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Standardized Web-based Leadership Development for New Managers in a Tertiary, Public
Safety-Net, Academic Medical Center

A dissertation submitted in partial satisfaction of the
requirements for the degree Doctor of Nursing Practice

by

Jerome Mendoza Dayao

2020

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ABSTRACT OF THE DISSERTATION

Standardized Web-based Leadership Development for New Managers in a Tertiary, Public
Safety-Net, Academic Medical Center

by

Jerome Mendoza Dayao

Doctor of Nursing Practice

University of California, Los Angeles, 2020

Professor Lynn Doering, Chair

Nurses and other clinicians are promoted to their first manager roles due to expert clinical performance; however, nurses and other clinicians also require nonclinical skills to succeed as a new manager. Many health care organizations (HCOs) are unprepared to develop clinicians as effective leaders. Across the United States, fewer than 30% of HCOs have formal leadership development programs. This study explores an evidence-based nurse leadership training program based on the American Organization for Nursing Leadership (AONL) Nurse Manager Competencies. The impact on the institution's return on investment—specifically, on improving new managers' perceived competency and acumen to effectively run their departments—was supposed to be measured with the Nurse Manager Skill Inventory Tool (NMSIT). However, due to the COVID-19 pandemic, I was only able to collect pretest and demographic information from

the participants. I was also not able to complete my goal of using a repeated measures design to evaluate new managers who were given an online educational intervention using the University of Washington's Percipio platform, though the participants were all enrolled to the program.

Keywords: Nurse manager, new leader, onboarding, leadership development.

The dissertation of Jerome Mendoza Dayao is approved.

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Mary-Lynn Brecht

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Lynn Doering, Committee Chair

University of California, Los Angeles

2020

Dedication

I dedicate this work to the many brave nurses who are at the forefront of our current national health crisis. While the rest of the world stayed home, nurses at the frontline have continued to come to work to deliver the transformative action of human caring. I dedicate this work to the nurses who, even in these unprecedented times with all the uncertainties and risks, have valiantly continued to come to work like true warriors and heroes.

I also dedicate this work to the nurse leaders who have continued to transform how health care is delivered everywhere. These nurse leaders have led their units and departments during these difficult times through managing tasks and leading people.

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Biographical Sketch

Jerome Mendoza Dayao, MSN, RN, NEA-BC, CPHQ, CCRN-K is currently serving as the senior associate administrator of patient care services and chief nursing officer at the University of Washington Medicine, Harborview Medical Center (HMC) in Seattle, Washington. HMC is the only designated Level I adult and pediatric trauma center in the state of Washington. HMC also serves as the regional trauma and burn referral center for Alaska, Idaho, and Montana and the designated disaster preparedness and control hospital for Seattle and King County. As CNO, Jerome is responsible for leading over 2000 nurses and allied health professionals.

Before coming to HMC, Jerome was the chief nursing officer at Arrowhead Regional Medical Center. Arrowhead Regional Medical Center is a 456-bed, public teaching hospital; it is also one of the busiest trauma and emergency centers in California with >100,000 emergency department visits annually. Arrowhead Regional Medical Center is also the only regional burn center within a 60 miles radius of San Bernardino County. Jerome previously worked at Cedars-Sinai Medical Center, Ronald Reagan UCLA Medical Center, and Long Beach Memorial Medical Center. Jerome is clinically trained as a cardiovascular nurse, specializing in the care of heart failure and heart transplant patients.

Jerome earned his Bachelor of Science in nursing from Wesleyan University, Philippines where he graduated magna cum laude. He received his Master of Science in nursing administration from California State University, Los Angeles, and has completed executive education in nursing leadership from the Wharton School at the University of Pennsylvania.

Jerome is nationally board-certified in executive nursing practice, health care quality, and critical care nursing. He is an active member of the Northwest Organization for Nurse Leaders and the American Organization for Nurse Leaders (AONL), where he is currently serving as an

elected board member. He also serves as an ex-officio board member for the American Hospital Association Region 9 Policy Board.

Jerome served as a member of the CNO Advisory Committee for the California Hospital Association and the Hospital Association of Southern California. In 2017, Jerome was named as one of Becker's Hospital Review's "Rising Star: 60 Healthcare Leaders Under 40" list.

Standardized Web-based Leadership Development for New Managers in a Tertiary, Public Safety-Net, Academic Medical Center

Care across many avenues of health care delivery is becoming increasingly complex; thus, the leaders of today's health care organizations (HCOs) must be excellent nurses with exceptional clinical skills who are also dynamic, adaptive, and astute leaders. It is widely understood that effective leadership requires targeted training and onboarding; however, many HCOs are not prepared to meet these vital needs. In a study commissioned by the National Center for Healthcare Leadership, it was found that many HCOs are ill-prepared to develop their leadership pipelines (Anderson & Garman, 2014); fewer than 30% of HCOs have structured leadership onboarding and enhancement programs. Additionally, a third of the U.S. nursing workforce will be of retirement age within the next 10 years (Health Resources and Services Administration, 2013). This imminent retirement wave across the nursing profession poses a vital need among HCOs to develop clear and executable plans for leadership succession. Though it is widely noted that effective leadership skills are crucial to the success and vitality of HCOs (Houser, 2003; Kanste, 2008), it is important to note that effective leadership requires deliberate training focused on competency enhancements (Hughes, 2009). Developed leaders are beneficial in creating engagement among the staff and can deliver measurable positive outcomes within organizations. Patient satisfaction improves in clinical areas with strong leaders (Shipton, Armstrong, West, & Dawson, 2008). In response to this need, I conducted a Doctor of Nursing Practice (DNP) scholarly project related to a targeted leadership development program through the implementation of a national guideline for leadership competency inventory.

PICOT Question

A problem, intervention, comparison, outcome, and time (PICOT) statement was developed to provide context and clarity to the scholarly project. The aim of the PICOT statement was to understand the effect of a standardized, online, leader training program on the perceived competency of new leaders who used the American Organization of Nurse Leaders (AONL) leadership competency domains. The PICOT question was as follows; in new leaders working at a large tertiary academic medical center (P), how does a structured online new leader development program (I), compared to no program (C), affect the perceived self-competence of new nurse leaders utilizing the Nurse Manager Skills Inventory Tool (NMSIT; O) based from the AONL nurse manager competency framework within 3 months post implementation (T)?

