AWAKENING NURSE MANAGERS' SPIRIT OF SELF-CARE WITHIN

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DEDICATION

I would like to dedicate this work to my fantastic husband, Steve Ricossa, Sr. He has been at my side for more than 4 decades supporting me on all of my academic pursuits. Steve is amazing and I am so grateful to him for encouraging me every step of the way. He has always been my best champion. I could not have achieved this auspicious degree without him at my side. I am blessed to have him in my life!

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ABSTRACT

Background

Nurse Managers (NMs) are vulnerable to leaving the profession due to dissatisfaction from mounting on-the-job pressures and perhaps unknowingly lack the practices of loving-kindness and self-care, which may help build resilience. There is a gap in the literature where the practice of self-care has not been addressed on behalf of NMs.

Purpose

The purpose of this dissertation was to determine if there is a correlation between demographic characteristics as it relates caring practices among NMs with their perceptions of their immediate supervisors (caring leader) and to discover if there is a correlation between a caring for self and caring leaders.

Study Methods

This study was descriptive, exploratory, and quantitative. The convenience sample consists of directors, nurse managers and assistant nurse managers. The setting is an organization called the California Association of Nurse Leaders. An IRB was obtained by the University of Hawai'i at Mānoa. Demographic information was collected with two instruments that measured self-care and leadership. The Watson Caritas Self Rating® (WSCRS) and Watson Caritas Leader Rating® (WCSRS). WSCRS had a Cronbach Alpha of .89. WSCRS had a Cronbach Alpha of .82, Recruitment and survey questions were distributed electronically. The study period was May 19, 2021, to June 30, 2021.

Data Analysis

The sample size consisted of NMs (n = 23). Missing data revealed that bias existed with family composition. For both WCSRS and WCSR surveys, the least responded items were: helping

and trusting relationships, and values, belief and faith. Cronbach alpha indicated good internal consistency. Using a regression model, findings indicate statistical significance ($p < 0.05$).

Findings

Family composition revealed bias, indicating those who live alone may have had more time to complete the survey. Results were examined separately and then combined to establish significance. The following independent variables were statistically significant when tested separately: advanced degree (masters' and doctorate) and marital status (married or partnered). However, when these variables were combined only advanced nursing degree was significant. The caring leader and advanced degree in nursing remained significant when tested separately. When combined, the advanced degree in nursing was significant. Caring for self and caring leader had a positive correlation.

Conclusion

This study was considered a pilot due to the small sample size. Findings indicated that advanced degree in nursing (masters' or doctorate) remained the most single predictor of caring for self throughout the study. A supervisor (caring leader) was correlated to the NMs' ability for caring for self.

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ABBREVIATIONS.

Abbreviation	Meaning
ACNL	Association of California Nurse Leaders
ANM/ANMs	Assistant Nurse Manager/s
B	Beta
B	Standardized Coefficient Beta
BMI	Body Mass Index
CINAHL	Cumulative Index for Allied Health Literature
C.I.	Confidence Interval
CP	Caritas Process®
CP1	Caritas Process 1
F	F-Test
IRB	Institutional Review Board
MBISR	Mindfulness Based Intervention for Stress Reduction
MOQA-R	Measuring Organizational Quality Assessment – Revised
®	Registered Trademark
NM/NMs	Nurse Manager/s
R^2	R squared
$R^2 \Delta$	R squared change
SE	Standard Error
T	T -Test
WC	Waist Circumference
WCSRS	Watson Caritas Self-Rated Score© Survey
WCLS	Watson Caritas Leader Role© Survey
UHM	University of Hawai'i at Mānoa

CHAPTER 1. INTRODUCTION

PROBLEM

The job responsibilities of the nurse manager (NM) are very complex. NM is defined as a nurse who supervises staff in hospital environments on an ongoing basis with direct or non-direct patient care responsibilities. The problem is the inability of the NM to perform the full scope of the work, leading to job dissatisfaction and resignation. It was predicted that by 2020, 75% of NMs would have left the labor force while the need for nursing care will increase by 30% (Phillips, Evans, Tooley, & Shirey, 2018; Andrews & Dziegieleswki, 2018). Turnover rates continue to be higher for NMs are even higher than senior nursing and hospital executives (Loveridge, 2017). Current rates of NMs turnover in 2019 (12.8%) and in 2020 (11.4%) (NSI Nursing Solution, Inc, 2021). These statistics are of concern and need further investigation. It is critical to uncover the causal factors of why those in the role of the NM are at risk in order to understand how to mitigate issues for support.

The position is very challenging, requiring the NMs to juggle priorities to ever changing work demands. These work demands center around three areas of focus: operations, patients, and employees. The operations function concentrates on the business elements of the work focusing metrics on the following: financial expectations, performance outcomes, regulatory activities, senior leadership demands with unyielding time constraints, and adequate staffing (Doherty, 2009; Gelsema, Van der Doef, Maes, Akerboom, & Verhoeven, 2005; Kristiansen, Westeren, Obstfelder, & Lotherington, 2016; Steege, Pinekenstein, Arsenault, & Rainbow, 2017; Van Bogaert, Adriaenssens, Dilles, Martens, Van Rompaey, & Timmersmans, 2014). There are generational considerations: those who are in the role of NMs who are retiring, and new nurses who witness firsthand the complexity of the role and are not interested in taking on such huge

responsibilities with minimal financial rewards or recognition (Dunham-Taylor, 2013). These operational demands take away face-to-face time with both patients and staff with patients being the central focus. The NM work requires constant scrutiny of: practice at the bedside, prevention of harm, and creation of a human connection to promote healing through a holistic care environment to touch the hearts and minds of patients (Watson, 2008). Additionally, NMs provide support and attention to frontline staff by: mentoring, problem solving, and meeting staffs' needs, scheduling flexibility, and ensuring staff competencies are complete.

Since the role of the NM is multifaceted, the scope of job responsibilities is ill defined. Also, leadership support is fragmented and detracts from the success of the NM. Many NMs experience the following: pressure, feeling overwhelmed, inability to perform the duties of the job, and subsequently leave the position (Johansson, Sandahl, & Hasson, 2013; Kristiansen et al., 2016; Steege et al., 2017; Van Bogaert et al., 2014). NMs are considered the basic management infrastructure within hospital operations. With mounting duties and impossible expectations, this results in NMs being blamed for not achieving positive outcomes and becoming discouraged about the work (Paliadelis & Sheridan, 2007; Shirey, Ebright, & McDaniel, 2008). These demands are vast while the span of control for decision-making is limited. NMs function as the administrators of their department centering on the duties of the job rather than leading professionally (Kristiansen et al., 2016). Due to the complexity of the job, some NMs may leave the position or leave the nursing profession entirely (Gunawan, Aungsuroch, Nazliansyah, & Sukarna, 2018).

SIGNIFICANCE OF THE PROBLEM

On the job stress may affect NMs' physical and psychosocial health issues (Happell, Dwyer, Reid-Searl, Burke, Caperchione & Gaskin, 2013; Wilkins, 2007). In fact, NMs and house

supervisors were identified to have the highest level of occupational stress (67%) among health care occupations, as compared to bedside nurses (58%), and nursing assistants (34%) (Wilkins, 2007). Other factors that contribute to stress in the workplace are identified as: alternative shift assignments, traditional gender responsibilities, age, daily pressure, expectation of life satisfaction, impact on general health, as well as a personal expense to self and family (Wilkins, 2007). NMs often work more than 45 hours a week contributing to on-the-job strain that peaks between thirty-five to forty-five years of age (Wilkins, 2007). Firmin & Bailey (2008) studied caregiving among NMs who were also mothers. These NMs were unable to maintain work-life balance and ongoing self-care practices, which curtailed job advancement (Firmin & Bailey, 2008). No studies were identified about modifying the workload for NMs.

As addressed above, most stressors are directly related to workforce issues and personal consequences. However, the result of poor performance or ill-health focuses around personal sacrifice or not taking care of self. There is a disparity in the literature that centers attention on dissatisfaction and job turnover rather than identifying opportunities to support the NMs from a human care perspective. NMs are consumed by job duties at the expense of self-care needs (Watson, 2008). There is a gap in the literature in regard to self-care. Conducting a research study on the cultivation of loving-kindness will concentrate on self-care. This study did provide novel perspectives from NMs by generating new ideas on holistic caring practices. From the NMs vantage point, this investigation did uncover critical findings that may be impactful for support, fulfillment, and ultimately to help the NM to thrive in this role (Watson, 2008).

CONCEPTUAL FRAMEWORK

For more than a century, nurse theorists have advanced both the science and art of nursing practice. The Theory of Human Caring has continued to evolve through the years

building on each nurse theorist's viewpoint. There will be a synopsis of a historical perspective on caring by experts in nursing field to including: Nightingale, Leininger, Rogers, Watson, Boykin and Schoenhofer, and Swanson. The earliest nursing theory documented in 1860, was Notes on Nursing authored by Nightingale (1946). She pioneered the notion of holistic care identifying humans as being multifaceted focusing care around: the mind, body, spirit, and social interaction (Pfettscher, 2010). The core principles focus on caring and healing versus curing and treating disease in the physical body. Nightingale defined the gold standard for nursing practice that features both the science and art of this profession. There was an explosion of nurses who used the scientific process to develop theories in the twentieth century. Several theorists examined human caring with different conceptual models, like: Leininger, Rogers, Watson, Boykin, Schoenhofer, and Swanson. Each of these nurse theorists' caring frameworks illustrates their focus area of work (Table C.1).

Watson's theory is dynamic and has evolved for greater than four decades, incorporating fundamental concepts of the caring of human beings. Watson established ten Caritas Processes® that guide all practices of human caring starting with self and then impacting all humanity. Caring as a professional practice affects the development of patient-oriented care and evidence-based care in nursing and specialties worldwide. Research using Watson's theory is expansive: not only have frontline staff nurses been studied , others who work in healthcare have also been also investigated, such as: faculty members, nursing students, and patients (Cherry, Ashcraft, & Owen, 2007). Thus far, research pertinent to NMs using Watson's theory of caring also has not yet been fully explored. This dissertation aims to illuminate relational characteristics of self-care from NM perspective based on Watson's Theory of Human Caring.

BACKGROUND

The examination of the difficulties within the role, two points emerged: staff nurses' promotion to the role of NM and senior nursing leader relationships were not developed or supported. Great staff nurses are regularly are promoted to the role of NM since they are excellent clinicians in the world of patient care. They lack understanding of the scope of management principles that requires twenty-four hour/seven days a week coverage to meet the complex demands of this work (Doherty, 2009; Kristiansen et al., 2016).

The lack of support systems results in the NM not having the required skills and direction to complete the job. Senior leadership and often colleagues do not provide required mentorship. Lack of acceptance from the frontline staff frequently occurs especially when the new NM transitioned from a staff position to a new NM role (Gmeiner & Poggenpoel, 1996). Additionally, poor collaboration from the others who impact the job responsibilities leads to the inability to perform the duties of the job (Gelsema, Van der Doef, Maes, Akerboom, & Verhoeven, 2005; Kristiansen, et al., 2016). With the intricacies of the work, it is difficult to set time to care for self (Paliadelis, Cruickshank, & Sheridan, 2007; Watson, 2008).

NMs have little time to acclimate to the role and are not yet part of the culture of the department and leadership team (Shirey, 2004; Warshawsky & Havens; 2014). Supportive relationships are not actualized either, which affects the NM capability to feel supported (Udod, Cummings, Care, & Jenkins, 2017; Sarafis, Rousaki, Tsounis, Mallarou, Lahana, Bamidis, Niakas, & Papastavrou, 2016). In hopes to support NMs, some hospital systems have developed training courses to ensure management development occurs through education (Titzer, Phillips, Tooley, & Shirey, 2013).

Along with the job requirements, the NM has not established hierarchal or staff relationships in the role which make the work even more difficult to achieve where nurse-to-nurse incivility may occur (Kaiser, 2017). Furthermore, the lack of acceptance reduces the opportunity of social support within this role often leading to the NM internalizing stress in the workplace (Gelsema et al., 2005; Gmeiner & Poggenpoel, 1996). Personal stress leads to tension beyond the workplace resulting from a lack of self-care due to: fatigue, exhaustion, job strain, and health issues causing the NM not being able to perform duties at home (Gelsema et al., 2005; Shirey, 2004; Warshawsky & Havens, 2014).

The literature exposed a variety of consequences (effects) when in the NM role. Primarily negative consequences have been featured in the Problem portion of this chapter. In addition, positive consequences have been identified. In total, forty-seven consequences were established in the literature: 33% (n = 16) were positive and 66% (n = 31) were negative. Upon the review of the literature, only one citation mentioned "human presence" (Sarafis et al., 2016). Examining the Theory of Human Caring, human presence is translated to a transpersonal caring relationship (Watson, 1999). Transpersonal caring relationship is distinct where moral commitment with one another safeguards and promotes respect by elevating that person's sense of self (Watson, 1999). The gap in the literature about caring relationships was surprising.

Themes were identified and separated by positive consequences (Table C.2). Connotations for negative outcomes are displayed for review (Table C.3). These results can either elevate the NMs to become successful in the role or cause the NM to leave the role (deCastro, Gee & Takeuchi, 2008; Ersoy-Kart, 2009; Gallagher & Gormley, 2009; Hertel, 2009; Mosadegh, 2014). A concept analysis used the evolutionary method which examined Watson's

Theory of Human Caring to gain insight from the evidence from the literature uncovered different types of consequences experienced by the NM. (Ricossa, 2018).

Four guiding principles were utilized to categorize themes and characteristics. The assumption NMs who experience only positive consequences would be most likely to be successful in the role. NMs with positive consequences were reported to develop healthy life style, promote self-renewal, and find work meaningful with outcomes resulting with increased retention, job satisfaction and decreased turnover (Chan & Perry, 2012; Udod et al., 2017; Brown, 2009). The opposite is hypothesized. NMs who experienced only negative consequences were reported to develop poor quality of life, work family conflict, exhaustion and stress (Sarafis & et al., 2016; Leineweber, Westerlund, Chungkham, Lindqvist, Runesdotter, & Tishelman, 2014). Gallagher & Gormley, 2009). These NMs would be most likely to be unsuccessful in the role leading to decreased retention, high turnover, and decreased job satisfaction. When both positive and negative consequences were experienced at the same time, NMs would be likely to demonstrate success or failure in the role. A framework was developed to examine both unity and combination to examine successes and failures (Rodgers & Knafl, 2000). All possible combinations were examined (Table C.4).

SUMMARY

Much has been written in the literature about the vulnerability of the NM. Most references identified workforce issues as the major concern that encroached into the individuals' personal space affecting self and others outside of the work environment. The literature did not represent self-care practices among this population. There is a gap in the literature where NM self-care has not been explored. Jean Watson once said, "What we do for ourselves benefits others and what we do for others benefits us" (Watson, 2008, p. 17). Through this research study,

insight from NMs did provide pivotal information about the benefits of self-care. The subsequent sections of this dissertation will examine and clarify the perceptions of self-care practices of the NM and the inter-relationships among co-workers and senior leadership.

CHAPTER 2. LITERATURE REVIEW

INTRODUCTION

The research topic and area of inquiry is to examine the available literature in the area of human caring for exploration of self-care practices from the NMs perspectives based on Watson's Theory of Human Caring. This dissertation is organized as follows: significance, literature review, synthesis, critique, conceptual framework, discussion, gaps in the literature, and purpose statement.

There were 3 reasons to review the literature on this topic. First, was to examine the presence of available references on the topics on the Theory of Human Caring among NMs. The second reason was to review the literature to determine whether there is an association between Caritas Processes and self-care among NMs. Third, a synthesis of the literature has uncovered different methods for examining human caring.

Several nursing studies were conducted using Watson's theoretical framework. Despite this, NMs and their perspectives on caring have not been studied. During this time of change within the health care system, it is important to remember the role the NMs plays. NMs have great responsibility and are the heart and soul in the infrastructure of the hospital (Shirey, Enbright, & McDaniel, 2008). Because of the variety of expectations and competing priorities, little time if any is spent on human caring and self-care. In this chapter, research studies featured evidence with positive and negative consequences on human caring centering on the practice of loving-kindness to self.

Most references that emerged from this literature review indicated that the search term "human caring" has been covered extensively. The references were voluminous when searching Watson and caring (n = 75,538). However, with the review of literature sources on NMs, fewer

articles were found (n = 292). When combining key terms: Watson, caring, NM, and perceptions revealed less than 1% of relevant studies to review. Most recent published research studies and articles about caring with clinical applications surfaced in the literature focused on: international settings, transforming health care systems, examining different levels and specialties of nurses, and with focus on anecdotal information on self-care practices.

In preparation for reviewing the literature, it was helpful to have met with two different librarians: one from University of Hawai'i at Mānoa and the other from the author's employer, Kaiser Permanente Santa Clara Medical Center, who provided their expertise and assistance to examine various databases and keywords to produce a substantial number of references for review. The creation of a paper trail was used to record the databases along with the keywords reviewed with inclusionary and exclusionary criteria with the number of articles listed using Garrard's (2013) a matrix of search terms with and without limits in selected databases (Table C.5).

