide meeting at which the SALSA asked for my suggestions regarding her conflict with on call. This SALSA had a planned one-week vacation and was traveling out of the country. Although she had submitted a written request for this time off that had been approved, no action had yet been taken by her company to arrange for a replacement for her during that time. State regulations require that the vacation replacement be one registered nurse who works 40 hours per week during the absence of the SALSA. The company's lack of a plan to secure this replacement did not remove the SALSA's ultimate responsibility for the clinical care provided during her absence. This SALSA had never had any help or support with on call—the company's expectation was that she would be on call 24 hours per day, seven days per week, 51 weeks per year. Her annual vacation would be without clinical coverage. This SALSA had experienced the reality of being called in to work on the night shift (11PM to 7AM) because a nurses' aide had called in sick and no replacement could be found.*

The issue of being on call is one that engendered significant commentary from all SALSA respondents to my interviews. The following are several comments made relative to the issue of being on call:

> . . . you've still got that feeling wherever you are [that I've] gotta keep check on my phone. I've gotta make sure because I've gotta put the phone by my night stand because they could be calling me. (S#17)

> You're never off. You're always on. . . you're always on. Always. Always. Always. (S#9)

> When it's at the hardest at night when you're at home, when you get that phone call, and even though you feel you've made the right decision, you don't go back to sleep—did I make the right decision? You end up calling, did you check on them? How are they doing? That is seriously the hardest part of the job. But it is the main reason people leave is either because of inconsistent staffing, not enough staffing, or the constant, constant every night knowing that the phone has potential to ring. (S#16)

The category of *clerical* support became surprisingly significant in the situational analysis. I was unprepared for the volume of comments I received relative to the general lack of clerical support at assisted living sites. While several people observed that the utilization of a licensed professional to perform clerical support functions was a poor use of funds and a squandering of a limited and already much-occupied resource, the SALSAs often felt that it was a signal of the lack of value they held within their companies. To be accurate, several comments were also made regarding the initiation of clerical support services to assist the SALSA in the work. However, in most communities in this study, no such plans exist. The following includes comments relative to this issue from individuals in the theoretical sample who have both nursing and business background.

> It's like for some reason the whole industry [assisted living] assumes that nobody needs any clerical support. (T#13B)

> I don't know of any community that gives clerical hours as a main item to assisted living. They might take a lead aide for some filing tasks, or something like that, but that's not additional hours in the budget. (T#10N)

> If you had clerical support, that person could take away all of the nonprofessional hours that the nurse [does], trying to keep her head above water… I always say we're paying a nurse, let's just say for the sake of it, $30 dollars an hour to be a clerical assistant. It's the same with scheduling . . . [It] goes to the front desk. It goes to somebody that I'm not paying $28, $30, $25 dollars an hour. It's such a no brainer but they don't see it. (T#10N)
>
> . . . We are actually recruiting for a part-time 20-hour clerical person. (T#11B)

The interrelationship of the primary situational areas created confounding situations in which the solid and often regulated requirements of one area negatively impacted another. Younger, healthy residents did not require the level of clinical scrutiny that more frail residents demanded. Aging in place is a value of the assisted living model, but the consequences of this philosophy created conflict between the services the residents needed, that the clinical expert worked to provide, that the family assumed were available, and that the company often did not perceive. Resolution in one of the primary situational areas often created problems for another area, making resolution difficult.

Conclusion of Situational Analysis Findings

The Primary Situational Areas identified in the situational analysis depict the structure of the assisted living situation---Company and Customer and Clinical Expert---as it exists in the Connecticut model. All three areas are influenced by all others areas. . Each of these situational areas exerts influence on the assisted living site from their specific positional view. In spite of the concurrence of positions in relation to *community ambiance and the establishment of facilitative relationships* with the customer, there was substantial evidence of conflicting positions around issues that emerge around the categories of *senior housing with healthcare, aging in place, clinical decision-making, care planning, and respecting SALSA time.*

The situational analysis presented here has drawn a picture of the broad landscape of the current experience of assisted living in Connecticut as described by 13 SALSAs from 10

companies, both proprietary and nonprofit, free-standing assisted living settings to continuing care retirement communities (CCRCs). Additional comments have been provided by 11 professionals in the purposive theoretical sample who have deep and varied experience with assisted living in Connecticut, four of whom have a nursing background, seven of whom have a business background. The totality of the data sources reflected in the situational analysis also includes Connecticut Department of Public Health Regulations with respect to assisted living as well as nursing, new legislative initiatives, publicly available information from national assisted living organizations, and assisted living marketing materials found in the public domain.

On the basis of these sources of data, the situational analysis has identified and explored the social, political and economic forces that shape the experience of those involved. While there is alignment related to appreciation for the ambiance of the physical setting, the basic philosophical underpinnings of the assisted living concept, and the depth of relationships formed with the residents, this study has identified greater disparity than alliance. The areas of conflict are numerous and reflect a primary ambiguity related to the business' orientation to the mission of the enterprise and the reality of resident needs and clinical care that exist within the situation. The inventive assisted living model has gathered components from multiple sources to respond to preferences of elder citizens for alternative housing options. The addition of the healthcare emphasis is another response to increasing needs. Understanding the situation as a whole is integral to incorporating new viewpoints in a way that, hopefully, reinforces the innovative and approachable design. The grounded theory interview analysis, presented in the next section, examines the particular perspective on the SALSAs role in this situation and uncovers their experience of these situational forces.

Grounded Theory Interview Analysis

The grounded theory interview analysis provides greater depth of explanation and understanding of the underlying themes that inform the SALSA role and the situation of assisted living in Connecticut. Interviews of the SALSA participants and the members of the theoretical sample are included in this analysis. The theoretical sample that includes professionals with both nursing and business backgrounds provides multiple perspectives on the SALSA role in assisted living in Connecticut. This study uses the triangulation of the theoretical sample to add depth and credence to the interview analysis. Three primary themes emerged in the interview analysis, *Defining*, *Expecting*, and *Owning Authority* (see Figure 4). Each primary theme relates to vital elements within the situation that exert significant influence on the SALSA role. In the grounded theory interview analysis a *root or core* theme is identified. The root theme that emerged in this analysis was *Dis-congruence.* The theme of *Dis-congruence* is connected to all primary themes in the interview analysis and contributes to the development of a conceptual model of nurses' experience of leadership in assisted living in Connecticut.

The primary themes are comprised of related properties that are developed in the axial coding process. Appendix I lists a third generation iteration of categories and descriptive properties. These categories and properties are conceptualized in the construction of the explanatory analyses that include conditions, strategies, and consequences related to the primary themes. In this chapter, first the primary themes with categories

Primary Themes with Categories and Sub-Categories from the Interview Analysis

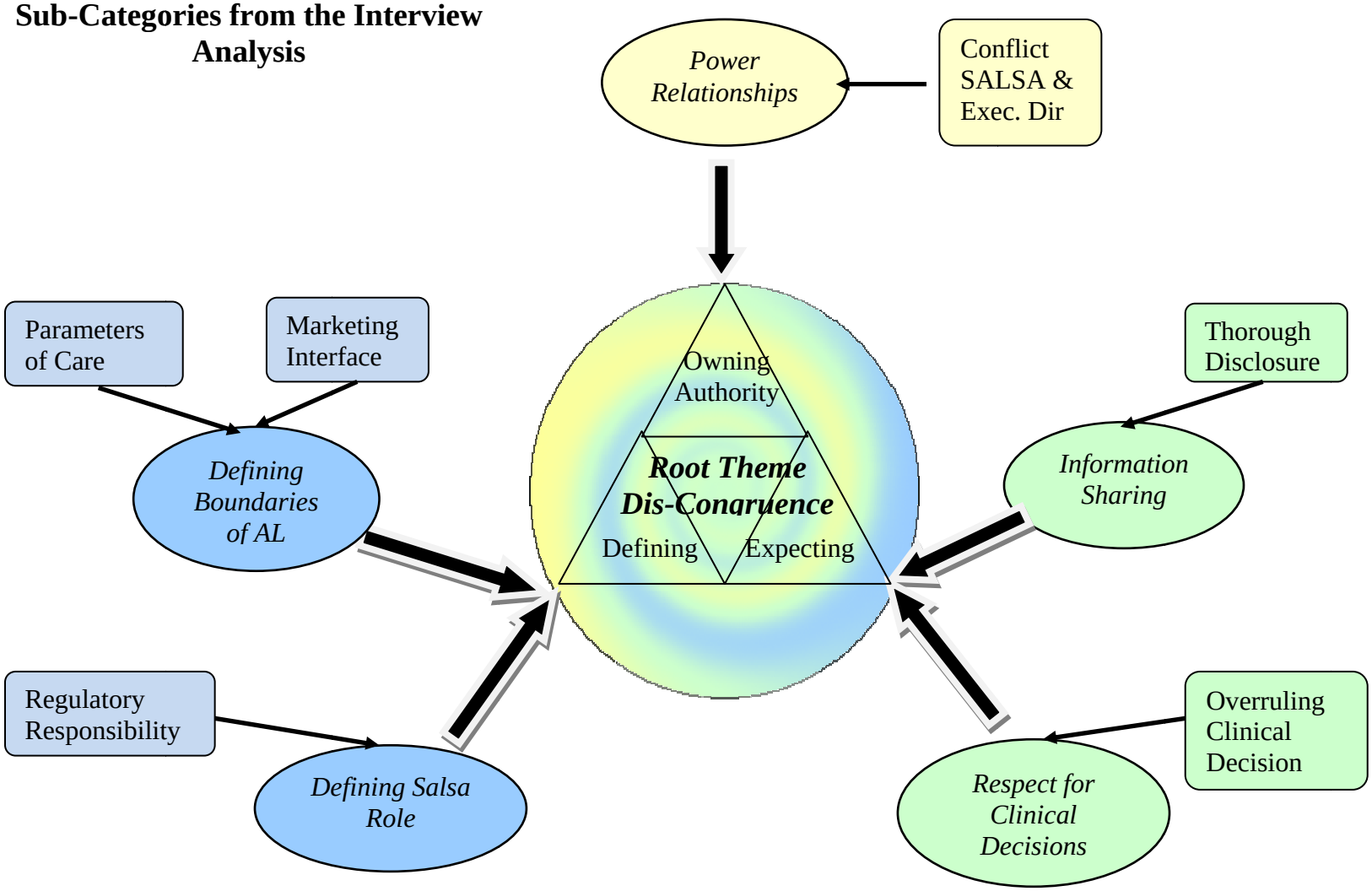


Figure 4. Primary Themes with Categories, Sub-Categories, and Root Theme

will be described followed by the explanatory analysis that emerges from the theme. The primary themes and the explanatory analyses will be illustrated with interview text. Finally, the root theme will be presented as it relates to all other themes.

As with the situational analysis, all direct quotes in the grounded theory interview analysis are presented in single space and indented. Interviews have been given an alpha-numeric combination that is unrelated to the sequence with which the interviews were conducted. The SALSA interviews contain the letter S; the theoretical sample contains the letter T. To further delineate the appropriate perspective from which the members of the theoretical sample speak, an additional alpha designation of N identifies a person with nursing background; the designation of B identifies a person with business background.

Theme of Defining

A fundamental issue identified in the grounded theory interview analysis is that of defining the roles and business of assisted living. The regulatory structure in Connecticut establishes the SALSA as the manager of the assisted living services agency (the ALSA) that provides healthcare support to the residents who are included in the ALSA. The regulations also identify that residents in assisted living communities must be pronounced 'chronic and stable' by their healthcare practitioner, but offers no further written guidance on that subject.

> I think that the SALSA's role is enormous. That there is just so much for her to be responsible for. (T#9N)

> . . . in an environment like assisted living where it's getting more and more challenging, where the seniors are frailer and frailer and they're coming later on in life and they're coming with a lot of co-morbidities . . .. (S#12)

The theme of Defining refers to the lived perspective on the SALSA role in assisted living. Defining the nature, boundaries and responsibilities of the role predominated many of the

participants' remarks. Two categories of definition and their respective sub-categories emerged within the primary theme. These categories and their sub-categories were: Defining the SALSA Role, Sub-category SALSA Regulatory Responsibility; and Defining the Boundary of Assisted Living, Sub-categories; Parameters of Care and Marketing/Clinical Interface. An explication and illustration of these categories and sub-categories further elucidates the character and meaning of the primary theme *Defining*.

Category: Defining the SALSA Role

The SALSA role is the primary clinical expert within the assisted living setting in Connecticut. That role is a singular one, with no other support positions defined in the regulations. The role is responsible for providing education, assessment, planning, coordinating, and supervising of services for the residents who are part of the assisted living services agency (ALSA) in Connecticut.

> . . . there's nobody there to back you up. I mean there's nobody else…if you work in a skilled facility you have an assistant director of nursing and people all around. (S#17)

> If it's a wellness issue, I have to be responsible but if it's also some kind of other issue that affects the resident I have be tied into that. We are more interdisciplinary, as far as nursing goes with everyone and anybody else. We have to be in contact with dietary. We have to be in contact with social work. Activities, definitely, we're the ones that have to contact first thing. (S#9)

> It is just not good enough to be a good nurse anymore and it's not enough to be a good nurse and run a good building. The nurse has so much to worry about with staffing issues, the pressures from Quality Assurance, all the monitoring that goes on from the companies and the State. (T#8B)

Sub-category: SALSA Regulatory responsibility. There are broad regulatory responsibilities that accrue to the SALSA role. The SALSAs and the members of the theoretical sample enumerated several of the most complex issues. One of the major areas of responsibility

is coordinating services with entities external to the assisted living setting. These services begin with physicians, who provide medical care to their patients who happen to be residents, and extend to pharmacies, home care agencies, hospice, short term rehabilitation settings and others. The increasing complexity of residents' clinical issues that the SALSA must coordinate creates greater pressure on their clinical management skill and their time.

> You talk about 50 residents most all have physicians out in the community managing that piece and the communication that goes back and forth with the physicians, or even outside home health agencies, and getting that information so that it can be documented and worked into a service plan if necessary. (T#11B)

> So those nurses really have a lot of skilled people (residents), chronic and stable people, people who are changing constantly. They have a large number of residents that they are a primary nurse for. (T#9N)

> **. . .**the day-to-day monitoring, checking in the medication process and how they setup their MARs (Medication Administration Records). Everything from how the CNAs are setup with their daily books and their documentation system, how they're doing the medication prompting and reminding and their documentation of that ---just the day to day systems needed to be in place to keep up with the regulated paperwork, the routine assessments that are done every four months, and having a system in place to make sure those are done accurately and they're kept up, and we've got as much input as we needed. (S#14)

> The more acute somebody is the more issues they have, the more medications they have to be on, the more doctors visits they're going to have, the more correspondence there's going to be between here and outside agencies, whether it be the pharmacy or home health agency or VNA. Then they have to do more charting. This means they will be passing more medications. It means that they're probably going to be responding to more incidents. So you can definitely see that the time needed to care for these acute residents from the nursing perspective has definitely changed. (T#5B)

Both the Category of Defining the SALSA Role and the Sub-category of SALSA Regulatory Responsibility contribute to the Theme of *Defining.*

Category: Defining the Boundary of Assisted Living

Assisted living settings offer a wide range of clinical services and supports to elder residents. The regulatory definition of 'chronic and stable' provides little operational guidance to the assisted living communities. The philosophy of supporting residents' preference to 'age in place' increases the probability of increasing clinical needs congruent with advancing age. The Sub-category of Parameters of Care includes comments from the SALSAs and theoretical sample related to the boundaries as described in specific assisted living settings. The Sub-category Marketing/Clinical Interface uses SALSA and theoretical sample comments to highlight conflicting priorities within the assisted living environment.

> Guidelines are not clear. When—when you're talking about people, every situation is different and so, it really matters—when the same care needs may be a concern for one client and not for another depending on their cognitive abilities, and their own self direction,, and when I look at the DPH (Department of Public Health) regulations, and look at what is self administered medication with assistance versus when it's really being administered. . . (S#6)

Sub-category: Parameters of Care. The interview analysis explicates a variety of parameters that are allowed within assisted living settings in Connecticut.

> We advertise in our mission statement that it's gracious living and that we're going to have high quality. And if we have a resident living here with a 24-hour live-in who is abusive, who is non-compliant and is going to, in a negative way, affect other residents, they can't stay. It's pretty simple. (S#16)

> We do insulin, eye drops, inhalers, nebulizer treatments, and all the finger sticks (blood sugar testing) are done by the nurses. (S#11)

> Normal criteria is they have to ambulate or transfer (Move from bed to chair) independently. S#9

> We never thought we'd see mechanical lifts. We don't see a lot of them but we do see some.T#10N

> We've had Hoyer lifts here but primarily that's when private care is involved, so there was a caretaker there most of the time.S#14
>
> . . must be able to manage their incontinence themselves or at least alert the staff or ask for help when they need it S#5
>
> On our (dementia unit), we manage incontinence---residents are too confused to be able to do it themselves. (S#8)
>
> We don't do any crushing (of medications) here—they take their pills whole. (S#9
>
> . . .we have 26 residents on the dementia unit that need medications crushed…medications mixed with applesauce. (S#11)

A review of these comments reveals that there is little definitional conformity related to parameters of care across communities in Connecticut. The very broad range of possibilities for clinical service provision creates concern for the SALSA who is responsible for developing and delivering individualized plans of care for the residents.

Sub-category: Marketing/Clinical Interface. Marketing goals are met with census; clinical goals are met with supporting residents' healthcare needs. When parameters of care are a moving target, establishing congruence between those goals can be a problem. The assisted living option was developed initially as a senior housing model. As such, marketing efforts were focused on the physical ambiance and amenities of the property. With an aging resident population, it is important for residents and their families to have accurate information about healthcare services that are available. A professional interface between marketing and the SALSA is essential.

> And the marketing person says 'no problem we can do that . . . we have nurses here'. So mom and dad move in and the daughter is infuriated and runs screaming into the nurse's office saying ' . . .what do you mean--- you're not doing what Marketing promised you'd do!' (T#6N)
>
> You have to decide what you're going to sell—what is your building going to be and make every effort to keep it. Once you start moving in

> because of that financial need, higher and higher acuity when a new client walks in, that's what they see and that draws more people like that level. If they see active residents coming and going it draws that person to your building. (S#16)

The Category of Defining the Boundaries of Assisted Living, with its Sub-categories of Parameters of Care and Marketing/Clinical Interface contribute to the Theme of Defining. The following section describes the relational analysis of the Theme of Defining. The explanatory analysis conceptualizes the relationships between the Categories and Sub-categories by analyzing their role in the context of Defining. The categories and sub-categories are examined in light of their role in creating Conditions under which defining takes place, strategies that are used under these conditions, and the consequences that may result. The next section will include a discussion of the Conditions, Strategies and Consequences related to the Theme of Defining.

Conditions Related to the Theme of Defining

The explanatory analysis conceptualizes those conditions that emerge within the SALSAs experience that are related to the importance of the Category: Defining the SALSAs Role. The SALSAs, who participated in this study, revealed the significance of a thorough orientation as a condition that would contribute to their success in the role. As the singular clinical authority, the SALSA needs to have a confident command of their responsibilities from both the regulatory and the corporate perspective. The SALSAs had strong feelings about the necessity of the orientation process, and reported that this is an area that could benefit from significant emphasis.

> I learned on the job. I learned on the job and I think a lot—that most SALSAs get that. The SALSA Course helped out a lot. It's just a basic outline for what you need to be doing. But that class wasn't offered until maybe 6 months after I started working. (S#9)

> I had to guess. I had a pretty good guess it was going to be a lot of work but as far as the picture of all the ins and outs and day to day stuff---not so much. (S#14)

> SALSA has left. A new one comes on. She knows absolutely nothing about how the (services were) run. She has to do that all on her own, until they can send her to the training program, which thank goodness is available. But many times it doesn't come until 4 months later. (T#9N)

> I was shown to my office which was locked—I was kind of surprised when I came in and found notebooks and many things piled on top of the desk, piled on top of the table, and on the floor, and I was really quite surprised by that. Now, I was told that the office had not been entered since my predecessor left which I believe was approximately—six to four weeks before my arrival, if it had been that long. It couldn't have been any longer than that. (S#7)

If the SALSA was not adequately oriented to the role, it would be difficult to guide the clinical needs of the community related to acceptable parameters of care. Another condition within *Defining* was the *Category: Define the Boundaries of Assisted Living* and relates to the philosophy of aging in place, a concept that was strongly present in the situational analysis. Support for a philosophy of aging in place, which is prevalent throughout the assisted living setting, becomes a critical condition for the SALSAs boundary management of role. Aging in place allows residents' to remain in their assisted living home as they experience increased medical/healthcare needs due to the addition of acute conditions or the exacerbation of chronic conditions related to the aging process. Because of the necessary shifts in healthcare needs for deteriorating health, the conditions under which the SALSA manages the clinical role to accommodate resident care shifts.

> We absolutely see people that ---forget age in place, they've done that. Now they are here and what's most troublesome to me is that they are at the level of needing assisted living when they get in here, but we're not really geared to thinking that way. (S#10)

> **. . .** the residents that first moved in here on—18 or 19 years ago or whatever it was, they were coming in their 70's, and now, they're 80's or 90's and early 100's. (S#5)

Strategies Related to the Theme of Defining

The explanatory analysis conceptualizes the strategies that the SALSA employed under the conditions of *Defining the SALSA Role and Defining the Boundaries of Assisted Living.* These strategies include efforts to balance census priorities with clinical concerns, effective and honest communication with families related to admission and to the philosophy of aging in place, and support for a balance between safety and resident choice.

> . . . assisted living, it's always a numbers game. (S#16)
>
> There is a lot of competition out there. And it's tough to get the beds filled. (T#9N)
>
> The resident who is stable today isn't stable tomorrow. (S#15)
>
> If you can't develop a care plan to meet their needs then corporations tend to look at you and say, "Well, you're not being—you're not working with the team."(S#15)
>
> I do believe choice is a good thing but again liability-wise when it comes to doing nursing you have to be very careful to make sure everybody understands. (S#17)
>
> Well, very often the social worker and I come to —a little bit of disagreement because I see the need for care and the social worker sees the need for the resident to have the right to make their own choices and to remain—you know independent where they are. We let a little time go by and—and so far, it's—it's worked out. Either somebody improves and—and I'm willing to say, "You know you were right. It's good that they had a chance," or the social worker backs down. (S#5)

As evidenced by these excerpts from the SALSA interviews, strategizing actual day to day clinical issues under conditions that do not have well defined parameters of care is extremely difficult. Emphasizing choice over safety or independence over support is a constant juggling act of allaying concerns regarding health and resident advocacy for independence. The SALSA is in the middle of these competing needs and reported the struggle of finding strategies that worked to balance clinical judgment with resident need.