Purpose and Objectives

HCOs need structured leadership development programs, especially for new leaders. Online educational programs and platforms are widely available; thus, it is essential to explore alternate strategies to educate and equip new managers with the competencies needed to thrive in their current roles. Harborview Medical Center (HMC) does not currently have formal or structured programs to onboard new leaders; therefore, the purpose of this DNP scholarly project was to implement an effective, standardized, and structured web-based educational onboarding training program for clinicians who are new leaders. The aim of this project was to analyze the efficacy of the intervention—through pre and post testing—by measuring participants' perceptions related to the leadership competencies essential for thriving in participants' management roles.

Background

The scholarly project was implemented at Harborview Medical Center (HMC), a large academic teaching facility located in Seattle, Washington. Harborview Medical Center is a 413-bed, academic medical center and safety-net hospital located in Seattle, Washington. It is the only level 1 adult and pediatric trauma center within the four-state regions of Washington, Alaska, Montana, and Idaho.

The DNP project intervention focused on the new leaders who had fewer than or equal to 5 years of formal management experience within the Department of Patient Care Services (PCS). At the time of this study, 43 individuals held manager-level positions in the Department of Patient Care Services, with 37 managers being eligible to participate in the intervention. Out of the 37 eligible managers, only 23 (62%) ultimately participated.

To describe the components of the PICOT question, new leaders were defined as hospital clinicians with official management obligations for both licensed and unlicensed personnel. These leaders oversaw individuals within an assigned service line unit. Furthermore, these leaders were also accountable for the day-to-day operations of the service line cost center. These new leaders possessed fewer than or equal to 5 years of formal leadership experience supervising employees or managing a program.

The expense cost of the program was \$225 per participant, or a total of \$5,175 for all participants paid for by cost center 8721, Nursing Administration, under the department of PCS at HMC. The fee included 1-year access to the electronic platform Percipio, which was developed by SkillSoft and delivered through the University of Washington's Department of Organizational Development website.

Conceptual Frameworks

Benner's Theory of Skills Acquisition

One of the most known nursing theories on competency development is Benner's (1982) theory of knowledge acquisition. The DNP scholarly project aimed to implement a leadership development program for new nurse leaders; thus, Benner's framework was found to be suitable and relevant. Benner's framework categorized the five stages in which nursing skills progress over a time period. The categories are (a) novice, (b) advanced beginner, (c) competent, (d) proficient, and (e) expert (Benner, 1982). Benner's framework was originally developed to describe the skill acquisition process for clinical nurses practicing at the bedside. According to Davis and Maisano, 2016, Benner's model has transferable applicability for use beyond the context of clinical skill progression.

Benner (1982) classified skill acquisition through unique defining attributes present in each of the five categories. Novice nurses are those who have no experience. Typically, novice nurses are recent graduates. Novice nurses require specific guidelines and follow strict rules coming from figures of authority. Advanced beginners are nurses with some experience who are able to apply their knowledge in context whenever necessary. The competent nurse typically has 3 years of work experience; competent nurses can put together goals and plans of care with little redirection or cueing. Competent nurses can respond with grace under pressure; however, competent nurses do not have the swiftness of decision-making demonstrated by proficient nurses. Proficient nurses can quickly ascertain plans of care and expeditiously execute on them. Because of their years of experience, proficient nurses can draw from contextual knowledge to identify problems and use the right approach to solve them. Lastly, expert nurses are nurses who can look at care delivery in a holistic manner. Expert nurses have more than 10 years of

professional nursing experience within their specialties. Expert nurses are quick on their toes and are highly respected by their peers and colleagues for their knowledge.

Benner's theoretical framework was highly aligned and applicable to the implementation of the nurse leader development program. Many of the intervention participants were experienced nurses and were categorized as proficient or expert clinicians; however, the participants were categorized as novices or advanced beginners in the role of formal nurse leaders based on years of experience. Nurses are commonly promoted to their first leadership role by demonstrating expertise and competency in their units (Omoike et al., 2011); however, many of the skills that were pivotal to a nurse's first promotion as a formal leader may not necessarily be the same skills that will allow the nurse to succeed in their leadership role.

Peter and Hull's Peter principle (2014) describes the discrepancy between nurses clinical and leadership skills. The Peter principle is the phenomenon wherein workers in a hierarchical system are promoted to the highest level of their incompetence (Romaine, 2014). Competent workers are often the inevitable candidates for promotion; as these workers ascend the hierarchical ladder, their abilities to address unique occupational challenges using previous competencies will no longer suffice. Each of these highly competent workers will eventually be promoted to a job they cannot competently perform, thus preventing these workers from moving vertically in the organization (Romaine, 2014). Newly promoted leaders must be continually provided with the knowledge and competencies to perform their jobs. Benner's (1982) theory can be used to further acknowledge nurses' knowledge progression and skill acquisition, thus promoting the development of an effective standardized education for new nurse leaders. Benner posited that skill progression from novice to expert occurs in a linear fashion; however, it must be noted that Benner's theory does not explore the concept of transferable expertise from one

discipline to another, meaning that nurse leaders can be an expert clinicians while being a novice nurse leader.

AONL Nurse Manager Competencies Framework

The AONL Nurse Manager Learning Domain Framework (see Appendix A) was developed through the collaboration of two professional nursing organizations: AONL and the American Association of Critical Care Nursing (AACN; American Organization of Nurse Executives, 2015). This evidence-based framework captures the skills, knowledge, and abilities that are necessary for effective practice of nursing leadership. The AONL nurse manager competencies, based on the Nurse Manager Learning Domain Framework (NMLD) framework is a valid and reliable tool to measure nurse manager competencies through periodic job analysis and role delineation studies (American Organization of Nurse Executives, 2015).

The AONL nurse manager competency framework is composed of three overlapping elements (see Table 1).