LITERATURE REVIEW

Search Strategies

Several more search terms were explored and described as loving-kindness with and without nursing; Caritas Processes, and caring for self with nursing. These key terms were explored in the following eight databases: PubMed, Cumulative Index for Allied Health Literature with Full Text (CINAHL), ProQuest, Psychology and Behavioral Sciences Collection, PsycINFO All, PsycINFO, PsycARTICLES, and Web of Science. Using the above databases, the key term, loving-kindness without filters yielded a range of references from 32 to 21,290. These references needed to be filtered further. Based on these different databases, titles were carefully reviewed to identify any connection between loving-kindness, nursing, or NMs with this first

review in both CINAHL (n = 36) and Psychology and Behavioral Sciences Collection (n = 32). Both databases did not reveal any usable information. PubMed and ProQuest were examined next. These databases revealed a range between 100 to more than 120,000 references with an additional search conducted to reduce the size.

The second search was more refined, examining two terms, such as: loving-kindness and nursing. Within this search, four databases revealed findings from: PubMed (n = 14), CINAHL (n = 1), ProQuest (n = 31,570), and Web of Science (n =11). Of the fourteen identified references in PubMed, all abstracts and two articles were read with only one being selected. CINAHL had one total reference, which was usable. Additional filters were used to reduce the total number of references from ProQuest. The filters used are as follows: in the first search, full text and peer review was searched (n = 108); the second search included the above filters and research studies (n = 79); and the final search included all of the above filters and references within the last 10 years (n = 23). Based on these four searches, no new studies were identified.

The next search term applied was Caritas Processes. It was used since it encompassed the term “loving-kindness”. Among the eight databases, references ranged as follows: CINAHL (n = 19), PubMed (n = 31), ProQuest (n = 23), Psychology and Behavioral Health Collection (n = 2), PsycINFO All (n = 49), PsycINFO and PsycARTICLES (n = 48), and Web of Science (n = 26). A new search term, NM, was added to Caritas Processes. Finally, there were a more manageable number of studies identified (n = 23). However, upon review of all databases, no studies were identified for review.

Finally, the search using these key terms without limits: nursing and caring for self revealed references in these databases: PubMed (n = 90) and Psychology and Behavioral Health Collections (n = 44). These databases required filtering: full text and peer review. These filters

are a technique to obtain a manageable number of references for review. Other limits were added to the search, like full text and peer review with the following databases still using the key words identified above: ProQuest (n = 20), PsycINFO All (n = 4), PsycINFO (n = 0), and PsycARTICLES (n = 4). Each of these databases was further sorted: CINAHL and Web of Science. For CINAHL, full text and within five years yielded a manageable number of references (n = 28). Three limits were employed within the Web of Science: Full Text, within five years, and English language. A full review of the literature was performed which examined the following: titles, abstracts, and references. After an exhaustive review of the literature, only nine studies met criteria.

Keywords were identified as: NMs, loving-kindness, self-care and human caring the were incorporated within each of the identified databases. This provided an opportunity to sample what was available in the research on loving-kindness or self-care in the area of nursing or NMs. Research studies that centered on the practice of loving-kindness were included despite samples outside of nursing. Limits and filters made each search succinct and more manageable for review. Two studies were identified in Chapter 1 when searching for significance of the problem (Brown, 2009; Drach-Zahavy & Marzuq, 2012). At the 2018 International Association of Human Caring conference, there was a presentation about an interesting study on the practice of loving-kindness. This study was located in Google Scholar and PubMed were included in the literature review.

References included within this literature review examined key terms and databases to identify potential studies for review. Findings in the literature included many self-help or how-to articles targeted with the exact key terms. These references were problematic since there was no evidence to support claims. Oftentimes editorial or anecdotal information was shared in nursing

management journals under editorials or how to care for self (Boyle, 2008; Cheesley, 2015; Odeom-Forren, 2004, Risner, 1997; Ryan, 2017). The prior references were spotlighted without substantiation of the evidence. These citations were excluded from the body of knowledge of this dissertation.

Selection of Studies for Review

Giovannoni, McCoy, Mays, and Watson (2015) conducted a hybrid research design both qualitative and quantitative focusing on reducing stress through cultivating loving-kindness of self and others with Parole Officers in Honolulu, Hawai'i. Parole Officers carry much the similar burdens of on-the-job stress as NM. Watson's Theory of Human Caring provided the infrastructure employing Caritas Process 1 (CP1). First, the research design had a hybrid approach. The qualitative portion solicited a "one word response" about their feelings pre and post-workshop. The quantitative approach utilized an assessment tool entitled the Perceived Stress Scale. This assessment tool was administered as a pre and post-test. Dr. Jean Watson was a study investigator within the study and delivered the intervention as a lecture discussing CP1. Results within the thirty days post workshop were statistically significant that demonstrated a reduction in physiological stress. Subjects were able to incorporate components practices of CP1 personally and professional. These practices were identified as: being authentically present, having a positive regard for clients, listening actively, and addressing negative emotions. Pre-intervention, subjects mostly identified feelings as relaxed or curious. Post-intervention, feelings identified included: calm, open, validated, and inspired. CP1 was integrated among parole officers given tools to reduce stress and develop human caring of self and others.

Pipe and Bortz (2009) examined healing practices through mindfulness with nursing leaders. Her premise was to focus on the effects of stress reduction by equipping the nurse leader

to better examine their own self-care strategies through internal rewards as: strengthen, self-worth and happiness leading to transformation (Pipe & Bortz, 2009). Using Watson's Theory of Human Caring, CP1 was featured as the spotlight of this study. This study centered on two types of relationships: attention and nurturing from leaders and identify internal rewards. From the nurse leader perspective, internal rewards included: strength, meaning of the work, and joy.

This was a qualitative study, using a convenience sample where these nurse leaders (n = 33) were employed in healthcare settings. Watson's Theory of Human Caring was the underpinning. CP1 was central for implementing the treatment called the Mindfulness-based Intervention for Stress Reduction (MBISR). MBISR aspects consisted of the following: guiding self-reflection, developing a better sense of self and knowledge with change as one moves through the role, self-discovery about through examination of prior caring experiences, exploring self to examine strength, meaning, and joy. This intervention was a two-hour a week session, four-week program making the most of self-reflection through structured questions. The results of this study established a decrease in the following areas: stress, anxiety, symptom intensity, and depression. Positive findings demonstrated an increase with being authentically present, consciousness about self, sensitivity to self, and self-discovery through transformation. This study revealed MBISR training provided nurse leaders an opportunity to look internally and scrutinize the cultivation of the practice of loving-kindness that provided triggers for understanding and empowering self and self-care.

Brown (2009) examined the meaning of caring of self among nurse leaders. This research utilized the qualitative approach of hermeneutic phenomenology. This tradition examined perceptions of the lived experience. This convenience sample consisted of nurse leaders (n = 10). The setting was in a for-profit, 187 bed community-based hospital in South Florida. A 10-week,

self-care practice program was established. All subjects were interviewed by asking structured questions. A holistic peaceful environment was created to calm the subjects during interviews. The researchers had to be authentically present, ready to listen with an open heart to understand the essence of responses. Interviews were taped and transcribed, then reviewed and validated by the subjects. Four themes were identified: journey of life, why care for self, how to care for self, and wisdom learned along the way.

Based on the findings, nurse leaders identified different strategies and recommendations for self-renewal activities in the workplace. Understanding life's journey through reflection of self-care revealed the following: fatigue stretches beyond mental and physical, work life is imbalanced, issues with problem solving, no time was allotted for self-care, and need to regain life back. The second theme focused on respondents' two questions of why self-care or what rewards will benefit me? Responses encompassed motivational care: exercise, time to invest into self, personal growth, and do what makes the subjects happy. Third, how to care for self-centered on a holistic approach identifying self-renewal activities: making time for self and others, aromatherapy, taking a bath, reading a book, driving alone to and from work to refresh and renew, and identifying what is important in their lives. Experienced nurse leaders were insightful as they understood their role and the span of responsibility. These nurse leaders were able to perform self-care practice, such as: re-centering and re-focusing 5-10 minutes daily, listening to your body, reflecting what makes the nurse leader a better person, not taking home negative feelings or stresses, and understanding that a negative environment is toxic and radiates self to others. Nurse leaders were considered the healing environment. They needed to take control to make decisions for others, but most importantly to prioritize self-care during the day. Through

reflection on negative experiences, it allowed one to be open to develop strategies to promote harmony of self, which had implications for others.

Peng, Lui, and Zeng (2015) studied perceptions from the lens of frontline staff about caring behaviors for NM. The intent of this study was to provide a new frontline NM point of reference about caring behaviors frontline staff nurses prefer. This qualitative study used a Descriptive Phenomenological approach. This sample size consisted of frontline staff nurses (n = 15) selected by purposeful sampling. The setting was a tertiary comprehensive hospital in Mainland China. Structured open-ended questions were used. Interviews were conducted in Mandarin Chinese. Interviews were taped, field notes were taken, verbatim comments were transcribed and validated with subjects, and then were translated into English. Data analysis was used Colaizzi's Technique for identification of themes (Peng et al., 2015).

As a result of findings, three themes were identified from this study: promoting professional growth, exhibiting democratic leadership style, and support. Examples of opportunities to promote professional growth for frontline staff development includes: offering new work to advance professional practice, empowerment, and recognition. Exhibiting democratic leadership was the second theme referring to: having a relaxed environment, leading through a humanistic approach, mutual respect, and fairness (Peng et al., 2015). Support was the third theme that identifies caring behaviors as work-life balance, such as: empathy, celebrations with peers to include birthdays, and NMs bringing in food for staff.

Peng, Lui, and Zeng's (2015) study centered on caring behaviors frontline staff wanted from their NMs. These are perceptions about what is important for survival of Mainland China frontline staff nurses. This study may not be generalizable to other countries of the world. The premise of this study provided guidelines to orient NMs. The findings centered on setting the

tone to promote a leadership style conducive to the frontline staff nurse in Mainland China. Interestingly, these behaviors were egocentric from the frontline nurse perspective without consideration of human caring.

Drach-Zahavy and Marzuq (2012) investigated how nurses were able to restore health through a short reprieve of two days off work. It was identified that nurses' work caused emotional exhaustion and stress. The respondents found it is difficult to rejuvenate the body, mind, and spirit. The premise of this study was to identify whether two days either during the week or weekend would provide enough time to recuperate from work stress and reestablish well-being. This research design was quantitative design using a longitudinal panel survey with data collection at three intervals: before time off, again during respite activities, and after the respite. This convenience sample consisted of frontline staff nurses (n = 200). To measure burnout and vigor (stamina), two instruments were used: Maslach Burnout Intervention - General Survey and the Engagement Scale. Within the above survey, there was a section was called the Vacation Experience. Vacation Experience portion was modified from the original instrument created by Sonnentag and Fritz (2007). The Vacation Experience was referenced since this study examined time off from work. The inclusionary criteria were subjects employed in one of two acute care hospitals with a work schedule that offered two consecutive days off, either weekend or weekdays.

Three post recovery themes were identified: relaxation activities, mastery and control experiences. Relaxation activities experienced were tranquil and quiet. Passive activities included: watching television or listening to the radio. Meditation and yoga demonstrated active relaxation techniques used. Both of these types of activities provide recovery with little demands on mental reserves (Drach-Zahavy & Marzuq, 2012). The second type of relaxation activities

was called Mastery Experiences, where the focus was to enhance the sense of developing expertise with a new hobby. Benefits of Mastery Experiences demonstrated positive effects of self-worth and esteem. Control Experiences were the third type of relaxation activities where the nurse determined the interest they want to pursue. Family time was an example that could either be perceived with positive or negative connotations. Families could provide external resources to improve self-control and esteem. However, families found to also have the opposite effect by causing stress and deplete recovery efforts.

The results of this study showed positive impact. All elements demonstrated improvement in relaxation and reduction in stress. In fact, timing for respite and relaxation was statistically significant. Drach-Zahavy and Marzuq's (2012) research uncovered benefits of having two consecutive days off that promoted relaxation and reduction in stress. Managing relaxation activities was superior to passive methods of relaxation. Educating nurses about passive versus active relaxation made a difference in reducing emotional exhaustion. Results found NMs were to consider coupling days off each week to give nurses an opportunity to have work-life balance.

Speroni, Williams, Seibert, Gibbons, and Earley's (2013) research study focused on lifestyle changes for nurses, which suggested caring for self. This evidence-based practice examined lifestyle changes (diet and exercise) and outcomes. As nurses promoted health and wellness for their patients, they often neglect themselves resulting in stress leading to poor eating habits and inactivity where the outcome can lead to obesity (Speroni, et al., 2013). The Nursing Living Fit Intervention centered on physical fitness and a healthy diet to reduce body fat. The sample totaled 217 nurses who worked among seven different hospitals. This convenience sample was split in half: the control group consisted of 108 participants and the intervention

group totaled 109. Those in the control group participated in a 12 consecutive week Nurse Living Fit program focusing on lifestyle changes that included: exercise (yoga), nutrition, water consumption, sleep and journaling three times weekly during the program. Weekly exercise was conducted and each month a new lifestyle change was featured. The motivation for participation in this study for the group without intervention was not explored. However, the results revealed the control group had a heightened reduction in their body mass (-0.5kg/m^2) and waist size (-0.9 inches) as compared the no intervention group: where there was a small drop in both body mass (-0.25kg/m^2) and waist size (-0.2 inches).

This study design used a hybrid approach with both quantitative and qualitative elements. The quantitative portion examined body mass index and waist measurements throughout the program along with reviewing journal entries centering on water consumption and activities for the purpose of highlighting the program of healthy lifestyles. The qualitative segment reviewed comments within the evaluation survey using four open-ended questions. The subjects promoted health and wellness to continue to participate with lifestyle changes of the Nurse Living Fit Program. Other findings identified by the control group included positive outlook: enjoyed a better quality of life and acknowledged ongoing performance of self-care activities. Offering nurses lifestyle classes foster healthy behaviors of self-care. Along with reduction in body measurements, other benefits were demonstrated. As a nurse became more aware of self-care, they would be in a position to identify an outlet to eliminate stress and provide better care of self.

Lamke, Catlin, and Mason-Chad (2014) investigated the effects of an exercise technique called Jin Shin Jyutsu® to promotion self-care to reduce stress and improve the efficacy for patient care. Twenty registered nurses participated on three, two-hour sessions of Jin Shin Jyutsu® with a certified instructor. The study lasted 30 days and design was a quasi-

experimental design, using pre-posttest. The pre-test was administered before the study, the post-test 30 to 40 days after the study. These participants performed self-care practices 20-minutes daily. Study results were determined using the Measuring Organizational Quality Assessment – Revised (MOQA-R) and Coates Caring Efficacy. HeartMath®, an organization that focuses on stress reduction and improved resilience, created the MOQA-R instrument.

The findings from the MOQA-R identified various personal traits from the pre-test: fatigue, resentfulness and the symptoms of stress. The subjects also identified signs of physical stress: sleeping difficulties, body aches, upset stomach, increased heart rate, tensed muscles, and headaches. The post-test findings resulted in positive changes in behaviors: including optimism, gratitude, motivation, and calmness. There was also a decrease in physical stress and a resolution of physical symptoms. The Coates Caring Efficacy Traits post-test showed an improvement in eight characteristics, with a statistical significance in five characteristics that improved the nurses' ability to care for patients: improved serenity and energy, the ability to be authentically present, confidence with patient interactions and the ability to use innovative methods to convey human caring.

Gabrielle, Jackson, and Mannix (2007) examined health and self-care practices with older female nurses who still worked as bedside caregivers. As the nurses aged, physical demands of the job became increasingly difficult and health issues became pronounced. Dealing with health issues and engaging in self-care practices was not common for these nurses. The respondents' patients were the priority. This convenience sample was 12 nurses, ages 40-60 years old that worked in several acute-care public hospitals in Australia. The study was qualitative and used a feminist approach. Nursing shared their experiences through storytelling. This method allowed promoted self-reflection, and uncovered factors which influenced self-care through discovery

and examination of current practices with the identification of possibilities that may influence self-care. These techniques focused on the subject by the researchers' modeling behaviors by being authentically present and actively listening. They used structured and unstructured questions, taped the responses, then transcribed and validated them. Ethical considerations were obtained, scientific rigor and credibility established.

The findings revealed two major themes: aches, pains, and ageism in Gabrielle and colleagues' study (2007). Four sub-themes were also identified: neglecting self, physical changes, tiredness and evolving lifestyles. Evolving lifestyles had the aspect of: exercise, eating healthy, and acclimating to the changes from growing older. Responses on neglecting self-care mostly cited putting the patient or their family first. Bodily changes made most of the nurses less able to perform physical tasks such as moving patients. Many of the nurses worked the night shift and when off work, their schedule would normalize to a day arrangement, where time changes impact the circadian rhythms that resulted in fatigue. Evolving lifestyle changes were not necessarily healthy. For example, evolving lifestyle changes did not consider diet and exercise. The nurses established topics for self-care exploration opportunities, such as possibly changing shifts from night to day or changing roles from the bedside to a less physically taxing work schedule. The main conclusion from the study was that a protective work environment should include flexible scheduling that promotes healthy life practices with the aging nurse. Patient care was the nurses' priority. It is recommended that managers appreciate the contribution of older nurses and supporting them as a valuable member of the workforce (Gabrielle et al., 2007).