Consequences Related to the Theme of Defining

The explanatory analysis for *Defining* conceptualizes the consequences that ensue under the conditions and strategies related to *Defining the SALSA Role and Defining the Boundaries of Assisted Living*. Under the aging in place model, the clinical needs of residents and the professional role of the SALSA often create disequilibrium within the system of care. As residents' health care needs continue to escalate in the assisted living population, the consequences of ignoring management of clinical boundaries can be significant. One such consequence reported in this study was the high turnover rate in the SALSA position and the related consequences of operational disruption.

> The turnover rate in the SALSA role in Connecticut is reported to be 100% annually. (T#5B)

> It comes back to being overwhelmed. You know, the more tired you are the more you can't see the light at the end of the tunnel, and if nobody is listening to you, you have no support, you don't know, your brand new, you have probably never worked in assisted living, you have no one to call, '. . . should I be accepting this client or not? I don't know'. (T#10N)

The explanatory analysis built within the theme of *Defining* has conceptualized the natural relationship between the significance of defining the SALSAs role within the conditions of aging in place philosophy, the struggle to find strategies for clinical decision-making under these conditions, and the ultimate consequences of high attrition of SALSAs in the assisted living environment. Further, the impact of SALSA turnover on the ability of the community to provide appropriate care to increasingly frail residents is significant. Aging in place and decisions related to choice versus safety persist as conditions within the assisted living setting. Current strategies to manage these conditions are simply stop-gap measures implemented on a case-by-case basis. Without attending to the competing pressures that SALSAs experience under these conditions, the consequences will be dire. The community as a whole will be unable to

address the preferences and needs of residents and their families, manage census and occupancy goals, retain healthcare staff, and provide quality of care for the very people the community is established to assist.

Theme of Expecting

The Theme of Expecting relates to assumptions of individuals and groups regarding the assisted living environment. It includes understandings of information and influence that is used by people with varying priorities and perspectives. The families, the SALSA, and the company view situations from their unique vantage point and have expectations of influence, communication, and service delivery that represents their perspective. Each group may have a slightly different interpretation of the situation, which can result in misaligned expectations.

> Most of the time, it's a work in progress . . .(S#15)

> Are they {the owners/non-clinical management} going to be able to maintain the type of environment that they truly envision by having those kinds of really needy residents? (T#10N)

The Theme of Expecting is comprised of two Categories with their respective sub-categories: Expecting Respect for Clinical Decision Making, Sub-category: Overruling Clinical Decision Making; and Expecting Accurate Information Sharing, Sub-category: Thorough Disclosure. Illustration of these categories and sub-categories follows.

Category: Expecting Respect for Clinical Decision Making

The SALSA is the person with professional and regulatory responsibility for managing residents' clinical needs. The combination of residents' preference for remaining in their private homes longer and the aging in place philosophy of assisted living communities creates a situation in which astute clinical management is essential. As a senior housing business model, the

assisted living setting has the dual priority of creating an attractive ambiance and providing appropriate healthcare supports.

> . . . It's a hotel with all kinds of healthcare services provided. (S#17)

> . . . nursing in assisted living---there's a range and it depends on the company that you're working with, from my experience. The company you're working with, the corporate structure and support, and their concepts and philosophies of healthcare and then how that flows over to assisted living. (T#6N)

> Ultimately, SALSAs are supposed to have the last word in regards to who's appropriate and who isn't. But the waters get muddy because there are other people intervening and, as a result of that, it tends to be a little harder to maintain what we believe to be the ideal resident. So, it becomes—you know it's a joint decision and I've had to broaden my criteria as far as what is acceptable and what isn't. (S#15)

Sub-category: Overruling Clinical Decision Making

Families expect that healthcare issues will be managed; companies expect that residents/families will be satisfied with both the physical amenities and the personal care; and the SALSA expects that clinical expertise will be respected. Both the SALSAs and the members of the theoretical sample report a pattern of non-clinical managers questioning and often overruling clinical decisions if those decisions threatened census goals.

> . . . {when} there's such a wall between administration and nursing that the administration/owner person has little or no regard for nursing and their opinions and their functions within the assisted living and they see them as a throw away then they bring people in without regard to nursing. (T#6N)

> I can think of a circumstance that happened not in this community but in a previous community that I was in that it did happen; and there was somebody on the regional team that basically overruled and moved the person in. (T#5B)

> . . . it's best not to refuse to admit anyone. (S#12)

> I haven't had as much experience as other people about me trying to say no I don't want to take this person and them (non-clinical management)

> saying well we need to. Again it's based on business practices; our community has been pretty full. If they're not they'll make you take anything, there will be a lot of heat to take any kind of resident. We haven't had to be quite that way so I think that the business drives that and pushes that. (S#17)

> If the tug of war were where I would actually say this, you know, this can't be, I get the support. (S#16)

In a clear majority of the SALSA interviews, I was told that they either had a personal experience of having clinical decisions overruled, knew of a SALSA colleague who had had that experience, or believed having clinical decisions overruled by non-clinical management was possible at any time.

Category: Expecting Accurate Information Sharing

Decisions regarding residents' appropriateness for admission to assisted living generally involved SALSA assessments. This process presupposes that accurate information would be available and would be shared.

> The amount of information that we are getting is often not complete. It's as comprehensive as it can be or could be, but then once they move in, in a community where we're able to now see how they're doing, see how they have lived, then that, of course, that paints a different picture. (S#12)

Families were often totally unaware of the parameters of care available in assisted living communities. As we have already seen, the assisted living entity contains multiple rather conflicting definitions that add to resident and family confusion about the appropriateness of a particular setting.

Sub-category: Thorough Disclosure

As reported earlier in the situational analysis, Connecticut assisted living regulations reinforced by recent legislation, require that accurate and complete disclosure of services be provided to residents/families prior to admission. Often the family needs education regarding the

definition of assisted living care parameters that the specific community provides. The marketing emphasis was on selling, not necessarily educating. From a clinical perspective, the difference could result in an incorrect impression being conveyed and therefore inaccurate expectations created for the families.

> They sell them a bill of goods that they can't necessarily deliver in the long term. All customer service is really important. (S#15)

> **. . .** you know presenting to the family—not a rosy picture necessarily, but a realistic one of what they can anticipate is helpful. (S#15)

> And if (whatever the specific issue is) it's not brought up upfront as a charge for the family they are now screaming and nursing is going to make damn sure that this person is staged in his healthcare needs (getting his needs met) and to make sure they get the Insulin and that they get their eye drops while the two warring sides fight it out and this family finds some place else to take their mother. All because they've been inappropriately placed. (T#6N)

> I would have delivered the message that there is no guarantee that it's gonna work. And I would also have delivered the message that, if it doesn't work, what would be the next step? And I think the family would be appreciative of that, rather than make a move and shortly thereafter have to make an immediate decision for another move. (S#12)

Especially if communities were 'census-challenged', there is the inclination to '. . . promise them anything' just to add to the census. Thorough disclosure is not only required by regulation, it is essential to achieving aligned expectations between the resident/family and the community.

The following section discusses the explanatory analysis of the Theme of Expecting. This section will conceptualize the relationship of the categories and sub-categories as Conditions, Strategies and Consequences within the Theme of Expecting.

Conditions Related to the Theme of Expecting

Interview analysis reveals conditions that further explicate the Theme of Expecting. Both of the Categories: Expecting Respect for Clinical Decision Making, and Expecting Accurate Information Sharing, contain conditions that describe a potential conflict of competing priorities. In the role of clinical decision maker, the SALSAs expect the company to respect their clinical expertise and experience. The residents and their families expect to receive services that have been promised and that meet the needs of the resident. The company expects the census goals to be achieved and the community's reputation to be enhanced or improved.

> That was a new battle for me to get marketing and other people to agree because—you know they don't like to make the clients unhappy. (S#10)

> I do have an executive director that values my clinical judgment highly. He's someone that does not have a health care background and checks in with me quite often and really, really, does value my judgment. (S#17)

> I valued nursing recommendations. (T#7B)

> I just lay it out on the line. Things change. This is where you are today or your loved one is today. Five years from now, six months from now, it may change and that's the expectation. (S#7)

> Well, sometimes the families think it's one stop shopping and once they bring—you know Mom or Dad here—they're here for the rest of their lives and you know the average stay at assisted living is 2-1/2 years. So, that would be pushing it nowadays depending on what their diagnosis is. (S#10)

Strategies Related to the Conditions of Expecting

The strategies that SALSAs employ to manage conditions of competing expectations include staffing to support residents' health care needs and respect within the community for the SALSA role as the clinical expert.

> It's getting to the point where my concern is that the workload has outgrown the budgeted hours and that's something I think corporations in general that run assisted living communities must start looking at. It's a

> tremendous amount of paperwork and especially in this state where we're regulated so heavily. It's a medical model and we've got a lot of regulations to abide by. (S#14)

> **. .** because their needs are getting more acute and we are lucky enough here to be—what do I say—non-profit so we are a little more lenient with the staffing patterns. (S#10)

> . . . those places where it's corporate dominant not for profit or for profit are having a really high acuity and are taking care of people that they don't have the staff to really care for appropriately and adequately. (T#6N)

Consequences Related to the Theme of Expecting

The consequences that accrue due to inattention to clinical decision making or to overruling clinical decisions by non-clinical managers are many. Initially, the likelihood that residents will not receive the care they expect is great. This consequence results either because the residents' needs exceed the community's ability to provide services or because the residents'/families' expectations of clinical support are inconsistent with staffing realities. The respondents clearly named their concern that environments that did not value the clinical contribution in establishing expectations for residents may experience destabilization from staff turnover and resident/family dissatisfaction.

> That brings us to who makes the final decision as to who enters an assisted living entity. And I think it has to rest with the nursing department - whoever is responsible. The SALSA, of course, and maybe the other nurses that are working with her. That they make the final decision as to who can come to the community and who is appropriate for the ALSA at this point. Not a non-nurse, executive director, who is making that decision because they need more people in that facility. (T#9N)

> . . . everybody tries to communicate and there may be differences in opinion but that's something that really has to be the clinical peoples decision. (T#5B)

> On one hand they acknowledge that you know it's an extremely important position in turning it over all the time is you know expensive

> and it's a detriment to our company and residence but they don't exactly know what to do about it. (T#8B)

The explanatory analysis of the theme *Expecting* has conceptualized the conditions that establish conflicting expectations and goals among clinical staff, residents and their families and business initiatives. It appears that within the SALSA role there are few strategies that could be successfully employed to manage these conflicting expectations. In some cases, the degree of flexibility in the business plan to add additional clinical staff allows for maintaining a sufficient level of clinical care. However, the strategy that was called for by clinicians was the authority to make solid admission and retention decisions based on the resident's clinical needs. Unfortunately, SALSAs reported that this strategy was often sabotaged by clinical decisions being overruled by non-clinical managers. SALSAs also expressed that clear information to families and residents regarding level of care available within the setting would establish realistic expectations from the outset. It appears that the consequences for provision of incomplete or inaccurate information to residents and ignoring clinical concerns expressed by the clinical staff are a combination that will ultimately lead to lower census and poor reputation for care.

Theme of Owning Authority

The theme of owning authority is relates to the SALSAs owning of their legitimate professional authority within their role as clinical expert in the assisted living setting. This theme surrounds the influence dynamics that are inextricably implicated in the Connecticut model of assisted living. The power differential between the SALSA and non-clinical management produces pressure and conflict that impact the SALSAs clinical responsibilities. The subject of Owning Authority is addressed here as it relates to the Category: Owning Authority in Formal and Positional Power Relationships, and its Sub-category: Conflict between SALSA and Executive Director Power.

> The ED (executive director) rules. (S#17)

Category: Owning Authority in the Formal and Positional Power Relationships

The SALSAs regulatory authority has been described in several sections of this study. Despite their assigned responsibility, the experiences the SALSAs most frequently identify in the interview analysis, supported by the theoretical sample, highlight the practice of the non-clinical manager having ultimate authority over all aspects of the assisted living setting.

> In assisted living the Executive Director is the person that of course ultimately leads. . . (S#12)
>
> . . . the executive director is above me—has the last say, so to speak, and even though it's patient care. . . (S#8)
>
> But there's a good number of SALSAs that have . . . said, you know, 'I am so frustrated that I can't be making these decisions as to who appropriate and who isn't'. (T#9N)

Sub-category: Conflict between SALSA and Executive Director Power

If the companies perceived the executive director as the ultimate decision maker within the community, the knowledge base discrepancy between the executive director and the SALSA became a significant factor.

> The company has developed a system that in some ways is saying that we don't necessarily always agree with what the nurses will finally decide or they may not be creative. In other words they were questioning nursing judgment. That undermined the whole role of the supervisor (SALSA). One SALSA resigned saying "I do not want my ethics on the table and have to make a judgment because this (a particular situation) came close to it." And that was one of the really deciding factors. (T#7B)
>
> What I've seen is the acuity increases when the nurse has less power and input over the marketing choices to move people in. (T#6N)

The power relationship issue presents a conflict whether the non-clinical management assumes or demands power over the clinical department:

> They (executive directors) don't separate medical versus business a lot of times. They get involved and they get it all mucked up. (S#17)

> I think when push comes to shove, if someone above you says, this is what you must do, you don't really have - you don't have the power to say I'm not going to do it, unless you leave the job. (T#9N)

. . . or whether the nurse relinquishes her legitimate regulatory authority as a result of pressures from non-clinical management.

> If you are going to have an executive director in a building who constantly has the final say and who doesn't have any respect for you, or your position, or little respect, I don't mean total disrespect, but you know, when it comes to the hard decisions, if they're not going to support you, then your going to stop making leadership decisions. (T#10N)
>
> I am more comfortable in the care giving role than I am in the cut throat administrative kind of role. (S#5)
>
> And I would say that 50% of those nurses are so, I don't know, insecure with their job or their position or their ranking, or whatever it is, that they would never ever challenge it (non-clinical management overriding). That they would just say, well this is how it is, I'm not even going to try to fight for this. (T#6N)
>
> I feel autonomous with the executive director, but I also know that person can override my decision. (S#7)
>
> A nurse says to their executive director—'no, that person is not appropriate for this setting anymore', but I think it's a rare case; it's the very strong SALSA who will take somebody off the service and against their ED's(executive director) advice. (T#10N)

Although some SALSAs and members of the theoretical sample express respect and support for the SALSAs clinical authority,

> I feel that if the nurse is saying to me that I can't take care of this then I've gotta listen to that. So I wouldn't much discount what the nurse was telling me. (T#12B)
>
> I have a very supportive executive director. He knows I'm the one with the clinical knowledge, so he's usually comfortable letting me make the decisions and even if he balks a little bit because it is a business, he usually will eventually understand why I am making the decision that I am. (S#9)

the majority of respondents reinforced the existence of the power differential around clinical decision making, with the emphasis on the non-clinical management's ultimate control in this area.

The following section begins the explanatory analysis of the Theme of Owning Authority. This section will include discussions of the Conditions, Strategies, and Consequences related to the Theme of Owning Authority.

Conditions Related to the Theme of Owning Authority

A condition related to the Theme of Owning Authority includes the SALSAs confusion around the exercise of leadership in the assisted living setting. Although this was a study of nursing leadership within the assisted living setting in Connecticut, the word 'leadership' was not used in the SALSA interviews in the initial question as a prompt. The question that initiated all the interviews was 'talk to me about your experience of nursing in assisted living'. Only 2 of the 13 SALSA respondents used the word 'leadership' at any time during the interviews. All respondents enumerated leadership tasks---coordinating, supervising, and communicating---but most of these references were related to clinical nursing responsibilities and not to a concept of an overall community leadership context.

> I needed to get some hands on here because for me that was the way I was going to get to know the residents and at the end of the day, it's all about the residents. (S#7)
>
> And then following up if somebody falls and following up with this and that and again it's just more and more and more and if you were in a skilled facility certainly you wouldn't have an 85:1 ratio. Not that we have to chart on every single person every single day like they do, thank goodness, but we have a lot of things that happen in one day. (S#17)

Both SALSAs and members of the theoretical sample describe situations in which the SALSAs authority was overlooked, discounted, or undermined.

> The major reality is that your nurses have no status in the organization or very little status. (T#13B)
>
> They (non-clinical management) keep the nurse out of the autonomous and really good business position by not allowing her access to the pieces that will give her the big picture to work with. They do that with the budget dollar and they do it by keeping information away from the nurse. Knowledge is power and they keep that. There are companies that don't even tell the nurses what their budgets are. They'll tell them to stay within the budget and the only way they know that they are or they aren't is when the big stick comes down. (T#6N)

Several members of the theoretical sample expressed impressions of nursing leadership. They are describing the conditions under which nursing does not *own their authority* as a leader in the assisted living community.

> A lot of nurses tend to be whiny and just not very professional. Instead of coming up with solutions, they are always coming up with the problems and I think that plays a big role in it and that's where it starts to be the slippery slope. (T#10N)
>
> I don't think nurses are natural leaders. I think, historically, nurses have not been in leadership positions. (T#10N)
>
> . . . it's because of lack of empowerment. Many times it's lack of a sense of empowerment and they feel understaffed and they just…they don't have any leadership to kind of show them the way. (T#10N)
>
> I think they don't have the authority. I think they feel that they are hired, given the feeling that they do have that authority. But then once it comes down to making that decision, they feel that their authority is overlooked. (T#9N)
>
> The SALSAs feel that all the responsibility is put on them, and along with that, they don't have the authority to make decisions. (T#10N)

And the SALSAs discussed their feelings about their role:

> It's not a good feeling when you have to manage something that you don't have the control over. (S#17)

> It's me. . . and so that was my biggest obstacle when I first came here was trying to adapt to actually being the end of the chain and there's nobody else to buck it up to. (S#14)

> The role with management has changed a bit because I've changed. It took a long time for me to feel established as we were really a part of the family and that kind of thing, but I would do a lot of shutting up at management teams just to kind of listen and the CEO would probably tell you he wishes I would go back to that because in the last couple of years, I really very much speak up for the issues that I feel strongly about. (S#10)

> You're doing managerial work because you have to mange a whole number of people, you have to make decisions, and you have autonomy in many areas. (S#17)

> It makes for a long, wonderfully diverse day, but at the end of the day, I sometimes feel like I haven't done anything well because it hasn't ever been finished. (S#5)

These comments vividly illustrate the complexity of the execution of leadership by the SALSA role, within a setting that presents conditions that promote conflicting expectations around issues of authority in clinical and management decisions. Whether the SALSAs legitimate authority was removed or relinquished, their confident owning and demonstrating of that authority was significantly limited.

Strategies Related to the Category of Owning Authority

Strategies related to *Owning Authority in the Formal and Positional Power Relationships* include reciprocal efforts of the SALSA to take a more assertive role in exercising leadership and the non-clinical managers to create space for this new leadership to emerge.

> I think nurses need to talk a different language or learn how to talk a different language. Their talking nursing language to people who don't even understand they're providing nursing services. (T#13B)

> There would be more nurse leaders in assisted living if there was a safe way to give them the education and information and the tools and then support to use those tools. They need someone to come back to, they need a mentor, they need a safe place to come back to and say 'okay now this is what I'm facing. . . I've got the marketing guy filling the place and telling

> everybody I'm going to give the injections. I've got the administration three levels up so far removed--- this guy has his ear---I don't. Help me figure out what the corporate dynamics are so I can do this'. Because each place is a little different. They need some more tools and then more nurses would be leaders and be more successful if perhaps they understood that there are many things that they can do without asking permission that they will not get smacked for or get fired for. And those things are within the scope of nursing. (T#6N)

> (The SALSA) is going to have to be a person who can really organize and delegate. And very, very carefully. And have a good knowledge of home care, as well as SNF care. You kind of have to fall into both of those categories. (T#9N)

Non-clinical management must begin by augmenting their understanding of and respect for the SALSA role.

> If ED's (executive directors) bothered to really get to know what nursing does, they could play a huge role in help and support, because a lot of the SALSAs time is that emotional support and counseling, or just being a friend to these families. Why does the ED get to take a back role there? Maybe it's only in Connecticut although I do see this across the country. But in Connecticut in particular, we give ED's licenses <u>not to be involved.</u> (T#10N)

The next strategy is for companies to increase their respect for the SALSA role and their investment in the SALSAs professional growth.

> I don't understand why the SALSA, who is pivotal to the success of this type of community, holds an enormous amount of responsibility and accountability to the company, the residents, staff, the Department of Public Health—why there isn't more education—on going education, inservicing, team building—the things that are available for the ED. (S#8)

The next strategy is for the SALSAs to gain a greater understanding of and appreciation for the business requirements of assisted living.

> And until nurses can see that business model, value that, and learn how to translate, the wall is going to stay there. (T#6N)

The final strategy is for the SALSA and non-clinical management to acknowledge that their roles are complementary, not conflictual, and that both are essential to the continued functioning of the assisted living setting.

> Each time there is something new there aren't a lot of in-house resources. There is no Infection Control, there is no Staff Development. It is a team effort with the executive director and the nurse to make all of this happen. (T#7B)

> You better respect each other and be able to count on each other because you're gonna need each other. (T#8B)

Changing an existing power dynamic is never simple. But efforts in this direction are important for assisted living to maintain its creativity and flexibility. It was significant to note that the majority of strategies to impact nursing owning its professional authority were suggested by members of the theoretical sample and not the SALSAs. This reality is symptomatic of feelings of powerlessness within the situation and believing that changing the existing conditions were not likely or possible.

Consequences Related to the Category of Owning Authority

The SALSA carries the regulatory responsibility to assume a leadership role within the assisted living environment and exercise that authority by making accurate clinical assessments and recommendations. Both the SALSA and the non-clinical management create outcomes that are at odds with their intended purpose for resident well-being and clinical care. The consequence of unassumed clinical leadership is dire.

Communities can be faced with escalating resident care needs with inadequate clinical supports to provide care,

> They need to learn to say if you let this person come in you're biting off a huge lawsuit, which is a disaster waiting to happen, or something like that. It would be more effective. (T#13B)

> . . . being seen as. . solution seekers. (T#10N)

increasing SALSA dissatisfaction and turnover,

> Because at the end of the day I have to love what I do, feel challenged, but feel validated and feel that, that I can provide the services that I'm paid to do. And if that doesn't happen, I'm gone. S#16)

and occupancy decline leading to financial constraints.