Table 1

Overlapping Framework Elements

Elements of nurse manager competencies	Components
Science of managing business	Financial management Human resource management Performance improvement Foundational thinking skills Technology Strategic management
Art of leading people	Human resource skills Relationship management Influencing behavior Diversity
Leader within	Personal and professional accountability Career planning Personal Journey disciplines

Review of Literature

Numerous online databases were queried for relevant literature on the topic related to leadership development. PubMed, Cumulative Index to Nursing and Allied Health Literature, and PyschInfo were the three databases queried. The search terms used were *nurse manager*, *clinical nurse leader*, *nurse onboarding*, *succession planning*, *leadership development*, and *leadership training*. Database searches were limited to peer-reviewed articles written in English that were published between 1998–2018. The time range was expanded to 20 years because the initial 5 years range did not provide an adequate number of articles to produce a well-synthesized review. English was selected as the primary language to narrow the literature retrieval process. A total of 50 articles were initially deemed relevant and appropriate for answering the PICOT question. A final count of 9 articles were reviewed and synthesized upon further application of exclusion criteria and critical appraisal of evidence.

Synthesis of Evidence from the Literature

Nine research articles were selected from the literature to answer the PICOT question. The studies selected have three integral elements applicable to the PICOT question: (a) organizational success is a product of competent leadership, (b) structured leadership development programs help achieve reliable care delivery, and (c) formalized and purposive leadership training and development are essential to the survival of 21st century HCOs.

Baxter and Warshawsky (2014) studied the gaps in leadership competences among nurse managers in two acute hospital sites located in Kentucky: The Veteran's Administration Medical Center and the University of Kentucky Health Care Enterprise. Baxter and Washawsky analyzed the sample distribution of 37 nurse leaders with between 2 to 10 or more years of experience. Baxter and Washawsky also studied the nurses' leadership competencies using 15 assessments from the Nurse Manager Skills Inventory Tool. The Nurse Manager Skills Inventory Tool also incorporated the domains from Benner's skill acquisition framework, where numbers 1–5 were assigned a competence rating from novice to expert. Baxter and Warshawsky found that nurses who possessed a strong clinical competence were promoted to nursing leadership roles. Additionally, managers with varying levels of clinical experience had varying levels of leadership competence. The study results indicated that managers with more years of clinical experience had a higher perception of leadership self-competence.

Ramseur, Fuchs, Edwards, and Humphreys (2018) identified the gaps in leadership knowledge, skills, and abilities among nurse leaders. Ramseur et al.'s study only involved a singular health system: Duke University Health System. Ramseur et al. reviewed existing literature on leadership development and found that a baseline assessment of competency among a sample is necessary to garner information related to the program that can be used training. Both

Baxter and Washawsky (2014) and Ramseur et al. used the AONL framework to build the training programs at different HCOs. Furthermore, both studies used Benner's model of skill acquisition to examine the potential and progressive needs of the learners who were part of the intervention sample. Both Both Baxter and Washawsky and Ramseur et al. used Benner's model as a key foundational theory and used the AONL framework leadership competencies. The Ramseur et al. study used the pretest and posttest design of Kouzes and Posner Leadership Practices Inventory Self-Assessment to ensure the measurement of continual improvements among the intervention groups. The inventory tools used by Baxter and Washawsky and Ramseur et al. are valid and reliable tools for assessing competence related to leadership and performance.

Ramseur et al. (2018) used an available web-based training solution called the Essentials of Nurse Manager Orientation to deliver the intervention. This program was developed by the AACN in partnership with the American Organization of Perioperative Nurses. Among the 41 participants, 40 successfully completed the program. The pretest and posttest results from the inventory tool had 67 items partitioned in three subscales. The responses were categorized in an ordinal scale: 0–3, with 0 meaning no experience and 3 meaning expert. A Wilcoxon signed rank test, a non-parametric test of hypothesis, was used to obtain the median scores and compare the two related samples. Additionally, the results produced statistically significant results ($p < .05$). All of the competence categories measured demonstrated increases.

Shen, Peltzer, Teel, and Pierce (2018) measured the efficacy of a leader development program related to a formal residency model. Shen et al. evaluated how the Kansas Nurse Leader Residency impacted the knowledge acquisition and performance of nurse leaders. Thirty-six individuals participated in the study. Sixty-six percent, or 24 participants, ultimately completed

the program. Shen et al. used a modified assessment tool called the Leader Knowledge and Skill Inventory to measure leadership skills instead of using the nurse leadership inventory tool. Pretest and posttest measures were collected to determine the effects of the intervention. Based on the results, a statistically significant improvement ($p < .05$) was seen at the end of the five month intervention compared to the baseline. To further support the importance of standardized education programs in developing leadership competence, Flatekval and Corbo (2019) evaluated the efficacy of nurse manager skill inventory tools in measuring nurse leaders' self-reported competency after the targeted intervention on nurse leader development. Flatekval and Corbo invited 20 nurse managers to participate in the study; however, only 40% (8 participants) joined the program. Small sample sizes can be troublesome because small sample sizes can affect the generalizability of the results; however, it is important to note that the Flatekval and Corbo's intervention produced a correlation of .898 ($p < .001$). This high correlation indicated the positive relationship between leadership development and competency levels among the participants.

Titzer, Shirey, and Hauck (2014) aimed to determine (a) if perceptions about management and leadership competencies impacted leadership development, (b) if organizations could devise an effective succession planning for leaders, and (c) if effective succession planning had any impact on measurable outcomes in HCOs. Titzer et al. posited that nurse leadership development programs have a statistically significant influence in creating high-performing nurse leaders as measured by participant self-reporting post intervention. The study led to improved levels of leadership competence and produced other positive outcomes evaluated through: (1) Levels of leadership and management competency levels, (2) stake holder satisfaction, (3) participant retention, and (4) internal promotions. Participants of the study

remained at the organization 1 year after program implementation, which reflected positively on nurse leader turnover and retention. Additionally, 73% of nurses who participated in the study ($n = 12$) were promoted to leadership roles. These 12 study participants were all female and were sorted into four age groups: 21–30 ($n = 2$), 31–40 ($n = 2$), 41–50 ($n = 6$), and >50 ($n = 2$). In terms of educational preparation of participants, 58% ($n = 7$) were prepared at the baccalaureate level, 33% ($n=3$) were prepared at the associate level, and 8% ($n = 1$) were prepared at the masters level.

