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Nursing Home Leadership: Experience and Perceptions of Directors of Nursing

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NURSING HOME LEADERSHIP:

EXPERIENCE AND PERCEPTIONS OF DIRECTORS OF NURSING

by

Mary Louise Fleming

DISSERTATION

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DEDICATION

In memory of my first mentor, my big sister

Kathryn Ann Fleming

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> The greatest compliment that was ever paid me was when one asked me what I thought, and attended to my answer.
>
> Henry David Thoreau

In this moment when gratitude moves from the bottom of my heart into full public view, I am filled with joy and appreciation for the love and support of my mentors, my colleagues and friends, and my family.

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In closing, I want to express my heartfelt appreciation to Mike, Bryan, and Nate. My home and family has been my cocoon. I was able to enjoy and complete my doctoral degree because I was loved and cared for by my three guys. Every day. I love you.

ABSTRACT OF DISSERTATION

Nursing Home Leadership: Experience and Perceptions of Directors of Nursing
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This ethnographic study investigated leadership from the perspective of directors of nursing (DON) in proprietary nursing homes. Data from semi-structured and in-depth interviews and extensive participant observation with ten DONs were analyzed using open coding and content analysis to understand the experience of nursing home DONs. Findings describe the DON role, their definition and approaches to leadership, and the factors that facilitate and impede leadership in the nursing home context.

Role-related findings include the reasons participants began working in nursing homes, conditions antecedent to entry into the position, and preparation for the role. Five role responsibilities were consistent across all sites: 1) leadership, 2) administration, 3) clinical, 4) personnel, and 5) staff development. Common challenges included blurred work-home boundaries, 24/7/365 responsibility, inadequate staffing, and working in a "marginalized setting." The unrelenting burdens led to feelings uncertainty, exhaustion, discouragement, and professional embarrassment.

Major leadership findings include: 1) DONs identify themselves as leaders and their position as a leadership role; 2) unique profiles of veteran, reflective, and beginning leaders had an effect on staff performance and resident care, and 3) the nursing home context influenced DON leadership in positive and constraining ways. Mentored preparation, strong DON-administrator partnerships, adequate nursing infrastructure, and professional connections beyond the nursing home setting promote DON confidence and

competency. Conversely, lack of nursing infrastructure, over reliance on corporate standardization, and constraints on creativity and risk-taking fundamentally impede DON leadership. Findings were presented as a rich description constructed from the stories, thoughts, and observed actions of participants.

This study drew on transformational leadership theory to examine structural and interactional aspects of the DON role. This study extends the theoretical literature by contributing a conceptual description of contemporary DON leadership in the nursing home context. Findings offer direction to support and develop leadership capacity of DONs in practice, and provide a foundation for subsequent research.

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CHAPTER ONE

BACKGROUND AND PURPOSE

A quarter of a century has passed since Eliopoulos (1982) first proffered the notion that well prepared directors of nursing (DON) could lead focal efforts to improve nursing home conditions. While DONs hold a key organizational position to affect both quality of care and day-to-day operations (Rowles, 1995), relatively few studies have examined the role, and fewer still have attempted to explicate DON leadership.

Decades of increased regulatory enforcement and clinical mandates have failed to realize expected improvements in the overall quality of care and life for nursing home residents (Zhang & Grabowski, 2004). Leadership is considered central to addressing these intransigent problems. Therefore, the purpose of this ethnographic study was to describe and analyze the phenomenon of leadership from the perceptions of DONs within the context of the nursing home setting. How DONs defined and enacted leadership in everyday activities and the factors that influenced their leadership style and effectiveness were analyzed and described.

This chapter presents the background for the study and sets forth the purpose, aims, and significance of the research.

Statement of the Problem

The nursing home population: projected growth

People over age 85 comprise the fastest growing segment of the U.S. population (Bennett & Flaherty-Robb, 2003). This group has significantly greater functional deficits and disabilities and uses more healthcare services and nursing home beds than other

cohorts (Aroian, Patsdaughter, & Wyszynski 2000; Harrington, Chapman, Miller, E., Miller, N. & Newcomer, 2005; Harrington & O'Meara, 2003). As the number and proportion of Americans age, nursing homes will play an increasingly vital role in the overall healthcare system (Vladack, 1980). More than 6.4 million people over age 65 today will need long term care, and one in two will need skilled assistance with activities of daily living (Metlife, 2002).

Older adults indicate that moving into a nursing home is one of their greatest fears (Biedenharn & Normoyle, 1991; Chan & Kayser-Jones, 2005), nonetheless, over three million people receive care in nursing homes annually (Stone, 2000). Despite expansion of home and community-based alternatives, the nursing home population is expected to reach 5.3 million by 2030, and soar to over 8.3 million by 2040 (Stone, 2000, Yeaworth, 2002). Over 100,000 California elders reside in 1,350 nursing homes (Harrington, Schenelle, O'Meara & Kitchener, 2002), and this population will likely double by 2030 (Centers for Medicare and Medicaid Services [CMS], 2003).

Nursing home conditions: unresolved problems

Challenged by a poor public and professional image, labor shortages, and complex care demands, nursing home staff struggle to meet basic mandates for resident safety and quality of care (Cheah & Moon, 1993; Reif & Estes, 1982; Wunderlich & Kohler, 2001; Zhang & Grabowski, 2004). Regulatory oversight and interventions such as best practice guidelines, quality improvement programs, and new care delivery models have failed to accomplish the expected broad-based change needed in to improve nursing home conditions (Wunderlich & Kohler, 2001; Zhang & Grabowski, 2004).

While many nursing home studies have described poor care, some suggest better nursing leadership would improve care, and that good care is cost effective (Anderson, Issel & McDaniel, 2003; Ballard, 1995; Cherry, 1991; Heine, 1995; Kayser-Jones, 1997, 2002a, 2002b, 2003; .Kayser Jones & Schell, 1997; Kayser Jones et al., 2003; Kayser-Jones, Wiener & Barbaccia, 1989; Lodge, 1985; Lodge & Pietraschke, 1986; Mueller et al., 2006; Polich, Bayard, Jacobson & Parker, 1990; Rantz et al., 2003; Schnelle, 1990). Others reporting inadequate staffing, administrative turnover, and organizational failure to adopt and sustain clinical improvements also point to the need for more research on effective management and leadership practices (Castle, 2005; Harrington, 1990, 2005a; Institute of Medicine [IOM], 1986, 1996, 2001; Wunderlich & Kohler, 2001; Zhang & Grabowski, 2004). Despite these compelling results, the need for empirical study of DON leadership continues (Brannon, Smyer & Cohen, 1992; Eliopoulos, 1982; Harrington & Cruise, 1984; IOM, 1986, 1996; Lodge, 1985; National Institute of Nursing Research [NINR], 1992; Wunderlich & Kohler, 2001; Zhang & Grabowski, 2004).

DON position requirements

Federal law stipulates that every skilled nursing facility must employ a registered nurse (RN) as the designated DON (U.S. Federal Register, 1998). Compliance with this mandate was confirmed in a 1998 national survey (Harrington, 2005b, 2005c). Findings revealed that most states permit facilities with a census below sixty to use DONs to meet direct care staffing requirements, and facilities with a census between sixty and 100 may use the DON as a charge nurse (Harrington, 2005b, 2005c). As a result of these allowances, DONs are often the only RN on site or on call, and thus have little time to provide essential supervision, management, or engage in leadership activities.

Considering the plethora of unresolved nursing home problems and the diffuse expectations of the role, it is not surprising that attracting and retaining qualified DONs is a serious problem. Deemed one of the least desirable sites for professional practice, few nurses pursue careers in nursing homes (Johns, 1996: Cheach & Moon, 1993). Thus, there exists a severe shortage of qualified nursing administrative specialists to meet the demands of the geriatric population (Bednash, Redman, Barhyte & Wulff, 1990).

DON tenure and turnover

The 2002 American Healthcare Association survey reported the DON vacancy rate at 4.8%. All but three states reported over 25% turnover (Decker, et al., 2003), and two states exceeding 100% turnover. These alarming statistics, further confirmed in a recent study by Tellis-Nayak (2005), indicate that DON dissatisfaction and turnover has reached an all time critical level.

Unstable DON leadership is a serious concern for residents, families, providers, advocates, the industry, and society (Anderson, Issel & McDaniel, 2003; Castle, 2001, 2005, Castle & Engberg, 2006; Johns, 1996; Tellis-Nayak, 2005). Longer DON tenure has been correlated with better resident outcomes (Anderson, Issel & McDaniel, 2003; Harrington & Swan, 2003; Olsen, 2001; Zimmerman, Gruber-Baldini, Hebel, Sloane & Magaziner, 2002), and with staff satisfaction and stability (Castle, 2005). Castle (2005) posits that stable DON leadership is at the core of maintaining quality, while turnover creates a downward spiral of poor morale, dissatisfaction, and caregiver turnover, which subsequently leads to poor care and performance on state surveys. To address this cycle of instability and poor care, research is needed to explicate factors that promote DON satisfaction, including the rewards and conditions that encourage leadership.

The need for DON leadership research

In sum, the nursing home population is increasing while problems of improving care, developing staff, and retaining experienced and qualified professional nurses persist. Despite growing recognition that strong nursing leadership is central to creating and sustaining improvements in nursing home conditions, little evidence exists about the leadership practices and capacity of DONs. This ethnographic study addresses the gap in our knowledge by investigating and describing leadership from the perspective of nursing home DONs.

Purpose

The purpose of this research was to investigate the leadership role of nursing home DONs. Specific aims were to explore, describe and analyze: 1) DON perceptions, definitions, and approaches to leadership, and 2) factors that influence DON leadership.

Significance

This research is important clinically and theoretically. The discussion is thus divided into substantive and theoretical significance.

Substantive significance: While studies illustrate a need for better nursing home leadership, there is scant empirical evidence on how, or if, DON leadership exists. The significance of this research is threefold. Explicating how DONs perceive and enact leadership in everyday situations: 1) strengthens our ability to implement and sustain improvements in the quality of care and life for nursing home residents, 2) increases our knowledge of how DONs support, supervise, and develop staff, and 3) improves our ability to recruit, prepare, and retain DONs in nursing homes.

Theoretical significance: Previous DON research is primarily atheoretical and focused on tasks, demographics, and educational needs of DONs. Virtually no studies examined DON leadership, and none used leadership theory as a theoretical framework. This study drew on transformational leadership theory (TLT) to examine structural and interactional aspects of the DON role (Burns, 1978; Bass, 1985, 1990).

Consistent with TLT, this study adds to the theoretical literature by contributing to a conceptual description of contemporary DON leadership. Findings offer direction to support and develop leadership capacity of DONs in practice, and provide a framework for use in subsequent research.

Summary

DON leadership is an important and understudied issue. This ethnographic study investigated leadership from the perspective of nursing home DONs. TLT provided a conceptual framework for analyzing and describing the DON leadership role, DONs' definition and approaches to leadership, and factors that facilitate and impede leadership enactment. Results provide a foundation for future research. Findings also inform new strategies to recruit, develop, and retain DONs who can support professional staff and caregivers, and ultimately improve quality of the care of nursing home residents.

CHAPTER TWO

REVIEW OF THE LITERATURE

This chapter provides empirical and theoretical background for this study of DON leadership. A review of the state of the science on nursing home DONs is followed by an overview of transformation leadership theory as the conceptual framework informing this study.