> I also have to really buy into the pre-assessments and get somebody else in here. So, I spend a lot of time doing pre-assessments and I think that some SALSAs don't see that the value of that lost revenue of me being out in the community doing pre-assessments because they don't understand that relationship between the two. (S#6)

The explanatory analysis of *Owning Authority* has conceptualized a critical set of relationships that establish the conditions that lead to the relinguishing of authority by the SALSA, the strategies that are often suggested by those from the theoretical sample to exercise clinical leadership and the significant consequences that result from the overall situation. This study has afforded multiple examples of non-clinical management's propensity to discount clinical judgments and exert pressure solely for the purpose of maintaining or increasing census. The consequences of this method of operation include jeopardizing resident care; risking regulatory citations; declining resident/family satisfaction; diminishing community reputation; rapidly extending parameters of care beyond the community's capacity; and experiencing SALSA turnover and related destabilization of the assisted living community. Reciprocally, if the SALSA relinquishes the legitimate authority that is assigned to the role, the process will include tolerating census-related pressure, submitting to having clinical judgments overruled, resigning to the preference for census over resident care, and consenting to the continuation of inadequate management information related to the responsibilities of the role. The consequences of this continued process leads to a devaluing of the SALSA role, rapidly escalating resident

acuity, increasing resident/family dissatisfaction, expanding licensed staff dissatisfaction, and ultimately the destabilizing effects of SALSA turnover.

Root Theme: Dis-congruence

The root theme of the grounded theory analysis was a central organizing dimension that tied together the primary themes that were identified in the analysis. The root theme contributes to the underlying understanding of the experience and the meaning that respondents bring to the interview. The root theme in this interview analysis is *Dis-congruence***.** This is different than a theme of incongruence, which would suggest an environment that simply contained unrelated elements. Dis-congruence implies a setting in which harmony and compatibility is out of alignment; a setting filled with elements that create incompatibility and disharmony. The coinage of the word, *Dis-congruence* attempts to capture the essence of the dynamic and systemic lack of congruency across the definitions of the SALSA role, the misaligned expectations of the boundaries and responsibilities within the role, and the absence of authority that is exercised within the role. Each of these elements relate to the described themes of *Defining, Expecting* and *Owning Authority* and their explanatory analysis of conditions, strategies and consequences. *Dis-congruence* appears to account for the inability of census and care priorities to converge operationally in an effectively aligned way; and the discrepancy within the assisted living environment related to who has or assumes the authority to define the priorities and describe the business.

> The major challenges I would say, owners are misaligned, owners are about the bricks and mortar that keep money coming in. And nursing is about the health and wellness and all the challenges that go along with that. There's no alignment. (T#10N)

> One of the major problems for assisted living is that so many of the the owners or key corporate people view it as a housing industry. It's simply that's the way that assisted living was originally conceived. That

> is what investors generally understand it to be. And care is secondary. (T#13B)

> The vast majority of assisted livings in Connecticut if we looked back, probably opened up thinking they were going to, you know, have many more independent living beds and have now converted over to having people on service and having assisted living beds. I think this was driven by aging in place but also by financial gain, by offering less independent beds and bringing people in who are much more needy, having many more medical needs. (T#6N)

Lack of conformity between (a) what the assisted living business was created to be and what it has evolved to, (b) what each of the principle participants—residents/families, companies and clinical experts—identify as primary issues that materially impact their expectations of each other and the setting, and (c) who has the authority to make the decisions and manage the environment creates a situation that is fraught with misunderstanding. With even the best of intentions, this situation would be characterized by episodic chaos and inherent complexity.

A review of the explanatory analyses, taken together, reveals the curious phenomenon that strategies in this setting are most often unsuccessful in realizing positive consequences. The interrelationships between perspectives, power and purpose that both the situational analysis and the grounded theory interview analysis brought to light reinforce a strong impression of the fragile tenacity that assisted living environments in Connecticut display. The overpowering force of the system of care generally assures that efforts taken by individuals to alter existing dynamics and initiate change will be met with defeat. A sincere commitment to the philosophy of assisted living coupled with a desire to enhance quality of life for elder residents, values espoused by all interview participants, is not enough to overcome the intensity of the longstanding systemic status quo.

Dis-congruence is a root theme that was conceptualized as a central process in the dynamic interplay of this situation. In the next section, I will present a theoretical modeling that

integrates across the findings of the situational and interview analyses. The root theme, *Dis*-congruence, plays a central role in conceptualizing the relationships between the primary situational forces inherent in *Company, Customer* and *Clinical Expert* arenas and the themes of Defining, Expecting and Owning Authority, leading to a deeper understanding of the SALSA role within this situation. The dis-congruence that the situational analysis and grounded theory interview analysis explicated was a systemic condition that involved and energized the entire assisted living environment. It was the root similarity that wound its way through all aspects of the business.

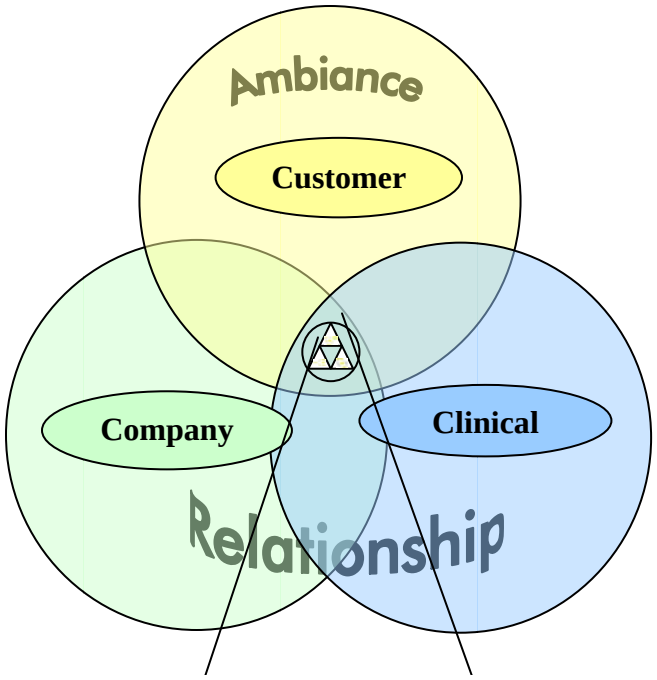
Theoretical Modeling of the Findings from the Situational and Interview Analyses
Systemic Dis-congruence in Assisted Living

The final stage of analysis in this study involved the integration of findings from the Situational and Interview analyses. Integration of these findings is dependent on the researcher's full understanding of the situation and the analyses of data. It is not a full theory that is proposed, but rather a *theoretical modeling process* that incorporates the primary findings of the study and serves to explain the relationships among these findings. This model incorporates the turmoil that innovative operational designs can prompt. The schema entitled Primary Theme with Categories and Root Theme (Figure 4) represents the integration of findings from the Primary Situational Areas (Figure 3) of Company, Customer, and Clinical Expert and the primary themes of *Defining, Expecting*, and *Owning Authority* that the grounded theory discourse analysis revealed. The root theme of Dis-*congruence* has been conceptualized as the underlying process that emerges from the primary themes of *Defining, Expecting* and *Owning Authority* and flows through each of the situational areas of Company, Customer, and Clinical Expert. The inherent *dis-congruence* within the situation creates a stabilizing tension that holds together the conflicting perspectives and external pressures, but still allows a certain flexibility within the

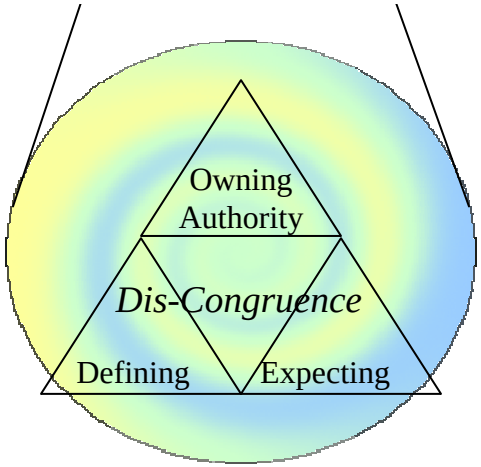
situation**.** Thus, although the environment contains multiple issues that are viewed from substantially differing and conflicting perspectives, it is still possible for the system to maintain itself albeit not without some degree of friction. Perhaps a helpful analogy is the way opposing muscle groups work together to allow the body to stand erect. As long as the dynamic stress between the opposing muscles remains functional, walking upright with an ease of motion is maintained. If the tension within the musculature alters disproportionately for any reason, functional stress becomes dis-stress. In light of the conceptualized role of dis-congruence across the entire system, the *theoretical modeling* has been referred to as Systemic Dis-congruence in Assisted Living.

Figure 5 represents the full model developed from the findings of this study. It is apparent from the figure that the previous figures illustrating the situational and interview analyses have been adapted to illustrate the relationship across all major findings of the study. The intersecting circles of the Primary Situational Areas, Company, Customer, and Clinical Expert (see Figure 3) within the assisted living environment are depicted in the upper left corner of Figure 5, in a stable state when the inherent tensions both within and external to the operation sustain functionality. The interview analysis, highlighted in the primary themes of *defining*, *expecting* and *owning authority* (as represented in the Figure 4 triangles and repeated in the lower left corner of Figure 5), reveals that typically the system is able to maintain this functionality. In usual circumstances, the shared commitment of staff to provide service and care to the

Primary Situational Areas



Primary Themes



Stabilization
Aligning Values

INTERNAL OR
EXTERNAL CRISIS

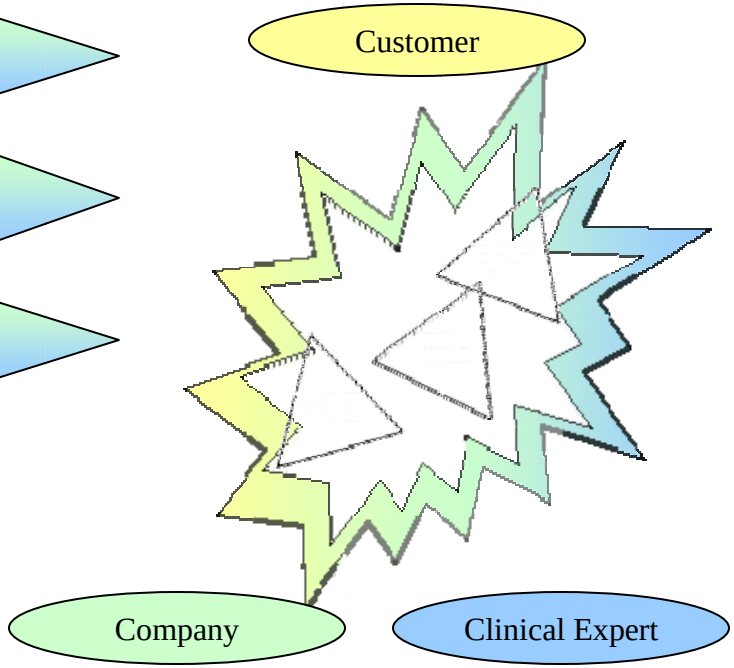
Senior Housing

Aging In Place

Care

Overruling Clinical Decisions

Respect of SALSA



De-Stabilization
Conflicting Values

Systemic Dis-Congruence in Assisted Living

customers was maintained in spite of considerable stress experienced in the SALSA role and in the overall assisted living environment, represented by the swirling colors contained in the circle in the lower left corner, that depict the primary themes embedded in the situation. However, tolerance for any increased stress from sources both internal and external to the system can result in increased volatility (see arrows in Figure 5), and subsequent crises When that happens, the stabilizing tension of *dis-congruence* snaps and the tenuous balance of forces from the Company, Customer and Clinical Expert can be destroyed (see exploded space in Figure 5).

The voices of the participants speak to the type of crises that were most likely to de-stabilize the system. These crises emerged from any one of the primary situational areas: (a) census decline for the Company, (b) dissatisfaction with care and services for the Customer, and (c) SALSA turnover for the Clinical Expert (See Figure 5, rounded arrow indicating 'internal or external crisis'). Often, these crises were interrelated, as when decreased census caused the Company to exert pressure to admit residents that the Clinical Expert assessed as too frail for assisted living, resulting in the Customer's dissatisfaction with the care provided and possibly also in the SALSAs' resignation. Oftentimes the system's response to externally generated initiatives, such as new regulations and legislation, or changes in company policies and procedures resulted in destabilization, especially of the assisted living community also had sufficient staff turnover that resulted inconsistency as a significant artifact of the operation. In other words, organizational responses to internal crisis and external pressures, especially in the presence of dis-continuity and unpredictability, were not adaptive or functional. The model proposes that it is the inherent fragility with which the stabilizing tension of *dis-congruence* holds the various competing perspectives together that contributes to this lack of systemic flexibility. The model suggest that if the stabilizing tension was one of similarity of perspective

or perhaps transparency regarding conflictual positions, the community would experience a period of disequilibrium as its members transitioned to tolerate and integrate the new change in the environment (see left side of Figure 5, labeled ‘Stabilization: Aligning Values’) but would not undergo the systemic dis-congruence that more fundamental perspectival or interpersonal disparity caused. In the next chapter, I will discuss the implications that this theoretical modeling has for the operations of assisted living, the role of the SALSA within this situation, and future research that could further explore these findings.

CHAPTER V: DISCUSSION AND IMPLICATIONS

This study used situational analysis and grounded theory discourse analysis to examine the role and experience of the registered nurse who is the chief clinical leader, the supervisor of assisted living service agency (SALSA), in assisted living settings in Connecticut. The role and the setting jointly created the unique situation that contained the study. In this chapter, I will present the background of the study, a brief overview of the findings, a theoretical model that integrates the primary findings of the situational and thematic analyses, the research limitations, and implications for research, practice, and policy.

Background of the Study

This study explores the gap between the familiar healthcare atmosphere, with its prevailing view of "practitioner as expert," and the innovative assisted living environment. Assisted living is congregate living but is not exactly home care; it includes various levels of clinical intervention but is not exactly health care; and it involves renting/purchasing separate apartments but is not exactly living independently. Assisted living in Connecticut is an amalgam that does not neatly conform to conventional classifications of either housing or health care. Rather, it represents an innovative model created in response to the social phenomenon of aging and the elder citizens' preference for choice, dignity, and independence. This unique situation sets the stage for both creative solutions and frustrating inconsistencies. Societal values generally viewed as laudable collide in this setting. Independence can clash with assistance; private bumps up against congregate; choice conflicts with safety; and profit intimidates care. These realities cause as much disequilibrium as discord as the various primary players bring along their underlying personal assumptions of social value, power, and role. The unique assisted living

situation requires that these fundamentally divergent notions operate coherently within the company structure. The organizational tension that this situation produces fosters the innovation the business needs to evolve while simultaneously creating operational resistance that could threaten stability.

Brief Overview of the Findings

The composite results of situational analysis mapping and grounded theory discourse analysis create a picture of disparity, complexity, and leadership opportunity. Three schematics have been created to illustrate the complexity and nuance of the situation. The first schematic addresses the foundational structural elements in the situation (reference Chapter IV, Figure 3, Primary Situational Areas) related to the *Company,* the *Customer*, and the *Clinical Expert*. The second schematic (reference Chapter IV, Figure 4, Primary themes with Categories and Root Theme) depicts the Primary Themes (*Defining, Expecting, and Owning Authority*) that weave within and between each of the Primary Situational Areas and that are bound together with the operational tension of dis-congruence. The third schematic presents a theoretical model that concentrates on the interrelationship between the Primary Situational Areas and the underlying themes that describe the situation of assisted living in Connecticut. This third schematic depicts operational destabilization that systemic dis-congruence can cause (reference Chapter IV, Figure 5, Systemic Dis-congruence in Assisted Living

Primary Situational Areas

The first schematic is The Primary Situational Areas map (Figure 3). This model identifies the three primary players within the situation—the Company, the Customer (residents/families), and the Clinical Expert (the SALSA). This model illustrates the two aligned topics (Ambiance and Relationship) and the five conflictual topics (Senior Housing, Aging in

Place, Care Planning, Overruling Clinical Decisions and SALSA Respect) that were derived from the discourse analyses and that identify specific issues common to each of the three situational elements but that represent significantly different understandings and impacts.

Primary Themes

The grounded theory discourse analysis discovered primary themes that were foundational to the conflicting perspectives and the organizational dissonance that was identified within the situation of assisted living in Connecticut. These themes were derived from the interview analysis with 13 SALSAs and the 11 members of the theoretical sample who had both business and clinical experience with assisted living. These themes are characterized as *defining, expecting, and owning authority*.

The *Theme of Defining* refers to the lived perspective of the SALSA role in assisted living. The *Theme of Expecting* relates to assumptions of individuals and groups regarding the assisted living environment. It includes understandings of information and influence that is used by people with varying priorities and perspectives. The *Theme of Owning Authority* is related to the SALSAs owning of their legitimate professional authority within their role as clinical expert in the assisted living setting. This theme surrounds the influence dynamics that are inextricably implicated in the Connecticut model of assisted living.

The thematic model (Figure 4) presents three triangles that contain themes that are contained within and between each of the Primary Situational Areas but that also are held together by the dynamic tension of Dis-congruence. The categories represented as circles associated with each of the themes of *Defining, Expecting, and Owning Authority* derive from the five conflictual areas represented in Figure 3. In this way, the five conflictual topics included in the Primary Situational Areas in Figure 3 (Senior Housing, Aging in Place, Care Planning,

Overruling Clinical Decisions and SALSA Respect) are interpreted by the specific participant in ways consistent with their particular area of interest. This model allows the differing perspectives that each theme explicates to become visible, as described in the findings in Chapter IV.

Root Theme

The complexity and lack of cohesion in interpretation that the situational analysis and grounded theory discourse analysis reveals contributes to the identification of the root theme of systemic *dis-congruence* within the assisted living environment in Connecticut (Figure 5). This is different than a theme of incongruence, which would suggest an environment that simply contained unrelated elements. Dis-congruence implies a setting in which harmony and compatibility is out of alignment; a setting filled with elements that create incompatibility and disharmony.

The root theme of *dis-congruence* allows senior managers and investors, residents and families, and the SALSA to perceive the business of assisted living from fundamentally different perspectives that create varying definitions and expectations.

Increasing acuity /frailty and aging in place (Frank, 1994; Golant, 2004; Mason, 2003; Mitty, 2003, Mollica, 2005; Wallace, 2003) factors in all situations represented in this study regardless of the business model espoused by a specific community. The SALSAs' clinical vantage point allows them to identify residents' intensifying healthcare needs and their resultant escalating clinical management requirements. This perspective, however, was significantly different from that of the Companies, creating an environment in which SALSAs often had their input ignored or discounted. Despite this dynamic, the SALSAs often unwittingly collude with the companies to maintain the status quo of the assisted living environment as they continue to carry out the full responsibilities of providing the needed resident care.

This situation is complicated for the SALSAs, who are regularly subjected to considerable risks regardless of the decisions that are made. If the SALSA opposes a family's preference for choice over safety, the SALSA risks the family's displeasure and the resident's endangerment. If the SALSA allows non-clinical management to dictate the clinical course, there is the risk of colluding in the creation of an unsafe situation for the resident, disavowing professional responsibilities, and disregarding the accountability that the assisted living regulations ascribe to the SALSA role. If the SALSA does not embrace the authority that her role requires and does not assert it in appropriate situations, she risks reifying that disenfranchised position. And if the SALSA refuses to accept the authority of non-clinical management in clinical decision making, her options are to resign or risk being fired.

Similarly, dis-congruence in definition and expectation creates risks for families and companies. These risks pertain to lack of definitional consistency related to care parameters with resultant misaligned expectations that create poor resident outcomes and community reputations.

Theoretical Model: Systemic Dis-congruence in Assisted Living

The schema entitled Systemic Dis-congruence in Assisted Living (Figure 5) was developed on the foundation of the Primary Situational Areas (Figure 3) of Company, Customer, and Clinical Expert that the situational analysis identified. Embedded within these areas are the primary themes of *Defining, Expecting,* and *Owning Authority* that the grounded theory discourse analysis reveals. These primary themes explicate the underlying conflicting perspectives and influences that the explanatory interview analysis illustrates. The conflicting situation incorporates factors within, between, and among the primary situational areas but also encompasses factors external to these entities, namely the regulatory and legislative environment, and corporate and national Web-based information. The Systemic Dis-congruence

in Assisted Living (Figure 5) exposes the tenuous balance that this complex situation maintains. Complex contemporary organizations such as assisted living facilities in Connecticut must respond to uncertainty, variability, and unpredictability while operating in an environment defined by rapid change. The *dis-congruence* is always present, like the stress on opposing muscle groups. The factors that create distress within the organization can impact its existing functionality and produce systemic *dis-congruence* that can quickly undermine both the work and the business of assisted living in the state.

Discussion of the Findings

"The primacy of the whole suggests that relationships are, in a general sense, more fundamental than things, and that wholes are primordial to parts. We do not have to create interrelatedness. The world is already interrelated" (Senge, Kleiner, Roberts, Ross, & Smith, 1994, p. 25).

In the complex, interrelated and fast-changing world of assisted living that this study depicts, even the slightest change can have unpredictable results. This study acknowledges that the landscape is not stable. New thinking regarding whole systems approach and complexity (Capra, 1996; Senge, 1990; Wheatley; 1992) underscores the importance of creating and maintaining stability at the core to reinforce the community's ability to withstand episodic disturbances. Because of the interconnected nature of the assisted living situation in Connecticut, it would be possible to effect a systemic change by employing well-placed interventions within any one of the sections. This concept draws its inspiration from the so-called "butterfly effect." This refers to the meteorologist Edward Lorenz's discovery in the 1960s that large-scale consequences can be realized in complex systems as a result of minute initial changes (Capra, 1996). This theoretical assertion supposes that a butterfly stirring the air today in Beijing can

cause a storm in New York a month later. Assisted living communities in Connecticut experience the effects of this premise when residents and families acknowledge their preference to exercise choice in remaining in their home as they age in place. Organizational change initiatives have recognized that an intervention that affects any of the conditions within the environment will shift the dynamic and result in changes to the other conditions. Senge, Kleiner, Roberts, Roth, Ross, & Smith., (1999) assert that the

> challenges of profound change are dynamic, nonlinear, and interrelated. They are dynamic because they arise from balancing processes that naturally "push back" against efforts to change. They are "nonlinear," in the sense that you cannot extrapolate reliably from one experience to another. In a different setting, with only a few small distinctions, a given challenge may play out entirely differently. Last, they are interdependent. Addressing one can increase the challenge of addressing another. Or, in other cases, make it easier. (pp. 557-558)

The Theoretical Model of Systemic Dis-congruence (Figure 5) depicts the primary themes that can, with aligned values, stabilize the primary situational areas despite environmental complexity. Subtle changes that originate in one area can impact all areas. This 'Butterfly Effect' can be visible under many circumstances. Some examples are: (a) residents/families dissatisfied with services or care voice their complaints or move out; (b) SALSA dissatisfied with non-clinical management overruling clinical decisions assumes a more assertive position in describing aging in place parameters and in recommending alternatives to families; (c) company can initiate marketing strategies that reward appropriate levels of care and not simply admissions.