Longo (2015) examined perceived behaviors of caring towards nurses. This convenience sample consisted of male (9%) and female (81%), from a university in the Southeast who were

employed in a hospital setting. They were employed as staff nurses (81%) and assistant NM (9%). Boykin and Schoenhofer's Theory of Caring by Transforming Nursing Practice was the framework for the study. The premise of this theoretical framework notes that characteristics of relationships are transformed through caring (Longo, 2011). The research design was a descriptive qualitative approach. An IRB was obtained for each participant who also completed an informed consent prior to the onset of the study. The nurses were separated into three focus groups in a hospital setting based on their response to three structured questions. To engage study participants, a twenty-dollar gift card was given after responding to the questions. Data collection included an audio recording with items transcribed verbatim.

Data analysis for Longo's research (2015) used an inductive process to categorize information into themes. Three themes emerged: caring through helping and supporting, caring through appreciation, and acknowledging unappreciated caring. The first theme was derived by helping and supporting coworkers and each other. Other supporting activities were centered on providing assistance to the team, frequent engagement with the team, assigning and ensuring staff take work breaks, authentically listening, and NMs defending staff during conflicts. The second theme of caring through appreciation listed these behaviors: recognition of unique talents and gifts, supporting nurses when a family crisis occurs, and considering the needs of other nurses when in distress. The final theme, acknowledgement of unappreciated caring, highlighted these characteristic behaviors for some nurses that created a negative workforce atmosphere. To combat negative staff attitudes, NMs would perform: positive role-modeling, treating others as you would like to be treated, and examining a positive outlook by laughter when one is stressed. NMs' negative behaviors could result in undesirable effects with other health-care professionals and patients (Longo, 2011). Longo (2011) used a metaphor "Dance of Caring Persons" to

describe the different personal and professional caring characteristics a person has that are supportive of the team. Relationship-based care engages other members of the team initiated by nursing leadership passed down to the frontline (Longo, 2011). Caring was defined as everyone working in harmony to create a supportive caring environment (Longo, 2011).

SYNTHESIS

This section compares and contrasts the research methodology of each study. Elements of this critique will include: purpose, sample, setting, theoretical framework, research design, methods, protection of human subjects, instruments, interventions, statistical method, data analysis, and results.

Purpose

Each of these nine studies focused on a different aspect of self-care. Research studies reviewed identified caregiver stress, where the caregiver has the obligation to care for others before oneself. “Help healers first help themselves so that they can better care for others!” (Speroni et al., 2013). Oversight or supervision of either patients or clients was featured in all studies. The majority of the studies (89%) centered on nurses (RNs) with self-care, holistic health, and healthy life styles being the primary focus. Parole officers were also examined. The parole officers’ role may serve different type of clients compared to the traditional hospital-nursing model. Both roles (parole officer and NM) carry physical or emotional stress related to the job with same responsibilities of oversight of others (Giovannoni et al., 2015; Pipe & Bortz, 2009; Brown, 2009, Drach-Zahavy & Marzuq, 2013; Lamke et al., 2014).

In this synthesis of the literature, researchers took different approaches to promote self-care. Authentic presence, active listening, being curious and Mindful leadership were identified as important approaches for caring for self and others (Giovannoni et al., 2015; Pipe & Bortz,

2009). Pipe and Bortz (2009) concentrated their study on examining the nurse leaders' scope of responsibilities; strength or breadth of responsibilities. Brown (2009) uncovered the nurse leader's priority was in relations to self-care.

Self-care programs (63%) predominantly investigated interventions: self-care workshops, mindful-based interventions, healthy lifestyle programs, and self-renewal activities (Giovannoni et al., 2015; Pipe & Bortz, 2009; Brown, 2009; Drach-Zahavy & Marzuq, 2013; Speroni et al., 2013; Lamke et al., 2014). Peng, Liu, and Zeng (2015) examined different perspectives on caring practices among NMs. They queried staff nurses on the type of caring behaviors they would prefer in their immediate supervisors. While behaviors identified may support the frontline staff nurses, they may not be appropriate behaviors for managers leading a team or to advance or elevate professional practice. Other tactics classified self-care practices as an investment in time for renewal, rejuvenation, and relaxation (Drach-Zahavy & Marzuq, 2013; Brown, 2009, Pipe & Bortz, 2009). Personal time was encouraged by: healthy lifestyles and understanding stressors through reflection and storytelling (Pipe & Bortz, 2009; Gabrielle, Jackson, and Mannix; 2007). Developing an understanding through self-discovery and cultivation of human caring contributed to personal insight along with the practice of loving-kindness to self (Brown, 2009; Giovannoni et al., 2015; Pipe & Bortz 2009). Physical activities were explored as a means of reducing stress or emotional exhaustion and improve emotional health (Drach-Zahavy & Marzuq, 2013; Gabrielle et al., 2007; Lamke, et al., 2014; Speroni et al., 2013).

Sample

Sample composition and size differed among studies. Sample sizes ranged from ten to four hundred. These convenience samples included two populations: nursing and parole officers. Ninety percent of the samples were within the profession of nursing. One research study was

conducted by nurses and focused on parole officers (Giovannoni et al., 2015). Parole officers carry the similar burden of on-the-job stress as NMs. This study was relevant because self-care used Watson's Theory of Human Caring by examining the practice of loving-kindness.

Specific convenience samples were targeted. Brown's (2009) sample (n = 33) was identified as nurse leaders who were employed in healthcare settings. The median age of the sample was forty-five years with an average number of twenty-one years in the workplace in a nurse leadership position (Brown, 2009). Longo (2011) however, studied nurses currently in enrolled in an academic program for an RN-BSN, MS, or RN-MS degree. This sample is predominately female (81%) with average age ranging from thirty-one to fifty years (53%). They identified their job role as either a staff nurse (81%) or assistant nurse managers (ANMs) (9%). The maximum years working in these roles was between four and seven years (27%) and total years worked as a nurse between six and ten years (36%) (Longo, 2011).

Another convenience sample involved RNs who identified perceptions of acceptable caring behaviors for NMs (Peng et al., 2015). Drach-Zahavy and Marzuq (2013) primarily focused on unionized nurses who were bedside caregivers. Speroni, Williams, Seibert, Gibbons, and Early (2013) recruited from seven hospitals where nurses were able to participate in this study. Lamke et al. (2014) recruited and self-selected participants. Gabrielle, Jackson, and Mannix (2007) centered their study on older female nurses between forty and sixty years old who worked as bedside caregivers within a community health hospital. However, Giovannoni, McCoy, Mays, and Watson's (2015) sample consisted of male (43%) and female (57%) with ages of forty-three and forty-four years respectively. Of the studies that revealed gender: females (90%) far exceeded males (10%) (Giovannoni et al., 2015; Drach-Zahavy & Marzuq, 2013; Gabrielle et al., 2007; Longo, 2011).

Setting

The study locations differed. Two studies (22%) were conducted outside the United States: in Mainland China (Peng et al., 2015) and Australia (Gabrielle et al., 2007) and six studies were in the contiguous United States with one performed in Hawaii (Giovannoni et al., 2015; Brown, 2009; Pipe & Bortz, 2009; Drach-Zahavy & Marzuq, 2012; Speroni et al., 2013; Lamke et al., 2014; Longo, 2011). Most of these studies were performed in the hospital setting (78%) (Pipe &Bortz, 2009; Brown, 2009; Drach-Zahavy & Marzuq, 2013; Speroni, et al., 2013; Lamke et al., 2014; Gabrielle et al., 2007; Longo, 2011). Two other settings were selected: correctional facility (11%), and university (11%) (Giovannoni et al., 2015; Peng et al., 2015).

Theoretical Framework

Five of the studies referenced a theoretical framework. Of these studies, four used Watson's Theory of Human Caring through Caritas Process 1: the practice of loving-kindness to self and others (Giovannoni et al., 2015; Pipe & Bortz, 2009; Lamke, et al., 2014). Giovannoni, McCoy, Mays, and Watson (2015) directed self-care practices among parole officers. Pipe and Bortz (2009) focused on nurturing loving-kindness through self-reflection and self-discovery. Lamke, Catlin, and Mason-Chadd (2014) used Watson's framework to promote self-care to reduce stress.

Two qualitative studies supported different theoretical frameworks. Longo (2011) used Boykin and Schoenhofer's as the underpinning for her study. This theory used the premise that each person has the ability to nurture and make a human connection for self and others (Longo, 2011). The Feminist Approach guided Gabriellle, Jackson and Mannix's (2007) study with five references cited to support their theoretical framework. This was a homogenous female sample.

Gabrielle, Jackson, and Mannix (2007) used a feminist approach, but did reference Watson's approach.

Research Design

These research designs differed among the nine studies. Five were qualitative (Brown, 2009; Pipe & Bortz, 2009; Peng et al., 2015, Gabrielle et al., 2007); Longo, 2011), two were quantitative (Drach-Zahavy & Marzuq, 2012; Lamke et al., 2014), and two a hybrid approach (Giovannoni et al., 2015; Speroni et al., 2013).

Of the qualitative designs, Brown (2009) employed the hermeneutic phenomenology tradition. A descriptive phenomenological approach was featured as the research design used by Peng, Lui, and Zeng (2015) and Longo (2011) described her study as descriptive and qualitative. Two reports did not identify their qualitative framework (Pipe & Bortz, 2009; Gabrielle et al., 2007).

A quantitative approach was used by (Lamke et al., 2014; Gabrielle, et al., 2007; Longo, 2011). Additionally, two studies used a hybrid approach with both quantitative and qualitative methods. (Giovannoni et al., 2015; Speroni et al., 2013). An exploratory intervention with a quasi-quantitative design was identified (Giovannoni et al., 2015).

Methods

Most of these studies were qualitative and used structured questions that allowed participants to reveal information (Pipe & Bortz, 2009; Brown, 2009; Peng et al., 2015; Speroni et al., 2013; Gabrielle et al., 2007; Longo, 2011). Mixed methods were utilized for this study, a standardized instrument was administered called the and one word responses were solicited pre and post intervention. (Giovannoni et al., 2015). Zahavy and Marzuq (2013) used a quantitative approach using two standardized instruments.

Protection of Human Subjects

All studies were identified as works of research. Only six of the studies were conducted, they obtained approval from an Institutional Review Board (IRB) (Giovannoni et al., 2015; Brown, 2009; Speroni et al., 2013; Lamke et al., 2014; Gabrielle et al., 2007; Longo, 2011). The hospital ethics committee gave approval for this study (Drach-Zahavy & Marzuq, 2012).

Instruments

A qualitative design was the predominant approach for this synthesis of the literature, researchers used structured and unstructured questions with open text boxes to solicit responses. (Gabrielle et al., 2007; Pipe & Bortz, 2009; Longo, 2011; Peng et al., 2015).

Three quantitative studies used various instruments. Giovannoni, McCoy, Mays and Watson (2015) examined stress reduction and used an instrument called the Perceived Stress Scale. Drach-Zahavy and Marzuq (2012) used three different instruments to examine: burnout, vigor, and mastery experiences during a vacation. The instruments were entitled: Maslach Burnout Intervention – General Survey, the Engagement Scale, and the Recovery Experience Scale. Maslach Burnout Intervention – General Survey explored burnout in the workplace (Maslach, Schaufeli and Leiter, 2001). The Engagement Scale (Schaufeli & Bakker, 2006) was used to measure vigor along with another instrument called Recovery Experience. This explored mastery experiences during vacation (Sonnetag, Fritz & Casper; 2007). Speroni, William, Seibert, Gibbon, and Early 2013). Williams, Seibert, Gibbons, and Early (2013) examined healthy lifestyles that used the Nurses Living Fit instrument. Lamke, Catlin, and Mason-Chadd (2014) used questionnaires called the Personal and Organization Quality Assessment Revised and the Coates Caring Efficacy Scale for stress reduction, and to promote care for self and patients.

Interventions

The interventions among studies varied. A pre-test was performed prior to the intervention which was a lecture provided by Jean Watson on the practice of loving-kindness Six weeks later a post-test was performed (Giovannoni et al., 2015). Nurses were surveyed over a 3-time period: prior, during, and post a two-day rest period to determine the status of emotional exhaustion (Drach-Zahavy & Marzuq, 2012). A twelve-week program called Nurses Living Fit was established as the interventions for a treatment group providing weekly sessions on: lifestyle changes, yoga, nutrition, water consumption, and journaling (Speroni et al., 2013).

Self-reflection was examined weekly during a four-week class of mindful training (Pipe & Bortz, 2009). A Self-Care Practice Program was provided to nurse leaders, during sessions where structured questions were asked (Brown, 2009). Frontline staff nurses were asked about their lived experiences or exploration of experiences with NMs (Peng et al., 2015). The sample consisted of a total sample (n = 15) with staff nurses (n= 14) and a nurse leader (n = 1) who were interviewed on three structured questions centering on caring behaviors of the following: NMs, nurses and caring for peers (Longo, 2011). Each researcher has a different perspective of inquiry using distinctive approaches for seeking out information about self-care.

Statistical Methods

Statistical tests were performed for quantitative studies. T-tests were used for pairing groups, which compared and contrasted differences over time (Drach-Zahavy & Marzuq, 2013; Speroni et al., 2013; Lamke et al., 2014). Speroni, et al., (2013), in addition to t-tests, analyzed data using the following statistical measures: descriptive statistics, analysis for variance Mann-Whitney U Test, and Pearson Correlations with the level of significance ($p < 0.05$). In addition,

physical measurements were taken from this sample at the start and finish of this study (Speroni et al., 2013).

Data Analysis

Four qualitative studies used structured questions (Brown, 2009; Peng et al., 2015; Gabrielle et al., 2007; Longo, 2011). Only two studies were taped, transcribed, and validated by subjects (Gabrielle et al., 2007; Longo, 2011). Journaling self-reflection responses were examined (Pipe & Bortz, 2009). Two studies used mixed methods; for the qualitative portion of the study, text boxes were used to allow the subjects to enter free text responses (Giovannoni et al., 2015; Speroni et al., 2013). All of these responses were categorized into themes and validated to confirm findings to prevent researchers' bias. One study used Colaizzi's Technique, a formalized method utilized to sort, arrange information and examine trends (Morrow, Rodriquez, and King, 2015; Peng et al., 2015).

For quantitative studies, data was analyzed by varied approaches. A software program called Predictive Analytics Software was used to analyze data; with Giovannoni, McCoy, Mays, and Watson (2015) utilizing version 19 and Speroni et al., (2013) using version 20. Drach-Zahavy and Marzuq (2013) utilized a statistical package, called Program for Epidemiologists (PEPI for Windows) for analysis of data. Lamke, Catlin, and Mason-Chadd (2014) had two different independent groups analyzed data by hand. The Personal and Organizational Quality Assessment – Revised survey was evaluated by the HeartMath Institute (Lamke et al., 2014). Local biostatisticians from a local hospital system analyzed the findings from the Coates Caring Efficacy Scale (Lamke et al., 2014).

Results

From the qualitative perspective, several caring themes were recurrent. Caring characteristics was the highest priority: support, appreciation, respect, enjoyment, joy, camaraderie, acceptance, recognition, acknowledgement, active listening, being authentic, and adaptation of aging (Giovannoni et al., 2015; Pipe & Bortz, 2009; Brown, 2009; Peng et al., 2015; Speroni et al., 2013; Gabrielle et al., 2007; Longo, 2011). Self -renewal activities spotlighted on: time for self, renewal activities before and after work, centering techniques, spending five to ten minutes during the day for self, and creating authentic relationships with others (Giovannoni et al., 2015; Brown, 2009; Gabrielle et al., 2007). Investment in self allowed for personal growth by promoting a positive transformation in self, and appreciated what responsibilities were within their work span of control (Brown, 2009; Pipe & Bortz, 2009; Peng et al., 2015). Promoting work life balance was a prominent theme centering on exercise and healthy eating (Brown, 2009; Speroni et al., 2013; Gabrielle et al., 2007).

From the quantitative perspective, four studies were distinct and examined different aspects of caring. These nurse scientist's methods may be different, but the goal was to establish approaches to reduce stress and emotional exhaustion, improve vigor, promote healthy diet and exercise (Giovannoni et al., 2015; Drach-Zahavy & Marzuq, 2013; Speroni et al., 2013; Lamke et al., 2014).

Giovannoni, McCoy, Mays, and Watson (2015) examined stress levels. Stress scores were higher prior to the intervention: mean (14.75) and standard deviation (6.22). Thirty days post intervention stress levels were lower and statistically significant: mean (10.61) and standard deviation (6.24) (Giovannoni et al., 2015).

Drach-Zahavy and Marzuq (2013) explored emotional exhaustion using this instrument called the Maslach Engagement Scale which measured only vigor. Vigor means stamina and free of illness. One question asks, "During work, I feel vital and strong." This item was measured at three intervals using independent t-tests. Both emotional exhaustion and vigor was measured. Cronbach alpha coefficients for the following were measured pre and post intervention. The findings indicate was emotional exhaustion (0.82 and 0.80) and vigor was (0.76 and 0.82. Three items from the Recovery Experience Questionnaire were measured to examine vacation experiences: "During the respite, I kick back and relax" (0.84); "During the respite, I learn new things" (0.85); and "During the respite, I set my own schedule" (0.92). There was little difference between emotional exhaustion pre and during the study, but there was an improvement in vigor at the second interval during the study. More importantly, during respite there was a difference between being passive, pursuing activities and taking control when on vacation (Drach-Zahavy & Marzuq, 2013).