The State of the Science: Directors of Nursing

Twenty-three DON studies of the role and work of DONs provide background for this study of nursing leadership. Studies are presented in four categories representing the major focus of the study. Included in the review are eight role studies, four education-related studies, four decision-making/use of clinical knowledge studies, and seven organizational studies.

Role studies

Eight role studies conducted between 1985 and 2001 described DON role characteristics and demographics, comparison studies, and factors influencing role effectiveness.

Role characteristic and demographic studies: The seminal study conducted by Lodge and colleagues (1985, 1986) was jointly funded by the American Nurses' Foundation (ANF) and the American College of Health Care Administrators (ACHCA), and partially supported by the W.K. Kellogg Foundation. This first and only major demographic study of nursing home DONs (n = 1,234) issued a two-phased report.

Respondents were primarily diploma or AD nurses, had been promoted through nursing home ranks to the DON position, earned less than acute care staff nurse, and worked more than 50 hours per week (Lodge, 1985). The ANF/ACHCA *Statement of Roles, Responsibilities, and Qualifications for Nursing Administrators/DON in Long Term Care* (RRQ) instrument was developed. It included four DON roles, organizational management, human resource management, nursing/health service management, and professional nursing and long-term care leadership and forty-five associated responsibilities. The survey reported that DONs were most involved in regulatory-focused tasks and least involved in management and leadership activities. Direct involvement in clinical care issues also required a significant proportion of their time.

Findings led to a short term partnership between the ANF and university nursing schools to develop weekend and evening programs to accommodate for DON work schedules (Lodge & Pietraschke, 1986). The progressive vision failed due to a lack of interest, both by schools of nursing and the nursing home industry (Mueller, 1998).

Use of the ANF/ACHCA RRQ survey instrument provided consistent findings in other studies conducted by Abedzadeh and Heine (1992), a 1995 study later reported by Heine (Mueller, 1998), and by Aroian, Patsdaughter and Wyszynski, and colleagues (2000). From this series of studies it was possible to track the lack of advancement in the role characteristics over time and, except for Aroian's 2001 report of unusually high graduate preparation of DONs, the educational demographics have also remained constant. All studies verified that DONs were primarily focused on regulatory compliance and providing direct care and spent minimal time in management and leadership activities.

In addition to role characteristics, Giordano and Panfil's (1987) survey study of 225 Illinois DONs described reasons for job satisfaction. The small respondent sample of forty-five DONs (20%) indicated their work was satisfying. They stayed in their position for one of four reasons--a dedication to geriatric nursing, the challenge of the role, the convenient proximity of work to home, or the opportunity to work as a manager.

Comparison studies: From 1985 to 1987, Simms, Price, and, Pfoutz conducted two grounded theory studies to examine differences in roles and preparation across acute, home care, nursing homes (Simms, Price & Pfoutz, 1985; Simms, Pfoutz & Price, 1986; Simms, Price & Pfoutz, 1987) and long term care academic educators (Pfoutz, Simms, & Price, 1987). .

Nursing home DONs (n = 10) differed from other groups in satisfaction and preparation for teaching. DONs were heavily involved in staff development but only two (20%) were satisfied with this aspect of their work (Simms, Price & Pfoutz, 1985; Simms, Pfoutz & Price, 1986; Simms, Price & Pfoutz, 1987). Only 20% of nursing home DONs held BSN degrees, whereas 100% of DONs in acute care and home care had either BSN or master's degrees, and 100% of the academic educators were prepared at the graduate level. It is important to note that these studies were conducted before OBRA enacted 1987 guidelines mandating nursing homes with greater than 99 beds employ a full time staff development RN, though no level of education was specified.

Carroll and Byers (2001) conducted a secondary analysis of survey data (Byers, 2000) from Florida long-term care leaders about needed skills, attributes and knowledge. DON responses were compared with non-nurse leaders. Nursing home and assisted living DONs (n = 61), were part a larger of study of 175 respondents. The DON role was

ranked highest for clinical knowledge. All other leadership factors--business, budget, decision-making, strategic planning, and research, were ranked highest for non-nurses. There were no differences in roles between nursing home DONs and DONs in other settings (Carroll & Byers, 2001).

Factors influencing effectiveness: Ballard's (1995) survey of DON and nursing home administrator (NHA) reported job factors considered important for effective functioning in the nursing home setting. An adapted version of the *Nursing Director Survey* (Patz, Biordi & Holm, 1991) asked respondents to rank the importance of resource management, CEO support, management, general nursing skills, and medical staff relations. DONs ranked CEO support and management skills as most important for their effectiveness. In contrast, NHAs ranked governmental, agency and regulatory knowledge were the most important factors for DON effectiveness (Ballard, 1995). Both groups rated human management skills and general nursing knowledge as highly important (Ballard, 1995).

Education-related studies

As gleaned from the role studies above, the last twenty years have yielded little change in the DON educational demographics. Considering the magnitude of the problems that have been consistently linked to DON preparation, or the lack thereof, the small amount of research on this topic is disquieting. Recalling the failed project to develop an industry and university partnership led by Lodge in 1985, and Ballard's (1995) assessment of the slow response from academia a full ten years later, it is apparent that fundamental changes to meet the needs for the nursing home DON have not yet been realized. The problems in better preparing this group of nurses remain complex and

without easy solution. The following four studies, all conducted in the 1990's, comprise the body of knowledge that specifically addresses the educational and development needs of the nursing home DON.

Vaughan-Wrobel and Tygart's (1993) study examined educational needs and management support for Arkansas nursing home DONs to return to school. Almost 45% of DONs had less than one year of DON experience, 50% had less than six months tenure in their current position, 66% were first time DONs, and 76% had never worked in a nursing home before becoming a DON. Though most had no leadership or management preparation, 71% believed they had skills necessary for their work. By contrast, only 49% of NHAs thought DONs were adequately prepared. DONs and NHAs ranked human relations, management, and facility monitoring as the most importance areas for further education (Vaughn-Wrobel & Tygart, 1993).

Luggen (1997) surveyed a random selection of fifty members of the National Association of Directors of Nursing Administration/ Long-Term Care (NADONA) and fifty members of the National Gerontological Nursing Association (NGNA) to determine their opinions on ten graduate level administrative curriculum items. Using a six-point scale, respondents ranked the importance of ten items representing graduate level administrative curriculum content and eleven items related to leadership. Budgetary, practicum experiences, human resource management, and organizational theory ranked highest for essential content. Communication, planning, long-term care knowledge, negotiation and organizational skills ranked highest for leadership curriculum. Results indicated that administrative content for graduate courses for nursing home DONs was

appropriate for all graduate programs. One open-ended question revealed that knowledge of leadership and quality improvement were desired content areas (Luggan, 1997).

Mueller (1998) published results of a 1995 study with North Carolina DONs using the ANF/ACHA Statement of Roles Responsibilities and Qualifications scale to investigate responsibilities, time allocation, demographics, educational background, and preferences for continued education. The relationship of continuing education needs to specific roles and responsibilities was the major contribution of this research. The study reconfirmed Lodge's 1985 finding that DONs both perceive a need for more education, and have a desire to further their academic preparation.

Ross and colleagues (2001) examined the influence of corporate philosophy on the educational programs in nine nursing homes. Key informants were four NHAs, three executive directors, and one DON, clinical coordinator, and quality management director. A paradox between philosophy and fiscal constraints on supporting staff development was found. High ideals for comprehensive, relevant education were offset by the daily dilemma to choose between providing actual resident care, or improving the knowledge of staff to provide better care (Ross, Carswell, Dalziel & Aminzadeh, 2001).

Decision-making/use of knowledge studies

DONs are responsible for staff supervision, performance evaluation, and setting a clinical direction that incorporates evidenced-based standards as well as regulatory mandates. Four studies examined DONs' fund of clinical knowledge, and application of that knowledge in practice. This group of studies, all conducted after 2000, provided a new level of interest in the expectation for DONs to direct and lead clinical changes.

Bottrell and colleagues (2001) conducted a qualitative study of factors that influenced decision-making about transfer of dying residents from nursing homes to hospitals at the end of life. Focus groups with thirteen DONs from three states found that decisions were influenced by knowledge of resident/family preferences, interactions with physicians and other staff, and the nursing concerns about institutional liability. Lack of technology and low staffing emerged as barriers to keeping a dying resident in the nursing home. DONs reported that no evaluation or performance measures for patient transfer were used. (Bottrell, O'Sullivan, Robbins, Mitty & Mezey, 2001).

Mueller (2002) studied DON decision-making related to staffing. Semi-structured interviews with eight DONs found that although DONs initially claimed their staffing decisions were based on standards, when questioned further, they could not describe or identify the standards that guided their decisions. DONs asserted that a case-mix model was primarily used for staffing assignments; despite that fact they thought the model inadequately addressed resident needs. Few DONs had access to computers or staffing programs needed to ensure congruence between case-mix and staff assignments. Mueller (2002) described the general staffing decision-making process as intuitive, labor intensive, repetitive, inconsistent, and likely unreflective of resident or staff needs. Further, RNs and LPNs were used interchangeably.

Bassett and Smyer (2003) conducted a secondary analysis of survey data about DONs knowledge and use of American Cancer Society (ACS) guidelines for screening older adults. The single significant finding was the inverse relationship between years of DON experience and ACS knowledge (r = -.367, p = .05). While up to 87% of DONs knew ACS guidelines, they were included in policies from 0% to 13% of the time.

Despite acquisition of new knowledge, changes in practice were not guaranteed (Bassett & Smyer, 2003). This finding suggests a need to explore the influence of organization culture on supporting better practice, as well as the need to understand the DON perspective on their responsibility for instituting and leading clinical improvements.

Resnick, Quinn and Baxter (2004) completed a mixed method study to explore the feasibility of implementing clinical practice guidelines (CPG) in nursing homes. The study was conducted in twenty-three Maryland nursing homes and used a single-group repeated measures for the quantitative design, and face-to-face or telephone semi-structured DON interview data for qualitative analysis (Resnick, Quinn & Baxter, 2004).

Significant improvement in process indicators for the falls CPG was found ($p \leq .05$), and while practice changes were identified in implementation of the pain CPG, improvements were not statistically significant. Less that half (45%) of the original forty nursing homes actually implemented one or both guidelines, but evidence existed that if implemented, guidelines were followed (Resnick, Quinn & Baxter, 2004).

Organization-related studies

In bureaucratic settings like nursing homes, organizational factors such as work climate and support are related to DON satisfaction and tenure, which in turn, leads to better resident care and workforce retention. The seven studies in this category offered distinct views of the work of the DON as a part of the nursing home organization.

Anderson, Arid, Slater, Tamara and Haslam's (1993) survey study in 100 Utah and 200 west Texas nursing homes described factors associated with DON satisfaction. An astonishing number of DONs in both states were not RNs. Only twenty-four (24%) in Utah and seventy (35%) in Texas were RNs. No mention of waivers for a staffing

variance was made, and no description or account of survey responses by differences in licensure was given. Moving beyond these concerns, this study attempted to correlate factors associated with the top 30% (high satisfaction) and bottom 30% (low satisfaction) groups but found no difference. DONs reported being proud of their work but frustrated with poor wages, paperwork, and lack of orientation to the job. With the high numbers of LVNs as DONs, little beyond commentary can be gleaned from the results of this study.