To further support Titzer et al.'s (2014) findings, Groves (2019) examined the impact of succession management practices in an organization's performance. Groves noted that the rapidly changing landscape of health care contributed to the complexity of shifting from volume-based to value-based care, which required HCOs to develop effective and sustainable models of care delivery. Groves noted that HCOs ability to create and implement models for care delivery are contingent on HCO officials' ability to respond to the rapidly aging workforce and the imminent wave of executive retirements. Groves hypothesized that HCO officials who use succession management practices across key clinical leadership positions produce better patient outcomes and achieve better operational performance through achievement of efficiency measures. Though Groves' focused on executive-level succession planning rather than manager level succession planning, Groves' findings aligned with recommendations made by both Titzer et al. (2014) and Shen et al. (2018). Groves, Titzer et al., and Shen et al. all demonstrated that standardized onboarding programs prepare leaders to better lead their organizations. Groves performed an organization-wide assessment of leadership readiness through the validation of the Succession Model Assessment. The Succession Model Assessment was a reliable tool (Cronbach's alpha of $> .7$ in all seven dimensions). In addition to the reliability of the tool, the

Succession Model Assessment was also helpful in predicting performance outcomes metrics of the HCOs. For example, patient satisfaction and staff turnover were lower in HCOs that had formal succession management practices because leaders in these organizations are better equipped to deliver superior management practices that cultivate strong cultures of ownership and transparency (Groves, 2019). Similarly, Jeon et al. (2018) studied the impact of a structured training program on perceptions of leadership competence on ethical leadership among nurses. Jeon et al. conducted a randomized survey of 200 nurses from 48 units in a tertiary care hospital and found that competency perceptions of managers regarding orientation of employees ($p = .04$) and concerns for ethical leadership ($p = .002$) were positively impacted by a standardized ethical leadership training program given to nurse managers. Though Jeon et al.'s study was conducted in a large tertiary medical center, a central limitation was that the study was conducted in Seoul, South Korea. This raises concerns for generalizability because South Korean nurses and U.S. nurses have cultural differences.

Omoike, Stratton, Brooks, Ohlson, and Storfjell (2011) studied whether hospital and academic partnerships can influence and improve leadership competence among nurses. Omoike et al.'s study was conducted by the School of Nursing at the University of Illinois in collaboration with three Chicago HCOs. Omoike et al. reviewed the implementation of six courses geared at structured leadership and management development. The study sample ($n = 43$) was derived from a pool of future nurse leaders, assistant managers, managers, and directors. These applicants were identified by senior nurse executives from the three participating HCOs. A blended learning strategy was implemented for the program. The program was hybrid; 40% of the program was delivered online and 60% was conducted with face-to-face video conferencing. Omoike et al. used Edwards and Romer's Leadership Survey in the pre and post-test study. The

survey was created to assess the management (technical) and leadership (application) skills of nurse managers. The tool has 61 statements with 12 subscales in a Likert-type scale format. A paired *t*-test was used to distinguish nurse leader ratings and to measure the importance and competence of tasks performed. The initial outcomes from the pretest resulted in a perception mismatch in both importance and competence. However, an improvement was found in the results of the posttest, with an increase from 2.96 to 3.71 related to perceived competence ($p = .03$).

The efficacy of the hybrid-blended learning modality is further supported by Sowcik et al.'s (2018) study on the efficacy of a standardized leadership training program delivered primarily through an online format. Sowcik et al.'s study was conducted in Florida and the authors examined a 3-month online leadership development program for county extension directors. The leadership development program evaluated the participants' satisfaction, learning outcomes, and changes in behavior using only standardized online education. Twenty-two individuals participated in the study, 17 of whom completed the program. Two instruments were created to measure levels of training: reaction and learning outcomes (level I) and behavior change (level II). Reaction and learning outcomes had a total of 17 statements, while behavior change had 21 statements centered on perceived personal leadership changes. The perceptions of the participants on the program for level I were measured using self-report on a Likert-type scale (average score of >4 in a 5-point scale with a standard deviation of .64). Furthermore, level II measurements also indicated self-reported perceived leadership skills after the completion of the program. Fifteen out of the 17 leadership skills evaluated had a significance of $p > .05$.

Summary

Though the concept and impact of leadership development is not new, the development of new managers using online learning delivery is a novel concept; thus, leadership development through online delivery is the focus of this DNP scholarly project. This modality allows future opportunities for leadership development and succession planning to be delivered using a more convenient approach.

The quality of leadership has a direct and measurable impact on patient and staff outcomes (Shipton et al., 2008; Groves, 2019). The dynamic and complex nature of today's HCOs are made more challenging by the narrowing margins and tremendous pressures for efficiency; thus, it is crucial that HCOs invest in leadership training and innovate in ways that emphasize quality, efficiency, and measurement. A preponderance of literature supports the notion that operationalizing standard approaches in leadership development can deliver positive outcomes on the perceived acquisition of knowledge at the same time producing organizational efficiency through standardized learning (Ramseur et al., 2018; Omoike et al., 2011).

In health care, and particularly in nursing, leaders are typically trained and onboarded through nonstandardized approaches (Omoike et al., 2011; Titzer et al., 2014). Shadowing or receiving mentorship from another leader who may have previous experience with the role are examples of these onboarding approaches. Data were lacking on the full efficacy of online-delivered educational programs for adult learners and professional managers. Additionally, the applicability of current frameworks related to skills and knowledge acquisition must be tested further. For instance, Benner's theoretical framework was developed in 1982; thus, the framework may not be as applicable today as it was 30 years ago. Benner's framework would benefit from being redefined with new empirical evidence related to leadership. Information on

emerging methods of knowledge and skills transfer—such as the use of web-based, online, and virtual reality modalities—can challenge or build on previously held concepts related to the timeline of expertise development. For instance, Sowcik et al. (2018) introduced the perceived value of online education for adult learners. Though Sowcik et al.'s study did not test nurses or individuals from the health professions, the study findings confirmed the notion that online training can be valuable for leadership development learning.