The grounded theory analysis reveals the SALSAs rather pervasive feelings of misunderstanding (the primary theme of *defining*), confusion (the primary theme of *expecting*), and disempowerment (the primary theme of *owning authority*). Weinberg describes similar feelings in nurses who experienced the merger of Beth Israel Hospital and Deaconess Medical

Center in Boston (2003). Laschinger has often researched the influence of Kanter's (1977) model of structural power in organizations on nursing practice (Laschinger, 1996; Laschinger et al., 1997). Gordon (2005) has written passionately about power dynamics affecting nursing. The message conveyed in these various studies is that the specific issues identified in assisted living facilities in Connecticut are consistent among nurses throughout the healthcare arena. In fact, the persistent explanation for nurses' dissatisfaction with their jobs has been their inability to control their own practice (Bednash, 2000; Buerhaus & Staiger, 2001; Gordon, 2005; Havens & Aiken, 1999; Sochalski, 2002).

Sensitizing concepts enumerated in Chapter II anticipated several of these issues. Patriarchy related to nursing identifies the persistence of socially defined roles that describes nursing. Power related to nursing appears in this study in a variety of ways: (a) the lack of a '. . .voice of agency" (Buresh & Gordon, 2006, p. 5) that the *Theme of Owning Authority* describes; (b) the structural conditions contained in the SALSA role and the assisted living influence dynamic with the executive director that withholds resources, information, and support (Kanter, 1977); and (c) the expressions of powerlessness visible within the *Themes of Defining* (lack of adequate SALSA orientation; inadequate boundary definition), and *Expecting* (the pattern of non-clinical managers overruling clinical decisions), and *Owning Authority* (legitimate professional authority removed by non-clinical management or relinquished by the SALSA). Additionally, the pattern of non-clinical managers overruling SALSAs' clinical decisions disparages the knowledge and professional experience of the clinical expert; while non-clinical management's lack of knowledge of or respect for the complexity of the SALSA role reinforces the gendered nature of the assisted living environment While it is clear that these issues have been evident throughout nursing's history, their presence within the assisted living environment

appears more nuanced. Autonomous nursing practice was written into Connecticut's assisted living regulations in 1994. The significant dilution of that expectation of autonomy and its current abated reality engenders far greater reliance on or acceptance of non-clinical governance of nursing practice (Theme of Expecting). SALSAs experiencing the pressures of this governance, especially in the face of increasing demands for more astute healthcare management, generally see the imbalance in this situation but seem relatively unable to construct more suitable limits (Theme of Owning Authority). Because physicians are only episodically present in the assisted living environment, the SALSA has the role of clinical authority and decision-maker. The absence of physicians was anticipated by the sensitizing concepts; the actual depth of nursing's downgraded legitimate authority was not.

The primary Theme of *Owning Authority* identifies the reciprocal power dynamic that is observed when authority is removed and/or relinquished. Throughout the interview process, SALSAs and members of the theoretical sample acknowledge the responsibility, accountability, and frequent ineffectuality of the SALSAs' role and their performance within it. Although the SALSAs display professional demeanor (Schoenhofer, 2002), clinical expertise (Benner, 1984), and deep dedication (Cummings, 2004; Locsin, 2002) they also express frustration with feeling both persevering and devalued.

Making changes to this existing dynamic requires (a) SALSA realization that developing or retrieving their sense of professional agency and authority is essential; (b) Company acknowledgement that the SALSA role is integral and not tangential; (c) Company acknowledgement that a mutually authoritative relationship between the SALSA and the non-clinical manager is most beneficial to the success of the enterprise; (d) SALSA seeking and incorporating behavioral change strategies such as (1) language that more clearly identifies

clinical issues to non-clinical management, (2) deeper understanding of business parameters of the assisted living environment, (3) coaching and mentoring in leadership behaviors; (4) broader definition of SALSA influence to extend beyond clinical expertise and embrace operational leadership.

Any change initiative creates a disturbance in the accepted way of viewing authority relationships, even as it can simultaneously strengthen the inherent systemic tensions by creating more parallel operational dynamics. A cohesive, stable, and mutually respectful leadership structure within the assisted living environment will reinforce its ability to withstand episodic and unpredictable organizational challenges. These are the factors that, when absent or simply insubstantial, can result in Systemic Dis-congruence and lead to operational decline, as depicted in Figure 5.

Initial organizational changes that would have minimum operational disruption but an immediately positive impact on SALSAs' satisfaction with their role include aggressively resolving the issues of (a) on call and (b) clerical support, and ensuring (c) thorough orientation for the SALSA along with (d) ongoing peer support. The next critical fundamental change would involve (e) immediately stopping non-clinical managers from overruling the SALSAs' clinical assessment recommendations. This alteration in business operation would likely have deeper organization-wide repercussions; whether positive or negative would remain to be seen. Reducing the business disruption caused by frequent SALSA turnover could go a long way toward enhancing census and resident/family satisfaction goals. Organization-wide change initiatives would require recognizing existing composite operating assumptions and developing processes to create more stable coherence. The fundamental complexity and interrelatedness of the Connecticut assisted living model demands that any significant change initiative be

thoughtfully considered, respectfully implemented, consistently supported, and effectively followed up (Olson & Eoyang, 2001). The confluence of the (a) aging of the population, (b) increasing frailty of residents and development of dementia related services, (c) increasing nursing shortage, (d) increasing scrutiny of regulatory bodies on assisted living settings, and (e) increasing family discrimination related to expectations of care creates powerful incentive for SALSAs and their assisted living organizations to change ineffective practices along with unsuccessful behaviors.

Limitations of the Study

In this section I will discuss the limitations I believe exist in this study. First, relative to the subject of transferability, the areas that have had an impact are (a) scope of the sample, (b) the exclusive focus on the state of Connecticut, and (c) the data composition with respect to both proprietary and not-for-profit assisted living communities. The second limitation refers to my role as an involved and knowledgeable practitioner. The last limitation is concerned with dependability and addresses the grounded theory methodology and the decisions that were made to highlight certain themes and background others.

Sampling Limitations

The picture presented in this study reflects the abundant detail created by the voices of the people who participated—the SALSAs who volunteered their contribution and the members of the theoretical sample whose input was sought. Different voices might have offered alternative comments that could have prolonged the study before saturation was achieved, or could have offered more divergent views than the people in this sample shared. Adding residents and/or family members to the theoretical sample could have broadened the overall perspective and provided more depth and nuance to the underlying theme explication.

The experience of nurses exercising leadership in states with different regulatory environments would present a more comprehensive view of the actual situation of assisted living from a regional or national perspective.

The composite of data from proprietary and not-for-profit organizations could be separated to contrast the comments and develop matrices more reflective of issues specific to each business design. Only one SALSA in the sample had experience in assisted living environments of an affordable nature (Medicaid-funded program). All other respondents had experience with proprietary and nonprofit communities that catered to a private paying clientele. Assisted living is predominantly a proprietary business, but more affordable options are being developed in many states, including Connecticut. A study of this trend and its particular complexities would be informative.

My Role as Researcher

As discussed in Chapter I, my broad background in the healthcare field and recent experience in assisted living has afforded me a unique point from which to view the situation. The research team of colleagues not knowledgeable in the healthcare arena provided the balance to my insider familiarity. Most of the SALSAs who volunteered to participate in this study had not been known to me prior to our interview, but they were aware of my involvement with the Connecticut Assisted Living Association (CALA). It is a challenge to be simultaneously within and outside. However, I was struck by the candor with which all participants shared their views. Many of their comments were provocative, but they acknowledged a belief that their identities would be protected and a feeling that the information was critical to share—they welcomed the opportunity to have their voices heard. It is hard for me to know if there were issues of catalytic or tutorial authenticity. The open-ended question with which I entered all interviews afforded the

participants the freedom to move in a direction of their choosing. All participant responses were reported in a balanced manner within the study. The relatively early point at which saturation was achieved in the interviews with the SALSAs suggests significant uniformity of issues. Members of the theoretical sample also reinforced this consistency.

Research Decisions

All studies require sifting and selecting data. The choices I made led me to the place of my arrival—different choices might have resulted in a different destination. Grounded theory is often criticized by scholars for this perceived threat to dependability. The situational maps and coding lists plot the initial data composition and identify roads not taken. The volume of individual quotes chronicle both differences and corroboration of participant perspectives. The underlying themes derive directly from the source documents in a readily traceable fashion.

An original concept of the study related to the relationship between nurses and physicians in the assisted living setting. While this subject has engendered a great deal of study in other settings over the years (Partridge, 1984; Porter, 1991; Stein et al., 1990), it was not reinforced by the participants as a challenging issue. In fact, any comments made relative to relationships with physicians were positive and reflected a sense of professional collaboration. However, the lack of physician presence in the leadership dynamic within the assisted living setting potentially creates space for nursing leadership to emerge. The theme of O*wning Authority* describes the fundamental difficulty that the SALSAs experienced in filling that space. Clinical expertise was consistently demonstrated by the SALSAs. Confidence in operational authority and leadership in a broader context were not.

Comments related to the nursing shortage were made frequently, but were offered relative to recruitment problems and not addressed as the business-altering subject it is predicted

to become in Connecticut within the next ten years. It is helpful to note that in order to begin addressing these critical nursing shortage issues, the University of Connecticut School of Nursing convened its first 'Nursing Summit' in February 2006. This meeting united nursing professionals from practice-based areas, education, hospitals and other healthcare settings to identify creative and cooperative action plans for addressing the existing and projected shortage in Connecticut (University of Connecticut, 2006). The high turnover rate among the SALSA group is an issue with which the assisted living communities in Connecticut must soon come to grips. Nursing shortages historically have been fueled by nursing's frustration with lack of control of its own practice and dissatisfaction with the work environment. This study has highlighted that similar frustrations and dissatisfactions exist in the non-healthcare environment of assisted living. Regulations in Connecticut require the presence and professional involvement of registered nurses. Increasing resident frailty and cognitive impairment necessitates the active involvement of experienced and astute clinicians. Operational disruption, described in the theoretical model of Systemic Dis-congruence, results in resident/family dissatisfaction, regulatory non-compliance, and financial loss. All these realities, identified in the sensitizing concepts in Chapter II, create an impressive impetus for organizational change.

Implications for Research

Literature searches on the subject of nursing leadership yield articles focused primarily on clinical practice. The fact that nursing is a practitioner profession reinforces the logic of this reality. Although the volume of research in assisted living is sparse, it is increasing. However, the historic predominance of research in this area relates to public policy, regulations, model design in different states, and resident/family perspectives. Nursing in assisted living has not garnered significant interest as yet, although there have been recent articles identifying the

complexities of (a) increased resident frailty and aging in place (Ball et al., 2002; Bernard, Zimmerman, & Eckert, 2001); (b) family satisfaction (Edelman et al., 2006); (c) admission and continued stay criteria (Kissam et al., 2003; Phillips et al., 2003), and (d) measuring the quality of care in assisted living (Aud et al., 2007).

As this study shows, nursing presence in assisted living is a noteworthy issue. The operational and regulatory environments found in various states present rather different perspectives on the role of the nurse in this setting. However, the Future Forum conducted by the Assisted Living Federation of America (ALFA) in 2006 reflected the belief that assisted living settings nation-wide are resembling skilled nursing settings and skilled nursing settings are resembling acute care settings. This reality signifies potential or existing changes in levels of resident frailty across the country. There is real need for further research addressing the myriad issues suggested by the innovation of the assisted living model, the increasing frailty of elders in the nation, the nursing shortage, ethical issues related to healthcare access, and the impact of affordable housing alternatives, to name a few. This project contributes to the understanding of leadership processes within a practitioner culture that has historically been influenced or controlled by separate professional bodies. The importance of this study to the field of leadership and change relates specifically to the confluence of events and adjustments that currently exist and are expected to increase in importance in the near future. These events include (a) the prevailing fear surrounding an anticipated need for increased clinical involvement and oversight by nurses caused by the most noteworthy age bubble in history; (b) the significant nursing shortage currently being experienced in most industrialized countries that is predicted to intensify as a result of a variety of factors, among them nurses' discontent with their current role as well as the existence of more satisfying career alternatives; and finally, (c) the changes in

health care that have been well described and are anticipated to continue and increase in type and frequency over the coming decades. In order to contribute most effectively to the further development of professional practice models, nurses must develop a greater comfort with and capacity for exercising leadership both within their own unique sphere and in relation to larger operational contexts. The alteration in perspective that this change suggests is a focus on operational leadership as an entity related to but separate from clinical expertise. Nursing's caring foundation and commitment to patient advocacy need to be better understood within an operational leadership construct. Gaining a greater understanding of the exercise of leadership by operational professionals as well as expert clinical nurses, the contextual elements that enhance or inhibit this leadership maturity, and the impact that this leadership has in an environment without typical external structures could materially contribute to the actual development of personal and professional agency that is a basis for effective leadership.

The theoretical model of Systemic Dis-congruence could benefit from deeper research related to its (a) operational construct, (b) responsiveness to leadership interventions, (c) impact on evolving as well as established organizations, (d) impact on the members of those organizations, and (e) ability to predict developing operational instability.

Implications for Practice

The focus of this study has been the nurses in the role of supervisor of assisted living services agency (SALSA) in Connecticut. The results have revealed that the SALSAs often experience decreased autonomy and empowerment within this situation. Their clinical authority, which is mandated by regulation, is often second-guessed or overruled by non-clinical managers. The manner in which the SALSAs' authority is removed is as complex as the business itself. The processes include (a) operational priorities overtaking clinical knowledge, (b) the SALSA

remaining responsible for the clinical outcome, (c) reclaiming legitimate authority requiring the SALSAs to confront their supervisors, (d) the supervisors often being motivated by corporate priorities and unaware of potential clinical consequences, and finally (e) the SALSAs accommodating for being disempowered until the consequences to residents become too great or their personal tolerance for an increasingly overwhelming environment is reached.

Change is difficult. Organizational change is very difficult. Disparate power dynamics exist is most organizations. The confluence of those who understand and perform the work and those who manage and direct the workers is both age-old and increasingly complex as more rapid environmental change and unpredictable events create situations in which organizational stability is threatened. Every component of the health care industry has experienced monumental change over recent decades. Assisted living, as an innovative entrepreneurial venture, is just coming into its adolescence, with all the turmoil that stage includes. The complex organizational situations identified in this study reflect both the larger environmental instability and the more parochial assisted living situation. The SALSA role in this rapidly changing, multiply influenced setting is, by design, also experiencing modification.

This study brings forth the possibility of multiple practice implications. Among these are organizational changes that (a) alter the definition of assisted living to include a clear acceptance, by all players, of the presence and requirement for clinical expertise; (b) amend the pattern of non-clinical managers overruling clinical judgments, (c) create a space for a professional conversation relative to conflicting priorities of census and care; and (d) respect the role of clinical expert within the leadership structure. The nurses also must be open to change. Changes that the nurses would benefit from include: (a) understanding the operational context within which clinical service is rendered; (b) reviewing their professional practice parameters to

embrace a leadership role that is different from clinical expertise; and (c) developing a broader conceptualization of their role within the overall operational context.

Change initiatives demand personal reflection, honesty and willingness to engage in the uncomfortable processes that are required. This recipe applies to individuals and organizations alike. While certainly a change in any aspect of the organization can have an effect on the larger entity, described in the 'Butterfly Effect', sustainable change requires significant mutual commitment. The confluence of nursing shortage, aging of the population, regulatory scrutiny, and elders' preference for choice and independence within a system of care may be exactly what is needed.

As Professional Practice Models are being developed that include Clinical Nurse Leader roles, the focus on operational leadership in addition to clinical expertise may be created. The SALSA role within the non-institutional environment of assisted living can become a model for incorporating the tenets of the Clinical Nurse Leader role in a setting outside the acute care environment.

The theoretical model of Systemic Dis-congruence can provide explanation for intermittent chaos amidst complexity. It can provide a context for the cumulative nature of becoming overwhelmed as a result of the confluence of multiple unpredictable factors. It can help practitioners understand subtle though substantial differences between environmental and personal responses to unexpected occurrences. It can provide one specific operational portrayal of the ". . . permanent white water" that Vaill so aptly describes (1989).

Policy Implications

Long term care has become one of the most regulated of businesses. If long term care settings provided the individualized services that assisted living settings provide, there would be

no market for assisted living. However, although elders and their families have embraced the assisted living model, quality issues are beginning to be identified in that setting. It is likely that a percentage of these perceived quality issues are, in fact, a result of stretching the boundaries of care appropriate to a senior housing environment as well as family misunderstanding and mis-alignment of expectations. Nevertheless, many states are responding by promulgating more regulations. SALSAs can assume a more forceful role in quality care delivery, at the community and state levels, to influence organizational and public policy. SALSAs can also contribute their insider knowledge and professional experience to participate in conversations that look to reinforce the non-institutional, resident-affirming philosophy that they value in assisted living, while discovering more innovative, non-regulation-confined ways to address increasing clinical management.

Magnet Hospitals have proven to deliver quality care while empowering nurses. Creating an assisted living model similar to Magnet Hospitals, with attendant requirements, would reinforce operational excellence and stability in the SALSA position without resorting to increased regulations.

The national conversation related to aging in place in assisted living communities is one that bears great scrutiny. As the boundaries of the assisted living setting in Connecticut are being expanded, appropriate concern exists regarding staffing to support this increase in acuity. The public policy debate relates to both the elder citizens' preference for the assisted living setting and the public payers preference for an option that is less expensive than skilled nursing. Again, the issue of staffing support is crucial. This study has identified situations in which 1 nurse is responsible for the coordination of care for 50 or more residents. Medication assistance by unlicensed staff, with nursing oversight, is being replaced by licensed staff administration of

medications as the complexity of resident care issues increases. The policy debate is a worthy one that requires close attention to values as well as environmental realities. SALSAs have intimate experience with the day to day challenges of an evolving assisted living model that can both inform and animate the public policy debate.

The issue of nursing preparation is an essential one. Practitioner preparation inherently focuses on the activities involved in the work that will be done. However, an important addition is the understanding of the context within which that practice will be exercised. The power dynamics of many health care organizations place nursing in a marginally influential support position. A deeper understanding of organizational leadership within the health care context is essential to give nurses the tools they need to exert influence related to their own personal/professional agency. Nursing curricula that incorporates a leadership and organizational perspective that is integrated within the overall context of study will reinforce the expectation that leadership roles are required.

The theoretical model of Systemic Dis-congruence (Figure 5) describes a world of unpredictability, confusion, incoherence, and fundamental instability. The innovative and evolving world of assisted living is such a setting. ‘Holding it together’ takes enormous effort. Elders, their families, public policy makers, assisted living companies, and nurses experience the benefits of this setting that honors personal choice, human respect, and dignity. Policy debates that hold dear the values that inspired the assisted living model while allowing for its evolutionary alterations can bring more clarity to the consequences of conflicting priorities that the theoretical model of Systemic Dis-congruence describes.

This study identifies the need for registered nurses to occupy their rightful place in the leadership structure of assisted living organizations. This position is different than the clinical

expertise that the SALSAs in this study consistently exhibited, and reflects a need for exercising personal agency relative to administrative and operational functions. It also recognizes that this role is a relatively new one for the nurse and one that the business environment may be dismayed about or unprepared for.

Inertia is a powerful force. If the nursing profession wishes to occupy a more authoritative and involved role than it has historically played, it will have to take on the tasks of learning new leadership behaviors as it concurrently manages the backlash from administrative groups that derive comfort from the familiar status quo. This is a formidable undertaking.

Nurses are not satisfied with their working environments or practice parameters. That reality is consistently demonstrated in research findings and practice, from traditional intensive care units to innovative assisted living settings. This study demonstrates that regulations that support autonomous nursing practice within a non-healthcare environment do not guarantee the existence of autonomous practice. The implications for practice relate to nursing's acceptance of its responsibility to itself and its courage to act in its own best interests—before it is too late.

It is not possible to study any type of elder care without considering privilege and access and societal assumptions related to value. It is not possible to study nursing without considering social views on caring and gender. It is not possible to study assisted living without considering the multiply conflicting social issues of choice and safety, care and independence, aging in place, dementia, and increasing physical frailty.

Assisted living has created a prism through which to view dimensions of aging and nursing that have not been as clear through other perspectives. As a people, we can avoid looking at the picture this prism reveals. But the picture will become more of a reality whether or not we choose to see it or reflect on it.

People will surely get older and need care. But nursing has a choice. Nursing can elect to discover, understand, and claim the power of a leadership role that requires legitimate professional authority; or it can fearfully select a safe but subservient paraprofessional status. Delaying will not improve the options. It is my sincere hope that nurses will realize their potential power and begin to exercise it, thus harnessing the breeze from butterfly wings that will animate the profession for the future.

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APPENDIX

Appendix A

Traditional Vs. Constructivist Grounded Theory

Traditional GT	Constructivist GT
Positivist/realist	Constructivist/relativist
Discovering/finding	Constructing/making
Theory of truth	Theory of knowledge production
A priori rejection of contradiction as possible	Representation of contradiction(s) as analyzed/interpreted
Simplification desired	Complexity represented
Seeks to be conclusive	Tentative, opening, jarring, troubling
(False/overdrawn) clarity	Ambiguity of representation
'Normal'/average plus 'negative cases'	Difference, range of variation, outliers, positionality
Tacitly progressive; linear	Doubtful; reads against the grain
Assumption of normativity	Assumption of positionality
Metaphors of normal curve	Metaphors of cartography
GOAL: To delineate a basic social process and formal theory	GOAL: To construct processes, sensitizing concepts, situational analytics, and theorize

(Clarke, 2005, p. 32)

Appendix B

Connecticut Public Health Code for Assisted Living, 19-13-D105

Assisted Living Services Agency

19-13-D105. Assisted living services agency

(a) Definitions. As used in this section:

(1) "Agency" means assisted living services agency.

(2) "Assisted living services" for the purpose of this section only means nursing services and assistance with activities of daily living provided to clients living within a managed residential community having supportive services that encourage clients primarily age fifty-five (55) or older to maintain a maximum level of independence. Routine household services may be provided as assisted living services by the assisted living services agency or by the managed residential community as defined in subsection (a)(13). These services provide an alternative for elderly persons who require some help or aid with activities of daily living as described in subsection (a)(4) or nursing services in order to remain in their private residential units within the managed residential community.

(3) "Assisted living services agency" means an entity that provides assisted living services.

(4) "Assisted living aide" means an unlicensed person who has successfully completed a training and competency evaluation program in accordance with Section 19-13-D8t(1), Section 19-13-D69(d)(2) or Section 19-13-D83(b) of the regulations of Connecticut State Agencies. An assisted living aide may assist clients with one or more of the following activities of daily living: ambulation, feeding, bathing, dressing, grooming, toileting, oral hygiene, transfers, exercise and supervision of self administration of medications.

(5) "Client" means the recipient of the assisted living services provided by licensed nurses or assisted living aides.

(6) "Client service program" means a written schedule of assisted living services to be provided to, reviewed with and agreed to by a client or client representative.