Also in 1993, Larson's descriptive study of DONs in rural Colorado nursing homes analyzed interview data about job challenges, the most and least liked job activities, satisfaction, and career plans. Rewards, challenges, constraints and 'last straw' issues were identified and discussed within the context of the rural setting. Rewards included resident interaction and job autonomy; challenges included budget constraints and issues of poor staff morale; practice constraints included regulatory challenges, staffing problems and endless paperwork; and 'last straw' issues include job burnout, employee unrest and poor resident care. Further, DONs reported that they perceived the regulatory survey process as demoralizing and demeaning to the status of the DON (Larson, 1993).

Roth and Harrison (1994) conducted a study in a large metropolitan California area to determine if OBRA legislation facilitated or inhibited resolution of ethical conflicts DONs experienced. Focus groups were convened six months after the implementation of OBRA guidelines, hotly contested in California, to explore the impact of resident autonomy-enhancing legislation on nursing operations. Discussion prompts included recruitment and retention of staff, reimbursement for low income residents, discharge issues for difficult to place residents, maintenance of good care standards,

employee termination, and resident competency for decision-making (Roth & Harrison, 1994). Participants concluded that legislation alone was insufficient to create needed nursing home reform. Participants suggested convergence of regulatory engagement, policy reform and professional empowerment to become catalysts for more permanent change.

Gillies, Foreman and Pettengill (1996) conducted a pre and post intervention study of the effect of participation in a thirty-month continuing education program on the job satisfaction of forty-four DONs and educators across thirteen Midwestern states. The study was part of a long-term care grant administered by the U.S. Department of Health and Human Services. Of the original 112 study participants, only fifty-three (47%) completed the satisfaction evaluation at pre and post intervention intervals and only forty-four (39%) answered every question (Gillies, Foreman and Pettengill, 1996).

The Stamps and Piedmonte Index of Work Satisfaction (1986) was used to measure satisfaction on six subscales--autonomy, interaction, agency policies, pay, professional status, and task requirements. The continuing education intervention significantly increased satisfaction on only one subscale of the index, satisfaction with agency policies (Gillies, Foreman and Pettengill, 1996).

Anderson, Issel and McDaniel (2003) conducted a cross-sectional correlational field study to explore the relationship between management practices and resident outcomes in 64 Texas nursing homes. Four measures of management practices: open communication, formalization, participatory decision-making and relationship-oriented leadership were measured and correlated with secondary data obtained from the 1995

Texas Medicaid Nursing Facility Cost Report, part of the Minimum Data Set (MDS) (Anderson, Issel & McDaniel, 2003).

Resident outcomes from MDS data were aggregated into four categories of aggressive/disruptive behavior problems, complications from immobility, prevalence of fractures, and restraint use. Findings indicated that larger facility size and longer DON tenure significantly correlated with better resident outcomes, and that one or more of the four management practices were correlated with resident outcomes. The study demonstrated that management practices were directly linked to resident care and accounted for 15% of the variance in aggressive/disruptive behavior problems and complications from immobility, for 11% of the variance in the prevalence of fractures, and for 21% of the variance in restraint use (Anderson, Issel & McDaniel, 2003). Interestingly, different management practices correlated with improvements for each resident outcome. Larger facility size and greater RN participation in decision-making explained a lower prevalence of behavior problems. Lower complications from immobility were correlated with experience and a less formal, relationship-oriented leadership style of the DON. A relationship-oriented leadership style explained the lower prevalence of fractures, and lower restraint use was correlated with larger facility size and to DON characteristics of experience, tenure, and open communication (Anderson, Issel & McDaniel, 2003).

Because specific management practices were associated with improvements in different resident outcomes, a wide range of management practices and flexible leadership styles may be required for DONs to promote better resident care. These

findings suggested that experienced, knowledgeable leaders are needed in DON positions to effect change in nursing home quality of care.

A 1995 study with the same group of Texas nursing homes examined employee perceptions of the administrative climate and organizational communication on facility characteristics, resource allocation, and turnover (Anderson, Corazzini & McDaniel, 2004). Both climate and communication were both found to affect turnover, but lower turnover was dependent on the interaction between climate and communication factors. In nursing homes with reward-based administrative climates and higher levels of open and accurate communication, lower staff turnover was found. Adequate staffing and longer tenure of the DON were important predictors of lower staff turnover rates (Anderson, Corazzini & McDaniel, 2004).

A study conducted by Tellis-Nayak (2005) was commissioned by the Virginia Health Care Association to analyze the causes for the 147% DON turnover rate, the highest in the nation. Survey and participant observation data were collected to ascertain the motivation, preparation, and the frustrations experienced in the day-to-day work. Approximately 50% had been a DON for less than five years, and 20% were in their current position for less that one year. Over 50% did not belong to any professional organizations and had not attended a professional meeting in the past two years. DONs with higher education held more memberships in professional organizations, maintained a network of contacts and connections, and more often weighed their options to leave the nursing home. Over half of the sample had seriously considered leaving their position, and another 50% intended to leave within five years. A majority (84%) indicated that they were satisfied with the job overall but only 71% of this same group would choose

the role again, and only 52% would recommend the position to others (Tellis-Nayak, 2005).

Turnover was related to the tension between the incongruence of the DON's desire to be a nurse leader and mentor, and the overwhelming job demands that pulled her into the tasks of daily staffing, budget maintenance, regulatory compliance, and avoidance of institutional liability.

Summary of the State of the Science

Research related to the nursing home DON position is clearly in its infancy. It is important to recognize that even the most flawed of studies represents a bold attempt to bring attention to this otherwise invisible group of nurses who struggle to provide direction and leadership for better care in nursing homes.

For the past twenty-five years, the preponderance of studies has been descriptive and primarily atheoretical. Further, the body of science has lacked continuity, as evident in the number of one-time studies of a single area of interest, and thus it is difficult to reconcile and integrate concepts across studies. In light of the many critical areas that need attention in the nursing home setting, this discontinuity in research precludes the formation of a solid agenda from which to garner support for sustained development of the DON role.

In general, the strength of descriptive findings was constrained by the small samples and poor response rates to the surveys. The research designs that included face-to-face inquiry, or combined survey methods with open-ended or in-depth strategies were better able to uncover and describe the situations or opinions of the participants. Causal

and correlational relationships could only be made in a few studies. Summary findings for each group of studies are briefly recapped.

Role studies: The emphasis of eight role studies, six surveys and two grounded theory studies conducted between 1985 and 2001, was on the description of DON job characteristics, demographics, and the congruence between role expectations and actual practice. Use of the ANF/ACHCA RRQ survey instrument provided consistent findings in four studies conducted in 1985, 1992, 1995, and 2001. From this series of studies it was possible to track the lack of advancement in the role characteristics over time and, except for Aroian and colleagues' 2001 report of unusually high graduate preparation of DONs, the educational demographics have also remained constant. All studies reported that DONs were most involved in regulatory-focused tasks and least involved in management and leadership activities. Direct involvement in clinical care issues also required a significant proportion of their time.

Use of a survey strategy alone may be particularly challenging in research with nursing home DONs. Due to tenure and satisfaction issues, DONs may not be easily engaged in research. This may account for the small response rates in this group of studies. Another methodological concern related to self-report must also be noted as nursing home DONs are highly regulated, frequently publicly scrutinized, and reticent to disclose information that potentially increases exposure of practice and role problems.

Education-related studies: These studies drew attention to the disparity between DON preparation and the role requirements for management and clinical leadership. Again, the use of a single survey method for small samples further challenged the confidence in findings related to self-reported information. Two studies moved beyond

simple descriptions of the respondent groups and examined curricular and organizational factors related to the education and preparation of nursing home DONs.

While neither study has received additional empirical validation, Luggan's (1997) open-ended survey strategy with a 74% return rate, found that graduate content for nursing home DONs should parallel that of administrative nurses, a key finding for creating educational parity in roles across settings. Ross, Carswell and Dalziel (2001), in a qualitative study, surfaced important relationships and conflicts between organizational philosophy and the fiscal capacity to implement educational programs.

Use of knowledge studies: Examined as a group, the four use-of-knowledge studies, all conducted after 2001, provided a progressive view into the practice world of the nursing home DON. This group of studies examined the DON's fund of knowledge, their need for providing structure and direction for nursing, their decision-making abilities, and their ability to implement new clinical practices. Methods varied for each study with one using a focus group approach, another using in-depth qualitative interview, a third using a survey design, and the fourth using a mixed method interventional study in concert with qualitative analysis of structured interview data.

Organization-related studies: Since 1993, five studies were conducted to examine organizational factors related to DON satisfaction, tenure and turnover, and another two studies correlated DON tenure and administrative style with better staff and resident outcomes. Within this group of studies, a range of methods were used--focus groups, qualitative interviews, pre-post intervention, correlational descriptive designs, and a mixed method survey and ethnographic design.

Studies in this category demonstrated that more organizational support was needed for the DON to meet the complex requirements of the position. Whether in a study focused on a single phenomenon of interest such as satisfaction, tenure, or ethics in practice; or in multi-focused studies of the effect of management practices on improvements in care and staff retention, this group of studies provided empirical guidance for organizational, management and leadership decisions.

With additional research in this area, findings could serve as a basis for policy changes as well as for directing efforts to improve the circumstances constraining the development of the DON position. These more recent studies offer new directions for examining the role using theory in design, interpretation, and benchmarking of results.

The leadership gap: Studies attempted to describe the tasks of the DON role, how DONs were prepared for their position, how they used clinical knowledge to made key decisions, and how their leadership style and influence improved staff and resident outcomes. Findings stopped short of describing how DON leadership was enacted in practice, or how DONs conceptualized this aspect of their work. Presented next is an overview of transformation leadership theory as the conceptual framework used to examine and explain DON leadership findings in this study.

Transformational Leadership Theory

Transformational leadership theory (TLT) is an extension of Weber's (1947) description of bureaucratic leadership. Using Kohlberg's theory of moral development for a study of political leaders, Burns (1978) described and differentiated transactional (TA) from transformational (TF) leadership practices. The current TLT framework now incorporates both TA and TF practices as separate but interrelated dimensions of an

individual's leadership style (Bass, 1985). Research conducted by Bass and Avolio (1995) extended the original theory to also include laissez-faire (LF) leadership as a non-transactional dimension. This comprehensive theory and the dimensions of TA, TF and LF leadership provide utility in explicating the leadership components of the nursing home DON role, and are presented in greater detail in the following sections.

Transactional leadership

TA relationships, in the tradition of exchange theory, are based on principles of give and take, or the "transaction between a leader and follower" (Burns, 1978; p. 4). TA leadership is characterized by a leader-follower exchange of negotiated rewards that are contingent upon a follower's performance and upon the leader's use of positional resources to encourage the desired behaviors (Burns, 1978). In 1985, Bass further defined the leader-follower relationship as characterized by leaders who: 1) recognize and obtain resources that followers need to perform effectively, 2) exchange rewards for effort; and 3) respond to the immediate self-interests of followers when those interests facilitate the completion of work (Bass, 1985).

Howell and Avolio (1993) found that TA leadership was comprised of three main characteristics: 1) active management by exception, which includes close performance monitoring, and proactive anticipation of and intervention in problems before corrective action is needed; 2) passive management by exception, which is demonstrated by a lack of attention to people or problems until something goes wrong, followed by criticism and negative consequences; and 3) contingent rewards, which are methods for providing feedback through pre-agreed upon rewards for completing expected objectives and goals.