Speroni, Williams, Seibert, Gibbons, and Early (2013) examined differences between a control and contrast group. Measurements evaluated were body mass index (BMI) and waist circumference (WC) at baseline and upon completion of the program. Those in the Control group had a higher BMI at baseline, but upon the completion of the Nursing Living Fit Program there was a reduction in both BMI (mean 0.5kg/m^2) and WC (-0.9 in) as compared to the contrast group with little change in BMI (mean -0.2kg/m^2) and WC (-0.2 in) (Speroni et al., 2013).

Lamke, Catlin, and Mason-Chad (2014) used two instruments: Personal and Organizational Quality Assessment-Revised that are indicators of physical stress and Coates Caring Efficacy Scale examined the foundation to develop caring relationships with patients. Post-test there was a reduction in physical stress symptoms. For the Coates Caring Efficacy

Traits, the pre-test score was lower (5.03); and post-test an improvement in scores increased (5.29). Thirty-days post study the sample was able to sustain findings with a score of (5.28).

Each of the researchers examined self-care topics of interest where gaps existed in the literature. Interventions for each study were appropriate and uncovered new information

CRITIQUE

None of these studies were alike. Each of these studies was a collection of different approaches, which examined how stress could be reduced by introducing caring behaviors. These convenience samples were different, not homogenous. They were mixed with a variety of differences for example: age, gender, and body size. Only one study examined nurse leaders, but specific job classifications or length of time in that position were not identified (Pipe & Bortz, 2009). Just by virtue of conducting any of these research studies, subjects benefited by authentic presence, attention, active listening of the nurse scientists through interventions which provided support. Perhaps three studies had bias, since the subjects participated in an extended period of time. It is possible the subjects felt they received individual attention and were eager to participate as they had felt supported and cared for through participation (Pipe & Bortz, 2009; Speroni et al., 2013; Lamke, et al., 2014).

The purpose also varied among each study, along with different research designs, methodology, and analyses. However, each of the studies did offer recommendations for both stress reduction and self-care activities for self and others. All studies agreed concerning the positive effects of each of their studies and provided recommendations to senior leadership to facilitate self-care practices at their institutions.

The research design dictated the methodology along with the data collection and analysis. The two qualitative studies used the phenomenological approach (Brown, 2009; and Peng et al.,

2015). There were marked differences between these studies. None of the qualitative studies with the exception of Peng, Lui and Zeng (2015) used trustworthiness to validate findings, but the translation from Chinese to English could have affected the findings. The other studies conducted interviews, using structured and unstructured questions, captured verbatim comments, validated comments with samples, created themes, and made conclusions based on their findings.

Quantitative methods were dissimilar. Each researcher focused on research design based on their interest and what studies were available in the literature. Three of the four studies either used hybrid or quantitative methods that were consistent in their approach by: conducting surveys at different points in time, compared the findings by using the appropriate statistical tests, and comparing the results to baseline and to the different time intervals (Giovannoni et al., 2015; Drach-Zahavy & Marzuq, 2013; Speroni et al., 2013; Lamke, et al., 2014).

While interventions demonstrated reduced stress during the study period, none of these studies collected data for longer than 14- weeks. This may suggest improvements in self-care are short term, but sustainability may be an issue. If a research design was part of an existing program, then a longitudinal view of embedded caring behaviors could be identified.

One study was not written following formal formatting style when sharing statistical information: SPSS graphs were cut and pasted into the article (Giovannoni et al., 2015). All others followed a recognized written system. While all of each of these studies were sound and followed the scientific process, they were not generalizable. These studies were informative and provided diverse points of view on caring practices; however, caring was never universally defined.

Nurse scientists have the unique opportunity to examine any area of interest to develop a design to uncover new findings on holistic caring practices: psychosocial or physical behaviors.

Caring practices were not a consistent set of practice, rather they were dynamic throughout this synthesis.

CONCEPTUAL FRAMEWORK

Watson's (2008) definition of the discipline of caring has evolved and is very complex as it expands to the science and art of the Theory of Human Caring. Watson's earlier work used more than one sentence to describe her theory, rather caring was more elaborately defined as follows:

> Caring encompasses a humanitarian, human science orientation to human caring processes, phenomena and experiences. The Theory of Human Caring includes arts and humanities as well as science. The Theory of Human Caring perspective is grounded in a relational ontology of being-in-relation, and a world-view of unity and connectedness of all. Transpersonal Caring (Theory of Human Caring) acknowledges unity of life and connections that move in concentric circles of caring - from individual, to others, to community, to world, to Planet Earth, to the universe (Watson, 2008, p 1).

Watson was quoted to say, "It is ironic that nursing education and practice require so much skill to do the job, but very little effort is directed toward developing how to "Be" while doing the real work of the job" (Watson, 2008, p 47). In addition to Watson's (2008) views on human caring, ten caritas processes were created as the guiding principles of her theory. For this literature review Caritas Process 1 "Embrace" the practice of loving-kindness was explored (Watson, 2018).

Watson's book on Postmodern Nursing and Beyond (1999) examined the dichotomy between curative versus carative. The curative approach centers on scientific method, technology and medicine, which is male focused. The carative mode derives from holistic approach

spotlights the art of nursing practice concentrating on a feminine approach for health promotion and healing. Watson examines both the art and science of practice and breaking down gender barriers to demonstrate that caring practices exist with carative and curative holistic practice.

GAPS IN THE LITERATURE

There were three reasons identified early in this chapter to conduct a literature review. First, the purpose of this literature review was to examine the presence of available references on the topics of human caring among nurse managers. It was very difficult to identify any research studies on this topic. Of the hundreds of references reviewed, only one study met the criteria with NM and self-care (Pipe & Bortz, 2009). Even with that study, gaps existed with identification of the job classification of nurse leaders (Pipe & Bortz, 2009). Nevertheless, the literature was insufficient on this topic even with scrutiny of detailed examination of studies. Search terms identified were expanded to find common themes for inclusion, principally of: nurses, caring, and the practice of loving-kindness.

The second rationale was to review the literature to determine whether or not there was a relationship on self-care among nurse managers. There was a leap to include Parole Officers among this review (Giovannoni et al., 2015). However, the author was a nurse and a Caritas Coach who examined the practice of loving-kindness from different perspective. Peng, Lui, and Zeng's, (2015) study centered was on bedside nurdes'staff's perception to identify characteristics in a caring manager. This was an interesting approach as the frontline staff may have been self-serving within their perspective and biased with their findings. Researchers focused their studies on self-care by offering a variety of different interventions. Since each study was dissimilar, these studies could not be compared.

Finally, the rationale of the review of the literature was to identify different types of research studies conducted to evaluate methods and instruments used when studying caring. None of these studies were alike. Each study had diverse research goals, but all followed the scientific method. It was satisfying to review the variety of research designs focusing on self-care among the nurse population. Based on the scientific method, the research processes were followed for the most part. None of these studies were generalizable.

There is a definite gap in the literature regarding caring behaviors on self-care among NMs. The studies reviewed provided a foundation of the most current information in the last ten years. The gap found in the literature suggests opportunities to provide NMs with interventions to reduce stress, emotional exhaustion, and burnout.

PURPOSE STATEMENT

The purpose of this study is to engage NMs to participate in a quantitative study to determine if a relationship exists between self-care with demographics, NMs, and supervisor (caring leader).

SUMMARY

There is a critical need to investigate this population and self-care practices for NMs. Conducting a study using concise standardized instruments that would be generalizable will provide a new body of knowledge. These findings can inform nursing leadership to prioritize the practice of loving kindness to self by embedding these practices through integration of essential foundations, alongside finance, staffing, and other managerial responsibilities to create a holistic healing caring environment to support and retain among NMs.

CHAPTER 3. METHODOLOGY

This chapter covers the methods for this study. Elements explored were: purpose, study design, population, research method, data collection and analysis, and limitations.

OVERVIEW OF THE STUDY

The role of NMs continues to be difficult. Self-care practices were often forgotten during the workday. It was reported over time that NMs were not be able to replenish their mind, heart, and soul to reduce their stress at work, instead, the stress continues to linger at home. (Drach-Zahavy & Marzuq, 2012). Research on the topic of self-care for this population was scarce.

PURPOSE

Aims and Objectives

This study objectives are to uncover and analyze the findings through self-care behaviors from the NMs' and caring leader. As identified in Chapter 2, a gap exists in the literature with a lack of research about human caring regarding this at-risk population. This study has provided an opportunity for these subjects to convey responses through a standardized questionnaire and identify professional and personal self-care behaviors. This research study has provided a new perspective by comparing the practice of loving-kindness and self-care with NMs responses. These research questions and assumptions to the hypotheses have been addressed below.

Research Questions

1. What demographic characteristics impact caring practices toward self among NMs?
2. What is the correlation between loving-kindness and caring practices for self among NMs?
3. What is the correlation between loving-kindness and caring practices among NMs and their supervisor?

Assumptions to Hypotheses Testing

Based on the lack of evidence, NMs do not perform loving-kindness or practice self-care. There is no correlation between loving-kindness and self-care practices among NMs. There is no correlation between loving-kindness and caring practices between NMs and their immediate supervisor.

PARTICIPANTS

Sample

The entire membership from ACNL consisted of 1,400 members. The study population was a convenience sample of identified NMs who were members of the ACNL. The total sample size (n = 465) consists of different types of nurse leaders: Directors (n = 209), NMs (n = 203), and Assistant Nurse Managers (ANMs) (n = 53). Additionally, each member has self-identified different role classifications and jobs. This organization supports nurse leaders in the state of California, whose members are self-identified as chief nurse executives, directors, NMs, ANMs, educators (within academic institutions and facilities), quality consultants, vendors, nurse entrepreneurs, and retirees. It was implied that these participants were not homogenous since they were connected through membership in California and an organization focusing on nurse leaders employed under different sectors of healthcare.

Inclusion Criteria

Those dues paying members from ACNL were identified as NMs having the following job classifications: Directors, NMs, and ANMs were included in the study.

Exclusion Criteria

Those who are non-members from ACNL and are not NMs. Those who did meet the inclusionary criteria but did not meet the study period deadline for completion of the study were also excluded.

Recruitment Plan

Visibility from participants was essential, the following activities were performed: a digital flyer was distributed three times; once before the survey began, then twice during the 6-week study period which began on May 19, 2021 and ended on June 30, 2021. The digital survey was sent out by ACNL to their entire membership. Only those who identified themselves as NMs (Directors, NMs, and ANMs) were filtered and were able to continue to review informed consent and had the opportunity to complete the survey. The other members were notified about being excluded from taking the study since they did not meet the criteria and were thanked for their interest.

Power Analysis

Statistical power refers to a test of statistical significance with the chance of rejection of the null hypothesis. Power informs how likely it is to detect an effect (Shieh, 2018). The effect size is the magnitude of effect that determines the minimum sample size needed to obtain statistical significance at the selected level of probability and obtain sensitive results and detect a relationship between variables. (Brownlee, 2020; Suresh & Chandrashekara, 2012). The power parameters for this study are identified as the number of subjects needed to respond to the study (n = 231) include power of .99, alpha of .01, and effect size of .15. The power is the ability to distinguish the difference, if a difference exists, that is based on sample and effect size. Alpha

determines the level of significance. The effect size examines the strength of the relationship among two nominal variables.

METHODS

Study Design

This study approach was descriptive and quantitative. The descriptive approach was selected to identify characteristics, frequency, trends, and categories for surveying a specific sample (McCombes, 2020). Question 1 of the survey was sent out to the entire membership of the organization where eligible members were able to participate if they chose. The demographic portion of the survey sent out included 12 items where subjects would provide personal and professional information (Edwards & Thomas, 1993). Demographic questions were multiple-choice with text boxes. Two of Watson's surveys were also used: one self-report caring practices for self (5 items) and the second self-report on perception of caring practices from NMs immediate leader (5 items). These are standard survey questions based on the caritas processes totaling 10 survey questions to assess caring for self and caring of nurse leader using a 7–point Likert Scale ranging from never (1) to always (7). The entire survey totaled 22 questions. Utilizing quantitative methods allowed subjects to respond to questionnaires in a standardized format.

Setting

The setting for this study was the ACNL. Sample membership included all facets of different healthcare centers. These healthcare centers encompassed a variety of healthcare settings: ambulatory care facility, birth centers, blood banks, clinics or medical offices, diabetic education centers, dialysis centers, hospice homes, hospitals, imaging and radiology centers,

mental health and addiction treatment centers, nursing homes, urgent care, telehealth, and others (Flavin, 2018).

Data Collection

A questionnaire was emailed using Survey Monkey(R), a data management system that was selected because it is not only inexpensive and maintains anonymity (Ilieva & Healey, 2002; Picincu, 2018), and provides the survey response time of completion (Picincu, 2018). According to Ilieva and Healey (2002), emailed surveys have a better response rate than those delivered through the postal service. Variables were quantified and analyzed using SPSS 26.0. Power analysis was conducted using G*Power 3.1.9.7. Appropriate statistical methods strengthen the results and the relationship between variables and causal inferences can be explained (Torres-Esperon, 2017).

Chronology and Timeline

There were two timelines: one for the study procedure and the other for outlining the timeline for completion of this Dissertation (Table C.6). There are a variety of activities that needed to be completed in a timely manner. These activities include the following: proposal submission to the Dissertation Team, submission of Chapters 1, 2, and 3, proposal defense, the University of Hawai'i at Mānoa (UHM) Institutional Review Board (IRB) modification submission and approval, recruitment along with administration of the instrument, completion of the study, data analysis, submission of the dissertation, and dissertation defense. Simultaneously an ACNL Proposal was completed previously in alignment with the UHM timeline.

Variables

The dependent variable represents self-care. Two surveys were utilized to examine self-care practices for NMs and supervisor (caring leader). The instruments were entitled as Watson

Caritas Self-Rating Score® (WCSRS) and Watson Caritas Leader Score® (WCLS). Each of the surveys mirrored one another that included five self-care practices: practicing loving-kindness, meeting basic needs, having helping and trusting relationships with others, creating a caring environment that helps to flourish, and valuing one's own beliefs and faith allowing for personal growth (Watson's Caring Science Institute, 2019). The independent variables include: demographics and self-care report from the perception about caring-self from the NMs' immediate leader or supervisor. The demographics comprised the following: role, age, gender, marital status, family composition, academic degrees in nursing, degrees in another discipline, certifications in and outside of nursing, years in the role, formal leadership, and hospital beds.

Operational Definitions

Caritas Process 1 was defined as sustaining humanistic-altruistic values by the practice of loving-kindness, compassion, and equanimity with self and others (Watson Caring Science Institute, 2021). Self-care practices were defined by making oneself a priority by using holistic activities for self-renewal. NMs are defined as dues-paying members of ACNL who are self-identified with aforementioned job classifications. Perceptions are characterized by the NM's viewpoint about caring practices demonstrated by their immediate supervisor.

Instruments

A total of 22 items were included in the surveys. To understand the variability among subjects, their demographics were examined. The first study instrument consisted of 1 item to evaluate if potential responder met the inclusion criteria and 12 items asking about select demographics (Table A.1). Demographic responses were collected using multiple-choice formatting and text boxes. The demographic information collected consisted of personal professional information.

Two unaltered original instruments were selected for the study from the Watson Caring Science Institute (2019). Watson Caritas Self-Rated Score© survey included 5 items (Table A.2). Watson Caritas Leader Role© survey also included 5 items (Table A.3). All 10 items use a 7-point Likert scale with two open-ended questions. For the WCSRS and WCLS there was one open-ended question which was removed from the original instrument that queried information about sharing caring or uncaring moments you experience yourself and one with your experiences about your leader. The other item which was removed was a yes or no response inquiring about the respondent's recommendation of bringing your loved one to this hospital. This was a quantitative study, with one opened-ended question and an "invitation to share experiences about caring". The opened-ended question was, "would you recommend our hospital to someone you love?" The second statement was as follows: "We invite you to share any notable caring or uncaring moments you experienced while working with your leader". These items were removed on two counts: respondents worked in a variety of different work environments other than a hospital. Since this study design was not qualitative or hybrid the second statement was also removed. The authors of the instruments granted permission for use (Watson Caring Science Institute, 2018). Each of these instruments has been psychometrically tested. The Cronbach alpha for the WCSRS (0.89) and WCLS (0.82) demonstrate reliability and validity (Watson and Brewer, 2015).

Data Management and Analysis

This survey which maintained responder anonymity was emailed through a distribution list from ACNL to all members using membership email addresses with responses being collected through Survey Monkey. Responses were collected through online survey software.

Participants remained anonymous as no identifiable information was collected to protect human subjects' privacy.

Once the responses were received from the survey monkey, data was uploaded into SPSS 26.0 for analysis. The statistical analysis was performed with data securely stored. Human subjects were protected since ACNL distributed the survey to membership via email and the responses were entered into Survey Monkey without collecting any personal information. Data was stored on this researcher's computer and was backed up on an external drive which is password protected in a locked office.

HUMAN SUBJECT CONSIDERATIONS

A proposal was developed and submitted to ACNL for approval to conduct research (Figure B.1). Along with the ACNL approval to conduct research, an IRB was approved from the University of Hawai'i Mānoa (UHM) before beginning the study (Figure B.2). An informed consent disclosed the following: purpose, possible risks, type of questions to be asked and answers provided (Figure B.3). Instructions were given at the beginning of the questionnaire on how to use the Likert scale to respond to the questions. If subjects were interested in taking the survey, they gave their implied consent. Implied consent protects the subjects from discovery as no personal identifiers would be obtained. Subjects had the ability to end their participation at any point within the survey. The sample remained anonymous as the student researcher never had contact with the distribution list for emailing out the study questions. Participants' contributions were acknowledged in the aggregate and the organization may receive findings of the study post-graduation in UHM's library.