(7) "Commissioner" means the Commissioner of the Department of Public Health and Addiction Services, or the commissioner's representative.

(8) "Community" means managed residential community.

(9) "Core services" means the services described in subsection (c)(3) of this section which shall be made available in order for an assisted living services agency, for the purpose of this section only, to provide services within a managed residential community.

(10) "Department" means the Connecticut Department of Public Health and Addiction Services.

(11) "Full time" means on duty a minimum of thirty-five (35) hours per workweek.

(12) "Licensed nurse" means a registered nurse or licensed practical nurse licensed under chapter 378 of the Connecticut General Statutes.

(13) "Managed residential community" means a facility consisting of private residential units that provides a managed group living environment, including housing and services primarily for persons age fifty-five (55) or older.

(14) "Primary agency" means an assisted living services agency that contracts for the services of other organizations, agencies or individuals who provide care or services to its clients.

(15) "Private residential unit" means a living environment belonging to a tenant(s) that includes a full bathroom within the unit including a water closet, lavatory, tub or shower bathing unit and access to facilities and equipment for the preparation and storage of food.

(16) "Self administration of medications" means a client taking medication in accordance with directions for use and includes:

(A) the client removing an individual dose from a container of medications that have been ordered by a physician or health care practitioner with the statutory authority to prescribe medications and dispensed by a pharmacy or purchased over-the-counter by or under the direction of the client; or

(B) the client taking an individual or multiple dose(s) of medications that have been prepared or prepoured by a licensed nurse, family member or significant other and stored for client administration in the client's home.

(17) "Tenant" means a person who either owns, rents under a lease agreement or otherwise contracts for the use of the home within a managed residential community in which that person resides.

(b) Assisted living services agency

(1) If it is determined by the appropriate state agency that a certificate of need is required to operate an assisted living services agency, the certificate of need shall be a prerequisite to licensing.

(2) Application for licensure

(A) No person shall operate an assisted living services agency without a license issued by the department in accordance with Connecticut General Statutes, Section 19a-491.

(B) Application for the grant or renewal of a license to operate an assisted living services agency shall be made to the department, in writing, on forms provided by the department; shall be signed by the person seeking authority to operate the service; shall be notarized; and shall include, but not necessarily be limited to, the following information:

(i) a list of the managed residential communities where assisted living services shall be provided;

(ii) an affidavit attesting that assisted living services shall be provided only at managed residential communities that have complied with the requirements of subsection (c) of this section;

(iii) an affidavit attesting that assisted living services shall be provided on an individual basis to clients who fully understand and agree to the provision of services and are made aware of the costs involved prior to the initiation of

such services;

(iv) the total number of employees, by category;

(v) the services provided;

(vi) evidence of financial viability to include a projected two (2) year budget, with estimates of net income and expenditures, at the time of initial application;

(vii) a certificate of malpractice and public liability insurance;

(viii) a certificate of good standing, if applicable;

(ix) a statement of ownership and operation, to include, but not necessarily be limited to the following information:

(a) the name and address of each owner and, if the agency is a corporation, all ownership interests (direct or indirect) of ten percent (10%) or more; and

(b) the name and address of each officer, director and member of the governing authority;

(x) any relevant statistical information requested by the department;

(xi) the agent for service; and

(xii) a listing of the health care institutions or agencies owned or operated in other states, at the time of initial application.

(C) The assisted living services agency shall notify the department of any changes in the information provided in accordance with subparagraph (B)(i)(v)(vii)(viii)(ix) and (xi) of this subdivision.

(3) Issuance and renewal of license

(A) Upon determination by the department that the assisted living services agency is in compliance with chapter 368V of the Connecticut General Statutes and the regulations thereunder pertaining to its licensure, the department shall issue a license or renewal of license to operate the service for a period not to exceed two (2) years.

(B) Application for license renewal shall be made in accordance with subdivision (2)(B) of this subsection not less than thirty (30) days preceding the date of expiration of the agency's current license.

(C) A license shall be issued in the name of the entity that has submitted application for the license.

(D) The license shall not be transferable to any other person, entity or service.

(E) Each license shall list on its face, the name of the licensee, the "doing business as" name, the location(s) served and the date of issuance and expiration.

(F) The license shall be posted in the business office of the licensee.

(G) The licensee shall immediately notify the department in writing of any change in the supervisor of the assisted living services agency.

(H) Any change in the ownership of an assisted living services agency, owned by an individual, partnership or association or the change in ownership or beneficial ownership of ten percent (10%) more of the

stock of a corporation that owns, conducts, operates or maintains such agency, shall be subject to prior approval of the department. The licensee shall notify the department in writing of any such proposed change of ownership, at least ninety (90) days prior to the effective date of the proposed change.

(4) Suspension, revocation, denial, non-renewal or voluntary surrender of license.

(A) A license may be suspended, revoked, denied or its renewal refused whenever in the judgment of the department the facility:

(i) fails to comply with applicable regulations prescribed by the commissioner or statutes;

(ii) furnishes or makes any false or misleading statements to the department in order to obtain or retain the license; or

(iii) provides assisted living services in a managed residential community that fails to provide or arrange to make available the core services on a regular and continual basis.

(B) In the event of the suspension, revocation, denial or non-renewal of a license, the assisted living services agency shall have the opportunity for a hearing in accordance with the contested case provisions of Chapter 54 of the Connecticut General Statutes and Sections 19a-4-1 through 19a-4-31 of the regulations of Connecticut State Agencies, as applicable.

(C) Refusal to grant the department access to clients, records and staff of the agency shall be grounds for suspension, revocation, denial or non-renewal of the license.

(D) Surrender of license. The licensee shall notify, in writing, each client receiving services from the agency, the next of kin or legal representative, and any third party payors concerned, at least thirty (30) days prior to the voluntary surrender of an assisted living services agency license or surrender of license upon the department's order of revocation, refusal to renew, or suspension of license. Arrangements shall be made by the licensee for the continuation of care and services as required for any individual client following the surrender of the agency's license. This notice shall include at a minimum:

(i) a statement by the assisted living services agency identifying which services shall no longer be provided to clients; and

(ii) information regarding other resources available to provide health care services to clients.

(5) The assisted living services agency shall ensure that all of the core services are provided. In the event that a managed residential community fails to provide or arrange to make available one or more of the core services on a regular and continual basis, the licensee shall terminate the provision of assisted living services to the managed residential community. The department, each client receiving services from the agency, the next of kin or legal representative and any third party payors

concerned shall be mailed written notice from the licensee at least thirty (30) days prior to the termination of services. Arrangements shall be made by the licensee for the continuation of care and services as required by any individual client following termination of the assisted living service. In the event that the disruption of services is temporary, alternative arrangements for the health and safety of the clients shall be made immediately by the managed residential community, with full service restored in not more than seven (7) days.

(6) The assisted living services agency shall maintain records of all temporary service disruptions or the managed residential community's failure to provide core services and shall record the length of disruptions and provision of alternative arrangements.

(7) Waiver

(a) The commissioner in accordance with section 19a-6c of the Connecticut General Statutes, may waive provisions of this section for assisted living services agencies, only when such agencies provide services in state-funded congregate housing facilities. No waiver of this section shall be made if the commissioner determines that the waiver would:

(i) endanger the life, safety or health of any resident receiving assisted living services in a state-funded congregate housing facility;

(ii) impact the quality or provision of services provided to a resident in a state-funded congregate housing facility:

(iii) revise or eliminate the requirements for an assisted living services agency's quality assurance program;

(iv) revise or eliminate the requirements for an assisted living services agency's grievance and appeals process; or

(v) revise or eliminate the assisted living services agency's requirements relative to a client's bill of rights and responsibilities.

(B) The commissioner, upon the granting or renewing of a waiver of any provision of this section, may impose conditions, which assure the health, safety, and welfare of residents receiving assisted living services in a state- funded congregate housing facility. The commissioner may revoke such waiver upon a finding:

(i) that the health, safety, or welfare of any patient has been jeopardized; or

(ii) that such facility or agency has failed to comply with such conditions as the commissioner may impose pursuant to this subparagraph.

(C) Any agency requesting a waiver shall apply in writing to the department. Such application shall include:

(i) the specific regulations for assisted living service agencies for which the waiver is requested;

(ii) reasons for requesting a waiver, including a statement of the

type and degree of any hardship that would result to the agency upon enforcement of the regulations;

(iii) the specific relief requested;

(iv) reasons that the waiver would not endanger the life, safety or health of any resident or negatively impact the quality or provision of services to residents; and

(v) any documentation which supports the application for waiver.

(D) Waiver applications shall by signed by a person authorized to bind the agency and shall be notarized.

(E) In consideration of any application for waiver, the commissioner shall consider the following:

(i) the maximum resident capacity;

(ii) the impact of a waiver on care provided; and

(iii) alternative policies or procedures proposed.

(F) Waivers shall be granted for a period of no more than two (2) years. An agency shall reapply in writing to the department in order to renew such waiver at least sixty (60) days in advance of the expiration date of the current waiver.

(G) If the commissioner, upon the granting of a waiver, imposes any conditions to ensure the health, safety and welfare of residents, the agency shall acknowledge in writing his or her agreement to abide by such conditions.

(H) The department reserves the right to request additional information before processing an application for waiver.

(c) Managed residential communities served by assisted living services agencies

(1) Assisted living services may not be provided in a managed residential community unless the managed residential community has notified the department either in writing or by telephone of its intention to provide or arrange to make available licensed assisted living services and has submitted all information as required in this subsection and until the assisted living services agency has been issued a license to operate by the department. The information shall be provided to the department on forms provided by the department, shall be signed by the owner(s) or the operating or managing entity and shall be notarized. The form(s) shall include the following information:

(A) evidence of compliance with local zoning ordinances, local building codes and the Connecticut Fire Safety Code and Supplement;

(B) name of the management company or manager, as appropriate;

(C) legal entity that owns or operates the managed residential community;

(D) description of the manner in which tenants are advised that the managed residential community is not licensed by the department;

(E) description of the information provided to tenants informing them of the assisted living services and home health care services available for individual use and how to access itemized costs of services delivered by these providers;

(F) person to whom official notices are to be sent;

(G) name of the assisted living services agencies; and

(H) attestation that the core services described in subdivision (3) of this subsection are made available and are accessible on a regular and continual basis to those tenants who choose to use such core services.

(2) Upon receipt of the form(s) by the department, the department shall notify the managed residential community in writing within thirty (30) days that either the managed residential community's form(s) is complete and shall be maintained on file in the department or that the information submitted was incorrect or incomplete.

(3) A managed residential community shall provide or arrange to make available the following core services to its tenants who choose to use any or all of the core services:

(A) regularly scheduled meal service for three (3) meals per day;

(B) regularly scheduled laundry service for personal laundry and linens;

(C) regularly scheduled transportation for personal shopping, social and recreational events, health care appointments and similar needs and for which public bus transportation shall not qualify as the only form of transportation;

(D) regularly scheduled housekeeping services;

(E) maintenance service for tenants' living units, including chore services for routine domestic tasks that the tenant is unable to perform; and

(F) programs of social and recreational opportunities.

(4) A managed residential community shall also provide:

(A) a formally established program that provides tenants with twenty-four (24) hour a day security designed to protect tenants from intruders;

(B) an emergency call system in each living unit;

(C) on-site washers and dryers sufficient to meet the needs of the tenants; and

(D) common use space that is sufficient in size to accommodate fifty percent (50%) of the tenant population.

(5) The managed residential community shall employ an on-site service coordinator who reports directly to the operating or managing entity or the administrator of the managed residential community.

(A) The service coordinator shall possess at a minimum a bachelor's degree in social work or in a related human service field. Individuals without a bachelor's degree may be hired if they have an associate's degree in social work or in a related human service field and two (2) years of experience in a social service delivery system dealing with issues and coordinating services related to persons primarily age fifty-five (55) or older. Individuals without a bachelor's degree or an associate's degree may be hired if they have four (4) years of experience in a social service delivery system dealing with issues and coordinating services related to persons primarily age fifty-five (55) or older. The service coordinator should have prior supervisory or management experience. Any person employed as a

service coordinator prior to December 1, 1994 shall be eligible to continue in the facility of employment without restriction.

(B) Responsibilities of the service coordinator shall include, but not necessarily be limited to:

(i) ensuring that the services required by this subsection are provided or made available to all tenants;

(ii) assisting tenants in making arrangements to meet their personal needs;

(iii) establishing collaborative relations with provider agencies, support services and community resources.

(iv) establishing a tenant council, ensuring that a private space is provided to the group for meetings and providing assistance and responding to written requests that result from group meetings;

(v) serving as an ongoing liaison with the assisted living services agencies to include liaison with the assisted living services agencies' quality assurance committee as required in subsection (l) of this section;

(ii) ensuring that a tenant information system is in place; and

(iii) developing a written plan for the delegation of responsibilities and functions in the absence of the service coordinator.

(C) A service coordinator's absence of longer than one (1) month shall be reported to any assisted living services agencies servicing the community.

(1) The managed residential community, through its service coordinator or any other representative, may not provide health services, including but not limited to the provision of rehabilitative therapy, administration or supervision of the self-administration of medications, nursing care or medical treatment, unless it has been licensed as an assisted living services agency. It may contract with one or more assisted living services agencies, home health care agencies, or other appropriately licensed health care providers to make available health services for tenants provided by such licensed persons or entities.

(2) Managed residential communities may not require tenants to share units. Sharing of a unit shall be permitted solely upon the request and mutual consent of tenants.

(3) The owner or operating entity shall notify the department and any assisted living services agency that provides services to tenants of the managed residential community, in writing, of any proposed change of ownership or operating entity or elimination of core services at least thirty (30) days prior to the effective date of such proposed change.

(4) The owner or operating entity shall immediately notify any assisted living services agencies servicing the community of any change in the service coordinator.

(5) The managed residential community shall provide the department with unrestricted access to the community, tenants and tenant related documents.

(6) The managed residential community shall notify, in writing, each tenant concerned, the next of kin or legal representative, any third party payers concerned and any assisted living services agency servicing the community at least thirty (30) days prior to the voluntary elimination of its status as a managed residential community and immediately upon the department's order of revocation, refusal to renew or suspension of license of the assisted living services agency. This notice shall include at a minimum:

(A) a statement by the managed residential community identifying which core services and assisted living services shall no longer be provided to tenants and clients; and

(B) information regarding other resources available to tenants and clients to provide health care services.

(d) Governing authority of an assisted living services agency

(1) There shall be a formal governing authority with full legal authority and responsibility for the operation of the agency, which shall be the officers and directors of the corporation, and which shall adopt bylaws or rules that are reviewed in accordance with a schedule established by the governing authority and so dated. Such bylaws or rules shall include, but not necessarily be limited to:

(A) the purpose of the agency;

(B) a delineation of the powers, duties and voting procedures of the governing authority, its officers and committees;

(C) the qualifications for membership, method of selection and terms of office of members and chairpersons of committees;

(D) a description of the authority delegated to the supervisor of the assisted living services agency;

(E) the agency's conflict of interest policy and procedures;

(F) assurances that a written contract shall be maintained with one or more licensed home health care agencies if the licensed home health care agencies are not owned and operated by the managed residential community; and

(G) assurances that a written contract shall be maintained with one or more licensed assisted living services agencies if the agencies are not owned and operated by the managed residential community.

(2) The bylaws or rules shall be available to all members of the governing authority and all individuals to whom authority is delegated.

(3) The governing authority shall:

(A) meet as frequently as necessary to fulfill its responsibilities as stated in subdivision (4) of this subsection, but no less than two (2) times per year;
(B) maintain minutes for each meeting;
(C) ensure that minutes reflect the identity of those members in attendance and that, following approval, such minutes are dated and signed by the secretary; and
(D) ensure that the minutes of any of its meetings or any of its committees are available at any time to the commissioner.

(4) Responsibilities of the governing authority shall include, but not necessarily be limited to:

(A) ensuring the quality of services provided by the agency and the quality of care rendered to clients;
(B) establishing a quality assurance program in accordance with subsection (l) of this section;
(C) selecting and appointing a quality assurance committee;
(D) reviewing and accepting all minutes of meetings held by the quality assurance committee and assuring the implementation of corrective actions identified in these minutes;
(E) adopting and documenting the annual review of the written agency budget;
(F) developing policies and programs and delegating the authority to implement policies and programs;
(G) managing the fiscal affairs of the agency;
(H) establishing a schedule for the review of its bylaws or rules;
(I) establishing a schedule for the submission of the reports described in subsection (g)(2)(G) and (H) of this section to the governing authority;
(J) ensuring that a written contract is maintained between the assisted living services agency and one or more licensed home health care agencies or the managed residential community and one or more licensed home health care agencies unless the assisted living services agency operates under common ownership with the licensed home health care agencies that serve the same managed residential community; and
(K) ensuring that a written contract to include provisions that the assisted living services agency shall monitor the provision of core services to determine if the services are being provided on a regular and continual basis, is maintained between the assisted living services agency and the managed residential community unless the licensed assisted living services

agency is under common ownership with the managed residential community.

(5) If an assisted living services agency is owned by or is under common or related ownership with the managed residential communities it serves or a licensed home care agency serving such communities, the governing authority of the related managed residential community or licensed home health care agency may serve as the governing authority of the assisted living services agency provided that the requirements of this subsection are met and minutes of meetings clearly identify discussions related to the assisted living services agency.

(e) General requirements for an assisted living services agency

(1) An agency shall be in compliance with all applicable federal, state and local laws and regulations.

(2) An assisted living services agency, as defined in this section, shall only provide services to individuals residing in a managed residential community.

(1) Any assisted living services agency which contracts individually with a tenant of a managed residential community and is not under contract with the community shall comply with this section.

(2) Each agency shall have a designated office on the site of the managed residential community. This office shall provide adequate and safe space for:

(A) conferences with clients and their families;

(B) staff to carry out pre and post client visit activities;

(C) supervisory conferences with staff;

(D) storage and maintenance of equipment and supplies necessary to provide client services in an area, that may be separate from the business office; and

(E) maintenance of administrative records and files, financial records and client service records in locked file cabinets or an area that can be locked.

(5) Contracted services. Assisted living services agencies may contract with other organizations, agencies or individuals to provide the services defined in subsections (h) and (i) of this section to their clients. Services provided by the primary agency through arrangements with a contracted agency or individuals(s) shall be set forth in either a written contract or a written memorandum of understanding between participating agencies. The provisions set forth in this subdivision shall also apply when services are being provided at the same time to the same client by more than one (1) agency licensed to provide such services. The contract or written memorandum of understanding shall include, but not necessarily be limited to:

(A) a statement that clearly defines the assignment of primary responsibility for the client's care;

(B) the methods of communication and coordination between agencies to ensure that all information necessary for safe, coordinated care to clients is accessible and available to all participating agencies;

(C) the necessity to conform with all applicable primary agency policies, including personnel qualifications and staffing patterns; and

(D) the responsibility of participating agencies in developing and implementing the client service program.

(6) Each assisted living services agency shall have a communication system adequate to receive requests and referrals for service, maintain verbal contact with health service personnel at all times when they are providing services to clients, receive calls from clients under the care of the agency and tenants residing in the community and maintain contact as needed with the client's source of medical care and other providers of care, if applicable.

(7) Assisted living services, including nursing services and assistance with activities of daily living, may be provided to clients with chronic and stable conditions as determined by a physician or health care practitioner with applicable statutory authority at least on an annual basis and as needed. Chronic and stable conditions are not limited to medical or physical conditions, but also include chronic and stable mental health and cognitive conditions. The determination shall be made in writing and maintained in the client's service record.

(1) Each agency shall establish written criteria for admission to assisted living services. The criteria shall not impose unreasonable restrictions which screen out a client whose needs may be met by the agency.

(2) Each agency shall develop written policies for the discharge of clients from the agency. Agency discharge policies shall define categories for the discharge of clients and shall include but not necessarily be limited to:

(A) Change in client's condition. Termination of services when the client's condition is no longer chronic and stable;

(B) Routine discharge. Termination of services when goals of care have been met and the client no longer requires assisted living services;

(C) Emergency discharge. Termination of services due to the presence of safety issues which place the client or agency staff in immediate jeopardy and prevent the agency from delivering assisted living services;

(D) Financial discharge. Termination of services when the client's insurance benefits or financial resources have been exhausted; and

(E) Premature discharge. Termination of services when goals of care have not been met and the client continues to require assisted living services.

(3) Clients and other responsible parties shall be informed when their individual care and service needs may qualify for reimbursement by a third party payor. A summary of the information provided to the client shall be documented in the client service record and shall be signed and dated by the supervisor of assisted living services or his or her designee as well as by the client or the client's representative.

(4) Each agency shall develop and have readily available a policy and procedure to address the appropriate steps to follow in the event of a medical emergency. A review of the policy and procedure shall be included in the employee orientation program.

(5) Each agency shall establish a written complaint procedure regarding the provision of care and services, any allegations of physical or mental abuse or exploitation or the lack of respect for a client's property by anyone providing agency services including, but not necessarily limited to:

(A) a statement that a client or his or her family has the right to file a complaint without discrimination or reprisal from the agency;

(B) the manner in which the agency shall address the complaint with the client or his or her family including a full investigation into the complaint; and

(C) provisions to ensure that the agency shall promptly attempt to resolve complaints.

(6) The agency shall maintain a complaint log which shall include, but not necessarily be limited to the name of the client and the date, nature and resolution of the complaint. The log shall be available to the department upon its request.

(7) The agency shall apprise the client of his or her right to access the appropriate state agency should the complaint not be resolved to the client's satisfaction.

(f) Personnel policies for an assisted living services agency

(1) An agency shall have written personnel policies which shall include but not necessarily be limited to the following:

(A) Each agency shall have an orientation policy and procedure for all employees which shall include but not necessarily be limited to the following:

(i) organizational structure of the agency and philosophy of assisted living services;

(ii) agency client services policies and procedures;
(iii) agency personnel policies;
(iv) applicable regulations governing the delivery of assisted living services; and
(v) orientation dates, content, and name and title of the person providing the orientation as documented in the employee's personnel folder.

(B) Each agency shall have an in-service education policy that provides an annual average of at least one (1) hour bimonthly for each assisted living aide.

(i) The in-service education shall include, but not necessarily be limited to current information regarding specific service procedures and techniques and information related to the population being served.

(ii) The in-service education program shall be provided by or under the supervision of the supervisor of assisted living services or a designated licensed nurse who possesses a minimum of two (2) years of full time or full time equivalent experience in nursing, at least one (1) year of which shall be in a home health care agency or community health program that included care of the sick at home.
(iii) An assisted living services agency that utilizes an aide from a placement agency or nursing pool shall maintain sufficient documentation to demonstrate that in-service education requirements are met.
(iv) A nursing home or home health care agency having the same ownership as, or under common or related ownership with, as assisted living services agency may provide joint in-service education programs for all aides, provided that records of such in-services clearly reflect content, attendance and work location.
(v) An assisted living services agency may contract with a home health care agency or nursing home to provide in-service education to its assisted living aides in accordance with this section.