Bass (1985) raised concerns about the duality of Burns' (1978) original theory, in that it accounted for TA and TF behaviors as polar opposites. Believing that successful leaders use TA as well as TF practices, Bass (1985) opined that a more balanced view of leaders would examine *how* TA leadership practices *promote* transformation in followers. Stordeur and colleagues (2001) contended that among the few benefits of TA leadership was the ability of leaders to provide detailed knowledge of content-related problems for prompt solutions, particularly useful in times of crisis or when situations are stressful.

Burns (1978) described a TA leader as one who requires "a shrewd eye for opportunity, (and) a good hand at bargaining, persuading, reciprocating" (p. 169). He equated the TA leader to the corporate manager that maintains order, gets the job done, directs activities, rewards performance, penalizes nonperformance, and ensures that subordinates have the needed skills for their jobs (Burns, 1978). This type of leader was found to primarily use active or passive management by exception and contingent rewards in exchange for a good performance (Bass, 1990; Burns, 1978; Northouse, 1997; Wren, 1995).

Transformational leadership

Conversely, Burns (1978) described a TF leader as one who recognizes the needs of a follower and "looks for potential motives…seeks to satisfy higher needs, and engages the full person of the follower" (p. 4). TF leaders are viewed as change agents who seek to appeal to their followers "better nature and move them toward higher and more universal needs and purposes" (Bolman and Deal 1997; p. 314). TF leadership is described as a neo-charismatic style, characterized by the ability of a leader to achieve

"extraordinary levels of follower motivation, admiration, respect, trust, commitment, dedication, loyalty and performance" (House & Aditya, 1997, p. 23).

TF leadership practices promote creativity and communicate a future vision of the organization in ways that intellectually engage others, attend to differences among people, and use the leader's personal strengths, knowledge and experience to act as a coach and mentor for subordinates and colleagues (Yammarino & Bass, 1990; Yukl, 1989). Included in transformational practices are proactive problem solving, self-management, team-orientation and a ongoing quest for knowledge (Jacques, 1996).

Bass & Avolio (1994) theorized four dimensions of TF leadership: 1) idealized influence (charisma), characterized by risk sharing, consideration of follower needs over personal needs, and ethical conduct; 2) inspirational motivation, characterized by articulation of clear organizational expectations and arousal of team spirit through enthusiasm and optimism; 3) intellectual stimulation, characterized by inclusion of followers in problem-solving; and 4) individualized consideration, characterized by attentive listening, recognition of followers' contributions and investment in followers' development. Through these practices, leaders were viewed as offering meaning and challenge to the followers' work, thus creating a stimulating work environment, and attaining follower admiration, respect and trust (Bass & Avolio, 1994).

Through empowerment of others, TF leaders transform followers by increasing self-esteem, spiritual arousal and emotions that align with the leader's values, goals and vision (Bass, 1990). This style of leadership has been strongly correlated with above average organizational behavior (Aditya & Ram, 1997; House & Aditya, 1997; House, Aditya & Ram, 1997).

Laissez-faire leadership

LF leadership "represents a non-transaction" (Bass & Avolio, 1994, p.4) and is characterized by avoidance of interactions, delays in decisions, lack of communication and feedback to followers, and lack of long-range planning. Additionally the LF leader has limited contact with superiors or subordinates, remaining isolated from both reality and new directions needed for organizational improvement (Northouse, 1997). This leadership style has not been reported as a dominant style of nursing leaders, but may be observable in areas of practice that are either uncomfortable or unvalued (Northouse, 1997).

TLT and nursing leadership studies

No studies using TLT have been conducted with nurse leaders in nursing homes, though research using TLT has been conducted with nurse leaders in acute settings. Despite contextual differences between acute and nursing home settings, findings from the existing studies suggest that the theory may be useful for exploring and describing the leadership role of the nursing home DON. Several studies reported a significant positive relationship between TF leadership and staff retention (Kleinman 2004), job satisfaction (Dunham-Taylor & Klafehn, 1995; Medley & Larochelle, 1995; McDaniel & Wolf, 1992; Morrison, Jones & Fuller, 1997) and increased work effort and group effectiveness (Dunham-Taylor, 2000). Other studies examined the cascading, or domino effect that TF leadership has on staff and practice in organizations (Leach, 2005; McDaniel & Wolf, 1992; Stordeur & Vandenberghe, 2000). Interestingly, while organizational values were hypothesized to influence a leader's style, Perkel's (2000) correlational survey of 414

nursing leaders found no significant relationship between organizational values and TA, TF, or LF practices.

Of particular relevance to the study of leadership in nursing home settings was the 1997 study conducted by Morrison, Jones and Fuller in one Alabama regional medical center. The descriptive survey study examined the relationship of leadership style and empowerment to the satisfaction of licensed and unlicensed staff. Sixty-four percent of the 442 staff participated in the study. One finding of particular interest was the discovery that the influence of leadership and empowerment on job satisfaction varied between licensed and unlicensed staff.

The study reported that empowerment was positively related to job satisfaction, and job satisfaction was positively linked to both TA and TF practices. Empowerment, however, was only related to TF leadership. While unlicensed staff satisfaction was related to recognition and personal consideration--which occurred in both TA and TF leadership styles, licensed staff satisfaction was related to empowerment which only occurred with TF leadership. Because nursing homes primarily employ unlicensed staff. This finding is important as expectations of licensed and unlicensed staff may also differ in the nursing home setting and a DON's style of leadership may vary in accordance with specific staff needs.

In general, this body of nursing research reported TF leadership as the dominant style of nurse leaders, but findings from two studies, Dunham and Klafehn (1995) and Stordeur and Vandenberghe (2000), reported that leaders used mixed TA and TF leadership styles. This finding was congruent with studies conducted with leaders in other fields as well (Bass, 1990).

The relationship between leadership practices and workforce effectiveness provided support for the use of TLT as conceptual framework for this study of leadership in the nursing home domain. Specifically for this study, TLT provided guidance for developing interview questions to elicit information about DONs' perceptions of their leadership role, for organizing observational data of DONs in clinical, administrative, and supervisory interactions, and as part of analysis, data were reviewed with TA, TF, and LF dimensions of the theory. The following chapter presents the study's methodology and design.

CHAPTER THREE

METHODOLOGY

> Always, it seems, the concept of leadership eludes us or turns up in another form to taunt us again with its slipperiness and complexity (Bennis, 1998, p. 260).

Qualitative inquiry is an ideal method to study the complex and contextualized phenomenon of leadership from the actors' perspective (Alvesson, 1996; Bryman, Stephens & Campo, 1996; Conger, 1998). As research related to nursing home DON leadership is in its infancy, qualitative methodology was appropriate to study this topic about which little is known (Cresswell, 1994, Hammersley & Atkinson, 1995, Maxwell, 2005). For this study, ethnography, a context-sensitive methodology, was selected to investigate DON leadership in the natural environment of nursing homes.

Ethnography

Ethnography is the art and science of cultural interpretation. Defined as "the work of describing culture" (Spradley, 1980, p. 3), ethnographic research consists of gathering and interpreting information about a culture or a particular phenomenon of interest through intensive experience within the culture itself.

Rooted in anthropology, traditional ethnographers study cultures and communities about which little is known within the cultural context (LeCompte & Preissle, 1993). Particular individuals, customs, institutions, or events are of interest as they relate to a generalized depiction of the life-way of a socially interacting group (Wolcott, 1988). Thus, ethnographers aim to describe the shared beliefs, practices, artifacts, knowledge and behaviors of a culture or community.

Culture is more than a system in which social events, behaviors, or processes are causally linked; it is rather a context within which these processes can be intelligibly described (Geertz, 1973). Ethnographers study people who have something in common, exploring the influence of the larger group on individuals within the group (Boyle, 1994). In this study, DONs across nursing homes settings represent a specific cultural group as they are connected by the systems, regulations, and populations they serve. Ethnographic significance is derived socially from discerning how ordinary people in particular settings make sense of the experience of their everyday lives (Wolcott, 1988). Grounded in a constructivist world view, ethnographic inquiry allows discovery of multiple truths, emphasizing the value of individual perspectives that are time and-context-bound.

Until recently, in the tradition of Malinowski and Boas, anthropologists traveled to relatively unfamiliar parts of the world, shared a life with those being studied, learned the language and culture, then returned home to write about their discoveries (Barnard, 2000). Their goal was to find commonalities with other cultures and make the strange more familiar. Today however, ethnographic research occurs in everyday settings such as nursing homes to illuminate latent or taken-for-granted perspectives that promote understanding of familiar groups in innovative or refreshing ways (LeCompte & Preissle, 1993; Savage, 2000).

Central to ethnographic description are the beliefs, values, norms, and practices of people within a community, organization, or institutions (Field & Morse, 1985). For instance, in this study I was interested in the daily routines, patterns of interactions and communication, concerns, perceptions, and beliefs of nursing home DONs. Fieldwork consisted of first-hand, systematic observations and conversations with ten participants.

Understanding any human behavior is only achieved through long acquaintance with and immersion in a particular setting (Spradley, 1980; Wolcott, 1993). Hence, multiple in depth interviews, informal conversations, and participant observation sessions occurred over a six month period from September 2006 through February 2007.

Participant observation

Ethnographic inquiry focuses on the dynamic way multiple factors fit together in the natural setting. This study took place in the naturalistic setting of each DON's nursing home. On one occasion, I met with a DON in her home to accommodate her family schedule, but I also spent time with her at her facility. As a participant-observer, I shared in the everyday activities of DONs to learn their routines and beliefs from their perspective (Harris & Johnson, 2000). This helped me develop an emic, or insider view of everyday occurrences and experience being a part of each DON's group (Wax, 1980).

Interviewing

Besides seeking first-hand experience in a culture, ethnographers use interviews to access the opinions or beliefs of informants (Burns, 1994). Ethnographic interviews are one of the most effective methods to gather information, confirm experiences, and explore interpretations (Fetterman, 1989). Unstructured interviews rely substantially on the interaction between the interviewer and informant to gain information (Minichiello, Aroni, Timewell, & Alexander, 1995). They take the form of conversations and focus on the informant's perception of themselves, of their environment, and of their experiences (Burns, 1994). Unlike structured or semi-structured interviews, these conversations do not use questions that are pre-determined or standardized (Patton, 1990).

I was interested in learning about the subjective experience of each DON. Therefore, in depth, semi-structured interviews as well as informal conversations during participant observation were appropriate for this study. This approach elicited a full range of conversations about their work and experiences and also allowed DONs freedom to express their views without being directed. Further, this approach gave us the chance to engage as equals which enhanced rapport and trust (Burns, 1994).

Sample

Sample characteristics

Ten DONs from four corporate multi-facility (chain) nursing homes located in five urban counties in the Pacific Northwest were interviewed and observed. Participants with at least one year of combined experience as a DON or assistant DON (ADON) were recruited using purposive and snowballing strategies (Luborsky & Rubinstein, 1995; Morse, 1991). DONs from nursing homes with less than 50-beds, that only served rehabilitation or short-term convalescent residents, or employed a DON in more than one paid position, were excluded from the study.