LIMITATIONS

The desired sample size was not obtained which created a failure to use the initial a priori power analysis and the need to conduct a post hoc power analysis which may have an over inflated effect size that would not be reasonable to expect in a study. Considering the exploratory nature of this study, it was decided to proceed within careful examination of bias within the missing data and close study of residual diagnostics within the regression output. This exploratory nature of the study from the small sample size and varied work environments has implications for not being able to generalize findings.

The survey participants' responses were collected using standard instruments, demographics, WCSRS, and WCLS. Open-ended questions were not included in data collection and analyses. Possible valuable findings derived from the open ended questions may provide deep insight using thematic analysis or mixed methods and that is suggested for possible future research.

SUMMARY

This study design has provided insight into an area of caring science that has not been studied before. Careful analytic procedures and power analysis will maximize the use of the responses to provide insight into an area that has a gap. There is a need to understand what promotes NMs to enact self-care.

CHAPTER 4. RESULTS

INTRODUCTION

This chapter explores the results from this study with a review of the following: objectives and assumptions, description of the sample and responses, description of the responses, interpretation of the findings, testing of the hypothesis as compared to the literature and study results, followed by a summary.

OBJECTIVES AND ASSUMPTIONS

The aim of this study explored NMs engagement to participate in a quantitative study by accessing ACNL members who meet inclusionary criteria to participate in this study and to respond to demographic questions as well as two self-report assessments about self-care and caring by their direct supervisor. An analysis was conducted to determine if a correlation exists between NMs own self-care and demographics like and a correlation between caring by immediate supervisor.

DESCRIPTION OF THE SAMPLE

The survey was distributed to the entire organization of ACNL, where total membership comprised of 1,400. Those who met inclusionary criteria were 33.2% (n = 465). Based on the inclusionary criteria the portion of those members who accessed the survey was 17.8% (n = 83/465). Among the 83, there were 16 (19.3%) who opened and closed the survey without responding to a single item. The remaining 67 responses were examined, and it was found there were 44 of 67 (65.7%) who completed the demographic portion of the survey but did not fully complete the WCSRS and/or WCLS. There were 23 of the 67 (34.4%) who completed the entire survey and used for analysis.

Statistical Tests

The following statistical tests were performed post-survey: descriptive statistics such as mean scores and standard deviations, simple and multiple linear regression. Additional statistical tests were conducted post-survey including: post hoc analysis and Pearson's chi squared test using cross tabulations.

DESCRIPTION OF THE RESPONSES

Power Analysis

The original a priori power parameters were identified as: the number of subjects needed to respond to the study (n = 231), power (.99), alpha (.01), and effect size (.15). Since complete surveys for analysis fell short of 231, a post hoc power analysis was performed to identify the power parameters using a sample of 23. Post hoc analysis was an appropriate statistical test to perform after the completion of the study to adjust the power based on the sample size. (Beck, 2013). Post hoc power analysis revealed a sample size of 23 would realize a power of .90, alpha of .05, and effect size of 0.5. This sample size is still adequate for a pilot study which is suggested to have from 20-50 in a sample for a pilot study (Johanson & Brooks, 2010).

Missing Data and Bias

In order to evaluate responses from the data, it is critical to review missing responses which may lead to bias. Missing data was present within the final sample (n = 23). To evaluate if the complete 23 surveys had bias when compared to the non-responders, cross tabulations were used. Cross tabulations are a coding system for the comparison of categorical data where dummy codes were assigned and were converted into nominal codes for the examination of the mean value between different groupings for the analysis of linear regression. (Tu, 2014).

Missing data can reduce statistical power and produce bias estimations leading to invalid assumptions (Kang, 2013; Sandlewood, 2011; Schober & Vetter, 2020). (Kang, 2013; Schober and Vetter, 2020). If the rate of missing data was equal or less than 5%, then this indicated no need for imputation (Dong & Peng, 2013). Missing data represented 23.3% (23/67) of the survey. There was a need to model missing data by using the responses that were available that is called missing not at random (Kang, 2013; Sandlewood, 2011; Schober & Vetter, 2020).

Missing data was examined for possible bias based on the lack of responses from the demographics. Responses were missing throughout each of the surveys. However, there were two items which had the greatest number of missing data in both the WCSRS and WCLS (Table C.7). Item 3 was identified as I have helping and trusting relationships with others and Item 5 was identified I value my own beliefs and faith allowing for my personal success. Item 3 was missing 21 responses in the WSRS and 16 in the WCLS. Item 5 was missing 31 responses in the WCSRS and 22 in the WCLS.

Examination of Demographic Characteristics

Pearson's chi square statistic was used within cross tabulations to determine if there were more than expected missing data for any of the demographics when compared to the complete survey demographics. Or, to determine if non-responders (incomplete surveys) were roughly equal to the responders (complete surveys) for all demographics. This is important to do for any research study, but especially important in a small sample size that is more prone to influence of outliers or bias. Based on the responses, family composition (those living alone) had statistical significance indicating bias.

The breakdown of gender revealed only one male (4%) as compared to 22 females' (96%) response rate, thus gender was excluded from the cross tabulation analysis. By reviewing

the independent variables (demographics) with the dependent variable (self-care), family composition had significance (.034) (Table C.8). Family composition means for those who live alone were more likely to complete the survey. The following demographic characteristics were not statistically significant which indicated no bias occurred: role, age, marital status, academic degree in nursing, degrees outside nursing, national certification as NM or in other specialties, years in practice as a NM, training and hospital beds. The findings of the demographics were broken down by details, actual responses, mean and standard deviation. (Table C.9).

Research question 1 examined the relationship demographics had to self-care among NMs. Question 2 used hierarchical regression to determine if demographics related to the NM caring for self. Question 3 examined a correlation between caring practice of self and caring of the immediate supervisor.

Response to Research Question 1: What demographic characteristics impact caring practices toward self among NMs?

Examining independent variables (demographics characteristics) to the dependent variable (caring for self) was performed using a Correlation Matrix. Correlation tables help to understand relationships of statistical significance. These following independent variables revealed a correlation, advanced degree in nursing ($r = .67$) and marital status (married or partnered) ($r = .42$) (Table C.10).

The correlation table of all the independent variables revealed only marital status and education in nursing were found to have a statistically significant relationship with caring for self ($r = .42$, $p = .047$ and $r = .67$, $p = .001$, respectively) (Table C.10). Regression equations of all independent variables further confirmed these two demographics as the only two that predicted variance of self-care of NM. Advanced degree in nursing and marital status (married or

partnered) were examined and analyzed independently. Marital Status (married or partnered) was the first independent variable that was discovered to be statistically significant in a regression analysis with caring for self as the dependent variable. Not being married was the reference for marital status, meaning partnered or married. A positive correlation exists with being married as it relates to caring for self. (R^2 = .174, F (1, 21) = 4.437, p = .047) (Table C.11). The overall model explains 17.4% of the variance of caring for self. When looking at the specifics from the coefficient table of the regression model it was revealed that marital status (married or partnered) was a statistically significant predictor (β = .418, t (21) = 2.106, p = .047) (Table C.12). Specifically, being married was positively correlated to caring for self since being single, widowed or divorced as a "not partnered" group was the reference group.

Advanced degree in nursing was the other independent variable found to predict self-care (R^2 = 44.2, F (1, 21) = 16.6, p = .001) (Table C.13). The model for advanced degree in nursing explains 44.2% of the variance of self-care of NM. When looking at the specifics for the regression model, advanced degree in nursing was a statistically significant predictor (β = .665, t (21) = 4.082, p = .001) (Table C.14). Having an advanced degree was positively correlated with self-care of NM.

Multiple regression was significant for both marital status (married or partnered) and advanced degree in nursing as the independent variables and self-care as the dependent variable was a significant finding which revealed both an explained 50.1% of the variance of self-care of NM (R^2 = 50.1, F (2, 20) = 10.030, p = .001) (Table C.15). When looking at the specifics for the regression model, advanced degree in nursing was a statistically significant independent variable (b = .595, t (20) = 3.616, p = .002) while marital status (married or partnered) was not (b = .252, t (20) = 1.529, p = .142) (Table C.16).

Response to Research Question 2: What is the correlation between loving-kindness and caring practices for self among NMs?

An examination of demographics characteristics from question 1 and question 2 was performed using a hierarchical regression (Table C.17). In Model 1, solely examined advanced degree in nursing as a single independent variable was studied as a predictor of caring for self. Model 1 was significant, (R^2 = .44, F (1, 21) = 16.67, p <.001). In Model 2, combined advanced degree in nursing to caring of leader predicted caring of self but not statistically significant, ($R^2\Delta$ = .06, F (1, 20) = 2.54, p = .126). Model 1 accounted for 44% of the variance and was statistically significant. Model 2 accounted for 6% of the variance but the change between Model 1 and Model 2 was not statistically significant indicating advanced degree in nursing remained statistically significant.

Response to Research Question 3: What is the correlation between loving-kindness and caring practices among NMs and their supervisor?

Supervisor (caring leader) was found to be a statistically significant predictor of caring for self in a linear regression, (R^2= .323, F (1, 21) = 10.012, p = .005) (Table C.18). The overall model explains 32.3% of the variance of caring for self. Specifically, having a caring leader predicts caring for self. When looking at the specifics of the regression model, caring of the leader was a statistically significant predictor, (b = .568, t (21) = 3.164, p = .005) (Table C.19). Model 1 continued to examine advanced degree in nursing (p = 0.00) as an independent variable. For Model 2 advanced degree in nursing and caring leader were combined. Advanced degree in nursing was again statistically significant (p = 0.013) and the caring leader was not significant (p = 0.126) (Appendix C.20). The average score for caring for self was 5.04 (SD = .750) as

compared to the supervisor responses which were lower and more dispersed (M = 4.32, SD = 1.25).

When examining the histogram from the residual diagnostics for caring for self to caring leader, the histogram revealed a normal distribution without outliers with an examination of dispersement on either side of the bell curve ranging from -2 to +2 (Figure 1.1). The scatterplot within the residuals reveals no violation of assumptions. See (Figure 2.1) to view the scatterplot. The P to P Plot is a graphic representation of the alignment of data points. There was a positive correlation indicating this was a significant finding (Figure 3.1).

Reliability

Cronbach's alpha is a measurement of internal consistency or reliability that refers to the correlations between different items on a survey (Rogayan ,2017). The purpose of this measurement is to determine if the correlations between distinct items produce a consistent score. Cronbach's alpha score of .8 to .9 indicates that internal consistency is considered very good (Rogayan, 2017). Brewer (2020) reports the Cronbach's Alpha for WCSRS was identified as .89. and for the WCLS was identified as .82.

ANALYSIS OF RESPONSES

Marital status (married or partnered) and advanced degree in nursing were predictors for caring for self in response to question 1. Those who are married or partnered have both affirming and adverse interactions which lead to psychological well-being (Walen & Lachman, 2000). Peters and Liefbroer (1990) reported having a partner fulfilled basic human needs. Being married supports caring for self by promoting self-acceptance, purpose in life, becoming autonomous and contributing to personal growth (Hsu & Barrett, 2020).

Having an advanced degree (masters or doctorate) was identified as a predictor for caring for self. These advanced degrees provide insight into the profession into different career opportunities in the workplace away from the bedside (Healthcare Administration Degree Program, 2021). Perhaps caring leaders may find those opportunities more rewarding or satisfying which translates into better self-care.

To review question 2, two models were utilized to examine any statistical significance with advanced degree in nursing and caring of leader. Model 1 solely examined advanced degree in nursing which reveal 44% of the variance and was statistically significant which was a predictor of caring for self. When combined with advanced degree and nursing and caring leader, caring leader had no significance. This finding was disappointing as it did not reflect what was in the literature indicating caring leaders who perform self-care will care for others. Had the sample size been larger, this finding may have reached statistical significance.

When examining question 3, a caring leader predicted caring for self. Watson (2021) was quoted:

> One's caring consciousness presence in a given moment, affects the whole field experience for self and others. In doing so we open our hearts and minds to a sacred space where we can simply be with another, the often unseen process of deep human caring in nursing." Therefore, the caring leader will foster their subordinate, the NM to provide their own self-care.

The findings are supported in the literature as caring for self before caring for others (Mantesso, 2005, Hawthorne and Barry; 2021).

TESTING OF HYPOTHESIS

There was a correlation between demographics with NMs and supervisors (caring leaders). Findings indicate that there was statistical significance with the demographic independent variables: marital status, advanced degree in nursing and caring leader.

SUMMARY

Despite the small sample, this study provides initial insight into the relationship of demographics of NMs and caring from their direct supervisor with self-care. Bias needed to be explored due to the increased amount of missing data. Trends were identified from missing data from the WCSRS and WCLS surveys. Most notably, missing responses were based on 2 categories: helping and trusting relationships and value and belief and faith. It has been identified before in caring literature that used Watson's 2008 theory of transpersonal caring that it is not uncommon for respondents to report questions related to faith are a private matter and thus not responded to (Nelson, Felgen, & Hozak, 2021; Williamson, Smith, Brown, & Nelson, 2021). Possibly helping and trusting relationships and values of belief and faith were not experienced by the respondents, with chaos and uncertainty about the future during the pandemic. The supervisor (caring leader) may have been supporting both the operational needs of the hospital and staff but was not noticeable by NMs.

Statistical significance was established for each research question. For question 1, marital status (married or partnered) was a predictor of self-care. There were several covariates that were correlated with caring for self: caring leader and degree in nursing. Nurse Managers with an advanced degree (masters or doctorates) and caring leader were more likely to perform self-care. For the caring leader, age and leadership training were also correlated. Possibly, the supervisor (caring leader) was older, had obtained additional education, and experienced more self-care. In

question 2, two variables which had statistical significance were advanced degree and caring leader. These demographics were analyzed examining two models. The first model was the advanced degree in nursing (masters' and doctorate). The second model compared the advanced degree in nursing (masters' and doctorate) and caring leader. Model 1 revealed statistical significance indicating that degree in nursing is a predictor of self-care. In Model 2, caring leader was not significant but degree in nursing again was. Caring leader did not achieve statistical significance but was close. With a larger sample size, the caring leader score may have revealed significance. This was a small sample size which would be considered a pilot. It would be very difficult to generalize these findings. For question 3, it is predicted supervisors (caring leaders) who demonstrate caring towards NMs, then these NMs are able to care for self.

CHAPTER 5. DISCUSSION

RATIONALE FOR THIS STUDY

Nurse Managers (NMs) continue to be forgotten in the area of research, especially from the perspective of self-care. Based on evidence and observation from this student researcher's viewpoint, NMs do not stay in the job for long due to workplace pressures that often ends in voluntary resignation, transferring to other departments outside the hospital setting, or leaving the profession.

This research study was an opportunity to examine NMs' self-care through the lens of the Theory of Human Caring and gain insight about what relates to and even predicts self-care of NMs. This research adds to the body of nursing knowledge in the area of human caring and what factors might impact the NMs self-care.

BACKGROUND OF THIS STUDY

The challenges that NMs experienced has been featured throughout this dissertation. Furthermore, the advent of coronavirus disease (COVID-19) and the current work climate within the hospital has created more intensity and complexity and challenges for NMs overseeing systems and staff for clinical care. Recent literature continues to focus on frontline nurses' mental health and resilience (Duncan, 2020; Klatt, Bawa, Gabram, Blake, Westrick, & Holiday, 2020; Carmassi, Foghi, Dell'Oste, Cordone, Bertelloni, Bui & Dell'Osso, 2020; Chen, Sun, Chen, Jen, Kang, Kao, & Chou, 2021). Literature regarding clinical staff stress and the need for resilience was easy to find, but when contrasted to what was found about NMs within the same environment, the need to study NMs was evident. There continues to be a lack of investigation on self-care with NMs.

INTERPRETATION OF FINDINGS

Concordance with the Literature

Throughout this dissertation much has been shared about the work-life balance stressors experienced by NMs. The COVID-19 pandemic has certainly complicated the role for the NM as well as those caring for patients. Current literature revealed several studies on current stressors for NMs. Editorials or anecdotal informational articles addressed both issues and solutions without formal evidence (Hofmeyer et al., 2020).

Another formal review of the literature investigated NMs' stressors and caring practices related to the COVID-19 pandemic. This search began with identification of keywords: COVID-19, self-care and NMs, then utilized several databases to ensure a thorough review was conducted. Databases used were: CINAHL, PubMed, Psychology Behavioral Sciences Collection, PsycINFO, All, PsycINFO, PsycARTICLES, and ProQuest. CINAHL did not reveal any references utilizing the keywords identified above. PubMed produced references (n = 19) without any filters and only one reference was examined. Psychology and Behavioral Sciences Collection included these databases: All, PsycINFO, and PsycARTICLES with peer review as the filter. "All" generated seventy references. Results for the subsequent databases are as follows: PsycInfo (n = 69), PsycARTICLES (n = 1). For ProQuest yielded a range of references from 1,266 to 21,992. Several filters were added to this literature review: scholarly journal, abstract, full text, language, and one year. Still references were excessive (n = 1,266). For the top first fifty references, titles and abstracts were reviewed with a total of three studies meeting the criteria. These current studies were not explicit about human caring.