Methods

Ethics and Human Subjects

The study participants were recruited from the pool of managers within the Department of Patient Care Services at HMC. All qualified participants were sent an electronic invitation to participate in a face-to-face informational session about the project (see Appendix B). A presentation to the hospital's Clinical Inquiry Council was done prior to the information sessions. The Clinical Inquiry Council is the official nursing research committee that reviews all proposed nursing scholarly activities within HMC. Consent information, purpose, risks, and goals were discussed during the information session. Additionally, prospective participants were informed that participation to the scholarly project was voluntary, and participants could drop out of the project at any time. The online survey in which participant's demographic information and responses were contained was delivered through the University of Washington's Catalyst® platform. The Catalyst® platform is an online-only secured survey delivery tool that is password-protected and follows an enterprise level encryption. Access to data requires secure password entry and second-level dual authentication.

Project Design

This quality improvement project used a repeated measures design with convenience sampling from a tertiary teaching hospital in Seattle, Washington. The sample was comprised of new managers at a tertiary teaching hospital who had ≤ 5 years of managerial experience. A manager was defined as a unit-based leader who was responsible and accountable for the management and supervision of personnel. Exempt status was requested and successfully granted by the UCLA Institutional Review Board (IRB). A site IRB was not needed since the study is being conducted through UCLA (see Appendix C).

The NMSIT was used for the evaluation of competency across the four leadership domains derived from the AONL instrument. This instrument was developed by the AACN and Association of Perioperative Nurses and identifies the essential leadership competencies for nurse managers' success. The NMSIT 56-item assessment tool measures nurses' perceived competency using a Likert-type Scale (novice, competent, and expert). For this project, the new manager competency was measured and categorized through a numerical scale from 1 to 5 as follows: 1 = novice, 2=low competence, 3 = competent, 4= high competence, and 5 = expert. The 56-item assessment were categorized under 13 sections. These 13 sections are components of the three key domains of the AONL Nurse Manager Learning Domain Framework: (a) The science of managing the business, (b) the leader within, and (c) the art of leading people. The instrument was created, validated, and evaluated by content experts from the AACN and the Association of Perioperative Nurses.

The Percipio Online Educational training is a web-based program created by Skillsoft® to develop and equip managers with knowledge to lead and manage respective units effectively. Managers who were enrolled in this project were asked to complete the program by a cohort

learning model online, where everyone begins and ends the course in a predetermined schedule. A total of 45 minutes of educational time was allotted for each participant every week. The institution purchased the educational intervention for \$225 for each participant from the University of Washington Human Resources Professional Organization Development. The costs were paid for by Patient Care Services (PCS) department.

Thirty-seven new managers were identified as meeting study criteria. Information sessions related to the DNP project were held for all qualified participants. Discussions about the project, the content, the methods, and the time commitment were conducted. Out of the 37 qualified individuals, 23 ultimately decided to participate, yielding a 62% participation rate. Following IRB approval, all eligible participants completed the corresponding demographic questionnaire in addition to completing the baseline leadership competency assessment (pretest). The demographic questionnaire and the competency pretest were delivered through the University of Washington's Catalyst® Survey. The Catalyst® survey is a secure online platform that ensured that the collected data were encrypted.

The intervention program was not fully implemented due to the COVID-19 national pandemic, which significantly impacted the state of Washington. HMC is a tertiary hospital as well as the designated disaster control hospital for King County; therefore, participants were pulled to different roles as the central command center was established. Consequently, participants did not have enough time to follow through and complete the training modules as planned.

The intent of the intervention was to deliver a structured online leadership training through a web-based learning management system over a period of one year. The online training consisted of 54 modules grouped in accordance to the three AONL Nurse Manager Learning

Domain Framework. Module length ranged between thirty to 60 minutes. Participants were expected to complete two modules weekly. Additionally, to ensure consistency, participants were given schedules and instructions which module to complete and at what time. This allowed the participants the capability to complete the module in their own pace. The training program was a hospital sponsored initiative; thus, participants were expected to complete the modules onsite during work hours. Prior to the national public health crisis, the plan was for participants to retake the competency assessment (posttest) 3 months following the completion of the web-based intervention to determine if statistically significant changes of competency were evident.

Results

Thirty-seven individuals qualified and were invited to participate in the project. Twenty-three participants completed the demographic assessment and the pretest survey (62%). Tables 2 through 8 illustrate the demographic characteristics of the participants and their frequency distribution.

Table 2

Demographics of Sample Population

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	F	19	82.6	82.6	82.6
	M	4	17.4	17.4	100.0
	Total	23	100.0	100.0	

Table 3*Ethnicity Identification*

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Asian	3	13.0	13.0	13.0
	Black/African American	2	8.7	8.7	21.7
	Black/African American, Other:	1	4.3	4.3	26.1
	White/Caucasian	15	65.2	65.2	91.3
	White/Caucasian, Asian, Hispanic, Latino, or Spanish	1	4.3	4.3	95.7
	White/Caucasian, Hispanic, Latino, or Spanish	1	4.3	4.3	100.0
	Total	23	100.0	100.0	

Table 4*Highest Education Level*

		Frequency	Percent	Valid Percent	Cumulative Percent
Other		1	4.3	4.3	4.3
	Associates	1	4.3	4.3	8.7
	Bachelors	9	39.1	39.1	47.8
	Doctorate	1	4.3	4.3	52.2
	Masters	11	47.8	47.8	100.0
	Total	23	100.0	100.0	

Table 5*Current National Certifications*

	Frequency	Percent	Valid Percent	Cumulative Percent
Other	8	34.8	34.8	34.8
ACM	1	4.3	4.3	39.1
ACMA-RN	1	4.3	4.3	43.5
ANCC	1	4.3	4.3	47.8
ARNP-BC	1	4.3	4.3	52.2
CCRN	4	17.4	17.4	69.6
CMSRN	2	8.7	8.7	78.3
LICSW	2	8.7	8.7	87.0
LICSW, MHP	1	4.3	4.3	91.3
None	1	4.3	4.3	95.7
RN-BC	1	4.3	4.3	100.0
Total	23	100.0	100.0	

Note. ACM = acute case manager, ACMA = American case management, ANCC = American nurses credentialing center certificate, ARNP = acute registered nurse practitioner, CCRN = critical care nurse, CMSRN = certified medical surgical nurse, LICSW= licensed social work, MHP = mental health provider.