The sample was comprised of women ranging in age from 33 to 62 years with a mean age of 45.60 (SD = 9.20) years. Five (50%) were Filipina, three (30%) were Caucasian, one (10%) was Black, and one (10%) was East Indian.

Nursing education

Six of ten DONs received their basic nursing education outside the United States; five of these DONs earned baccalaureate degrees in nursing (BSN) in the Philippines, and one received an associate degree in nursing (ADN) in Barbados and a master's degree in public administration (MPA) from a U.S. college. Four participants attended nursing

schools in the U.S. and of these; two had an ADN degree, one a Diploma, and one had BSN and MPA degrees. One U.S. educated DON also held two baccalaureate degrees from a university in India, one in business and one in communication. Two participants had a master's degree in public administration, but none held advanced nursing degrees.

Years in nursing home practice

Participant experience in nursing homes ranged from four to 34 years, with a mean of 12.6 (*SD* = 9.60) years. Seven DONs had worked exclusively in nursing homes. All had experience in multiple roles including staff nurse (90%), Minimum Data Set (MDS) coordinator (70%), director of staff education (10%), and ADON (90%). One BSN-prepared participant, started as a nursing home assistant after coming to the U.S. (prior to certification regulations), became an LVN, passed the National Council Licensure RN examination, and held staff and ADON positions before becoming a DON.

DON role experience

Participant experience as a DON ranged from one to 28 years with a mean experience of 4.90 (*SD* = 4.35) years. Two had been employed as DONs in other nursing homes, and four (40%) had prior experience in ADON or supervisory roles. During the study, one participant resigned from her position to accept a DON position in a nursing home within a different corporate chain.

Other nursing experience

Two participants (20%) had professional nursing experience outside the U.S., one in the Philippines, and one in Barbados and England. Five had prior experience in acute, the military, or home health settings, and of this group two held major administrative positions in prior work settings. Sample characteristics are presented in Figure 3.1.

Setting

Ten nursing homes in four private, for-profit, multi-facility corporate chains located in five urban counties in the Pacific Northwest were study sites. Proprietary facilities were selected as they comprise the major sector of the U.S. nursing home industry (Harrington, Carrillo, & Crawford, 2005). Seventy percent of nursing homes exist as for-profit facilities (Gabrel, 2000; Strahan, 1997) and almost 67% are investor operated facilities (Harrington, Woolhandler, Mullen, Carrillo &, 2002) To ensure similarity in DON roles and organizational variables, only DONs from proprietary nursing homes with an average census of fifty or more residents were included.

Six of ten nursing home sites were owned by Corporation A, a large national chain that provides over one-fifth of the 1.6 million skilled beds in over 20 states. Corporation A had 12 facilities within a 100 mile radius, more than three times the number of facilities of other chains represented in the study.

Two sites were owned by Corporation B, a large diversified corporation that provides a wide range of healthcare services across the nation. Corporation B had four facilities within a one hundred mile radius.

One site each from Corporations C and D were represented in the study. Though both were smaller national chains, these corporations own facilities across the U.S., primarily in southern and western states. Both were newly established in the study area. Corporation C provides about one-tenth of U. S. skilled nursing home beds and had three facilities within a one-hundred mile radius. The Corporation C facility had changed ownership four times in the last ten years and twice in the prior five year period. Each of the four chains operated nursing homes, hospitals, contract rehabilitation or hospice

services, and pharmacies. Some were further diversified and each was publicly traded on the New York Stock Exchange.

Human Subjects Ethical Considerations

Risks and benefits

The Committee on Human Research at the University of California San Francisco reviewed and approved this research. The study was associated with minimal risk (Office for Protection from Research Risks, 1993). However, discomfort with disclosure of information, being audio-taped, or being observed in practice were all considered as potential risks. Participants were informed that study information was confidential, and assured that tapes would be handled as confidentially as possible, destroyed at the end of analysis, and used only for purposes of this study. Each was fully informed of her right to stop an interview or observational period, or withdraw from the study at any time. All procedures and protections were thoroughly explained and included on the consent form which participants signed before being enrolled in the study.

Study participation required DONs to spend extended periods of time with me. I made special efforts to accommodate each DON's schedule, minimize inconvenience, and support their responsibilities to residents, staff, and the organization. Interviews and conversations were constructed to show sensitivity and knowledge of each participant's level of comfort. For instance, individualized probes were used to reflect information from previous discussions, or indicate awareness of issues unique to a DON's work situation. While each DON was told they could end their participation at any time if the burden was too great, all seemed to enjoy talking about their work and looked forward to scheduling subsequent sessions. All voiced disappointment when the study ended.

Research Design

Entree

A list of DON contact numbers was constructed from public records such as Nursing Home Compare. DONs were called to solicit interest in participating in the study and confirm their eligibility. Three were unavailable during initial and follow up phone calls and did not respond to messages I left. Since this research involved observing DONs in the course of their everyday work, following their agreement to participate, support to conduct the study in each facility was obtained from facility administrators or corporate consultants. All consented to participate.

Each DON generously welcomed me into the facility by introducing me to staff as we toured the buildings or at the start of meetings I attended. Their pride in being in the study was evident in introductory comments such as, "She is my doctoral student," and "She is studying my role as the DON." Frequently responses from other staff included comments like, "You picked a good one," or "You will learn a lot from her," and "How long are you planning to stay? She has a big job!" General questions about the study included my university affiliation, whether I was going to publish study findings, and what my plans were after finishing the doctoral program.

Data Collection

Procedures: Data collection occurred between September 2006 and February 2007. A summary of data collection activities is presented in Figure 3.2. As participants were enrolled in the study, I scheduled an initial visit. For all but one, the first visit began with a semi-structured interview and tour of their nursing home. For one

participant, filling in for both the administrator and direct care vacancies, our first visit began with my shadowing her as she "covered the floor."

I used an interview guide (Appendix A) in initial interviews to organize and frame grand tour questions about the DON role. I allowed participants to talk freely and used general probes to seek added clarification or a deeper explanation of their perceptions, values, challenges and rewards of their work.

Conversations about leadership emerged naturally over the course of the first interview. Prompted by a general question to describe their role without reference to leadership, five (50%) DONs began their answer with a statement about being a leader. Five others described leadership as a part of their initial answer to the question. Again, I used focused probes to elicit examples and descriptions that illustrated how DONs viewed leadership, and the activities they associated with the leadership role.

The initial interview was projected to last sixty minutes; however, the majority of participants wished to talk longer. Initial interviews ranged from one to two hours with a mean of 1.58 (SD = 0.41) hours. After the interviews, DONs completed a short demographic information sheet and then provided a tour of the facility to orient me to the setting. This guided tour allowed me to see the organization through their eyes as each DON shared general information, issues, and successes they considered important for me to know.

Subsequent observational periods were scheduled so I could observe what participants' days were like and what activities were parts of their work (Hammersly & Atkinson, 1995; Spradley, 1980). My goals for participant observation were threefold: 1) to obtain contextual data on the nursing home including the physical, social, and

practice environment, 2) to gather information on key DON activities and relationships to see how and when leadership took place, and 3) to observe and record factors that facilitated or discouraged leadership enactment. I spent 164.25 hours in 43 participant observation sessions. The number of sessions with participants ranged from three to seven with a mean of 4.3 (*SD* = 1.42) sessions. Hours of participant observation with each DON ranged from eight to 33.50 with a mean of 16.43 (*SD* = 8.18) hours. The total time spent in each facility was determined by the quality and range of new data available from talking with and observing each DON. More time was spent with key informants who provided a depth of content during interviews and a greater range of activities during observational periods.

I spent time with participants on multiple occasions to obtain data on how they approached and structured their work in: 1) administrative activities (e.g., office work, staffing and scheduling, personnel activities, and organizational meetings); 2) clinical activities (e.g., rounds, direct care, and interdisciplinary team meetings); 3) formal and informal interactions with staff, superiors, residents and families; 4) nursing home activities and resident programs; 5) departmental team meetings; 6) educational activities; and 7) special events (e.g., regulatory visits, unusual clinical events, and staff parties). Frequently during observational periods, DONs initiated conversations to explain aspects of their work or point out examples of previously described issues. I also initiated brief conversations to seek information or enhance my understanding of an observation. These conversations occurred naturally and did not use pre-determined questions (Patton, 1990). At the end of each observation period, we spent time reflecting on the day, completing interrupted conversations, or clarifying information.

Over the course of the study, I conducted twenty six unstructured, follow-up conversations with participants for a total of 22.75 hours. The number of conversations ranged from one to four with a mean of 2.60 (*SD* = 0.97), and the amount of time in follow-up with each DON ranged from one to 6.5 hours with a mean of 2.28 (*SD* = 1.99) hours. These conversations helped clarify and expand themes and patterns that were emerging from data analysis (Minichiello, Aroni, Timewell, & Alexander, 1995).

Field notes: I jotted notes while in the field and dictated or wrote detailed field notes immediately after observational periods. These comprehensive recordings were descriptions of activities, processes, people involved, interactions, timing, and the environmental factors (Hammersly & Atkinson, 1995). I also made drawings of the physical plant and wrote in depth descriptions of each DON's personal work environment including her office, classrooms, privacy and noise factors, and equipment and supplies.

Memos: I used memos to record theoretical insights, personal reflections and operational reminders (Maxwell, 2005; Spradley, 1980). Theoretical notes were used to document my thoughts and reflections on interviews and observations and provided keys to early theorizing about the meaning of the data. These memos also helped surface linkages between my findings and established theoretical concepts. I used reflexive memos to document my personal journey and development throughout the research process. Mental notes, or management memos, helped with organization and systematic progress of the study.

Reflexivity

As the primary research instrument, my relationship with participants was the cornerstone of the research endeavor. Denzin and Lincoln remind us that behind the

ontology, epistemology, theory, methodology, and analysis of qualitative research "stands the personal biography of the researcher, who speaks from a particular class, gender, racial, cultural, and ethnic community perspective" (2000, p. 18).

Having had experience as a nursing home DON, part of my challenge was to balance reflexivity and analytical openness. I kept a reflexive journal (Lincoln & Guba, 1985) to capture insights, concerns, self-reflections, and feelings related to my prior experiences. I also kept lists of assumptions and preconceived ideas as I became aware of them. This process helped me sort out my pre-understandings from new knowledge or insights emerging from data.

Because DON leadership had both contextualized and individualized meanings for participants, my knowledge and sensitivity to the day-to-day life and work of the DON was beneficial. I was familiar with many aspects of the local language and customary ways of doing things. This allowed me to probe more deeply into the meaning of statements or processes, which led to fuller interpretations and thicker descriptions of the culture and how DONs perceived and enacted leadership.

Data management

Audio-taped interviews were transcribed verbatim, reviewed for accuracy against the tape recordings, and destroyed at the end of analysis. To preserve confidentiality, participant names were removed from all documents and code numbers assigned. One master list of names and code numbers was maintained in a locked file. Pseudonyms were used as identifiers for each DON. Only members of the research team had access to interviews, field notes, memos, and study records. All data were stored in a locked file available only to the research team. Back-up data were stored on a USB port kept in a

locked area, different from the location of the paper-files. Atlas.ti, v 5.2, a computer-based software program, was used to help store, code, retrieve, and organize text. All computers, software programs, and electronic storage files were password protected.