Eighteen references were established and were examined for stressors and self-care practices for different healthcare professionals. The breakdown of those studied included were:

healthcare professionals at 50% (n = 9), nurses at 39% (n = 7), and NMs at 11% (n = 2). Though only two studies best met the criteria.

Stressors had been exacerbated for NMs as a result of the COVID-19 pandemic as evidenced by Post Traumatic Stress Disorder (PTSD) or poor mental health (Gab Allah, 2021; Vázquez-Calatayud, Regaira-Martinez, Rumeu-Casares, Paloma-Mora, & Esain, 2021; White, 2021). PTSD has impacted mental health issues as manifested by: depression, anxiety, loneliness, stress, and exhaustion (Gab Allah, 2021; White, 2021).

White (2021) conducted a qualitative study performed in the United States examining NMs' experiences during the pandemic. The study participants were a convenience sample (n = 13) of NMs (46%) and ANMs (54%) from a 23 facility system in the Mid Atlantic. Mental health issues or job challenges were prevalent among NMs, such as: organizational support, disaster management, ethical decision making, coping, and being present for everyone (White, 2021). During these extreme times, NMs felt a strong responsibility to their staff by providing an operational focus to support the team through providing time off and flexible scheduling (White, 2021). Upon further investigation two themes were identified, included support and coping, and strengthening my role. Along with these themes, there were implications for caring for self.

From the struggles, support and coping were positive manifestations of the effects of the pandemic. However, negative manifestations were also demonstrated as physical and psychosocial issues, such as: weight gain, isolation, depression, anxiety, and feeling overwhelmed (White, 2021). Also, two positive sub-themes were identified in theme 1, support and coping, including identifying professional and personal assistance as an important support for NMs. Professional support was experienced through collaboration and encouragement from

the NMs peers, Director, and Chief Nurse Executive (White, 2021). Examples of personal coping identified by White (2021) included spousal support, pet therapy, and personal counseling.

The second theme was strengthening my role which included two relevant sub-themes: reflections on learning, and rewarding influences. Reflections on learning created a new paradigm shift where the NM parceling portions out of the work to the team which reduced the NMs burden and overall improved leadership skills (White, 2021). Rewarding influences was the second subtheme focusing in on external returns, such as: witnessing a COVID-19 patient recover, getting positive staff feedback for the support given, appreciating the sacrifices of others, and travel nurses who came to support the staff (White, 2021).

While this study did not examine care for self or caring leader, it was apparent that caring for self was revealed by the examples of personal coping strategies. There were several different approaches where the NMs were the caring leaders: providing for operational needs for the staff, leading by example, and being supportive of the team. Additionally, the immediate leaders were also caring leaders which provided support to the NM so they could care for themselves and others.

Vázquez-Calatayud, Regaira-Martinez, Rumeu-Casares, Paloma-Mora, and Esain, (2021) conducted a qualitative study performed in Spain examining frontline NMs experiences during the pandemic. This convenience sample (n = 10) of NMs was from a very specialized hospital who participated in this study. Six themes surfaced: adaptation to change, participation in decision-making, management of uncertainty, prioritization of the bio-psychosocial well-being management of staff, preservation of humanized care and “one for all”. Uncovering each of the themes revealed NMs were compassionate leaders especially in the midst of this crisis.

Characteristics of being a compassionate leader include: being present, understanding, responsive, and serving others (Vázquez-Calatayud et al., 2021). By being a positive force and compassionate leader, the NMs were able to care for staff by providing a welcoming work atmosphere. NMs were considered a caring leader since they met the needs of the staff. The term "all in one" uncovered two sub-themes: teamwork and collaboration (Vázquez-Calatayud et al., 2021). Teamwork was shared as a fellowship among the NM and staff responding to each other's needs and through collaboration implying unity and respect of the NM and staff as one. The NM was the caring leader who supported the staff during a time of uncertainty through the pandemic and the staff acting as the agents for providing their own self-care by supporting one another and the NM. This study concluded that emotional self-management and supporting efforts to foster proactive positive visionary attitudes will benefit the NMs. Advanced degree in nursing was examined which included bachelor's degree (20%) and master's degree (80%). Advanced degrees were found to have similar findings to this researchers' study that indicates master's degree predicts caring for self and others (Vázquez-Calatayud et al., 2021).

Conceptual Framework

Watson's theory was the underpinning for this study. This theory focuses on the foundation of human caring. The Caritas Processes (CP) are guiding principles which influence meanings for human caring behaviors. Watson identified the single most important CP, namely the practice of self-care, as discussed throughout this dissertation. CP1 was defined a sustaining humanistic-altruistic values by practicing loving-kindness, compassion and equanimity with self and others (Brewer, Anderson, & Watson, 2020). Using Caritas literacy, CP1 terms will be defined, then shared in a simpler sentence to promote understanding. Humanistic means having concerns for well-being of others. Altruistic values are defined as being selfless, kind and

considerate of others. Equanimity is the calmness and composure one exhibits under pressure. For clarity, CP1 means supporting concerns for human wellness by being selfless, kind, and considerate while remaining calm and composed during challenging times for self and others. According to Watson (2020), this is the single most important guiding principle in human caring. The science of human caring has been embedded throughout this study. As a graduate of the Caritas Coach program, Watson's Theory of Human Caring has been integrated personally, professionally and academically. The support received from expert members of Watson's Caring Science Institute has been invaluable and consultation has been sought out to support this dissertation by so many, by promoting the Theory of Human Caring for: mentors, nurse scientists, researchers, statisticians, and authors in peer reviewed articles and books.

Limitations of the Study

When submitting the proposal to ACNL, there were several changes that were requested and honored. The original sample size selected consisted of one-fourth of the NM membership (n = 111). ACNL felt the sample size was too small and wanted it increased to greater than 200. The sample size was increased to half of the population who met criteria (n = 231). This action led to change the power analysis from the original proposed sample (n = 111), power (.96), alpha (.05) and effect size (0.20). The new sample (231) supported this power analysis: power (.99), alpha (0.01, and effect size (0.15).

There were three categories of responders: those who opened and closed the survey, those who completed any part of the survey, or those who completed all of the demographics and only part of the Watson's survey. The sample was small (n = 23). Therefore, this study would be considered a pilot. A post hoc power analysis was conducted based on the sample size achieved with the following parameters: sample (n = 23), power (.90), alpha (0.05), and effect size of

(0.5). Missing data was explored and reviewed for bias, then the statistical tests were performed and analyzed.

The study period was increased from two weeks to six weeks in length. The increased recruitment time usually allows more subjects to participate. In this situation, the study period was extended and recruitment was only performed twice during the six-week period which may have impacted the visibility of the study to participants. It was suggested that the excessive study length and lack of recruitment contributed to the small sample. Communication via email may have been sent to junk mail where the participants may not have had the opportunity to see the invitation and participate. Furthermore, the study period ranged from May 19 to June 30, 2021, which coincided with one of the waves of the COVID-19 pandemic that could have also significantly impacted those NMs from completing the survey.

However, the two study instruments were created by the Watson Caring Science Institute (2018) and were psychometrically tested, each having five questions each accounting for 10 items total. Neither instrument had been used in research studies identified in previous literature reviews with a homogenous population of NMs. Brewer, Anderson, and Watson (2020) utilized WSCRS and WCSR in a study examining the effectiveness of a Caritas Coach (training program. This was sponsored by Watson's Caring Science Institute where the sample did include NMs along with a variety of different leaders but did not identify the type of respondents who participated. While WSCRS and WCSR were used in the prior study, the context of this study was different.

There was an issue of missing data, both on the descriptive portion and within the Watson instruments. Items on helping and trusting relationship and valuing beliefs and faith may have been difficult to answer especially during the pandemic where there was much uncertainty and

fear about the future from the impact of COVID-19. Another consideration is about how the questions were written. Respondents may not have understood the items which results in no response. Perhaps simplifying the language may have provided a better understanding of the item, where the participants would have felt comfortable to reply.

The underpinning of Watson's Theory of Human Caring is difficult to understand as the scientific language or terminology is very complex. For the recruitment flyer, simplifying the language for those unfamiliar with this theory may have improved the respondents understanding and encouraged more participation in the study. To illustrate the simplification of the language, caritas will be defined. Caritas denotes caring, love, and holistic healing of mind, body, and spirit for self and others (Nelson & Watson, 2011). Holistic healing is represented through love and caring promoting health through: mind meaning psychological, body meaning physical, and spirit meaning your inner self. Self-care practices were defined by making oneself a priority by using holistic activities for self-renewal. Self-care practices are individual holistic practices that may improve health and well-being (Jenson & Bonde, 2018). During the literature review, researchers identified self-care activities which supported by their studies. Holistic practices to support self-care are vast, but not collectively mentioned using the evidence. Examples of holistic practices to support self-care was broken down into three themes: mind, body and spirit for review by this student researcher (Table C.21). Simplifying the language of the Theory of Human Caring may have enabled the participants to respond

CONCLUSIONS

The role of Nurse Managers (NMs) continues to be difficult. Self-care practices were often forgotten during the workday. It was reported over time that NMs may be able to replenish their mind, heart, and soul and reduce their stress at work. Instead, they brought their stress home

(Drach-Zahavy & Marzuq, 2012). Research on the topic of self-care for this population was scarce.

This population has never been examined through a quantitative approach. Results of this study clarified practices on self-care from the NMs perspective. Based on the literature, the findings revealed that there was a lack of evidence to indicate NMs' perceptions about Caritas Process 1, the practice of loving-kindness and self-care, exists. Additionally, NMs' perceptions about self-care from the lens of their direct supervisor was non-existent.

These study results have added to the body of nursing knowledge by advancing the Theory of Human Caring. This evidence has exposed statistical significance among variables to support NMs self-care. Conceivably these caring practices provided a more powerful opportunity to create a culture of caring by impacting the longevity of NMs in the workplace. Future studies could identify explicit self-care practices that reduce turnover, retention, and improve job satisfaction.

This was the first time a quantitative study had been performed on a homogenous sample of NMs regarding self-care. This study had some challenges. The sample was small. This study is considered a pilot. Missing data were examined for bias with only one independent variable with statistical significance, family composition.

Examining self-care among NMs in the Model Summary revealed two independent variables which had significance: advanced degree in nursing and marital status (married or partnered). These same variables were separately tested, and advanced degree in nursing had significance. However, marital status (married or partnered) was not significant when studied with degree in nursing in the multiple linear regression. A comparison of the independent variables with the dependent variable to NMs self-care was performed. Each independent

variable was examined separately and combined with the coefficients to re-evaluate significance. Marital status (married or partnered) had no significance when combined with advanced degree in nursing. The advanced degree in nursing remained significant, meaning having a master's or doctoral degree was a predictor for NMs to perform self-care.

Next, advanced degree in nursing was compared to the caring leader. It was again found that advanced degree in nursing was significant. Additionally, the care for self and caring for leader was compared. Surprisingly, the correlation for caring leader did not have statistical significance. Advanced degree in nursing was a constant independent variable which demonstrated the prediction that NMs were more likely to perform self-care. When reviewing the p-p plot, the best fit line suggested that the caring leader was significant for supporting self-care of the NM.

Implications

NMs are more challenged than ever. The pandemic has increased workplace stressors. In the literature, stressors and support of nurses has been in the forefront, but these challenges have not been exposed for NMs. The Theory of Human Caring has not been studied nor disseminated into the nursing body of knowledge as it relates to NMs. Conducting research with a standardized tool may allow for more NMs to participate in studies on human caring and to benchmark findings across healthcare systems.

The necessity is paramount to incorporate Watson’s theory into all workplace settings and focus on CP1, the practice of loving-kindness for self and others. Variables impacting caring for self were advanced degrees in nursing, marital status (married or partnered), and caring leaders. Supporting both personal and professional development also influences caring for self. It is suggested that caring leaders predict self-care for others. Self-care for NMs and their caring

leader is essential for creating a culture of caring with work-life balance. For holistic self-care practices, refer to the Examples of Holistic Practices by Theme to Support Self-Care (Table C.21).

This study was groundbreaking as it is the first to utilize quantitative standardized methods. The timeframe to complete the study was short (less than 10 minutes), which may engage more NMs to participate in such a study moving forward. This type of investigation concentrated on the development of new knowledge and prioritizing awareness of findings to enhance nursing practice (Torres-Esperon, 2017). This study was to advance the Theory of Human Caring by establishing new information from the NMs perspective on the CP1, the practice of loving-kindness towards self-care, and their immediate supervisor.

Time has come to acknowledge the difficult role facing NMs as it was discovered through scientific examination in the literature. NMs demographics (independent variables) provided insight for self-care practices. This study uncovered three independent variables that were key for promoting self-care for NMs: advanced degree, marital status, and caring leader. These practices will positively impact the performance, self-satisfaction, and longevity in the role of NMs.

Future Directions

Upon graduation, the results of this study will be disseminated through publication in a scholarly journal and presented at national and international conferences. Disseminating this study can take many forms: blogs, posting abstracts on websites, seminar presentations, and posters to engage ACNL membership through local chapters and nationwide. Additional offerings to ACNL would include providing seminars on the Theory of Human Caring and centering on self-care.

Post-graduation, this researcher plans to continue to support research activities and partner with the Northern California Kaiser Permanente's Research and Innovation division in our quest to achieve American Nursing Credentialling Center Magnet® Designation at the local facility. The Magnet program focuses on nursing empowerment to improve patient outcomes. Conducting research is one vehicle to achieve this designation. There are three studies in the works: two studies are related to the Theory of Human Caring with resilience post COVID-19 pandemic and one study is on peer review and mentoring. This researcher will be participating on all three of these studies.

Recommendations

Based on the limitations of this study, repeating this study to increase sample size at one local hospital setting may validate findings. Other enhancements would include: creating a quick response or QR code, considering forced choices, increasing recruitment, and shortening the study period. Upon completion of the second study, conduct a comparison to validate findings and examine opportunities. It is this student researchers' obligation to continue to use research methods to advance nursing practice.

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APPENDIX A.

Table A.1

Demographic Instrument: Independent Variables by Category, Questions, and Subsets

Category	Question	Subset
Job Classification	Please identify your current role by selecting from the choices below.	Clinical Director, NM, or ANM
Age	What is your age range?	Range: 22-29; 30-39; 40-49; 50-59; 60-69; 70-79
Gender	What is your gender?	Male, Female, do not want to disclose
Marital Status	What is your marital status?	Single, Married, Widowed
Family Composition	What is your family composition?	Living alone, children living in the home, children living outside the home, extended family living in the home
Academic Degrees	If you hold an academic degree in nursing, what degree did you earn?	Education in Nursing: Non-Applicable, Diploma, Bachelors, Masters, Doctorate in Nursing Practice, PhD
Other Academic Degrees	If you hold another degree in another discipline outside of nursing, what degree did you earn?	Write in (Text Box)
Certifications	Do you have a national certification in nursing management?	Yes, No
Other Certifications	If you hold a certification in another specialty, please type in your response.	Write in (Text Box)
Years in Nurse Management Role	How many years have you been in the role of NM in your career?	0-2; 3-5;6-10; 11-15; 16-20; 21-25; 26-30; greater than 31
Leadership Management Training	Have you ever had formal leadership management training?	Yes, within current work environment, Yes, outside current work environment, Never, learned on the job
Hospital Beds	How many hospital beds do you have within your facility?	Less than 99 100-249 250-399 Greater than 500 Non Applicable – I do not work in a hospital

APPENDIX A.

Table A.2

Watson Caritas Self-Rating Score© Survey

Instructions: When answering the questions, please consider the overall consistency of human-to-human SELF-CARING you have experienced. Please check the number for the best response.

		Never						Always
	Item	1	2	3	4	5	6	7
1.	I treat myself with loving-kindness.							
2.	I practice self-care as a means for meeting my own basic needs.							
3.	I have helping and trusting relationships with others.							
4.	I create a caring environment that helps me to flourish.							
5.	I value my own beliefs and faith, allowing for my personal success.							

APPENDIX A.

Table A.3

Watson Caritas Leader Score© Survey

Instructions: When answering the questions, please consider the overall consistency of human-to-human CARING you have experienced while working with your leader/supervisor. Please check the number for the best response.

		Never						Always
	Item	1	2	3	4	5	6	7
1.	Treats me with loving-kindness.							
2.	Models' appropriate self-care as a means for meeting the basic needs of self and others.							
3.	Has a helping and trusting relationships with me.							
4.	Creates a caring environment that supports my personal and professional growth.							
5.	Values my own beliefs and faith, allowing for expected and unexpected successes in my role.							

APPENDIX B.

Document B.1

Research and Ethics*: ACNL Final Approval*

Association of California Nurse Leaders

May 5, 2021

KATHERINE RICOSSA
2625 Estella Drive
Santa Clara, CA 95051
(408) 248-5170

Dear Ms. Ricossa:

The ACNL Research committee has reviewed your revised proposal and this letter is to provide final approval for the proposal.

The Research Committee has the following suggestions for you to help ensure your success.