(C) Each agency shall have a policy and procedure for the annual performance evaluation of employees which includes a process for corrective action when an employee receives an unsatisfactory performance evaluation.

(D) Agency personnel policies and procedures shall include written job descriptions that specify the duties and qualifications of each job.

(E) Agency policies and procedures shall address documentation by a physician or health care practitioner with applicable statutory authority of annual physical examinations, including tuberculin testing, that are performed for the purpose of preventing infection or contagion from communicable disease. A statement that the employee is free from communicable disease, including results of the tuberculin testing, shall be obtained prior to assignment to client care activities.

(2) For all employees of the agency employed directly or via individual or agency contracts, the agency shall maintain individual personnel records containing at least the following:

(A) educational preparation and work experience;
(B) written verification of successful completion of a home health aide training and competency evaluation program or a competency evaluation program approved by the commissioner in accordance with Section 19-13-D8t(l), Section 19-13-D69(d)(2) or Section 19-13-D83(b) of the regulations of Connecticut State Agencies, if applicable;
(C) current licensure, if applicable;
(D) written annual performance evaluations;
(E) record of health examinations; and
(F) documentation of orientation.

(3) For persons utilized via contract with another assisted living services agency, a home health care agency, homemaker-home health aide agency or nursing pool, the assisted living services agency shall ensure it has access to the personnel records required in subdivision (2) of this subsection and shall make the documents available to the department upon its request.

(4) An assisted living services agency owned by, or under common or related ownership with, a nursing home or home health care agency, may maintain one (1) personnel file for each employee or independent contractor utilized by the nursing home or home health care agency and the assisted living services agency.

(g) Supervisor of assisted living services

(1) The supervisor of assisted living services shall be a registered nurse licensed to practice in this state who has one of the following:

(A) a baccalaureate degree in nursing and a minimum of two (2) years full time or full time equivalent clinical experience in nursing, at least one (1) of which shall be in a home health care agency or community health program that included care of the sick at home; or
(B) a diploma or associate's degree in nursing and at least four (4) years full time or full time equivalent clinical experience in nursing within the past ten (10) years, at least one (1) year of which shall be in a home health care

agency or community health program that included care of the sick at home.

(2) The supervisor's responsibilities include, but are not necessarily limited to:

(A) coordinating and managing all nursing and assisted living aide services rendered to clients by direct service staff under his or her supervision;

(B) supervising assigned nursing personnel and assisted living aides in the delivery of nursing services and assistance with the provision of activities of daily living;

(C) ensuring the evaluation of the clinical competence of assigned nursing personnel and assisted living aides;

(D) participating in or developing all agency objectives, standards of care, policies and procedures concerning nursing services and the provision of assistance with activities of daily living;

(E) participating in direct service staff recruitment, selection, orientation and in-service education;

(F) participating in program planning, budgeting and evaluating activities related to the clinical services provided by the agency;

(G) providing weekly reports to the service coordinator regarding any problems associated with the provision of the core services, or any problems or concerns associated with the managed residential community or the assisted living services agency, summaries of which shall be provided to the governing authority in accordance with the schedule established by the governing authority; and

(H) providing monthly reports to the service coordinator regarding statistical data including the number of clients served and services provided, summaries of which shall be provided to the governing authority in accordance with the schedule established by the governing authority.

(3) The supervisor of assisted living services may provide direct nursing services to clients in accordance with subsection (h) of this section.

(4) Any absence of the supervisor of assisted living services longer than one (1) month shall be reported to the commissioner. A registered nurse with a minimum of two (2) years full time or full time equivalent clinical experience in nursing, at least one (1) year of which shall be in a home health care agency or community health program that included care of the sick at home, shall be designated, in writing, to act during any absence of the supervisor of assisted living services.

(h) Nursing Services provided by an assisted living services agency

(1) An assisted living services agency shall have written policies governing the delivery of nursing services.

(2) Nursing services shall be provided by licensed nurses in accordance with subparagraph (J) of subdivision (3) of this subsection.

(3) A registered nurse shall be responsible for the following which shall be documented in the client's service record:

(A) admission of clients for service;

(B) development of the client service program and instructions for assisted living aide services;

(C) assessments, completed as often as necessary based on the client's condition but not less frequently than every one hundred and twenty (120) days, and prompt action when a change in the client's condition would require a change in the client's service program;

(D) coordination of services with the client, family, and other appropriate individuals involved in the client service program;

(E) participation in orientation, teaching, and supervision of assisted living aides;

(F) arrangements for training or supervision of the assisted living aide by other professionals, when appropriate;

(G) referral to appropriate professionals or agencies, whenever the client's condition necessitates, including the provision of current clinical information ensuring that if the client's condition is no longer chronic and stable, services of a licensed home health care agency are engaged or other appropriate arrangements are made;

(H) planning for clients who shall no longer receive or require the services of the assisted living services agency;

(I) implementation or delegation of responsibility for the availability of nursing services on a twenty-four (24) hour basis;

(J) nursing services which shall include, but not necessarily be limited to:

(i) client teaching;

(ii) wellness counseling;

(iii) health promotion;

(iv) disease prevention;

(v) medication administration and delegation of supervision of self-administered medications as specified in subdivision (4) of this subsection; and

(vi) provision of care and services to clients whose conditions are chronic and stable as defined in subdivision (7) of subsection (e).

(4) Supervision of medication administration by an assisted living service agency shall be provided in accordance with the following:

(A) A licensed nurse may administer medications to clients under the written order of a physician or health care practitioner with applicable statutory authority.

(B) A licensed nurse may pre-pour medications for clients who are able to self-administer medications, under the written order of a physician or health care practitioner with applicable statutory authority.

(C) With the approval of the client or his or her representative an assisted living aide may supervise a client's self-administration of medications. The aide shall only:

(i) remind a client to self administer the medications;

(ii) verify that a client has self administered their medications; or

(iii) assist the client with the self administration in the form of opening bottles, bubble packs or other forms of packaging if the client is not capable of performing this function.

(D) For clients who require only supervision of self-administration, a registered nurse may verbally verify the client's medication regimen with the client's physician or health care practitioner with applicable statutory authority and document the medication regime in the client's service record.

(E) The registered nurse shall verify written or verbal orders from the physician or health care practitioner with applicable statutory authority as needed, but at least once every one hundred and twenty (120) days.

(F) All medications shall be stored within a client's private residential unit.

(G) A licensed nurse shall ensure that the client or his or her representative is aware of the client's medication regime and able to make decisions regarding medication administration.

(i) Assisted living aide services provided by an assisted living services agency

(1) An assisted living services agency shall have written policies governing the delivery of services by an assisted living aide.

(2) Any person who furnishes assisted living services on behalf of an assisted living services agency shall have successfully completed a training and competency evaluation program in accordance with Section 19-13-D8t(l), Section 19-13-D69(d)(2) or Section 19-13-D83(b) of the regulations of Connecticut State Agencies, and shall have completed ten (10) hours of orientation prior to providing any direct client care service. This orientation shall be provided by the supervisor of assisted living services or a licensed nurse designated by the supervisor.

(3) When designated by the licensed nurse responsible for a client's care and services, the duties of the assisted living aide may include:

(A) assisting the client with personal care activities including bathing, oral hygiene, feeding, dressing, toileting and grooming;

(B) assisting the client with exercises, ambulation, transfer activities and supervision of self-administered medication; and

(C) performing routine household services essential to client care at home, including shopping, meal preparation, laundry and housecleaning.

(4) An assisted living services agency is not required to provide the services described in subparagraph (C) of subdivision (3) of this subsection. These services may be provided by an assisted living aide or any other person.

(5) Supervision of assisted living aides

(A) A registered nurse shall be accessible by telephone and available to make a home visit at all times, including nights, weekends and holidays, when assisted living aides are on assignment in a client's home.

(B) The licensed nurse assigned to the client is responsible for supervision of the services rendered by the assisted living aide.

(j) Assisted living services agency staffing requirements

(3) An assisted living services agency shall appoint, with the written approval of the governing authority, a supervisor of assisted living services and a designee, as described in subsection (g) of this section.

(4) An assisted living services agency shall employ or contract with at least one (1) registered nurse in addition to the supervisor of assisted living services. This registered nurse may serve as the designee in the absence of the supervisor and shall be available to provide relief for the supervisor as needed.

(5) The agency shall employ a supervisor of assisted living services to be on site as follows:

(C) at least twenty (20) hours per week for each ten (10) or less full time or full time equivalent licensed nurses or assisted living aides; or

(D) at least forty (40) hours per week for each twenty (20) or less full time or full time equivalent licensed nurses or assisted living aides.

(6) In addition to the supervisor of assisted living services, the agency shall be staffed with licensed nurses at least ten (10) hours per week for each additional ten (10) or less full time or full time equivalent assisted living aides.

(7) The supervisor of assisted living services shall be responsible for ensuring that licensed nurse staffing is adequate at all times to meet client needs.

(8) All registered nurses shall be supervised directly by the supervisor of assisted living services.

(9) All licensed practical nurses shall be supervised by the supervisor of assisted living services or a registered nurse designated by said supervisor.

(10) An assisted living services agency shall designate a registered nurse to be on call twenty-four (24) hours a day. The on-call registered nurse shall have two (2) years of full time or full time equivalent clinical experience in nursing, at least one (1) year of which shall be in a home health care agency or community health program that included care of the sick at home. The on-call registered nurse may be the supervisor of assisted living services or another registered nurse as specified in this section. An assisted living services agency may contract for on-call registered nurse services with a licensed home health care agency. The on-

call nurse shall be reachable by telephone and shall be available to make an on-site visit, if necessary in order to:

(A) respond to the assisted living aides during the provision of care to clients; and

(B) respond to client emergencies.

(9) In an assisted living services agency that serves no more than thirty (30) clients on a daily basis, one (1) individual may serve as both the supervisor of assisted living services and the service coordinator, as described in subdivision (5) of subsection (C) of this section, provided that the assisted living services agency is owned by, or under common or related ownership with the management of the managed residential community. The minimum qualifications required for the supervisor of assisted living services shall be sufficient to meet the minimum qualifications required for these shared positions. In the event that the monthly average of clients served per day exceeds thirty (30) for two (2) consecutive months, the agency shall not qualify for the sharing of the positions.

(10) The supervisor of assisted living services shall be responsible for ensuring that sufficient numbers of assisted living aides are available to meet the needs of clients at all times based on the clients' service programs.

(k) Client service record

(1) Each assisted living services agency shall maintain a complete service record for each client. All parts of the record pertinent to the daily care and treatment of the client shall be located in an accessible area on the campus of the managed residential community. The agency shall use a format that shall be provided by the department.

(2) The complete client service record shall include, but not necessarily be limited to:

(A) client identifying data including name, date of birth, sex, date of admission or readmission, marital status, and religion;

(B) name of family member or significant other, including address and telephone number;

(C) name, location and phone number of client's personal physician or source of medical care;

(D) complete medical diagnoses;

(E) all initial and subsequent orders by the physician or health care practitioner with applicable statutory authority, if applicable;

(F) assessment of the client including pertinent past and current health history, physical, mental and social status, and evaluation of client's needs;

(G) annual and other certifications by a physician or health care practitioner with applicable statutory authority of the client's chronic and stable condition;

(H) a client service program, completed by a registered nurse in consultation with the client, family and others involved in the care of the client, within seven (7) days of the client's admission to the agency, which shall be reviewed as often as the client's condition requires but not less than once every one hundred and twenty (120) days, shall be explained to, reviewed with and agreed to by the client or his or her representative, shall reflect the client's or his or her representative's or family's preferences and

choices regarding client services, and shall include but not necessarily be limited to:

(i) identification of client's problems and needs;

(ii) goals of management, plans for intervention and implementation;

(iii) types of frequency of services and equipment required;

(iv) types and frequency of services to be provided by the client's family or informal support system;

(v) medications to be self-administered with supervision or administered by a licensed nurse, treatments and other required nursing services;

(vi) written instructions for the assisted living aide which shall be completed before the assisted living aide provides care and services to include the scope and limitations of the assisted living aide's activities and pertinent aspects of the client's condition to be observed and reported to the registered nurse; and

(vii) frequency and plan for registered nurse supervision of the assisted living aides, including methods of ensuring ongoing competence of the assisted living aide;

(I) nurses notes including changes in client conditions and notification of appropriate source of medical care, family member or significant other, treatments, and responses to such treatments;

(J) a record of medications administered, including medications pre-poured for the client or medications refused by the client;

(K) documentation of coordination of services with the client, family, and others involved in the client service program;

(L) documentation of all care and services rendered, including assisted living aide notes which have been reviewed by the registered nurse; and

(M) referrals and discharge summary, if applicable.

(3) Upon a client's referral to a home health care agency, the name of the agency to which the client was referred and a summary of the reason(s) for the referral shall be documented in the client record including the staff person contacted and the date of contact with the agency.

(4) Upon a client's resumption of services by an assisted living services agency, a summary of the care and services provided to the client by the home health care agency shall be documented in the client record.

(5) All entries in the client service record shall be typewritten or written in ink and legible. All entries shall be verified according to accepted professional standards.

(6) Client service records shall be safeguarded against loss, destruction or unauthorized use.

(7) All client service records, originals or copies, shall be preserved for at least seven (7) years following death or discharge of the client from the assisted living services agency.

(8) Client records shall be confidential. Written consent shall be obtained from the client prior to the release of information to persons not otherwise authorized under law to receive said information.

(l) Quality assurance program for an assisted living service agency

(1) There shall be a quality assurance committee, appointed by the governing authority, consisting of at least one (1) physician, one (1) registered nurse with a minimum of two (2) years of clinical experience in home health care or one (1) nurse with a bachelor's degree in nursing and one (1) social worker with a bachelor's degree in social work or in a related human service field. Representatives appointed to the committee shall be in active practice in their profession or shall have been in active practice within the last five (5) years. No member of the quality assurance committee shall be an owner, stockholder, employee of the agency or related by blood or marriage to an owner, stockholder or employee of the agency. However, provision may be made for employees to serve on the committee as ex officio members only, without voting powers. The service coordinator of a managed residential community may be appointed to serve as the social worker for the assisted living services agency's quality assurance committee provided that the agency is not owned by, or under common or related ownership with the managed residential community.

(2) The quality assurance committee shall meet at least once every one hundred and twenty (120) days.

(3) Written minutes shall document dates of meetings, attendance, and recommendations. The minutes shall be presented and acted on at the next regular meeting of the governing authority of the agency following the quality assurance committee meeting. These minutes shall be available to the department upon its request.

(4) The professional advisory committee of a home health care agency that owns, or is under common or related ownership with, an assisted living services agency may also serve as the quality assurance committee for the assisted living services agency, provided that minutes and other records clearly distinguish committee activities.

(5) The functions of the quality assurance committee shall be to participate in the agency's quality assurance program to the extent defined in the quality assurance program policies and to, at least annually, review and revise, if necessary, the agency's policies on:

(A) program evaluation;
(B) assessment and referral criteria;
(C) service records;
(D) evaluation of client satisfaction;
(E) personnel qualifications;
(F) standards of care; and
(G) professional issues, especially as they relate to the delivery of services and findings of the quality assurance program.

(6) Each agency shall have a written quality assurance program which shall include,

but not necessarily be limited to:

(A) program evaluation; and
(B) client record review.

(7) The quality assurance committee shall conduct the program evaluation, which shall include, but not necessarily be limited to:

(A) the extent to which the managed residential community's policies and resources are adequate to maintain core services on a regular and continual basis and are appropriate to the community tenants and family needs; and
(B) the extent to which the agency's objectives, policies and resources, are adequate to meet health and personal care needs of the managed residential community tenants, including referral to other health care services agencies or professionals, as appropriate.

(8) At least every one hundred and twenty (120) days, the quality assurance committee shall review a random sample of active and closed client records. Each record review shall be documented on a record review form and shall include, but not necessarily be limited to verification that:

(A) agency policies are followed in the provision of services to clients;
(B) services are provided only to clients whose level of care needs can be met by an assisted living services agency;
(C) provision of care is coordinated within the agency involved in the care of the client; and
(D) referral of the client is made to a home health care agency or other services of care or health care professionals when the client's status and care needs are no longer limited to the services provided by an assisted living services agency.

(9) The agency's sampling methodology for reviewing client records shall be defined in its quality assurance program policies and procedures.

(10) An annual written report of the agency's quality assurance program shall summarize all findings and recommendations resulting from the quality assurance activities. This report and documentation of all actions taken as a result of the findings or recommendations included in the report shall be available to the department.

(m) Client's bill of rights and responsibilities. An assisted living services agency shall have a written bill of rights and responsibilities governing agency services which shall be provided and explained to each client at the time of admission to the agency. Such explanation shall be documented in the client's service record. All clients shall receive a written copy of any changes made to the bill of rights. The bill of rights shall include but not necessarily be limited to:

(1) description of available services, charges and billing mechanisms with the assurance that any changes shall be given to the client orally and in writing as soon as possible but no less than fifteen (15) working days prior to the date such changes become effective;
(2) criteria for admission to service;

(3) information regarding the right to participate in the planning of (or any changes in) the care to be furnished, the frequency of visits proposed, the nurse supervising care and the manner in which the nurse may be contacted;

(4) client responsibility for participation in the development and implementation of the client service program and the client's right to refuse recommended services;

(5) right of the client to be free from physical and mental abuse and exploitation and to have personal property treated with respect;

(6) explanation of confidential treatment of all client information retained in the agency and the requirement for written consent for release of information to persons not otherwise authorized under law to receive it;

(7) policy regarding client access to his or her service record;

(8) explanation of the complaint procedure and right to file a complaint without discrimination or reprisal from the agency regarding the provision of care and services, any allegations of physical or mental abuse or exploitation or the lack of respect for property by anyone providing agency services;

(9) agency's responsibility to promptly investigate the complaints made by a client or his or her family regarding the provision of care and services, any allegations of physical or mental abuse or exploitation or lack of respect for the client's property by anyone providing agency services;

(10) procedure for registering complaints with the commissioner including the address and phone number of the department;

(11) the client's right to have services provided by an individual or entity other than via an assisted living services agency;

(12) the circumstances under which the client may be discharged from the agency or may not be permitted to receive services from the assisted living services agency;

(13) a description of Medicare-covered services and billing and payment requirements for such services;

(14) information advising the client of his or her rights under state law to make decisions about medical care, including the right to formulate advance directives such as living wills and durable power of attorney for health care decisions;

(15) the client's right to make individual arrangements with an assisted living services agency which does not have a formal contract with the managed residential community in which he or she resides; and

(16) the client's right to terminate or reduce services provided by an assisted living services agency at any time.

(Effective November 29, 1994; Amended effective June 29, 2001.)

Appendix C

Assisted Living Companies Excerpts from Marketing Materials in the Public Domain

- We know that our company's success is directly tied to resident satisfaction.

  Each local community, which is supported by senior-care experts, employs caring staff members whose primary focus is resident needs and abilities.

  The management team at each community provides residents with a well-rounded, supportive and fun senior lifestyle. Each community is unique because it's a reflection of its residents and the area in which they live.

  We work each day to enhance and - ultimately - exceed our residents' lifestyle and to gain the respect of their loved ones.

- Personalizing services is our difference

  Excellence is the benchmark

  Respect and candor in all communication

  Stand for integrity

  One company of passionate associates

  No excuses - commitments count

  Accept and embrace change

  Leading and learning through innovation

- Our community offers supportive living environments as well as specialized care for those with early memory loss. Our goal is to provide all residents with the very best quality of life – a comfortable and dignified lifestyle that supports the desire for independence and personal freedom, enhances well-being and preserves the connection to family, friends and community.
- Our Core Principles have made us not just senior living experts but also senior living advocates. We work with seniors, families, community referral sources, non-profit organizations and government agencies to identify senior needs and to develop individualized programs to meet those needs.
- The vision is “to perpetuate quality of life for humankind by providing a continuum of services that support health, independence and dignity.”

- **Respect**
  We hold each individual in high esteem and treat all with dignity and respect.
- **Spirituality**
  We view each individual as a whole person and administer to spiritual concerns as well as physical needs.
- **Excellence**
  We improve quality by empowering our associates to continually improve our outcomes of service. We encourage innovation by seeking, listening and responding to new ideas.
- **Collaboration**
  We collaborate with staff, medical practitioners and community members in order to incorporate the creativity of all.
- **Stewardship**
  We are responsible for preserving all that has come to us from those who have come before us and we are responsible to those who will come after us.
- Our Mission
  Create a community where we want to live!
- Our Values
  Put Person Before Task
  We are friends caring for friends
- Know Each Person
  Relationships are the building blocks of a community
- Open Hearts Lead to Open Minds
  We are a diverse community and enjoy learning from each other
- Look, Listen, Feel
  Your moods and actions affect others' moods and actions
- Praise often
  What gets recognized gets repeated
- Celebrate Life
  Greatest disability one can have is to not have a sense of humor

Appendix D

Antioch UniversityPhD in Leadership & Change
INSTITUTIONAL REVIEW BOARD
Human Subjects Research Review

Participant Consent to a Study about Nursing in Assisted Living environments

I have been asked to participate in a research study conducted by Carole Bergeron, a doctoral candidate in the Leadership and Organizational Change program at Antioch University, Yellow Springs, Ohio.

This research involves the study of Registered Nurses' lived experience of nursing in Assisted Living settings. Carole Bergeron, the researcher, plans to conduct this study with 20 to 25 participants who are Licensed Registered Nurses in the state of Connecticut and who are all over the age of 18.

I understand that the study involves, at a minimum, one conversational interview which will be arranged at my convenience and which is expected to last about 1 hour. The interview will be taped. Once the interview has been transcribed, the researcher will share a copy of the transcription for my review. The total time involved in conversational interviews and follow-up should be no more than 2 hours. If there are any follow-up questions, I understand that a second and final interview, with my approval, will be scheduled following the same process.

I understand that my risk for participating in this study is believed to be minimal. The researcher will decrease any potential risk to me by:

1. my review of the interview transcript, checking for accuracy or misunderstandings;
2. the researcher's confidential handling of all interview information;
3. the removal of my name and organization's name prior to publishing the final report; and
4. the destruction of all electronic recording and transcripts at the completion of the project.

I am aware that my opinions may be utilized for research purposes, but that neither my name nor any identifying information will be revealed in the final written document.

I understand the research findings may benefit other nurses engaged in the exercise of their responsibilities within the nursing profession.