Data Analysis

In qualitative research, data are simultaneously collected, compiled, interpreted and analyzed. The goal of analysis in this study was to provide a description and understanding of the leadership role of the nursing home DON. A thorough review and analysis of data followed each interview and period of participant observation. Analysis began with transcribing and reviewing field notes, audio-tapes, and memos. Data from 44.25 hours of in depth interviews and 164.25 hours of participant observation were analyzed to identify how and in what ways DON leadership was accomplished in the course of everyday work. Preliminary coding schemas were developed, refined, and modified into themes. Early patterns, themes, and relationships between data guided subsequent interviews and observations. Themes emerged as detailed field notes and transcripts were read multiple times in part, and in their entirety to determine patterns and common ideas. These fell into natural groupings and were further examined to identify themes that typified participant accounts and experiences. Altas.ti, v 5.2, was used to assist with data management and to extract quotes from text to support findings.

Analysis of interview and participant observation data included the use of text, flow charts, and diagrams to facilitate description, interpretation, and understanding of the phenomenon of leadership within the nursing home context. Throughout the study, these documents were refined to organize, display, and facilitate recognition of complex relationships among various data that needed more investigation to accurately interpret

and inform data-based conclusions (Spradley, 1980). Saturation was achieved when no new themes or relationships in the data were identified and a description and understanding of the leadership role of the nursing home DON was fully developed.

As fieldwork concluded, I completed a comprehensive review of all data and memos. Data were reviewed and compared with transactional, transformational, and laissez-faire dimensions set forth in transformational leadership theory. Emergent themes were analyzed and woven together to form a comprehensive picture of the collective DON experience. Findings are presented in two chapters. Role related findings are presented in chapter four, and chapter five reports leadership related results.

Evaluating Qualitative Research

Qualitative research has been criticized for being subjective in part due to the constructive nature of analysis. Because data may be interpreted differently by individuals, or assigned to categories that may not reflect the emic perspective, validity and reliability are difficult to assess in qualitative research. The most accepted and used model for critique is attributed to Lincoln and Guba (1985). Their criteria to evaluate qualitative research include: 1) credibility (internal validity), 2) transferability (external validity), 3) dependability (reliability), and 4) confirmability (objectivity).

Moving beyond the basic tenets of reliability and validity, other experts have also suggested additional methods for evaluating qualitative studies. For example Whittemore, Chase and Mandle (2001) suggested that criteria such as explicitness, vividness, creativity, thoroughness, congruence and sensitivity have equal importance in evaluating the value of research. Becker (1996) set forth criteria that emphasize: 1) accuracy, which is based on close review of the data and its presentation; 2) precision,

which indicates the researcher's ability to adjust to the unexpected during the study; and 3) fullness or breadth, which accounts for the wide range issues that have potential affect on the question under study.

Taken together, these important evaluative criteria provided guidance for this research. Hammersley (1992) may provide the clearest and simplest direction for determining the acceptability of ethnographic work stating,

> The purpose of ethnographic analysis is to produce sensitizing concepts and models that allow people to see events in new ways. The value of these models is to be judged by others in terms of how useful they find them. (p. 15)

Triangulation

Triangulation was originally considered basic evaluative criteria for qualitative research (Lincoln & Guba, 1985) but is now regarded as an essential methodological strategy (Lincoln & Guba, 1989). Triangulation ensures that findings and descriptions are informed by a convergence from varying sources of evidence (Stake, 1995; Yin, 1994). This convergence of external information with study accounts of data decreases the possible threats to the validity of analysis (Hammersley & Atkinson, 1995). It is not an additive process where facts or impressions can be compounded into a single truth (Brannon, 2004) and neither is it a method for validating data, rather triangulation is a process of discovering if inferences derived from the data are valid (Hammersley & Atkinson, 1995).

In this study, data from multiple sources were triangulated to ensure accuracy, precision, objectivity, and fullness in constructing a description of DON leadership. DON accounts of their work and explanations of specific actions were examined in concert with observations I made of DONs engaged in tasks, conversations and

interactions with others in their day-to-day work. Follow up conversations provided further data. Interviews and observations with DONs across study settings provided additional opportunities for triangulation of data.

Summary

In sum, this chapter presented the ethnographic methodology, design, and analytical strategies used in this study to develop a rich description of DON role and leadership enactment in the nursing home context. Role related findings are presented next in chapter four.

CHAPTER FOUR

DON ROLE DESCRIPTION

Study results are reported in two chapters. The aim here is to provide an ethnographic description of the DON role. Findings include: 1) reasons DONs entered nursing home practice, 2) conditions antecedent to participants' accepting DON positions, 3) acquisition of role knowledge and competencies, and 4) role responsibilities and challenges. These results underpin and set the context for the description of leadership findings presented in chapter five.

Entering Nursing Home Practice

Nursing homes provided participants with opportunities to enter professional practice and advance their careers. DONs' primary reasons for choosing to work in nursing homes included opportunities to: 1) enter U.S. nursing practice (30%), 2) re-enter nursing practice (20%), 3) care for elders in a geriatric setting (30%), and 4) career advancement (20%). (See Figure 4.1)

Enter U.S. nursing practice: Three participants were graduates of BSN nursing programs in the Philippines and entered the U.S. nursing workforce through nursing home employment. Unable to find hospital employment, they accepted readily-available nursing home positions. Two worked as acute care nurses in the Philippines but were told they lacked "local experience" when applying at U. S. hospitals. Frances,[1] who worked in fast food and motel housekeeping jobs to pay for National Council Licensure Examination courses and state board of nursing examination fees remembered poignantly her entry into the nursing home setting.

[1] Pseudonyms are used to protect participant and facility identities.

> I got into long term care because when I got my U.S. license, I applied at the hospital and they were like, you don't have enough experience. This place [the nursing home] was like the only one who just took care of me and you know, welcomed me with open arms. I liked it. I stuck with it, so I'm still here.

While acute settings required "local experience," nursing homes accepted RNs with little or no professional experience. One participant, a new graduate from the Philippines with no nursing experience, was hired by a 65-bed facility to work on the evening shift as the only RN.

Despite initial hope for positions in acute care, all DONs in this group grew to like their work in nursing homes. One DON worked per diem shifts at an acute hospital for a brief period to "make a decent paycheck," but always considered her nursing home position as primary. Participants were grateful for the opportunity nursing homes gave them to work as RNs; however, each also expressed awareness that nursing home positions were less prestigious than acute hospitals. Carol remembered feeling rejected saying, "Beggars can't be choosers, right?"

Re-enter nursing practice: Nursing homes provided an opportunity for two U. S. educated participants to re-enter nursing practice. Each accepted nursing home positions to meet their personal goals, valuing schedule flexibility and the convenience of working close to home. Over time, they also grew to like their work as well as the nursing home setting.

Josie, a diploma nurse, resigned from a hospital position early in her career to raise small children. Returning to work after six years, she searched for a position to accommodate her needs as a single mother. Despite a low salary, the nursing home was "in the neighborhood … close to the kids' school." This allowed her to avoid childcare expenses and augment her salary by working extra shifts of her choosing at the facility.

Another participant moved to the west coast from the Midwest. Irma had held various clinical and administrative positions throughout her career in labor and delivery but had difficulty finding a position that utilized her expertise and experience. She accepted a temporary position as the director of staff development [DSD] in a small nursing home hoping "to meet people and maybe get my foot in the door somewhere else." When she took the DSD position Irma rationalized that her experience of teaching labor and delivery staff was sufficient. She thought it would be "easy to learn long term care on the job." When asked if that turned out to be true, Irma disclosed it was not. "I guess no. … See? Knowing how to teach is just a start, and it's not just about filling out forms like the MDS. I'm still learning about nursing for older people. It's more than I thought."

Care for elders in geriatric settings: For three participants (30%), nursing homes provided a professional opportunity to practice as a geriatric nurse. Unlike other DONs, these participants expressed a deep affinity for elders. Amy reflected this common sentiment, "I take care of my elderly parents. So working with older people, it was sort of close to home for me." All had experience in hospitals and chose to work in nursing homes rather than remain in acute care settings. One participant explained the difference she experienced in acute and nursing home practice.

> I didn't feel comfortable in the hospital. The work is fast and patients change everyday. It's not so much like that in nursing homes. You are getting used to the older people and getting attached to them. There is no attachment in acute. You go everyday and see different people. That part I think I didn't like it, so inside my heart I could not say yes to hospital work.

While each enjoyed caring for elders and liked the long term nature of working with residents and families, none had formal education in geriatric nursing. Despite a

lack of specialized geriatric training, each DON expressed a strong desire to improve care for elders. One participant described working with elders as her "calling." Another described how her prior experience with children that had difficulty expressing their needs prepared her to work with elders, "who need caring I like to give. Because they are old, or have dementia, or they have strokes and could hardly express what they need. So that's how it started for me and I am still here! I love it!"

Career Advancement: Historically, nursing home jobs have been considered entry positions for RNs; however, two participants with substantial nursing and administrative experience in other settings sought nursing home positions to advance their careers. While neither had experience in nursing homes or specialized education in geriatric nursing, both held MPA degrees and were immediately offered top positions.

After many years of acute and sub-acute care experience, Ellen decided to pursue her dream to become a teacher. Having an ADN from Barbados and a master's degree in public administration (MPA), Ellen felt best qualified to teach in an LVN program. She knew there was a need for better prepared LVNs in long term care, and consequently wanted to obtain experience in nursing homes. She accepted the DON position to learn firsthand the setting, LVN practice requirements, and the clinical needs of residents. She described the job as a "step backward" in salary and status but accepted the position to gain long term care experience and also work closer to home.

Another participant held BSN and MPA degrees from U.S. universities and had worked in a home health agency for five years. Seeking an opportunity to use her management skills, and after being turned down at several hospitals for "lack of relevant experience," Helen found an ADON position available at a local nursing home. She was

not surprised that hospitals rejected her because "just like nursing homes, they have their own ways of developing staff through the ranks." She explained that while hospitals may recruit from other hospitals to fill low and middle management positions, her community experience "didn't count." Like experience requirements hospitals set for entry level RN positions, management positions also required specific experience and job competencies not compulsory in nursing homes.

In sum, the nursing home setting provided opportunities for participants to begin or re-enter practice, pursue their desire to work in a geriatric setting, or advance their career goals. Facility proximity to home and family was an important factor for seven of ten DONs. No participants had formal preparation in geriatric nursing. Half of the sample (n = 5), entered or re-entered practice in nursing homes. While members of this group first accepted a position for personal or convenience reasons, all grew to enjoy the work and the setting and eventually took other positions that led to becoming a DON.

Only three of ten participants chose nursing home positions because of their desire to work with elders. Administrative positions drew two master's prepared participants into nursing home practice, one with no prior management experience and one an accomplished nurse administrator. Six participants experienced employment rejection by acute hospitals due to lack of experience, but were hired immediately in nursing homes. Finding an opportunity to practice or advance professionally was the common theme that attracted participants into the nursing home setting.

Accepting the DON Position: Antecedent Conditions

Antecedent conditions, or circumstances existing prior to participants accepting DON positions, had initial and lasting effects on their role and work. These conditions

shaped organizational expectations of DONs as well as entry and ongoing experiences of DONs. Data revealed that participants accepted DON positions to: 1) fill long standing vacancies (20%), 2) replace failed DONs (30%), or 3) replace successful DONs who retired or were promoted (50%). (See Figure 4.2)

Fill long standing vacancies: Two participants accepted DON positions that had been vacant between eleven and fourteen months. This absence of a DON resulted in resident care and practice problems incoming DONs needed to "tackle right away," and over time. Both described their struggle to re-establish the influence and authority of the DON role to initiate and sustain clinical and facility improvements.