- Page 3 – typo in the review of literature section "antidotal," I think you mean **anecdotal.**
- Page 5 – under Research Design, it is stated that there are 11 demographic questions. In the actual instrument, there are 12 – we recommend that this be reconciled in this section.
- Study timeline – We believe the time frame of 3-week period is insufficient to obtain the necessary number of participants given the effect size and power analysis calculated sample size (n = 231) since it appears that ACNL is your only participant. We would recommend increasing the time frame to at least 6 to 8 weeks if possible.
- Clarify the verbiage on implied consent. On page 12, We suggest that rather than the current sentence: "Going to the first page of the survey implies your consent to participate in the study" perhaps this rewording would provide greater clarity: "Proceeding to the first page of the survey implies your consent to participate in this study."

We look forward to hearing about the findings from your study and wish you the best in your endeavors. Please contact for assistance in sending your survey to the ACNL membership:

Wendy Smolich
Program Coordinator
Association of California Nurse Leaders
180 Promenade Circle, #300
Sacramento, CA 95834
916-200-8692
wendy@acnl.org

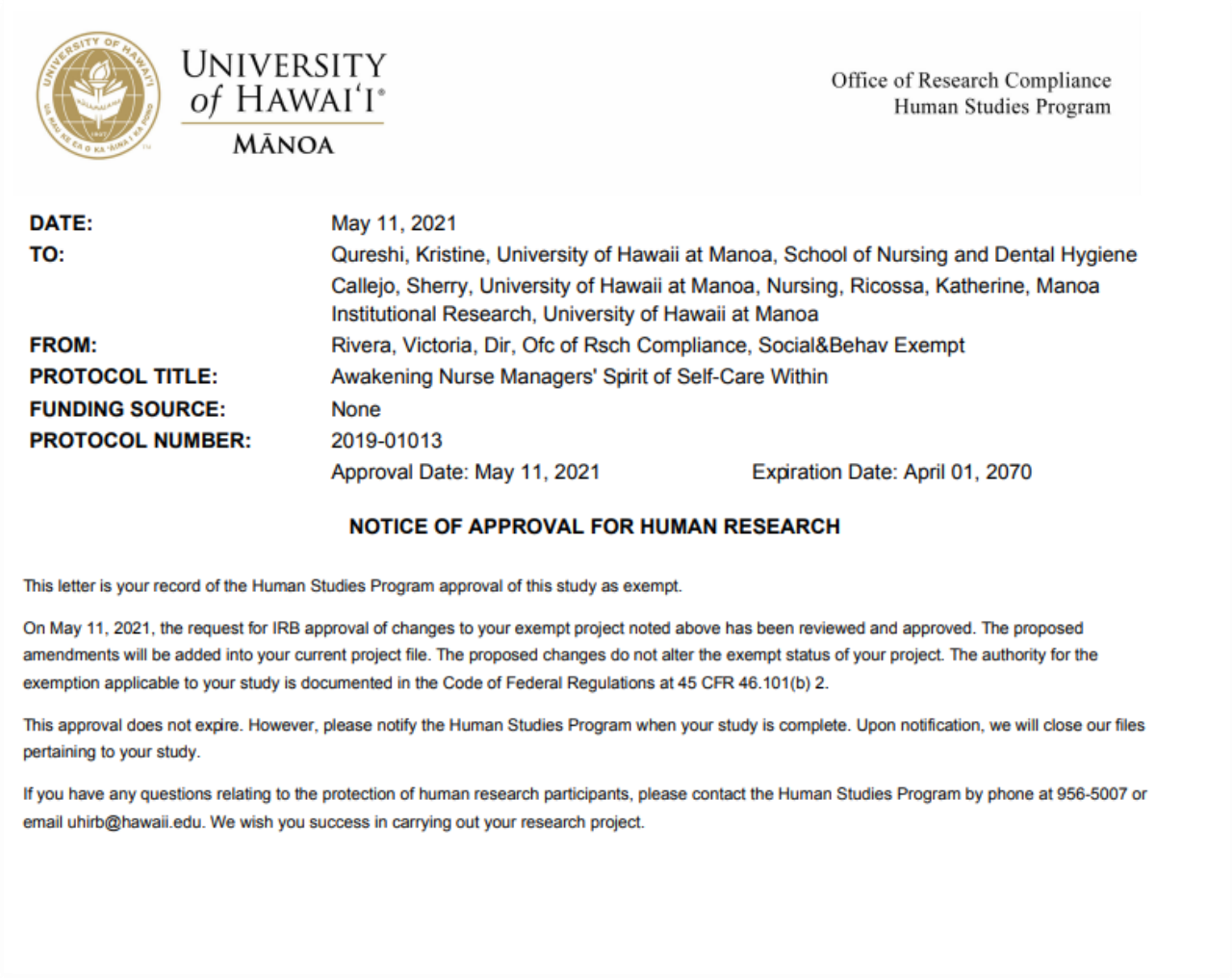
Cordially,
Patti Radovich, PhD, CNS, FCCM\
Chair Proposal Review Subcommittee
ACNL Research Committee

180 Promenade Circle, Suite 300 • Sacramento, CA 95834 • Telephone: (916) 779-6949 • Facsimile: 779-6945 • acnl.org

APPENDIX B.

Document B.2

Research and Ethics*: UHM Final IRB Approval*



UNIVERSITY of HAWAI'I® MĀNOA

Office of Research Compliance
Human Studies Program

DATE:	May 11, 2021
TO:	Qureshi, Kristine, University of Hawaii at Manoa, School of Nursing and Dental Hygiene Callejo, Sherry, University of Hawaii at Manoa, Nursing, Ricossa, Katherine, Manoa Institutional Research, University of Hawaii at Manoa
FROM:	Rivera, Victoria, Dir, Ofc of Rsch Compliance, Social&Behav Exempt
PROTOCOL TITLE:	Awakening Nurse Managers' Spirit of Self-Care Within
FUNDING SOURCE:	None
PROTOCOL NUMBER:	2019-01013
	Approval Date: May 11, 2021 Expiration Date: April 01, 2070

NOTICE OF APPROVAL FOR HUMAN RESEARCH

This letter is your record of the Human Studies Program approval of this study as exempt.

On May 11, 2021, the request for IRB approval of changes to your exempt project noted above has been reviewed and approved. The proposed amendments will be added into your current project file. The proposed changes do not alter the exempt status of your project. The authority for the exemption applicable to your study is documented in the Code of Federal Regulations at 45 CFR 46.101(b) 2.

This approval does not expire. However, please notify the Human Studies Program when your study is complete. Upon notification, we will close our files pertaining to your study.

If you have any questions relating to the protection of human research participants, please contact the Human Studies Program by phone at 956-5007 or email uhirb@hawaii.edu. We wish you success in carrying out your research project.

APPENDIX B.

Document B.3

Recruitment and Informed Consent

Aloha! My name is Kathy Ricossa, and you are invited to take part in a research study. I am a graduate student at the University of Hawai'i at Mānoa in the Department of Nursing. As part of the requirements for earning my graduate degree, I am doing a research project.

What am I being asked to do?
If you participate in this project, you will be asked to fill out a survey.

Taking part in this study is your choice.
Your participation in this project is completely voluntary. You may stop participating at any time. If you stop being in the study, there will be no penalty or loss to you. Your choice to participate or not participate will not affect your rights to services at the Association of California Nurse Leaders.

Why is this study being done?
The purpose of my project is to engage Nurse Managers to participate in a quantitative study to determine if a relationship exists between self-care and the practice of loving-kindness as compared to their perceptions about their immediate supervisor. I am asking you to participate because you are a nurse manager and are a member of the Association of California Nurse Leaders.

What will happen if I decide to take part in this study?
The survey will consist of 22 multiple choices, ranking responses, and open-ended questions. It will take 10 minutes. The survey questions will include questions like, "If you hold an academic degree in nursing, what degree did you earn?" "If you hold another degree in another discipline outside of nursing, what degree did you earn?" "I treat myself with loving-kindness". My immediate supervisor "creates a caring environment that supports my personal and professional growth". The survey is accessed on a website to which I will provide you a link.

What are the risks and benefits of taking part in this study?
I believe there is little risk to you for participating in this research project. You may become stressed or uncomfortable answering any of the survey questions. If you do become stressed or uncomfortable, you can skip the question or take a break. You can also stop taking the survey or you can withdraw from the project altogether.

There will be no direct benefit to you for participating in this survey. The results of this project may help improve the Career Development and Counseling program to benefit future students.

Confidentiality and Privacy:
I will not ask you for any personal information, such as your name or address. Please do not

include any personal information in your survey responses. I will keep all study data secure in a locked filing cabinet in a locked office/encrypted on a password protected computer. Only my University of Hawai'i advisor and I will have access to the information. The Association of California Nurse Leaders have legal permission have the right to review research records. The University of Hawai'i Human Studies Program has the right to review research records for this study.

Compensation:
You will not be compensated for participating in this study. Your participation in this research study will be helping Nurse Managers like yourselves in the future.

Future Research Studies:
Identifiers will be removed from your identifiable private information and may be distributed to another investigator for future research studies. We will not seek further approval from you for these future studies.

Questions: If you have any questions about this study, please call or email at: ricossak@hawaii.edu. You may also contact my faculty advisor, Dr. Kristine Qureshi, by phone at 808.956.2638 or email at kqureshi@hawaii.edu. You may contact the UH Human Studies.
To Access the Survey: Please proceed to the following web page: (https://www.surveymonkey.com/r/2G2TRTR). You should find a link and instructions for completing the survey. Going to the first page of the survey implies your consent to participate in this study.

Please print or save a copy of this page for your reference.

Mahalo!

APPENDIX C.

Table C.1

Historical Perspective of Caring from a Theoretical Framework

Theorist	Year	Focus	Description
Nightingale (Nightingale, 1946)	1859	Holistic Care	People are multifaceted; focuses on the mind, body, spirit and social aspect
Leininger (MacFarland, 2010)	1961	Transcultural Nursing Caring is essential to nursing Assist the person to improve condition	Nurturing Depends on the needs of the person Must be in alignment with the patients' culture
Rogers (Gunter, 2010)	1970	Unitary Human Beings	Examining humans as whole; one with the universe using energy fields. Identifying the patient and the environment as one as a continuum achieving health potential to death. Using non-invasive modalities to promote wholeness
Watson (Jesse, 2010)	1979	Dynamic Theory: Human Caring evolved to the Theory of Transpersonal Caring	10 Caritas Processes Transpersonal caring relationship Being the caring healing environment
Boykin and Schoenhofer (Purnell, 2010)	1981	Theory of Caring: Transforming Nursing Practice	Started with development of curriculum Promote professional practice of nursing to create nurturing relationships through personhood
Swanson (Wojnar, 2010)	1991	Theory of Caring Focused early work on Maternal Child Health patients and families with perinatal loss	Modified Caring Processes from Watson 5 Caring Processes

APPENDIX C.

Table C.2

Themes and Positive Consequences within the NM Role

Category	Positive Consequences	Reference
Personal Outlook	Healthy Lifestyle Health Promotion	(Chan and Perry, 2012; Waston, 2008;)
	Professionalism Professional Values	(Pieszak, 2009)
Work Life Balance	Great Quality of Life	(Sarafis & et al., 2016)
Human Caring	Human Presence	(Sarafis & et al., 2016)
External Rewards	Pay	(Andrews & Dziegieleswki, 2018)
Personal Expense	Self-Renewal	(Brown, 2009)
	Meaningful Work	(Udod et al., 2017)
	Work Engagement	(Mason, Leslie, Clark, Lyons, Wallace, Butler, and Griffin, 2014; Van Bogaert, Peremans, Van Heusden, Verspuy, Kureckova, Van de Cruyz, & Franck, 2017)
	Job Satisfaction	(Andrews & Dziegieleswki, 2018; Cherry, Ashcraft, & Owen, 2007; Hill, 2011; Lee & Cummins, 2008; Udod et al., 2017)
Responses to Stress	Coping Strategies Stress Reduction	(Kath, Stichler, Ehrhart, and Sievers, 2013; Udod et al., 2017; Smith, 2014)
Adaptation	Resilience	(Brennan, 2017; Doherty, 2009)
	Self -Renewal	(Brown, 2009)
	Well-Being	(Brennan, 2017, Tang, Tegeler, Larrimore, Cowgill, & Kemper, 2010)
	Vigor	(Drach-Zahavy & Marzuq, 2013)

Joy Engagement Work Engagement	(Van Bogaert et al., 2017; Wade, Osgood, Avino, Bucher, Bucher, Foraker, French, & Sirkowski, 2008).

APPENDIX C.

Table C.3

Themes and Negative Consequences within the NM Role

Category	Negative Consequences	Reference
Leadership Support	No Support Lack Supervision Nurse Incivility	(Kaiser, 2017; Udod et al., 2017; Sarafis, et al., 2016)
Personal Outlook	Organizational Stressors	(Udod et al, 2017)
	Emotional Exhaustion	(Drach-Zahavy & Marzuq, 2013; Leineweber, et al., 2014)
Communication	Conflict with Physicians	(Sarafis & et al., 2016)
Kinship	Care Relationships	(Nakrem, Solbjør, Petterson, & Kleiven, 2018)
Personal Commitments	Caretaking Education Family structure Spousal support Parental status Organization of Family and Personal Life Working full-time Alternative Shifts	(Leineweber et al., 2014)
Work Life Balance	Poor Quality of Life	(Sarafis & et al., 2016)
	Work Family Conflict	(Leineweber et al., 2014)
Stress Response	Not coping	(Udod et al., 2017)
	Mood Disturbance	(Mosadegh, 2014)
	Altered Sleep Status	(Han, Yuan, Zhang, & Fu, 2016)
	Family Stress	(Fang & Hung, 2014)

	Leader Fatigue	(Steege, et al., 2017)
	Burnout Absenteeism Exhaustion	(Leineweber et al., 2014)
	Stress	(Gallagher & Gormley, 2009; Johansson, et al., 2013; Kath et al., 2013; MacLaughlin-Frandsen, 2010; Rollins, 2008; Udod et al., 2017; Wilson, Squires, Widger, Cranley & Tourengeau 2008)
	Technology	(Smith, 2008)
Personal Expense	Compassion Fatigue	(Bush, 2009; MacLaughlin-Frandsen, 2010; Mason, et al., 2014)
	Moral distress	(Mason, et al., 2014)
	Violence in the Workplace	(Jackson, Clare, & Mannix, 2003)
	Health Issues	(Gelsema et al., 2005; Herberts & Eriksson, 1995; MacLaughlin-Frandsen, 2010; Shirey, 2004; Warshawsky & Havens; 2014)
	Anger	(Ersoy-Kart; 2009)
	Job Burnout	(Ersoy-Kart, 2009; Gallagher & Gormley, 2009; Hertel, 2009; Malasch, Schaufeli, & Leiter, 2001; Pieszak, 2009; Rollins, 2008; Van Bogaert, Peremans, Van Heusden,Verspuy, Kureckova, Van de Cruxys, & Franck, 2017).
	Job Dissatisfaction	(de Castro, Gee & Takeuchi, 2008)

APPENDIX C.

Table C.4

Four Guiding Principles of the Evolutionary Theory Represents Unity and Interaction to Establish Success in the NM Role (Ricossa, 2018)

Antecedent	Temporal Variation	Socio-Cultural	Unity	Interaction	Consequence
+	+	+	Yes	No	Successful
+	+	-	No	Yes	Successful or Unsuccessful
+	-	+	No	Yes	Successful or Unsuccessful
+	-	-	No	Yes	Successful or Unsuccessful
-	+	+	No	Yes	Successful or Unsuccessful
-	+	-	No	Yes	Successful or Unsuccessful
-	-	+	No	Yes	Successful or Unsuccessful
-	-	-	Yes	No	Unsuccessful

Note: (---) means negative outcome leading to being unsuccessful; (+++) means positive outcome leading to success; when combined, (--+) and (++-) means the outcome can either be successful or unsuccessful

APPENDIX C.