Table 6*Prior Formal Leadership Training*

	Frequency	Percent	Valid Percent	Cumulative Percent
No	10	43.5	43.5	43.5
Yes	13	56.5	56.5	100.0
Total	23	100.0	100.0	

Table 7*Prior Informal Training*

	Frequency	Percent	Valid Percent	Cumulative Percent
No	2	8.7	8.7	8.7
Yes	21	91.3	91.3	100.0
Total	23	100.0	100.0	

Table 8*Leadership Training Frequency*

	Frequency	Percent	Valid Percent	Cumulative Percent
1-3 times	10	43.5	43.5	43.5
4-5 times	7	30.4	30.4	73.9
6 or more times	6	26.1	26.1	100.0
Total	23	100.0	100.0	

Table 9 summarizes the mean scores for the 13 domains of competence measured through the NMSIT with a range of 1.96 to 3.47. The lowest domain of perceived competence was financial management and the highest was diversity awareness at 3.47.

Table 9*Domains of Competence*

	Mean	Std Deviation
I. Financial Management (FinanceMgt)	1.96	.76
II. Human Resource Management (HRMgt)	3.02	.82
III. Performance Improvement (PerfImprov)	2.64	.80
IV. Foundational Thinking Skills (FoudatThink)	2.54	.85
V. Technology	2.90	.69
VI. Strategic Management (StrategMGT)	2.69	.79
VII. Human Resource Leadership Skills (HRSkills)	3.16	.70
VIII. Relationship Management (RelationMGT)	3.45	.68
IX. Diversity	3.47	.76
X. Personal and Professional Accountability (PerfAccount)	3.38	.80
XII. Career Planning (CareerPln)	3.33	.86
XII. Personal Journey Disciplines (PersonJourn)	2.68	1.01
XIII. Reflective Practice (ReflectPract)	3.14	.90

Note. 1 = novice, 2 = low competence, 3 = competent, 4 = high competence, 5 = expert.

Independent samples *t*-tests were performed to determine if significant group differences existed between managers who had formal leadership management training and managers who did not, as measured by their perceived competency levels across the 13 domains. Of the 13 domains, two were found to be statistically significant ($p < .05$). HR skills and diversity were both significant. HR skills was significant at $t(21) = -2.509$, $p = .020$ and diversity at $t(21) = -2.196$, $p = .039$. Table 10 shows that further examination of these two significant variables revealed that managers who had management training had a mean of 3.44 compared to $M = 2.78$ for managers who did not receive such training. Similarly, for diversity, managers who had training had a mean of 3.75 compared to $M = 3.10$, for managers who did not participate in such training.

Table 10*Group Statistics for Domains of Competence: Formal Leadership Training*

	Formal Lead Mgt. Train	N	Mean	Std. Deviation	Std. Error Mean
FinanceMgt	No	10	1.79	.93	.30
	Yes	13	2.09	.60	.17
HRMgt	No	10	2.67	.90	.28
	Yes	13	3.28	.68	.19
PerfImprov	No	10	2.27	.65	.21
	Yes	13	2.92	.81	.23
FoudatThink	No	10	2.16	.96	.30
	Yes	13	2.83	.64	.18
Technology	No	10	2.75	.75	.24
	Yes	13	3.01	.64	.18
StrategMGT	No	10	2.50	.77	.24
	Yes	13	2.83	.81	.22
HRSkills	No	10	2.78	.70	.22
	Yes	13	3.44	.58	.16
RelationMGT	No	10	3.16	.55	.17
	Yes	13	3.67	.71	.20
Diversity	No	10	3.10	.62	.19
	Yes	13	3.75	.76	.21
PerfAccount	No	10	3.47	.72	.23
	Yes	13	3.30	.88	.24
CareerPln	No	10	3.30	.82	.26
	Yes	13	3.35	.93	.26
PersonJourn	No	10	2.66	.87	.28
	Yes	13	2.69	1.14	.33
ReflectPract	No	10	3.02	.70	.22
	Yes	13	3.23	1.04	.29

Note. 1=novice, 2=low competent, 3=competent, 4=high competent, 5=expert

Table 11*Independent Samples t-Test: Formal Training (Y/N) by 13 Domains of Competence*

	<i>M</i>	<i>SD</i>	<i>t</i>	<i>df</i>	<i>Sig (2-tailed)</i>	<i>Mean Diff.</i>	<i>Std. Error Diff.</i>
FinanceMgt ¹	1.79	.93	-.959	21	.349	-.31	.32
HRMgt ¹	2.67	.90	-1.869	21	.076	-.61	.33
PerfImprov ¹	2.27	.65	-2.062	21	.052	-.65	.31
FoudaThink ¹	2.16	.96	-2.014	21	.057	-.67	.33
Technology ¹	2.75	.75	-.904	21	.376	-.26	.29
StrateMGT ¹	2.50	.77	-1.017	21	.321	-.34	.33
HRSkills ¹	2.78	.70	-2.509	21	.020*	-.67	.27
RelatiMGT ¹	3.16	.55	-1.875	21	.075	-.51	.27
Diversity ¹	3.10	.61	-2.196	21	.039*	-.65	.30
PerAccount ¹	3.47	.72	.488	21	.631	.17	.34
CareerPln ¹	3.30	.82	-.159	21	.876	-.06	.37
PersonJourn ¹	2.66	.87	-.059	21	.954	-.03	.44
ReflePract ¹	3.02	.70	-.567	21	.576	-.22	.38

**p* < .05¹Equal variances assumed

Additional independent samples *t*-tests were performed to determine if significant group differences existed between managers who had informal formal training and managers who did not by their level across the 13 domains. Of the 13 domains, no significant differences were found at *p* < .05. Therefore, it appears that informal training did not play a role.