New to nursing home practice, Ellen responded to a local newspaper ad for the DON position and was hired immediately. Prior to Ellen's arrival, DON duties were assigned to a staff RN who felt "pushed into" the eleven month arrangement. While the RN worked long hours, she primarily filled in for sick calls and other direct care vacancies on all three shifts. Therefore, the facility administrator who was not a nurse assumed other DON responsibilities including staffing and making clinical decisions (e.g. care planning, admission and discharge decisions).

When Ellen began, she had difficultly re-establishing her role in clinical and operational decision-making. In fact, even gaining entry into routine meetings was difficult "because there had been no nursing presence for almost a year . . . and maybe none wanted." She identified her biggest challenge was the administrator who wanted ultimate control and to continue speaking on behalf of nursing. She remembered walking out of more than one meeting. "It sounds juvenile, but sometimes it was the only way I could get their attention at first."

An experienced clinician and nursing administrator Ellen identified being an advocate for residents and staff as a key responsibility of being a DON. One of her early accomplishments was the increase of staffing from the state minimum requirement of 3.2 hours per resident day (HPRD) to 3.46 HPRD for the 69-bed facility. Beyond basic staffing, Ellen initiated other improvements such as change of shift report and eliminating staff breaks during mealtimes. She insisted that dietary and therapy staff attend key meetings and family conferences.

Ellen said each change was met with resistance and resentment from facility department heads. "They felt I was taking over, not because of residents' needs, but for making nursing's job easier. To this day they think they're doing nursing's job." For the first year, Ellen felt she had to "fight for every little decision, no matter how small or how important." She remembered feeling exhausted and discouraged but found strength in the "little wins" that came from improving staffing and improving care plans. She also recalled positive responses from families. "Families know the DON makes the difference. If staff is happy and well-trained, the residents are going to get better care and be happier too."

I observed one exchange during the daily administrative meeting that illustrated the ongoing nature of Ellen's struggle. The environmental service director began her report by asking the administrator to "make those nurses clean up resident 'accidents' in the halls." The administrator turned to Ellen and asked, "Why don't staff do their jobs?" She replied in a measured tone, "We already decided that nurses clean up accidents inside resident rooms but the porter has to clean the ones in the halls." The administrator made

no comment and moved to the next item on his agenda. Ellen later explained her view of the situation.

> Nurses are on the bottom of the ladder here. They had no one to stand up for them for so long. I've tried to change that but I pick my battles. The main reason I got agreement for porters to clean the halls is because of customer service goals from the company. . . . When accidents happen in public areas CNAs can't leave their residents right away to clean the floor. So we worked out that porters would do these areas. Otherwise, families can have a bad impression of the building.

During subsequent visits I observed similar exchanges related to recurrent daily problems such as cleaning common areas, laundry, and transporting or "watching out" for residents. Poor staffing in all departments resulted in front-line staff sharing resident care duties that were rigidly defined but rarely effective. For instance, the facility had 69 beds and only one porter on the day shift and one for six hours on the evening shift. The day porter and CNAs argued about room cleaning during peak resident care times.

During four observational days, the average nurse staffing was 3.36 HPRD, below the facility's goal of 3.46 and the 2006 state average of 3.70 HPRD. Delays in meeting resident needs were apparent and the tension between staff was evident in comments from non-nursing staff such as, "I stopped your resident from going out the front door," or "I found Mrs. Jones' gown in the trash again."

Ellen believed the problems were "basically unsolvable" as long as resources were inadequate. Her approach with nursing staff was to help them learn to communicate "professionally with their peers and others, but that doesn't always work either. What helps most is that I always invite the porter and dietary and all to my meetings or pot lucks or birthday parties." Ellen described the progress in creating a team approach to care as incremental and painstaking.

> It feels like the same old problems, but the difference is I've worked out some of the compromises with departments and that's a help. No one has been here to do this in a long time. So at least we have decisions I can use to stand my ground. I keep saying it's for our residents and underneath it all, most everybody believes that too. I feel bad for all the staff, not just the nurses.

Carol was recruited by the facility administrator to fill a DON position that had been vacant or filled by a series of short term DONs for fourteen months. Four prior DONs stayed less than three months each. Carol believed the administrator's control over nursing practice and facility operations was the basis for their resignations. This was Carol's first position as a DON and she accepted the job knowing "I would not be getting the full DON role." By that she meant she would not be in control of the nursing budget or staffing. "I had never been the true leader, just really assisting my DONs before. So when I came here it was like the same thing and I thought that was good."

Carol had worked exclusively in nursing homes and admitted a reluctance to challenge operational procedures that existed before she arrived as the DON. "They see nurses making more money, so I give in on some things to keep harmony. . . . I draw the line for residents. That's my main thing and now they finally look to me to solve the nursing care problems." She gladly left organizational decisions to her administrator while she made improvements in the nursing department. When she started, shifts were primarily filled by registry nurses and "old timer aides who worked here as second or third jobs." During her five year tenure as the DON, Carol eliminated registry use and implemented corporate quality of care programs that reduced restraint use and pressure ulcers and helped the facility achieve its first deficiency-free survey.

When the administrator was promoted to a larger facility, Carol found she was alone and unsupported by district managers. She expressed frustration and excitement about new autonomy.

> I've had no help. You know I didn't even realize it until we are talking, but I don't have any assistant. I was like the assistant and now there is none. The district boss has his certificate hanging in the front office but he is never here. My administrator calls me because we were close, but the bad part is we were all dependent on him. I am learning everything now and running the whole show at the same time.

Carol vowed that she was going to be "a full DON" when the new administrator was hired. She reflected that her willingness to accept constraints on her role were "good initially, but kept me and everyone from growing. And it wasn't the best for residents but I didn't see that before." She cited her failure to take part in re-designing the resident dining room as an example of not fully participating in organizational changes. "I never gave an opinion as the DON. I thought it wasn't about resident care but it is. I talked to the workmen because I am the acting administrator. So I changed things so they work better for residents and staff."

Because the administrator position was vacant, Carol performed some of those duties and discovered other processes she wanted to change. For instance, she previously had no influence on staff scheduling and budget but now identified problems in changing pre-existing agreements about work hours and overtime. "These are his [administrator's] promises to staff and don't help us with the residents. See, if this was my job all along, my residents would be better off--my staff too." She worried that she had no one to help her develop as a DON and acknowledged she needed new skills to work with department head colleagues differently.

In sum, participants who filled long standing DON vacancies had to re-establish the influence and authority of the DON role. Organizational constraints and past nursing experience influenced their goals and approaches. Both made improvements in care and practice conditions however, Ellen's focus on organizational teamwork reflected her understanding of the importance system interventions had on resident care. Despite her skills, tenacity, and perseverance, lack of organizational support from the administrator and department head peers allowed only incremental changes in the culture over time.

Carol had a strong desire to maintain harmony. Combined with her limited experience and acceptance of control imposed by the administrator, these factors inhibited her ability to see how systematic changes affect resident care. Despite these limitations, Carol established better care programs. Her insight and desire to incorporate organizational improvements into her domain of responsibility remain undeveloped strengths.

Replace failed DONs: Three participants accepted DON positions after their predecessors were dismissed for poor performance on Department of Health Services [DHS] State surveys. Two were promoted from ADON positions within their facility, and one was recruited by a former administrator. Each confronted serious problems of regulatory compliance, poor resident care, and low staff morale. Their initial goal was to pass the DHS State survey.

Frances, an ADON at one facility, accepted another ADON position at a "poor performing facility" within the corporate chain to help with a critical DHS re- survey for sub-standard care. She soon found herself in the DON role, stepping in for the DON who was terminated mid-survey. Frances cautiously described the process.

> I kinda am following in the footsteps of someone who was not as good in the job. That's why they got all the deficiencies. . . . I think it was just timely too…like maybe it's not a total surprise she left. That was on a Monday. Tuesday the State came for a survey. Wednesday I was the DON.

Regulatory demands and survey success were key conditions circumscribing Frances' entry into the DON position. Her major responsibility was to bring the facility into compliance and sustain adequate survey results for the next year. These factors dominated her focus on clinical care and staff development. Her typical day was spent on the resident units auditing documentation and correcting mistakes, filling in for RN vacancies on the day shift, and conducting in-service education for all three shifts. Following a successful first re-survey, Frances maintained one overarching goal, "to keep everybody on a survey mode" for the next year.

Frances did not reflect on the consequences of her goals or approaches on actual resident care, staff development, and morale. "If the surveys are good, that's how I know I've done a good job." Frances hired several foreign-educated RNs who were new to the U. S. They had limited English and nursing skills and no geriatric experience. Frances explained that correcting their mistakes and documentation errors was easier than covering the floor. She did not consider the effect of this strategy on the quality of resident assessments, or on resident, family, and staff communication. In fact, her hiring plan was supported by the corporate nurse consultant.

Unlike Frances, Helen worked with a series of short term DONs within her facility, often "filling in" as the acting DON. She was offered the permanent position after a newly hired DON was fired for falsifying documents during survey preparation.

Helen's experience in the acting DON role provided organizational and clinical stability during the pre-survey period, and her administrative skill led the facility through

a successful survey. Following the survey, she met with the administrator to discuss changes she wanted to make such as developing flexible schedules to increase staff retention, changing staff assignments to "get them out on the floor," and creating a "professional space" for staff in-service classes. Eager to put her management experience into practice, Helen felt the meeting with her administrator "started out on the right foot … he gave me his full permission to do what I needed as long as our [DHS] surveys were good."

This conditional autonomy worked for Helen over her five year tenure as the annual surveys remained satisfactory. Intermittently, the administrator changed her decisions. Helen explained those occurrences were few in number and related to "cyclical issues." By that she meant when a problem was resolved, she could institute or re-institute her plan of action. One such cyclical issue occurred when the facility instituted a restraint-free initiative. Helen helped nursing staff to develop a plan to track and reduce resident restraints but the administrator insisted that Helen personally complete all monitoring forms. "He just didn't trust the staff to do it right and we had a lot riding on this. It was our major initiative. As soon as we met our target, I was able to use my plan." The initiative was one of the facility's corporate goals, and meeting the target ensured the administrative team was eligible for an annual performance bonus.

The 2006 DHS annual survey identified a problem which reinstituted tighter administrative control over Helen's autonomy. The specific problem was timely staff response to resident call lights. Though a serious citation was averted, the threat of a potential widespread care deficiency prompted the administrator to mandate an end to flexible staffing. Further, he demanded staff allocated previously to bedside care be re-

assigned to "cover the desk" to ensure call bells were answered promptly. He refused to consider alternate plans or consequences of his mandates. Helen was unhappy with the directives but accepted them as "cyclical." Changes in staff schedules resulted in Helen issuing twenty written warnings for lateness or absences. She "hoped" staff understood her position and would "hang in" until she could reinstitute their former schedules. "I hate to say it but if staff quit over this, that might speed up the process for changing back. We just exchange one problem for another. I just ride out the cycle."

Helen was more concerned about the issue of reassigning staff to the unit desk to monitor call bells rather than provide care.