I understand that there is no financial remuneration for participating in this study.I understand my participation is voluntary and I may discontinue participation at any time. I have the right to express my concerns and complaints to the University Committee on Research Involving Human Subjects at Antioch University (Carolyn Kenny, Ph.D., MT-BC, MTA, Professor of Human Development and Indigenous Studies, Ph.D. in Leadership and Change, Antioch University, (ckenny@phd.antioch.edu), Tel: 805-565-7535

I understand that no first or last names will appear on any materials that are collected. Conversations will serve as an iterative type of the process. The form below will be used to document my permission for the use of these materials.

I understand if I have any additional questions regarding my rights as a research participant, I can contact the researcher, Carole Bergeron or her advisor, Dr. Elizabeth Holloway, Professor of Psychology , Antioch University (eholloway@phd.antioch.edu, 805-898-0114).

Two copies of this informed consent form have been provided. Please sign both, indicating that you have read, understood and agreed to participate in this research. Return one to me and keep the other for yourself.

Carole Hersey Bergeron

_____

Name of researcher (please print)

_____

Signature of researcher

_____

Date

_____

Name of participant (please print)

_____

Signature of participant

_____

Date

Appendix E

Regulations Review Committee

Assisted Living Regulations Advisory Committee

(02/21/07)

DPH/FLIS

Joan Leavitt, RN, Section Chief
Irving Moy, A.B., M.Arch., M.A., PHSM
Victoria Carlson, RN, SNC
Donna Canalis, RN, NC
Maureen Mazzacane, RN, NC
Michael Smith, RN, NC

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Nancy Shaffer
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State Senator Edith Prague
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CALA

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East Haddam, CT 06423

Eleanora Tornatore Mikesh
The Greens at Cannondale
435 Danbury Road
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Atria Senior Living Group
501 South 4th Avenue, Suite 120
Louisville, KY 40202

David Vail
Atria Stratford
6911 Main Street
Stratford, CT 06614

Ct. Assisted Living Regulations Advisory Committee

January 24, 2007

Notes

Attended by 19 of the 21 members.

Irving Moy, staff of Ct. Dept. of Public Health (DPH), served as ad hoc Chairperson and opened the first meeting.

The Committee is comprised of the following: 7 members of DPH staff; 6 representatives of Ct. Assisted Living Association (CALA); and one from Ct. Dept. of Social Services (DSS); Ct. Association for Home Care (CAHC); Ct. Office of Attorney General; Murtha Cullina Law Firm; Ct. Association of Non-Profit Facilities for Aging (CANPFA); Wiggin & Dana Law Firm; Ct. Long Term Care Ombudsman; and State Senator Edith Prague, former Ct. Commissioner on Aging.

This Committee includes 6 people who served on the original Advisory Committee that created the present regulations, working on them from 1991 to 1995, including 3 staff members of DPH (Vicky Carlson, Donna Canalas, and Wendy Furniss); Martha Meng, Esq.; Richard Lynch, Assistant Attorney General; and David Vail. In addition, State Senator Edith Prague had played an important role in pushing for these regulations as then Commissioner on Aging. The current regulations became effective on January 1, 1995. In recent years, Senator Prague has become a critic of AL, calling for more regulation of the industry.

Irving Moy opened the meeting by handing out a list of 8 items that DPH feels are important for the Committee to address:

1. Educational requirements for both nurses and aides, including for special care dementia units.

2. Mandatory specified comprehensive assessments of clients (prior to admission and periodically thereafter). These should be consistent and reflect AL best practices.

3. Develop uniform discharge criteria necessitating placement at alternative settings.

4. Clarify definition and guidelines for supervision of self-administration of medications, especially for dementia units.

5. Develop designation on DPH license identifying "specialized units for Alzheimer's/dementia care."

6. Define "chronic and stable." (at an earlier meeting of some of the members, one person suggested "not medically complex and unstable").

7. Identify an individual responsible for the administrative functions within the ALSA (such as need for an administrative asst.).

8. Mandate ALSA to provide to each prospective client a list of services it will provide and those that it is prohibited from providing (i.e., Disclosure).

Discussion followed on the following issues:

<u>Disclosure</u>

- need uniform format that delineates things such as services and fee structure, resident rights, discharge criteria, how to get in touch with State Ombudsman, State Survey results and Plan of Correction (make available).
- Nancy Schaffer, State Ombudsman, said they are getting complaints there is not full disclosure on such things as discharge criteria, when to use a private aide or another health service, and transportation services.
- In response to a question, Chris Carter outlined CALA's support for Disclosure. CALA offers a Disclosure Statement Sample, Consumer Guide, annual Hartford Courant insert on AL that comes out each September, Website, and list of the State's 110 communities.

  CALA also has assembled Best Practices on such issues as elopement, dementia care, move-out/discharge, disclosure, negotiated risk, and Advance Directives.

- Senator Prague asked for samples of Residency Agreements and other materials given out to prospective residents (CALA will submit copies of Residency Agreements and attachments, and marketing brochures from Atria Stratford and Benchmark).
- For multiple site ALSA's, DPH wants one contact person.

DPH Dilemma

- Wendy Furniss, DPH, said DPH has no authority for enforcement.
- Michael Smith, DPH, said DPH faces a dilemma in that they are seeing higher levels of acuity and more complex medical conditions, but it is all called Assisted Living. He asked if we need two different sets of regulations, one for AL and one for Dementia. Vicki Carlson added that we need to define the essence of skilled care.

Staffing Concerns

- Assisted Living Services Agencies (ALSA's) need an Administrative Assistant position to the Supervisor of Assisted Living Services (SALSA, or Head R.N.) to assist with such things as scheduling, service planning, paperwork, ad verifying CNA credentials. The SALSA position is experiencing much burnout and turnover in the State. They need an assistant to help with the many administrative duties.
- Questioned nurse staffing requirements, and expanding them to require an RN 24/7, or at least an LPN, or a nurse on site in the evening until about 8:00 P.M. At present, there is only an RN required to be on-call for the CNA's overnight.

  Some concern that this is not necessary in most AL's, and if there is a requirement to increase staffing then the State will have to increase its reimbursement under the Pilot Program. -- Also, a concern expressed "are you moving towards licensed beds" as in nursing homes, which have been under a State mandated moratorium since 1990.

- More training and education for CNA's, especially Dementia education.
- Need background checks, drug testing and checking certification for all CNA's and Nurses. Discussion about using Nurse & CNA registry for latter, but that only applies to SNF's.

MRC in Relation to ALSA

- Some discussion about not needing to expand the regulations to cover the MRC. This is a very important point as we don't want to turn AL into SNF.
- Should health information be kept confidential within the ALSA (i.e., only available to the nurses and CNA's, and not shared with the employees of the MRC such as even the ED (who is Services Coordinator under the current regs). This would be problematic.

Special Dementia Units

- A major concern. Discussion of setting limits to Dementia units. Concerns expressed included fact some Dementia units are locked, and even lock residents out of their apartments during day. They need free access. Also, acuity is much different than for other AL, but it all comes under one set of regulations. There are big differences and different sets of needs. Some said this was never foreseen in the drafting of the present Regulations.

Supervision of Self-Administration of Medications

- Questioned how you can supervise a resident with dementia to self-administer their medications. Example of eye drop brought up. Suggestion that a nurse should do this.

Next meeting tentatively scheduled for Friday, February 23, at 9:30 A.M. However, this may be changed as a number of members can't make it.

Following meeting Senator Edith Prague said she would like to visit Atria Stratford. D. Vail has responded he would be happy to host Senator Prague. This may be a good opportunity to win her over to the AL side.

Note: Issues of concern as I see them.

1. Maintain current regulatory structure of licensing AL services, not the residential setting. Rationale includes fact and we don't want to turn AL into SNF, flexibility of operations, consumer choice, cost containment, and fact that the HUD projects and CCRC's may not be able to offer AL services.

2. Increasing nurse staffing requirements.

3. Medication administration changes.

4. Special Dementia Care Unit regulation changes.

Appendix F

Assisted Living Legislation in Connecticut—2007—Public Act 07-2

Sec. 30. (NEW) (*Effective October 1, 2007*) As used in this section and sections 31 to 38, inclusive, of this act:
(1) "Activities of daily living" means activities or tasks, that are essential for a person's healthful and safe existence, including, but not limited to, bathing, dressing, grooming, eating, meal preparation, shopping, housekeeping, transfers, bowel and bladder care, laundry, communication, self-administration of medication and ambulation.
(2) "Assisted living services" means nursing services and assistance with activities of daily living provided to residents living within a managed residential community having supportive services that encourage persons primarily fifty-five years of age or older to maintain a maximum level of independence.
(3) "Assisted living services agency" means an entity, licensed by the Department of Public Health pursuant to chapter 368v of the general statutes that provides, among other things, nursing services and assistance with activities of daily living to a population that is chronic and stable.
(4) "Managed residential community" means a for-profit or not-for-profit facility consisting of private residential units that provides a managed group living environment consisting of housing and services for persons who are primarily fifty-five years of age or older. "Managed residential community" does not include any state-funded congregate housing facilities.
(5) "Department" means the Department of Public Health.
(6) "Private residential unit" means a private living environment designed for use and occupancy by a resident within a managed residential community that includes a full bathroom and access to facilities and equipment for the preparation and storage of food.
(7) "Resident" means a person residing in a private residential unit of a managed residential community pursuant to the terms of a written agreement for occupancy of such unit.
Sec. 31. (NEW) (*Effective October 1, 2007*) (a) All managed residential communities operating in the state shall:
(1) Provide a written residency agreement to each resident in accordance with section 37 of this act;
(2) Afford residents the ability to access services provided by an assisted living services agency. Such services shall be provided in accordance with a service plan developed in accordance with section 36 of this act;
(3) Upon the request of a resident, arrange, in conjunction with the assisted living services agency, for the provision of ancillary medical services on behalf of a resident, including physician and dental services, pharmacy services, restorative physical therapies, podiatry services, hospice care and home health agency services, provided the ancillary medical services are not administered by employees of the managed residential community, unless the resident chooses to receive such services;
(4) Provide a formally established security program for the protection and safety of residents that is designed to protect residents from intruders;
(5) Afford residents the rights and privileges guaranteed under title 47a of the general statutes;
(6) Comply with the provisions of subsection (c) of section 19-13-D105 of the regulations of Connecticut state agencies; and
(7) Be subject to oversight and regulation by the Department of Public Health.

(b) No managed residential community shall control or manage the financial affairs or personal property of any resident.

Sec. 32. (NEW) (*Effective April 1, 2008*) The Department of Public Health shall receive and investigate any complaint alleging that a managed residential community is engaging in, or has engaged in activities, practices or omissions that would constitute a violation of sections 31 to 38, inclusive, of this act, the regulations adopted pursuant to section 38 of this act, or any other regulation applicable to managed residential communities, including the Public Health Code. The department shall include in its biennial review of a managed residential community, conducted in accordance with section 33 of this act, a review of the nature and type of any complaint received concerning the managed residential community, as well as the department's final determination made with respect to such complaint.

Sec. 33. (NEW) (*Effective April 1, 2008*) (a) The Department of Public Health shall conduct biennial reviews of all managed residential communities. Biennial reviews conducted by the department in accordance with the provisions of this section, shall be in addition to, and not in lieu of, any inspections of such communities by state or local officials to ensure compliance with the Public Health Code, the State Building Code, the State Fire Code or any local zoning ordinance. In addition to the biennial review, the department may conduct at any time a review of a managed residential community when the department has probable cause to believe that a managed residential community is operating in violation of the provisions of sections 31 to 38, inclusive, of this act, the regulations adopted pursuant to section 38 of this act, or any other regulation applicable to managed residential communities, including the Public Health Code. The purpose of any biennial or investigatory review shall be to ensure that a managed residential community is operating in compliance with the provisions of sections 31 to 38, inclusive, of this act, the regulations adopted pursuant to section 38 of this act or any other regulation applicable to managed residential communities, including the Public Health Code. A biennial review shall include: (1) An inspection of all common areas of the managed residential community, including any common kitchen or meal preparation area located within the community; and (2) an inspection of private residential units, but only if prior to such inspection the residents occupying such units provide written consent to the inspection. In the course of conducting a biennial or investigatory review, an inspector may interview any manager, staff member or resident of the managed residential community. Interviews with any resident shall require the consent of the resident, be confidential and shall be conducted privately.

(b) The department shall establish an administrative procedure for the preparation, completion and transmittal of written reports prepared as part of any review undertaken pursuant to this section or section 32 of this act. If after undertaking any such review the department determines that a managed residential community is in violation of the provisions of sections 31 to 38, inclusive, of this act, the department shall provide written notice of its determination of an alleged violation to the managed residential community. Such written notice shall advise the managed residential community of its right to request an administrative hearing in accordance with sections 4-176e to 4-181a, inclusive, of the general statutes to contest such determination. A managed residential community shall request such hearing, in writing, not later than fifteen days after the date of receipt of the notice of an alleged violation from the department. The department may issue such remedial orders as deemed necessary by the department to ensure compliance with the provisions of sections 31 to 38, inclusive, of this act. Remedial orders available to the department shall include, but not be limited to, the imposition of a civil penalty against a managed residential community in an amount not to exceed five thousand dollars per violation.

The department shall stay the imposition of any remedial order or civil penalty pending the outcome of an administrative hearing. The department shall maintain and make available for public inspection all completed reports, responses from managed residential communities and any remedial orders issued in accordance with the provisions of this section.

(c) Upon the failure of a managed residential community to comply with a remedial order issued by the department, the Attorney General, at the request of the Commissioner of Public Health, may bring an action in the superior court for the judicial district of Hartford to enforce such order. All actions brought by the Attorney General pursuant to the provisions of this section shall have precedence in the order of trial as provided in section 52-191 of the general statutes. The court may issue such orders as are necessary to obtain compliance with the order of the department.

Sec. 34. (NEW) (*Effective October 1, 2007*) (a) A managed residential community shall have a written bill of rights that prescribes the rights afforded to each resident. A designated staff person from the managed residential community shall provide and explain the bill of rights to the resident at the time that such resident enters into a residency agreement at the managed residential community. The bill of rights shall include, but not be limited to, that each resident has the right to:

(1) Live in a clean, safe and habitable private residential unit;

(2) Be treated with consideration, respect and due recognition of personal dignity, individuality and the need for privacy;

(3) Privacy within a private residential unit, subject to rules of the managed residential community reasonably designed to promote the health, safety and welfare of the resident;

(4) Retain and use one's own personal property within a private residential unit so as to maintain individuality and personal dignity provided the use of personal property does not infringe on the rights of other residents or threaten the health, safety and welfare of other residents;

(5) Private communications, including receiving and sending unopened correspondence, telephone access and visiting with persons of one's choice;

(6) Freedom to participate in and benefit from community services and activities so as to achieve the highest possible level of independence, autonomy and interaction within the community;

(7) Directly engage or contract with licensed health care professionals and providers of one's choice to obtain necessary health care services in one's private residential unit, or such other space in the managed residential community as may be made available to residents for such purposes;

(8) Manage one's own financial affairs;

(9) Exercise civil and religious liberties;

(10) Present grievances and recommend changes in policies, procedures and services to the manager or staff of the managed residential community, government officials or any other person without restraint, interference, coercion, discrimination or reprisal from the managed residential community, including access to representatives of the department or the Office of the Long-Term Care Ombudsman;

(11) Upon request, obtain from the managed residential community the name of the service coordinator or any other persons responsible for resident care or the coordination of resident care;

(12) Confidential treatment of all records and communications to the extent required by state and federal law;

(13) Have all reasonable requests responded to promptly and adequately within the capacity of the managed residential community and with due consideration given to the rights of other residents;
(14) Be fully advised of the relationship that the managed residential community has with any assisted living services agency, health care facility or educational institution to the extent that such relationship relates to resident medical care or treatment and to receive an explanation about the relationship;
(15) Receive a copy of any rules or regulations of the managed residential community;
(16) Privacy when receiving medical treatment or other services within the capacity of the managed residential community;
(17) Refuse care and treatment and participate in the planning for the care and services the resident needs or receives, provided the refusal of care and treatment may preclude the resident from being able to continue to reside in the managed residential community; and
(18) All rights and privileges afforded to tenants under title 47a of the general statutes.
(b) A managed residential community shall post in a prominent place in the managed residential community the resident's bill of rights, including those rights set forth in subsection (a) of this section. The posting of the resident's bill of rights shall include contact information for the Department of Public Health and the Office of the State Long-Term Care Ombudsman, including the names, addresses and telephone numbers of persons within such agencies who handle questions, comments or complaints concerning managed residential community.
Sec. 35. (NEW) (*Effective October 1, 2007*) No managed residential community shall enter into a written residency agreement with any individual who requires twenty-four hour skilled nursing care, unless such individual establishes to the satisfaction of both the managed residential community and the assisted living services agency that the individual has, or has arranged for, such twenty-four hour care and maintains such care as a condition of residency if an assisted living services agency determines that such care is necessary.
Sec. 36. (NEW) (*Effective October 1, 2007*) (a) An assisted living services agency shall develop and maintain an individualized service plan for any resident of a managed residential community that receives assisted living services. Such agency shall develop the individualized service plan after consultation with the resident and following an assessment of the resident by a registered nurse. The individualized service plan shall set forth in lay terms the needs of the resident for assisted living services, the providers or intended providers of needed services, the scope, type and frequency of such services, an itemized cost of such services and any other information that Department of Public Health may require. The individualized service plan and any periodic revisions thereto shall be confidential, in writing, signed by the resident, or the resident's legal representative, and a representative of the assisted living services agency and available for inspection by the resident and the department.
(b) An assisted living services agency shall maintain written policies and procedures for the initial evaluation and regular, periodic reassessment of the functional and health status and service requirements of each resident who requires assisted living services.
Sec. 37. (NEW) (*Effective October 1, 2007*) A managed residential community shall enter into a written residency agreement with each resident that clearly sets forth the rights and responsibilities of the resident and the managed residential community, including the duties set forth in section 19a-562 of the general statutes. The residency agreement shall be set forth in plain language and printed in not less than fourteen-point type. The residency agreement shall be signed by the managed residential community's authorized agent and by the resident, or the

resident's legal representative, prior to the resident taking possession of a private residential unit and shall include, at a minimum:
(1) An itemization of assisted living services, transportation services, recreation services and any other services and goods, lodging and meals to be provided on behalf of the resident by the managed residential community;
(2) A full and fair disclosure of all charges, fees, expenses and costs to be borne by the resident;
(3) A schedule of payments and disclosure of all late fees or potential penalties;
(4) The grievance procedure with respect to enforcement of the terms of the residency agreement;
(5) The managed residential community's covenant to comply with all municipal, state and federal laws and regulations regarding consumer protection and protection from financial exploitation;
(6) The managed residential community's covenant to afford residents all rights and privileges afforded under title 47a of the general statutes;
(7) The conditions under which the agreement can be terminated by either party;
(8) Full disclosure of the rights and responsibilities of the resident and the managed residential community in situations involving serious deterioration in the health of the resident, hospitalization of the resident or death of the resident, including a provision that specifies that in the event that a resident of the community dies, the estate or family of such resident shall only be responsible for further payment to the community for a period of time not to exceed fifteen days following the date of death of such resident as long as the private residential unit formerly occupied by the resident has been vacated; and
(9) Any adopted rules of the managed residential community reasonably designed to promote the health, safety and welfare of residents.
Sec. 38. (NEW) (*Effective October 1, 2007*) (a) A managed residential community shall meet the requirements of all applicable federal and state laws and regulations, including, but not limited to, the Public Health Code, State Building Code and the State Fire Safety Code, and federal and state laws and regulations governing handicapped accessibility.
(b) The Commissioner of Public Health shall adopt regulations, in accordance with chapter 54 of the general statutes, to carry out the provisions of sections 30 to 38, inclusive, of this act.

Appendix G

Connecticut Nurse Practice Act, Chapter 378

Sec. 20-87a. Definitions. Scope of practice. (a) The practice of nursing by a registered nurse is defined as the process of diagnosing human responses to actual or potential health problems, providing supportive and restorative care, health counseling and teaching, case finding and referral, collaborating in the implementation of the total health care regimen, and executing the medical regimen under the direction of a licensed physician, dentist or advanced practice registered nurse.

Declaratory Ruling—Licensed Practical Nurse Supervision

Based on the Board's interpretation of the terms of Conn. Gen. Stat. Section 20-87a(b) as further elucidated by the evidence presented at hearing, the Board hereby concludes that:
1. The LPN must perform his/her nursing functions and shared nursing responsibilities under the direction of a registered nurse.
2. The LPN is properly allowed to participate in all phases of the nursing process under the direction of the registered nurse, to the following extent:

A. Contribute to the nursing assessment by:

a) Collecting, reporting and recording objective and subjective data in an accurate and timely manner. Data collection includes:

1) Observation about the condition or change in condition of the client.

2) Signs and symptoms of deviation from normal health status.

B. Participate in the development of the strategy of care in consultation with other nursing personnel by:
Providing data.

Contributing to the identification of priorities.

Contributing to setting realistic and measurable goals.

C. Participate in the assisting, delegating and giving of directed care by:

a) Providing care for clients whose conditions are stabilized or predictable.

b) Providing care for clients whose conditions are critical and/or unpredictable under the direct supervision of the registered nurse and, when executing the medical regimen, under the direction of a licensed physician or dentist.
c) Implement nursing care according to the priority of needs and established goals.
d) Providing an environment conducive to safety and health.
e) Documenting nursing interventions and responses to care.
f) Communicating nursing interventions and responses to care to appropriate members of the health team.
The selected tasks and shared responsibilities of the licensed practical nurse are continually changing as the art and science of nursing changes. Thus, an itemized list of tasks and shared responsibilities cannot be identified. However, all licensed nurses are responsible for being adequately prepared for the nursing responsibilities they assume. Practical nurse licensure requires validation of completion of an approved preparatory program and successful completion of the licensing examination. This validation documents achievement of all theoretical and nursing skill competencies required of an entry level practical nurse in caring for individuals in any age group. This would comprise the proper and sufficient education and skills of the licensed practice nurse at the point of entry into the profession. Continuing education which validates competency may enable the licensed practical nurse to function competently beyond entry level.

All selected nursing tasks and shared nursing responsibilities must be carried out under the direction of the registered nurse. The direction of the registered nurse should be immediately available, on site, in health care agencies providing in-patient and out-patient nursing services. In community health settings, the registered nurse must be responsible for the total plan of nursing care and should be proximately available for on-site visits and available by telephone. The licensed practice nurse collaborates in the implementation of the total health care regimen under the direction of a registered nurse as described above.

SO ORDERED.

February 7, 1989 Bette Jane M. Murphy, R.N.