Table 12*Group Statistics for Domains of Competence: Informal Leadership Training*

	Informal training	N	Mean	Std. Deviation	Std. Error Mean
FinanceMgt	No Informal Training	2	1.27	.39	.27
	Yes, Informal Training	21	2.03	.76	.17
HRMgt	No	2	3.86	.00	.00
	Yes	21	2.94	.82	.18
PerfImprov	No	2	2.63	1.24	.88
	Yes	21	2.64	.79	.17
FoudatThink	No	2	2.70	.14	.10
	Yes	21	2.52	.88	.19
Technology	No	2	2.17	.94	.67
	Yes	21	2.97	.65	.14
StrategMGT	No	2	2.39	.86	.61
	Yes	21	2.72	.80	.17
HRSkills	No	2	3.80	.57	.40
	Yes	21	3.10	.69	.15
RelationMGT	No	2	4.12	.53	.38
	Yes	21	3.39	.67	.15
Diversity	No	2	4.00	.35	.25
	Yes	21	3.42	.78	.17
PerfAccount	No	2	3.50	1.77	1.25
	Yes	21	3.37	.74	.16
CareerPln	No	2	3.50	2.12	1.50
	Yes	21	3.32	.77	.17
PersonJourn	No	2	2.67	2.36	1.67
	Yes	21	2.68	.92	.20
ReflectPract	No	2	2.50	1.81	1.28
	Yes	21	3.21	.82	.18

Note. 1=novice, 2=low competent, 3=competent, 4=high competent, 5=expert

Table 13*Independent Samples t-Test: Informal Training (Y/N) by 13 Domains*

	t	df	Sig. (2-tailed)	Mean Diff.	Std. Error Diff.
FinanceMgt ¹	-1.374	21	.184	-.76	.55
HRMgt ¹	1.553	21	.135	.92	.59
PerfImprov ¹	-.029	21	.977	-.02	.61
FoudtThink ¹	.276	21	.785	.18	.64
Technology ¹	-1.632	21	.118	-.80	.49
StrateMGT ¹	-.557	21	.584	-.33	.59
HRSkills ¹	1.382	21	.181	.71	.51
RelatiMGT ¹	1.501	21	.148	.74	.49
Diversity ¹	1.036	21	.312	.58	.56
PerAccount ¹	.216	21	.831	.13	.61
CareerPln ¹	.279	21	.783	.18	.65
PersonJourn ¹	-.021	21	.984	-.02	.77
RefletPract ¹	-1.069	21	.297	-.71	.66

Two assumptions required for the independent samples *t*-test were examined to ensure the data were appropriate for the model: normality and equality of variance. Normality was inspected numerically, and the Shapiro-Wilks was utilized. All domains were normally distributed according to Shapiro-Wilks output except HRMgt; however, HRMgt was still in the acceptable range of normality. Levene's test of equal variances was also used and produced as part of the output for independent samples *t* test in SPSS. All domains met this assumption and therefore used equal variances.

Table 14*Tests of Normality*

	Kolmogorov-Smirnov ^a			Shapiro-Wilk		
	Statistic	df	Sig.	Statistic	df	Sig.
FinanceMgt	.102	23	.200*	.941	23	.189
HRMgt	.212	23	.009	.910	23	.042
PerfImprov	.180	23	.052	.921	23	.068
FoudatThink	.130	23	.200*	.966	23	.590
Technology	.114	23	.200*	.938	23	.165
StrategMGT	.121	23	.200*	.947	23	.250
HRSkills	.133	23	.200*	.927	23	.096
RelationMGT	.147	23	.200*	.956	23	.379
Diversity	.134	23	.200*	.963	23	.534
PerfAccount	.133	23	.200*	.959	23	.445
CareerPln	.172	23	.077	.942	23	.200
PersonJourn	.145	23	.200*	.948	23	.260
ReflectPract	.088	23	.200*	.975	23	.804

* Lower bound of the true significance

^a Lilliefors Significance Correction

Discussion

Only the demographic portions and pretest results were collected from the participants due to the occurrence of the COVID-19 pandemic. The participants, who served as managers on site, had been pulled away from their day-to-day work and were asked by organization officials to participate in the command center activities in preparation for a patient volume surge. Using the results of the pretest, educational needs of new managers were identified through self-reporting of current competencies. This scholarly project was used to identify the educational

needs of the sample population. The educational needs of the sample population provided insights into the benefits of developing structured and individualized education for new managers in HCOs.

Despite the absence of the intervention and post testing, it can be inferred from the baseline data that clinicians transitioning to a manager role have targeted needs that HCOs must address to ensure managers' success. Financial management is the competency domain that needs the most attention. The managers who completed the survey identified financial management to be their lowest competence, shown in table 9, with a rating at 1.96 in a scale of 5. Financial savviness is an essential skill that any manager must develop to contribute to the financial vitality of any HCO. Relationship management and diversity ranked the highest in terms of areas of high competence, scoring 3.45 and 3.47 respectively out of 5. These scores were not surprising, as these two domains are core components of nursing as a practice profession. For instance, nursing theorists such as Newman, Peplau, and Christensen have posited that nursing's core is built on the caring behaviors (Scott, 2008). These caring behaviors are traits necessary to the relationship basis of nursing practice (Scott, 2008). The average years of clinical experience of the study sample was 14.8 years, meaning that the population was represented by experienced clinicians.

This DNP scholarly project, which focused on leadership development delivered online to new managers, presented avenues that can be explored by HCOs seeking to prepare their next generation of leaders. Though the project was not completely implemented, the pretesting results revealed current perceived gaps and strengths among new managers. Having identified these gaps, HCOs can develop a more targeted, standardized, and individualized approach to the training and onboarding of new managers.

The DNP scholarly project was not completely implemented due to the occurrence of the COVID-19 crisis; thus, limited information was obtained regarding the efficacy of a web-based leadership training for new managers. My plan is to complete the project before the end of 2020. Additionally, I aim to disseminate the study findings beyond the HMC's Clinical Inquiry Committee. The findings from this project as they relate to new manager development may benefit organizations seeking new and innovative ways to provide knowledge and skills to their newly onboarded leaders. The project findings may also provide teachers of adult learning programs with necessary information related to the needs of the new manager learners.