Table C.5

Garrard's Matrix of Search Terms with and without Limits in Selected Databases (Garrard, 2013)

Keywords Limits	CINAHL	PubMed	ProQuest	Psychology and Behavioral Health	PsycINFO All	Psyc INFO	Psyc ARTCLES	Web of Science
Caring	7,867 4,915 (2)	10,717 (1) 8,596 (2)	868,882 (1) 20,226 (1, 2, 5)	4,621 (1) 4,275 (1, 4) 2,245 (1, 2) 2,218 (1, 2, 4)	677 (1) 194 (1, 2, 5)	176 (1) 0 (1, 2)	501 (1) 194 (1, 2)	1,222,898 814,942 (1 & 4) 614,939 (1, 3, 6)
Watson and Caring	176 (1) 2/10 (1, 2, 4, 7) 1/2* (1, 2, 5,7)	33 (1) 7 (1, 2, 5)	72,948 (1) 1,274 (1, 2, 5)	4 (1) 1 (1, 2, 5)	0 (1 & 5) 0 (1, 2, 5)	0 (1) 0 (1, 2, 5)	0 (1) 00 (1, 2, 5)	132 (1) 0 (1, 2, 5)
Caring Science and NM	7	8	136 (1, 2, 5) 135 (1, 2, 6)	17	0 (1, 2, 5)	0 (1, 2, 5)	0 (1, 2, 5)	1/129 (4, 6)
Watson, Caring, NM and Perceptions	0 (1, 2)	7 (1, 2)	135 (1, 2, 5) 104 (1, 2, 6)	0 (1, 2)	0 (1, 2)	0 (1, 2)	0 (1, 2)	1/129 (7)
Self-Care	34,671	46,208 (1)	2,256,575	3,736	86,891	81,984	2,769	23
Self -Care and Nursing	8,367	5,370 (1, 2) 3,365 (1, 3)	22,883 (1, 2, 4)	684 (1, 2) 231 (1, 2, & 5)	15,829	15,232	132	1/14 (7)
Self-Care and NM	10 (1, 2, 5)	62 (1)	10,683 (1, 2, 5)	5	205	136 (1, 2)	0	121
Self-Care Practices and NM	23 (1)	11 (1)	9,546 (1, 2, 4)	3	4	4	0	121
Loving-kindness	36	114	121,290	32	231 136 (5)	214	12	350
Loving-kindness	1	14	31,570 108 (1, 5)	0	0	0	0	11

and Nursing			79 (1, 5,8) 1/23* (1, 2, 5, 8)					
Caritas Processes	19	31	551 23 (9)	2	49	48	0	26 0 (9)
Nursing and Caring for Self	528 61 (1, 2) 28 (1, 3, 6)	90	20 (1, 5)	44	1,523 4 (1, 5)	1,470 0 (1, 5)	4 0 (1, 5)	1/5* (3, 5, 6)
Titles Reviewed	345	263	187	293	221	152	148	447
Abstracts Reviewed	43	33	46	15	16	3	2	32
References Selected	3	0	1	0	0	0	0	2

Legend: Limits
Free Full Text or Full Text
10 years
5 years
Academic or Scholarly Journal
Peer Reviewed
English
Fraction indicates number of references selected from that search
This asterisk "*" indicates repeated references from other databases that have already been reviewed

APPENDIX C.

Table C.6

Proposed Timeline

Activities	Proposed Completion Date
Resubmission of Chapter 1, 2, and 3	8/1/2019
Proposal defense	9/6/2019
UHM IRB application submission	9/20/2019
UHM completed IRB	4/2/2020
Resubmission of Chapter 3	2/25/2021
Resending Chapter 3	3/14/2021
Approval from Dissertation Team	3/16/2021
Submit ACNL Application for Review	3/16/2021
Approval from ACNL	3/19/2021
UHM IRB Modifications #3 submission	3/19/2021
UHM IRB Modifications #3 Approval	3/21/2021
Recruitment and Study begins	5/26/2021
Recruitment and Study Week ends	6/30/2021
Data Analysis reviewed and interpreted	7/7/2021
Submission Completed Dissertation	11/24/2021
Dissertation Defense	12/10/2021

APPENDIX C.

Table C.7

WCSRS and WCLS Survey Findings by Frequency and Percentages of Missing Data Items

Sample (n = 67)

	Item 1 Loving-Kindness	Item 2 Basic Needs	Item 3 Helping and Trusting Relationships	Item 4 Create Caring Environment	Item 5 Value, Belief and Faith
WCSRS					
Frequency	(n = 8)	(n = 4)	(n = 21)	(n = 13)	(n = 31)
Percentage	12.0%	6.8%	31.3%	19.4%	42.2%
Mean Score	5.08	4.82	5.94	5.6	6.2
WCLS					
Frequency	(n = 14)	(n = 9)	(n = 16)	(n = 18)	(n = 22)
Percentages	20.9%	13.4%	24.9%	27.9%	33.8%
Mean Score	5.03	4.53	3.44	5.09	5

APPENDIX C.

Table C.8

Missing Data to Examine Bias from Demographics based on the Sample (n = 67)

Demographic Items with Dummy Codes	Responses (n=67)	Expected Completion	Actual Completion	Pearson's Chi Square	Alpha (p=0.05)
Role				2.654	.103
Director	(n = 34)	15	11.8		
NM & ANM	(n = 32)	8	11.2		
*Missing Data	(n = 1)				
Age				.102	.750
Less 50	(n = 28)	9.6	9		
Greater 50	(n = 39)	13.4	14		
Marital Status				3.096	.078
Partnered (married)	(n = 52)	17.9	15		
Non-partnered (single, widowed)	(n = 15)	5.1	8		
Family composition				4.481	.034*
Children or family	(n = 51)	17.5	14		
Living alone	(n = 16)	5.5	9		
Degree in Nursing				.088	.766
Diploma or Bachelors	(n = 16)	5.5	5		
Masters or Doctorate	(n = 51)	17.5	18		
Degree outside of Nursing				.001	.981
Yes	(n = 29)	10	10		
No	(n = 38)	13	13		
Certification in Nursing				1.055	.304
Yes	(n = 23)	7.9	6		
No	(n = 44)	15.1	17		
Years as NM				.273	.601
Less than 10 Years	(n = 35)	12	11		
More than 10 years	(n = 32)	11	12		
Formal Management Training				2.219	.330
Never, learned on the job					
Yes, outside current work environment	(n = 14)	4.8	5		
Yes, within current work environment	(n = 22)	7.6	10		
	(n = 31)	10.6	8		
Number of Beds				.132	.717
Less than 400	(n = 30)	10.3	11		
More than 40	(n = 37)	12.7	12		

APPENDIX C.

Table C.9

Multiple Regression Results using the Correlation Matrix for Caring for Self and Demographics (n = 23)

Demographics	*1*	*2*	*3*	*4*	*5*	*6*	*7*	*8*	*9*	*10*	*11*	*12*
1. Caring for Self	1.00											
2. Degree in Nursing	.67**	1.00										
3. Caring leader	.57**	.54**	1.00									
4. Age	.45	.44*	.08	1.00								
5. Role	.32	.28	-.03	.54**	1.00							
6. Years as manager	.30	.34	.04	.30	.58**	1.00						
7. Leadership training	.26	.52*	.29	.26	.25	.17	1.00					
8. Number of beds	.15	.13	.04	.30	.03	-.05	.05	1.00				
9. National certification	.13	.07	.01	-.13	.43*	.47	.16	-.42*	1.00			
10. Degree outside nursing	.04	.25	-.03	-.02	.09	.14	.08	-.21	.28	1.00		
11. Family compositions	-.03	.23	.21	-.10	.16	.48	.14	-.23	.07	.34	1.00	
12. Marital status	.42*	.28	.15	-.02	.04	.40	.38	-.15	.23	.09	.35	1.00

*Note: Correlation Strength: Strong** (r = 0.5 to 0.9), Weak* (r = 0.1 to 0.5), negative correlation (-)*
*Statistical Significance: Single star (p value= 0.05), ** (p value=0.01)*

APPENDIX C.

Table C.10

Demographics versus Caring for Self by Sample Responses, Mean, and Standard Deviation

Descriptors	Details	Sample Responses	Mean	Standard Deviation
Role	ANM or NM	11	4.62	0.87
	Director	12	5.26	0.57
Age	Age under 50 years	9	4.72	0.85
	Age over 50 years	14	5.28	0.54
Marital Status	Married or Partnered	15	4.7	0.66
	Widow or Single	8	5.13	0.77
Family Composition	Living Alone	14	5.14	0.73
	Family	9	4.91	0.78
Degree in Nursing	Diploma or Baccalaureate	5	4.17	0.7
	Masters' or Doctorate	18	5.3	0.53
Degree outside of Nursing	No	13	4.94	0.89
	Yes	10	5.1	0.55
Certification in Nursing	No	17	4.92	0.79
	Yes	6	5.25	0.65
Years as NM	10 years or less	11	4.78	0.8
	More than 10 years	12	5.24	0.64
Formal Training	Never, learned on the job	5	4.77	0.77
	Yes, outside current work	10	5.08	0.86
	Yes, at current work	8	5.06	0.7
Number of Beds	Less than 400 beds	11	4.77	0.86
	400 beds or more	12	5.22	0.57

APPENDIX C.

Table C.11

Regression Model for NMs: Comparing Self Care and Marital Status (Married or Partnered)

Independent Variable	R^2	Degree of Freedom	F	Significance ($p < 0.05$)
Marital Status (Married or Partnered)	0.174	1, 21	4.48	0.047

APPENDIX C

Table C.12

Regression Results for NMs from the Coefficient Table for Caring for Self for NMs and Marital Status (Married or Partnered) (n = 23)

Independent Variable	B	SE	β	T	Significance ($p < 0.05$)	95% C.I.
Marital Status (Married or Partnered)	0.64	0.31	0.42	2	0.47	.01 – 1.28

APPENDIX C.

Table C.13

Regression Model for NMs by Comparing Self Care and Advanced Degree in Nursing (n = 23)

Independent Variable	R^2	Degree of Freedom	F	Significance ($p < 0.05$)
Advanced Degree in Nursing	0.442	1, 21	16.66	0.001

APPENDIX C.

Table C.14

Regression Results for NMs: Self Care among NMs and Advanced Degree in Nursing (n = 23)

Independent Variable	B	SE	β	t	Significance ($p < 0.05$)	95% C.I.
Advanced Degree in Nursing (Masters' or Doctorate)	1.18	0.29	0.67	4.08	0.001	.58 – 1.78

APPENDIX C.

Table C.15

Regression Model Summary for NMs: Caring for Self Combined with Independent Variables

(n = 23)

Independent Variables	R^2	Degree of Freedom	F	Significance ($p < 0.05$)
Marital Status (Married or Partnered) and Advanced Degree in Nursing (Masters' or Doctorate)	0.5	2, 20	10.03	0.001

APPENDIX C.

Table C.16

Regression Results for NMs from Coefficients for Caring for Self when Combined with Advanced Degree in Nursing and Marital Status (Married or Partnered) (n = 23)

Independent Variables	B	SE	β	t	Significance ($p < 0.05$)	95% C.I.
Advanced Degree in Nursing (Masters' or Doctorate)	1.06	0.3	3.6	3.616	0.002	4.5 -1.66
Marital Status: Married or Partnered	0.39	0.25	1.5	1.529	0.047	.8 - 1.275

APPENDIX C.

Table C.17

Regression Model Summary for Supervisors (Caring Leader): Caring for Self Combined with Advanced Degree in Nursing and Caring Leader (n = 23)

Independent Variables	$R^2\Delta$	Degree of Freedom	F	Significance ($p < 0.05$)
Model 1 Advanced Degree in Nursing (Masters' or Doctorate)	0.44	1, 21	17	0.001
Model 2 Advanced Degree in Nursing (Masters' or Doctorate) Caring of Leader	0.063	1, 20	2.5	0.126

APPENDIX C.

Table C.18

Regression Model Summary for Caring for Self Combined with Supervisors (Caring Leader)

Independent Variables	R^2	Degree of Freedom	F	Significance ($p < 0.05$)
Supervisors (Caring Leader)	0.323	1, 21	10	0.005

APPENDIX C.

Table C.19

Hierarchical Regression Results for Supervisors: Caring for Self and Advanced Degree in Nursing and Supervisors (Caring Leader)

Independent Variables	B	SE	β	t	Significance ($p < 0.05$)	95% C.I.
Model 1						
Advanced Degree in Nursing (Masters' or Doctorate)	1.18	0.29	0.67	4.08	.001***	.58 – 1.78
Model 2						
Advanced Degree in Nursing	0.9	0.33	0.51	2.71	.013*	.21 – 1.59
Supervisors (Caring Leader)	0.18	0.11	0.3	1.6	0.126	-.06 – 1.59

Note: $R^2 = .51$. * Significant at .05, ** Significant at .01, ***Significant at .001

APPENDIX C.

Table C.20

Regression Results for NMs and Supervisors: Caring for Self in Nursing and Supervisors (Caring Leader)

Independent Variable	B	SE	β	95% C.I.
Supervisors (Caring Leader)	0.34	0.11	0.57	.12 – .56

APPENDIX C.

Table C.21

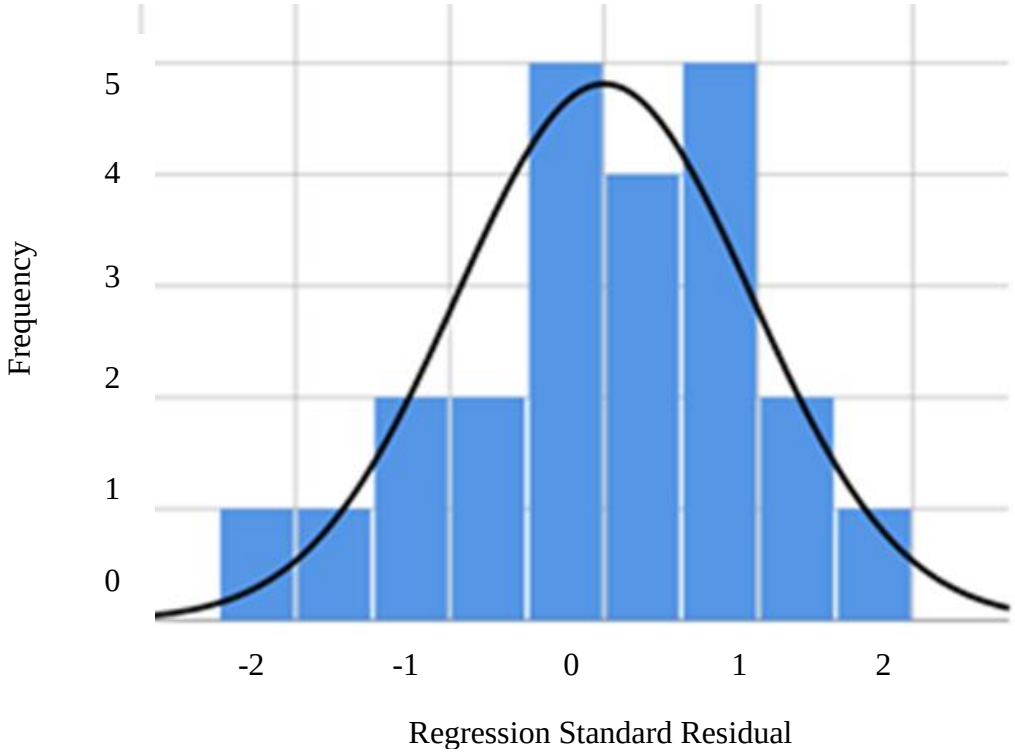
Examples of Holistic Practices by Theme to Support Self-Care

Theme	Self-Care Practices
Mind	Write down 3 things you are grateful daily Use Guided Imagery Read a book or magazine Go to a Museum Attend a concert Listen to music
Body	Take a nap Stroll or walk in the neighborhood or park Ride a bike Get a massage Enjoy being pampered by getting a manicure and pedicure
Spirit	Share what you are appreciative about another Spending time with the family Enjoying your partner Spend time with your pet Experience all that nature has to offer using your 5 senses

APPENDIX D.

Figure 1.1

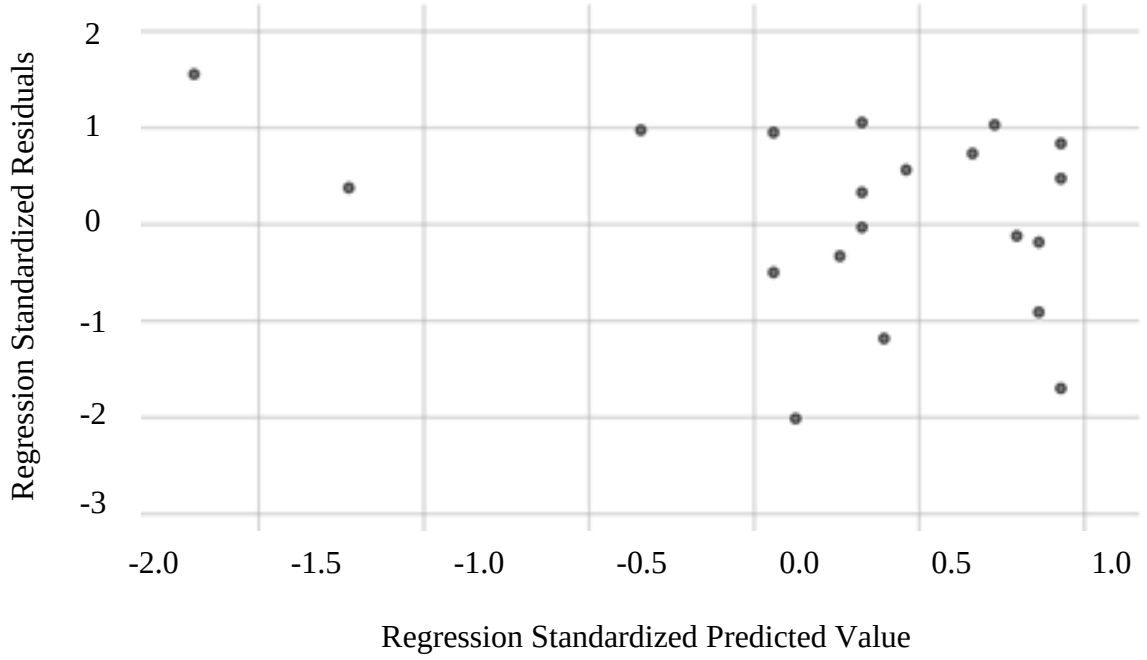
Histogram for Normal Distribution of Caring for Self and Supervisors (Caring Leader)



APPENDIX D.

Figure 2.1

Scatter Plot of Caring for Self and Supervisors (Caring Leader)



APPENDIX D.

Figure 3.1

P to P Plot for Regression Standardized Residual: Caring for Self and Supervisors (Caring Leader)