Chairperson

Connecticut State Board of Examiners for Nursing

Declaratory Ruling—Unlicensed Personnel

No task is to be delegated to unlicensed personnel without the consent of the delegating registered nurse, and the licensed practical nurse, if participating in said delegation, and through which the delegation may occur. It is the responsibility of said nurses to determine if adequate resources and support are available to them to support, direct, supervise and evaluate the delegation activity. (Exhibit F-21, p. 3) In addition, the criteria
identified in Subsection A of this Section, shall be applied. Therefore, in any situation in which a nurse, including a licensed practical nurse under the direction of a registered nurse, is delegating a specific task, the final say as to the appropriateness of the specific task delegation to unlicensed personnel rests with the nurse.

2. No delegation shall be made without the delegating nurse making a determination that, in the nurse's professional judgment, the delegated task can be properly and safely performed by unlicensed personnel to whom it is to be delegated, and that such delegation is consistent with the client's safety and welfare. If either the registered nurse, or the licensed practical nurse, responsible for the delegation believes that specific task delegation cannot safely occur, such nurse shall refuse to delegate that task and document, in writing and in a timely fashion, that he or she has informed his/her supervisor of this fact, and of its impact on client care.

C. TRAINING AND SUPERVISION

1. The Board finds that the case-by-case analysis of what constitutes the appropriate training and supervision of unlicensed personnel to whom the nurse may delegate nursing functions remains the responsibility of the registered nurse responsible for the overall plan of care for the client. Institutional policy does not abdicate the nurse's responsibility to ensure the appropriate delegation of the appropriate act to the
appropriate unlicensed personnel at the appropriate time and circumstances. However, the nurse shall only delegate nursing functions to unlicensed personnel in the presence of clearly written agency policies and role definitions, and documented competencies of the unlicensed personnel specific to the task being delegated.

D. CONCLUSION: TRAINING AND SUPERVISION

1. When delegating to unlicensed personnel includes tasks which meet client's basic human needs and activities of daily living, the delegating nurse shall ascertain that individuals to whom these tasks are delegated have demonstrated skill competency. Uniform training and certification of unlicensed personnel may be used as a basis to presume baseline competencies and serve to protect the safety and wellbeing of clients. Therefore, certification as a Certified Nursing Assistant or Home Health Aide may provide guidance. Certification for unlicensed personnel in the acute care setting pursuant to regulations promulgated by the Department of Health and Addiction Services in response to this ruling may be utilized. Also, documentation of task specific instruction requiring periodic validation of current theoretical and clinical competency by unlicensed personnel may provide guidance to a nurse before any such delegation may occur. Also, the nurse shall only delegate nursing functions to unlicensed personnel in the presence of clear written agency policies and role definitions, and documented competencies of the unlicensed personnel specific to the task being delegated.
2. Supervision of unlicensed personnel shall include: guidelines for each nursing task, including initial direction, and periodic evaluation of implementation and evaluation of outcomes. The proximity and availability of the nurse responsible for delegation, as
well as the nurse's knowledge of principles of delegation and supervision, also determine the appropriateness of delegation. The registered nurse shall be on-site in in-patient,
long-term care and clinic/out-patient settings. In community/home health care settings, the registered nurse shall be available by phone and for on-site consultation as needed.

E. NURSING PROCESS

1. Assessment and Evaluation - The nurse may delegate selected nursing tasks to unlicensed personnel if the nursing activities do not require nursing assessment and judgment during

implementation. The criteria that follow, and those referenced in Subsections B and D of this section, shall be met. The registered nurse is
solely responsible for the assessment, planning, and evaluation phases of the nursing process. The registered nurse may determine that the unlicensed personnel may collect certain objective and subjective data and report changes in client conditions which fall outside normal parameters of client status. The nurse shall determine what data require verification or further action. Interpretation of reports or diagnostic parameters is the
responsibility of the nurse. Also, comparing client outcomes to objectives and making adjustments in the plan of care are the ultimate responsibility of the registered nurse, with the assistance of the licensed practical nurse.
2. Planning - No component of nursing care planning may be delegated by a nurse to unlicensed personnel.
3. Implementation - Due to the fact that the practice of nursing is diversifying and constantly evolving no single list can provide an appropriate classification for all the client care activities that may or may not be delegated in particular cases or settings. Therefore it becomes even more critical for the nurse to have evidence of skill competency of individuals to whom the nurse is delegating those activities. Unlicensed
personnel may carry out certain planned approaches of client care. These approaches are planned by the registered nurse for clients and involve activities of daily living and basic human needs. These approaches can be delegated if they do not require assessment (other than data collection, planning, judgment, adaptation or evaluation. Nursing procedures, which require an understanding of the nursing process, or nursing assessment and judgment during implementation, are licensed activities. Therefore, a nurse may not delegate responsibility for the implementation of a task which requires such knowledge or skills. Medication administration by any route, including those required for the initiation and termination of dialysis, remains a licensed activity and shall not be delegated, unless specific statutory exemptions exist.

F. CONCLUSION: NURSING PROCESS

1. The Board finds that the nurse may delegate selected nursing tasks, which assist in implementing the registered nurse directed plan of care, to unlicensed personnel. Said nursing tasks shall not require nursing assessment, judgment, planning, and evaluation during implementation The delegated task shall be within the area of responsibility of the delegating nurse and shall not be such as requires any unlicensed personnel to exercise the knowledge, judgment, or skill required of a nurse. Collecting, reporting and assisting in documentation of data may be delegated. Activities which meet or assist the client in meeting basic human needs and activities of daily living may be delegated. No task may be delegated which requires an understanding of nursing process and principles necessary to recognize and/or manage complications. Health counseling, teaching, case finding and referral may never be delegated to unlicensed personnel. Medication administration by any route, remains a licensed activity, unless a specific statutory exemption exists. Nursing procedures, which require an understanding of the nursing process, or nursing assessment and judgment during implementation, are licensed activities. Therefore, a nurse may not delegate responsibility for the implementation of a task which requires
such knowledge or skills.

IV. CONCLUSIONS

Therefore, general criteria for delegating nursing tasks by nurses to unlicensed personnel are as follows:

A. The nurse delegating the activity is directly responsible and accountable for the nursing care given to the client. [The registered nurse retains ultimate accountability for appropriate delegatory decisions, supervision and the coordination of care].

B. The final decision as to what nursing activity can be safely delegated to unlicensed personnel for a particular patient is determined by the nurse on a case-by-case basis based on his/her professional judgment.

C. The nurse must make an assessment of the client's nursing care needs prior to delegating the nursing activity.

D. The nursing activity must be one that a reasonable and prudent nurse would determine to be delegable within the scope of nursing judgment; that would not require unlicensed personnel to exercise nursing judgment; and that can be properly and safely performed by unlicensed personnel without jeopardizing the client's welfare.

E. Unlicensed personnel shall have skill competencies necessary for the proper performance of the task; the nurse shall evaluate unlicensed personnel's competency to perform the nursing task.

F. In addition, the Board concludes that when delegating to unlicensed personnel tasks which meet client's basic human needs and activities of daily living the delegating nurse shall ascertain that individuals to whom these tasks are delegated have demonstrated skill competencies. Uniform training and certification of unlicensed personnel may be used as a basis to presume baseline competencies and serve to protect the safety and well-being of clients. Therefore, certification as a Certified Nursing
Assistant or Home Health Aide may provide guidance. Unlicensed assistive personnel
are presumed to have baseline competency if they are certified as Certified Nursing Assistant or Home Health Aide or hold another Board approved State certification, and if documentation of task specific competency, specific to the task being delegated, exists. If the nurse delegates a task to an unlicensed personnel who does not hold such certification and competency validation, the nurse bears responsibility to verify that the person to whom the task is being delegated is competent to perform such task.

G. The nurse shall adequately supervise the performance of the delegated nursing activity in accordance with the requirements of supervision. These shall include, but not be limited to, initial direction, periodic evaluation of implementation and evaluation of outcomes. The registered nurse shall be on-site in in-patient, long-term care and clinic/out-patient settings. In community/home health care settings the registered nurse shall be available by phone and for on-site consultation as needed.

H. If either the registered nurse, or the licensed practical nurse, responsible for the delegation believes that specific task delegation cannot safely occur, such nurse shall refuse to delegate that task and document, in writing and in a timely fashion, that he or she has informed his/her supervisor of this fact, and of its impact on client care.

I. When the nurse comes under scrutiny for disciplinary action by the Board, the Board will hold this nurse accountable for the delegation of nursing tasks to unlicensed personnel, as set forth herein.

This Declaratory Ruling shall become effective on April 5, 1995.

Voted on at Hartford, Connecticut the 5th day of April, 1995.

BOARD OF EXAMINERS FOR NURSING

Appendix H
Early Codes

	Old Coding Structure					

	Name					
	working with Regional level supports					
	why SALSA role not beneficiary of more support					
	what do Wellness Nurses do					
	wellness staffing					
	welcomed into role & community					
	volume of work the role requires					
	turnover of SALSAs in Al					
	tumultuous times					
	tumultuous and unsettling					
	Transition to SALSA role					
	transition challenges with new SALSA in role					
	thin line b et AL and dementia care					
	the SALES PITCH for AL					
	test					
	Teamwork					
	systems changes---challenges					
	supervisory issues					
	supervision of CNAs---non-clinical involvement					
	stretches regulations					
	stick to the rules					
	staffing supports resident frailty					

	Staffing for fluid situation					
	staff not felt listened to-heard					
	staff balking at needed resident changes					
	staff apprehensive re mgmt turnover					
	SALSA--Knowing the whole resident					
	SALSA-ED role expectations					
	SALSA WORRIED ABOUT NURSES					
	SALSA works without a break					
	SALSA works with nsg team					
	SALSA working with dept heads					

	SALSA wants staff to be happy					
	SALSA valued by ED--or not					
	SALSA value to company					
	SALSA uses all available resources					
	SALSA turnover					
	SALSA transition--scary					

	SALSA title					
	SALSA supports marketing efforts					
	SALSA supervising					

	SALSA sets up systems					
	SALSA sees both sides					
	SALSA second guessing herself					
	SALSA scope of responsibilities					
	SALSA ROLE--EXPECTATIONS CHANGING					
	SALSA responsibilities overwhelming					
	SALSA relationship with SNF DNS					
	SALSA relationship with families					

	SALSA reaction to being overruled					
	SALSA privacy					
	SALSA prepared for role but feeling lacking					
	SALSA position not highly admired					
	SALSA personal attributes					
	SALSA perceived leadership shortcomings					
	SALSA part of management team					
	SALSA orientation to role					
	SALSA opinion of nurses					
	SALSA only RN					
	SALSA on call					
	SALSA office					
	SALSA not working with the team---per Corp					
	SALSA not recognized for contribution					
	SALSA misunderstanding issues					
	SALSA might get more support					
	SALSA mentored in MRC expectations					

	SALSA -Marketing relationship					
	SALSA management style					
	SALSA likes teaching					
	SALSA leading management process but needing support					
	SALSA involved in Ind Living move in decisions					
	SALSA input re management decisions					

	SALSA hiring and firing					
	SALSA gets hands dirty					
	SALSA freed up					
	SALSA filling gaps					
	SALSA feels vulnerable					

	SALSA feelings about interview					
	SALSA feelings					

	SALSA feeling valued in role					
	SALSA feeling respected					
	SALSA feeling clinical skills depreciated					

	SALSA fears confrontation					
	SALSA fearful of clinical issue					
	SALSA experience scary					
	SALSA expands nursing services					
	SALSA enjoys the work & the AL model					
	SALSA doing clerical work					
	SALSA does patient education					
	SALSA does not have final say in clinical decisions					
	SALSA does not feel helpless					
	SALSA dislikes $$$ issues in AL					
	SALSA disagreement with marketing focus					
	SALSA disagreement with CEO					
	SALSA directs clinical follow up					
	SALSA decisions turfed to admin or MD					
	SALSA decision making authority					

	SALSA day to day involvement					
	SALSA compensation					
	SALSA collaborates in COC					
	SALSA clinically supervises aides					
	SALSA challengingposition					
	SALSA challenge re management role					
	SALSA buys into business goals					

	SALSA attributes--necessary					
	SALSA AS WELLNESS NURSE TOO					
	SALSA anticipating being overruled clinically					
	SALSA actively mnanaging issues---or not					
	SALSA abides by Regs & Policies					
	SALSA & non clin mgmt disagree re ssafety vs indep					
	SALSA & CCRC relationship					
	SAFETY VS CHOICE					
	responsibilities of the nurse					
	Respect for SALSA role					
	residents with insulin					
	residents well--not sick as in SNF					
	Residents mistrust					
	Residents getting services they pay for					
	Residents appreciate nsg					
	resident transfers--sign of higher acuity					
	resident safety					
	resident remifications for overruled clinical decision					
	Resident independence					
	Resident focused					
	residednts with O2					
	Res-fam doesn't want to pay for healthcare					
	Res--fam choice VS nursing assessment--safety					
	REimbursement for ALSA services					
	Regulatory issues					
	Regulations--challenging					
	Regional clinical involvement in decision making					

	REALIZE					

	quality of life for residents could be better					
	priviledge of working with the seniors					
	Private caregiver					
	Preferred way of being as a person					
	Prefer caregiving role to Admin role					
	physician involvement with nursing					
	philosophy of company					
	pharmacy services					
	patient care is important					
	Parameters of AL care					
	Overwhelming					
	Occupancy critical					

	NURSING WORKING ENVIRONMENT					
	Nursing staffing model					
	nursing shortage					
	nursing responsibilities					
	nursing reimbursement = aide reimbursement					
	nursing perception that AL has lesser nursing standards					
	nursing in AL has grown					
	nursing discomfort					
	nursing assessments					
	nurses--don't control time it takes to do work					

	nurses voice concerns to admin					
	Nurses very busy					
	nurses schedule--CNAs in charge					
	nurses' responsibilities per their license					
	nurses respected by CNAs					
	nurses liking the AL environment					

	nurses liked by residents					
	nurses have many job opportunities					
	non-clinical decisions re clinical issues					
	Non-ALSA management understanding Regs					
	non clin coords manage areas					

	Non ALSA management understanding caregiving idiosynchracies					
	no post-it survey					
	no mechanical lifts					
	No ED currently					
	new owner---perhaps changes					
	need more nsg hours to meet resident needs					
	multi-cultural environment					
	mini health centers					
	MENTOR PGM FOR CNA EDCTN & SUPPRT					
	MD-nurse communication and interaction					
	MD adjust care orders					
	Marketing doesn't tell the whole story					
	Marketing conveyed possibility					
	manipulating nursing work schedules					
	Managerial competency---or lack of it					

	MANAGEMENT TRANSITIONS					
	MANAGEMENT COMPANIES CHANGING					
	MAKE THINGS BETTER					
	love the residents					
	Living the Mission					
	live the mission					
	LIKES THE JOB					
	LEADERSHIP--described but focus deferred					

	Leadership					
	lack of understanding re AL					
	lack of understanding of role					
	lack of clerical support					
	knowing the residents					
	introduction					
	INTERFACE W HOME CARE--NSG RESPONSIBILITIES					
	incongruity between Regs and company policy					
	how nursing makes decisions					
	Hospice care					
	home care agencies change					
	higher acuity--frailty					

	heart sings to nursing					
	have to pay the bills					
	hands on nursing					
	guidelines & criteria for admitting					
	great learning esperience					
	gray area re residents needs					
	gray area re Regs					
	Future of AL					
	Feeling re company opinion of nurses' role					
	feeling profoundly responsible					
	feeling positive despite unsettling issues					
	FEELING LIKE I NEVER FINISH ANYTHING					
	FEELING ALONE IN THE SALSA ROLE					
	family preference re move in					

	family involvement and SALSA					
	Explaining the role of AL in the care continuum					

	exercise leadership skills					
	ethical issue re resident care					
	Enjoy working environment					
	ED values clinical judgment					
	ED really in charge					
	ED leads					
	ED gets credit for SALSA work					
	DPH surveyors--support & education					
	disorganized beginning					
	disclosure to families					
	Disagreement between resident safety and choice					
	difficult transition with new SALSA leadership					
	didn't know about AL					
	description re details of setting					
	description of role					

	description of experience					
	describe Regs that impact SALSA					
	depending on others to fulfill SALSA role					

	Denying admissions					
	dementia coordinator					
	dementia care challenges					

	decision making after assessment					
	decide what you're going to sell					
	creative clinical decisions					

	corporate transition at community					
	corporate alerts SALSA re transition issues					

	Corp policy vs state Regs					
	coordinating soup to nuts					
	COMPANY VALUES ed OVER salsa					
	cOMPANY VALUES					
	company puts stipulations on nursing					
	Community management structure					
	communication within Wellness					
	CLINICAL VS ADMIN DECISIONS					
	clinical software needs					
	clinical opinions--respected					
	clinical judgment supported					
	clinical disagreements resolved--HOW					
	clinical decisions--overruled					
	clinical decisions worth considering					
	clinical decisions supported					
	clinical decisions 2nd guessed					
	Clinical competence					
	clin conditions that cannot be managed incommunity					
	chronic & stable					
	CHARGING FOR CARE					
	changes made by SALSA					
	Changes imposed on SALSA					
	Census pressure					
	Census balanced with care					
	care planning process					
	Business component to AL model					
	build relationships with residents					
	budget more imp that pt care					
	budget constrains nursing hours					
	better in past experience					

	best not to turn anyone away					
	being respected					
	Before the Regs					
	balance sales with nursing					
	balance care and budget					
	balance budget with care					
	Assess residents for ALSA services					

	apprehension from staff					

	appreciation for staff					
	ALSA structure re MRC					
	ALSA srvcs with no dementia unit					
	ALSA requirements for resident care needs					
	AL not able to provide more complex care					
	AL good environment for residents					
	AL different than expected					
	AL basic philosophy					
	AL and interface with external community					

	AL always changing					
	aides not sharing info with nurses					
	Aging in place					

	After AL---WHAT					
	Administrative--clerical support					

	Admin support for safety decision					
	a challenging position--SALSA					

Appendix I

Third Generation Categories

BEING A CORPORATION--UMBRELLA			
	Name		Sources
	ED		
		Name	
		COMPANY VALUES ed OVER salsa	
		doesn't worry about details	
		ED gets credit for SALSA work	
		ED leads	
		ED really in charge	
		license NOT to be involved	
		No ED currently	
		Service Coordinator	
	MARKETING		
		Name	
		Customer preferences	
		decide what you're going to sell	
		Marketing conveyed possibility	
		Marketing doesn't tell the whole story	
		SALSA buys into business goals	
			Name
			nursing vs r
			SALSA & m

			SALSA exp

	SALSA disagreement with marketing focus	
	SALSA -Marketing relationship	
	SALSA supports marketing efforts	
	the SALES PITCH for AL	

	PARAMETERS OF CARE		

	Name	
	AL not able to provide more complex care	
	ALSA requirements for resident care needs	
	ALSA srvcs with no dementia unit	
	clin conditions that cannot be managed incommunity	
	guidelines & criteria for admitting	
	no mechanical lifts	
	Parameters of AL care	
	residednts with O2	
	residents with insulin	
	staff balking at needed resident changes	

	POLICY VS REGS		

	Name	
	Corp policy vs state Regs	
	describe Regs that impact SALSA	
	DPH surveyors--support & education	
	gray area re Regs	
	incongruity between Regs and company policy	

CLINICAL DECISIONS--ISSUES--UMBRELLA			

	Name		Sources
	AL always changing		
	Assess residents for ALSA services		

	Name	
	broaden my criteria	
	COMPLEX SITUATIONS	
	extensive rationale	
	incomplete information at admission	
	limited longevity in AL	
	marketing sells bill of goods	
	residents needs change after admission	
	SALSA explains situation differently	

	Clinical competence		
	clinical decisions 2nd guessed		
	clinical decisions--overruled		
	clinical disagreements resolved--HOW		
	clinical judgment supported		
	clinical opinions--respected		
	dementia care challenges		
	Regional support for SALSA		
	SAFETY VS CHOICE		

COMMUNITY MANAGEMENT--UMBRELLA			

	Name		Sources
	Community management structure		

	Name	
	Regulatory issues	

	Non ALSA management understanding care giving idiosyncrasies		

	Name	
	aging in place impact on nursing	
	DPH---negative surveys	
	lack of alignment between owners and nursing	
	lack of understanding of nursing itself	
	lack of understanding of role	
	new start up community---amount of work and unfairness	
	Non-ALSA management understanding Regs	
	SALSA and SALSA meetings	
	won't provide resources for SALSA	

INCREASED ACUITY-FRAILTY---UMBRELLA			

	Name		Sources
	AGING IN PLACE		

	Name	
	being admitted older & sicker	
	creative clinical decisions	
	Hospice care	
	resident gets better in AL	

		scrutiny re admission profile	
		staff frustrated	

	residents well--not sick as in SNF		

LEADERSHIP--SALSA---UMBRELLA			

	Name		Sources
	executive nursing leadership		
	hiring---quality staff		
	Leadership		

	Name	
	manage with no control	
	management vs. leadership	
	Need strong nursing voice	
	no one to delegate to	
	not included in mgmt decisions	
	profile of nurses	

	nurses say yes to anything		
	SALSA challenge re management role		
	supervisory issues		
	training		

NURSING DESCRIBES ITSELF---UMBRELLA			

	Name		Sources
	individual description		
	nursing perception		

	that AL has lesser nursing standards		
	nursing shortage		

	Name	
	turnover	

	professional description		

	Name	
	outsourcing of services	

	staffing supports resident frailty		

	Name	
	CNA pay	
	nursing hours	
	SALSA creative	
	staffing does not support resident frailty	

OPERATING THE BUSINESS			
	CENSUS		

	Name	
	Business component to AL model	
	Census balanced with care	
	Census pressure	

	Name
	census focu
	family prefe
	RESIDENT

	What business are we in		

RELATIONSHIP---IMPORTANCE OF UMBRELLA			
	disclosure to families		
	family involvement and SALSA		

SALSA Role---SALSA descriptions---UMBRELLA			

	Name		Sources
	CLERICAL SUPPORT		
	description of experience		
	description of role		
	FEELINGS		
		Name	
		SALSA fears confrontation	
		SALSA feelings	
			clinical
			discouraged
			frustrated
			good about
			good team
			no autonom
			overwhelme
			responsible
			stupid
			transitional
			vulnerable
		SALSA sees both sides	

	MD-nurse communication and interaction		
	On call		
	ORIENTATION		

	Name	
	AL different than expected	
	didn't know about AL	
	difficult transition with new SALSA leadership	
	SALSA orientation to role	

	stick to the rules		

Appendix J

Assisted Living Ambiance, taken from websites

Appendix K

Assisted Living Testimonials, taken from websites

"My house was too big, too much to manage. I was alone, shoveling snow, and my kids were a wreck wondering if I was ok. We were all ready for a change. I was one of the first to move into this beautiful new building. I love it here! Everyone is so friendly."

"Everyone knows my name--they stop in the hallway to ask me how my day is going and it makes me feel good about myself and where I am in my life."

“I wish I’d moved here sooner. I enjoy life much more and feel healthier than I have in years.”