Efforts were made to mitigate study limitations; however, due to the nature of the study, some were unavoidable. First, the study had a small sample size that was conveniently sampled with managers from one institution. The small sample size reduced the generalizability of the study. Second, though the inclusion criteria required that participants have less than or equal to 5 years of manager experience, many of the participants had varying years of clinical experience. Though participants' average years of experience as a clinical nurse was almost 15 years, the years of experience among participants ranged from 3 to 28 years. This variation in terms of clinical experience may impact a manager's self-assessment of their leadership skills when completing the NMSIT pretest. Third, educational background and the possession of advanced certifications may also reduce the generalizability of the study. The average educational preparation of participants was at the master's level; however, participants' degrees varied from associates to doctoral level. This wide educational range may influence the competency assessment of the participants.

DNP Role and Future Research

The DNP scholarly project on leadership development for new managers using an online delivery approach raised several opportunities for further exploration in terms of current theories on leadership development and succession planning. Additionally, this DNP scholarly project invited further investigation on the emerging trend of educational program delivery through online learning and in consideration for the potential impact of COVID-19 to face-to-face transactions particularly with training and onboarding.

The quality of leadership has a direct and measurable impact on patient and staff outcomes (Shipton et al., 2008; Groves, 2019). Today's HCOs demonstrate a complex and mercurial nature that is exacerbated with narrowing margins and mounting pressures for efficiency for which strong leadership is required. Thus, it is vital for HCOs to (a) invest in training their leaders and (b) find innovate ways of training that offer quality, efficiency, and measurement. The DNP scholarly project can potentially address the challenges mentioned earlier on effectively training new nurse leaders while concurrently achieving efficiency by delivering content online. Ramseur et al. (2018) and Omoike et al. (2011) demonstrated how various HCOs can operationalize the training of nurse leaders and achieve positive outcomes on the perceived acquisition of knowledge while increasing organizational efficiency through standardized learning.

This DNP scholarly project offered to try, test, and validate prevailing knowledge on the efficacy of standardized teaching and learning modalities. In health care, and particularly in nursing, leaders are trained and onboarded through nonstandardized approaches such as shadowing or receiving mentorship from another leader who may have previous experience with the role. This DNP scholarly project planned to use a well-developed program on leadership

training that is used by many organizations across the nation. The use of this standardized training program may achieve targeted content delivery to participants. Moreover, future study may provide insights regarding optimally efficient learning times while achieving acceptable practice competence; these insights would serve as a springboard for future research and interventions.

Conclusion

Managers promoted to their first formal leadership roles may be unprepared and may lack vital knowledge and skills competencies needed to be effective managers and leaders. Regardless of delivery methodology, structured leadership development programs are pivotal in producing positive improvements in knowledge, skill, and ability of novice nurses. Literature related to leadership development in nurses is lacking, and future studies should address (a) the need to assess how leaders assimilate and apply new knowledge and (b) how structured interventions can influence leadership proficiencies. Further assessment of the effects of educational and onboarding programs with regard to the aggregate performance of nurses and leaders is warranted. It will be essential for HCOs to consider investing in the development of their leaders as HCOs continue to witness the unfolding demands of high value care delivery, requiring organizations to perform at the same or higher levels with scarcer resources. Standardized leadership development programs not only show promise in developing new leaders with the knowledge and ability to thrive in their new roles, they also show prospective positive impact in creating sustainable leadership pipelines that can meet the complex and dynamic needs of HCOs today and in the future.

Appendix A: Nurse Manager Learning Domain Framework

Nurse Manager Learning Domain Framework (AONE, 2015)



Appendix B: Sample Recruitment Letter

My name is Jerome Mendoza Dayao, and I am a Doctor of Nursing Practice (DNP) student at the University of California Los Angeles School of Nursing. My scholarly project is to assess leadership and management competence among new managers within Patient Care Services Department at Harborview Medical Center (HMC) and implement a standardized web-based intervention based on the American Organization for Nurse Leaders (AONL) Leadership Development Framework.

I am inviting you, as a nurse leader, to participate in a confidential online survey using the Nurse Manager Skills Inventory Tool (NMSIT). The aim of this project is to assess your knowledge of leadership and management competencies as it relates to your daily practice as new leader. This information will inform future education offerings and new manager onboarding for nurse leaders within HMC.

The self-assessment is available via an online questionnaire that addresses the three manager leadership domains: (1) Science of Managing the Business, (2) The Leader Within, and (3) The Art of Leading People. The assessment will take approximately 15 minutes to complete. You may change your mind about participating in the study at any time and stop the survey. There is no penalty for stopping the survey early. There may be no direct benefit from participating in this study. There is no cost or payment associated with participation in this survey other than your time. Your answers will be kept confidential and secure.

Dr. Lynn Doering, Associate Dean for UCLA School of Nursing and serves as project chair, will be assisting me with this project. We consider the completion of the demographics and survey questions as consent to participate in the project.

Only aggregate (combined) data will be included when disseminating the findings of this study. Dissemination may be in the form of public presentations, publications, or other professional communication media.

If you have questions you may contact us at the following e-mail addresses:

Jerome M. Dayao, MSN, RN, NEA-BC, CPHQ, CCRN-K
DNP Student
UCLA School of Nursing

Lynn V. Doering, PhD, RN, FAAN
Associate Dean
UCLA School of Nursing

Appendix C: IRB Review Exemption

2/21/2020

<http://webirb.research.ucla.edu/WEBIRB/DocID/IR5GLKIT082435UORK72OUT2AE/fromString.html>



University of California Los Angeles
10889 Wilshire Blvd, Suite 830
Los Angeles, CA 90095-1408

<http://ora.research.ucla.edu/ohrpp>
General Campus IRB: (310) 825-7122
Medical IRB: (310) 825-5344

NOT HUMAN SUBJECTS RESEARCH DETERMINATION: UCLA IRB REVIEW NOT REQUIRED

DATE:	2/18/2020
TO:	JEROME DAYAO, Doctor of Nursing Practice SCHOOL OF NURSING
FROM:	PAUL LILLIG GIRB Administrator
RE:	IRB#20-000289 Standardized Web-based Leadership Development for New Managers.

Based on the information provided in the webIRB application, the UCLA Office of the Human Research Protection Program has determined that the above-named project does not meet the definition of human subjects research. The workspace for this project is now located in your archive folder.

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