> This one will hurt resident care. We have good staffing--at least 4.0 [HPRD]. But we can't afford to take someone out of direct care and get the same results. This will take time to fix and he [administrator] doesn't get that. We have problems because the units are not straight hallways like in most facilities. I need an extra staff to walk around each unit all shift to answer a call lights within five minutes--not take away a CNA to sit at the desk.

Helen was frustrated and hurt by the administrator's response and lack of support for solving the problem. Like other participants, Helen identified the "catch-22" of trading one set of resident problems for another just to resolve a new issue. She understood her "deal" with the administrator was "good survey results" in exchange for autonomous or creative planning. She did not believe "they want to go back to having bad DONs," and understood the potential consequences of the administrator's mandates on her effectiveness in the organization.

The assault on Helen's authority by the administrator did not go unnoticed by others. One relatively new ADON asked Helen if she should "come back to work," thinking she would be fired for supervising staff inadequately. Helen reassured her that the issue was cyclical and they just needed to "get through this period." Helen also

"forgot" to attend a night staff breakfast the week following the schedule changes. She was embarrassed by the affront to her authority and worried about the long lasting effect on her relationship with staff.

Unlike Frances and Helen, Irma knew only that a "terrible and unexpected bad survey" prompted her predecessor's discharge. Irma had extensive experience in clinical and administrative positions in acute hospitals, and recent experience in nursing homes. She was recruited by her former administrator to help bring the facility into regulatory compliance. Two conditions circumscribed her entry into the DON position, the multitude and depth of problems in resident care and staffing, and the unqualified support of the administrator.

Irma said the former DON "had really let things go," resulting in low staff morale, high registry use, and many care and practice problems. The administrator delegated full authority to Irma to address the problems she identified. His support mitigated potential resistance from others. "Everybody knew we'd worked together before. That really gave me a good start with the department heads and especially my staff. I think some would have left if I had any doubts about him, or he about me."

The administrator appointed Irma to lead the facility's DHS survey preparation plan. In morning staff meetings she presented status reports and guided the group discussion. This process recognized her contributions to the preparation process, allowed her to build relationships with other facility leaders, and provided the formal authority needed to lead clinical and operational improvements.

At first, Irma worked long hours to learn about the facility, the problems, and the issues from the staff point of view. She increased staffing, improved the skill mix, and

hired permanent staff to make needed changes. Her staffing goal was 4.0 HRPD for an average census of 112. During the prior four month period the HPRD ranged from 3.68 to 4.16, and fell at the lower end of this range during three observational sessions at this facility.

Irma's hours at the facility decreased after the first three months, but she periodically "visited" all three shifts to meet with staff, supervise shift managers, attend or teach in-services, and make rounds to talk with residents and families. Irma believed that her goals to bring the facility into compliance would only be accomplished by creating "good teamwork between good staff."

In sum, participants that replaced failed DONs confronted serious problems of regulatory compliance, poor resident care, and low staff morale. Their initial goal was to pass the DHS State survey. The intense focus on regulatory compliance established the foundation for how the DON role was enacted and valued by the organization over time. Satisfactory survey results were tied to financial goals of the larger corporation as well as decisional autonomy. For instance, Frances' goal to bring her facility into compliance was linked to reinstating resident admissions and "keeping the facility open." Helen's autonomy to make independent practice decisions and direct her department was conditionally coupled to satisfactory survey results. Again, financial gain--revenue for the facility and bonuses for staff were tied to Helen's success on the survey. For both Helen and Frances, actual resident care and staff morale were secondary concerns.

Good survey results and financial success were also important at Irma's facility. The administrator's empowerment of the DON however, mitigated potential resistance to change and established the organizational expectation for teamwork and better care.

Thus, Irma's initial goal included building relationships and changing care practices, not simply achieving survey success through regulatory compliance.

Replace successful DONs: Five participants (50%) accepted a DON position after successful predecessors were promoted or retired. Three replaced DONs within their facility and two moved to a different facility within the same corporation. In contrast with DONs filling long standing vacant positions or following failed DONs; these participants described their initial experience as positive. They reported broad support to sustain and develop facility programs for staff development and resident care improvements. All felt that following in the footsteps of a well respected DON helped them "pick up" where their predecessor left off. "I felt they wanted my ideas, even if they were different. Nobody questioned me about my right to make some changes here."

Gail was promoted to DON when her predecessor left to consult in another corporate chain. Gail felt well-prepared and confident to assume the DON position. "As the ADON I did all the tasks with my supervisor. So I know the job responsibilities completely. The difference is I never did it alone." Two factors helped Gail transition into the DON role successfully--continued mentorship with her former DON which was mutually constructed, and the support of the facility administrator.

Amy was also mentored by a successful DON and felt prepared to accept a DON position at a different facility within the nursing home chain. She believed that working with a successful and strong DON was the key factor that influenced her decision to "step up as a DON."

Despite positive entry conditions in general, an unsupportive or unstable relationship with the facility administrator resulted in similar problems described by

DONs in the previous two groups. For instance, Diana worked with two excellent and long tenured DONs. She described both as having "strong personalities" who could handle the stress of the job such as "standing up to the administrator for resident care" and dealing with staff who were performing poorly. When each left, she served as the acting DON but did not want '"the pressure of being the DON." Turnover in administrators created instability and additional stress that as an acting DON Diana could "pass on" to district managers. "See, we were a training ground for the company so administrators came here to learn and would move on to their own buildings." This lack of consistency coupled with "always filling in for them, then teaching someone new what to do, and then letting them take over" was time consuming and stressful because it "took me away from my real job with my residents and staff. . . .I spent more time training administrators than my staff who really need me."

Josie lost her "good administrator" one year after replacing her successful predecessor. Two administrators came and left within a year. "They had no experience in nursing homes or in clinical and tried to run us like a business." She conjectured that staff and residents "did not suffer too badly because we had long history of good nursing care." She remembered that year as the worst in her career. "I survived the stress and kept the staff and families happy."

Summary: Three antecedent conditions existing at the time participants accepted a DON position shaped the organization's expectations as well as the entry and ongoing experiences of DONs. Those filling long standing vacant positions had to re-establish the influence and authority of the DON role. Participants replacing failed DONs confronted serious problems of regulatory compliance, poor resident care, and low staff

morale. In contrast, DONs who followed successful predecessors felt welcomed and mentored into the position, had confidence in their abilities, and experienced team and staff support to make improvements in staff and resident programs.

Across antecedent conditions, strong DON-administrator partnerships supported DON efforts to sustain and initiate improvements, mitigated organizational resistance to change, and established expectations for teamwork and better care. Poor or inconsistent support from administrators constrained DON authority and effectiveness, permitting only incremental changes in the overall culture of the facility and resident care over time.

Acquisition of DON Role Competencies and Knowledge

Baptism by fire: All DONs reported "baptism by fire" as the primary mechanism for learning essential role competencies. The term, baptism of or by fire, originated in French literature as a reference to soldiers' first experience under fire in battle and is part of contemporary vernacular to describe anyone doing something "the hard way" for the first time (Oxford English Dictionary, 1989). As participants received little in the way of orientation to the DON or other professional roles from entry forward, the term aptly described their experiences.

Helen was an experienced nurse but had never worked in a nursing home. Her orientation as a new ADON began on the first day of the DHS annual survey. "I got four hours of orientation . . . the next day I was thrown out on the floor. Supervising! So I got the typical nursing baptismal fire and crisis management I hear happens in every nursing home." The bleak picture of inattention to professional orientation and development of nursing home DONs was captured in another participant's description of her experience.

> What training? There is none. Baptism of fire, right? No one to this day has shown me how to be a supervisor, or a nurse manger, or a DON. Actually when I took this job, I had a consultant come by, say "welcome" and give me a bouquet of flowers, and *that's it*! You're on your own.

Despite the importance of passing DHS annual surveys, participants also received minimal instruction in survey preparation. Each described their difficulty learning and implementing facility policies that were in constant flux. "I read the policies and procedures and they were *changing* every month because the new company is just getting onboard." To prepare for her first DHS annual survey as a DON, Carol applied what she learned as a staff nurse "during surveys at other facilities."

While in acting DON positions, two participants led successful annual surveys. Each believed, as did their staff and administrators, that survey success indicated their readiness to assume a DON position. Diana recalled, "After filling in as acting, and passing two surveys with not many deficiencies, which is good for this building, I knew I could do the job." Frances' facility achieved a zero-deficiency survey while she was the acting DON which resulted in regional recognition, a promotion within the corporation, and confidence to become a DON. "If you can do that in an acting position, I think you can be the permanent leader without many problems."

Though no participant had formal classes in geriatric nursing or had attended conferences on care of elders, all felt they had adequate clinical preparation. One cited training as the MDS coordinator as "special professional education." Another said she received ongoing education from pharmaceutical representatives and regulatory updates given for survey preparation. None had been evaluated on their clinical competency in current or past evaluations. One participant planned to enter an adult nurse practitioner program believing she had "more than enough" knowledge of geriatric care.

All participants recognized issues due to lack of professional training but also dismissed the problems as usual practice in nursing homes. In fact when asked if her orientation experience was typical Carol said, "At the time, I thought no. I was still waiting for help. . . . But now I think it's very common. There's not much training in long term care."

In addition to "baptism by fire," data revealed that DON competencies were acquired in four additional ways: 1) coming through the ranks (80%), 2) attending corporate training classes (50%), 3) having apprentice roles with former DONs (30%), and 4) acquiring competencies from outside nursing homes (20%). Multiple responses were given by each participant thus combined data exceed 100%. (See Figure 4.4)

Coming through the ranks: Eight participants believed that holding a variety of nursing home positions provided essential preparation and institutional credibility. Bella captured this perception in describing her experience. "I worked in all the different departments and done all the jobs--medical records, business office, infection control, MDS. I know the nursing home inside out . . . that's why I know what I'm doing."

These participants valued on-the-job training, but two of eight believed their prior experience only partially prepared them for the complexity of the DON role. Carol felt confident in her abilities as a staff nurse, MDS coordinator, and ADON. She took the DON position to "try to be the kind of leader that can do more for everybody--my residents and my staff." She identified many changes she wanted to make and had the courage, but lacked formal education to implement improvements. "I think I could be even better if I had more training on how to do certain things, like on system-type things and financials."

Gail identified her strength as being "a good organizer." Her success in managing her floor was recognized and valued throughout the organization. "Everyone endorsed me taking the job because they knew me from running the floor. They were comfortable with my style and I am now organizing many things for the whole building, not just for nursing." Her pride and accomplishments were tempered with recognition that the role required more than simply organization. She felt inadequately prepared to handle staff conflicts and wished for training on dealing with difficult situations. "Honestly, I don't know what to do sometimes. If I talk to people and it works I keep on using that. But RNs don't like to be told what to do."

Corporate training classes: Five participants received some preparation for the DON role in corporate classes that primarily focused on corporate policies, regulatory compliance, and budgeting. Across the board, data showed that DON's agreed these orientation programs were improving, but still lacked sufficient breadth. "We have to deal with diversity, conflict, and culture change issues. That takes more than a few days at a [corporate] conference, or in-service on a policy."

Quality initiatives had recently been incorporated in corporate trainings, but content was linked closely to budget constraints. One DON described her view of the training she received on implementing quality projects in her facility.

> We had leadership training on quality…how to focus on quality and not forget about the financial aspect while you're doing it. They want to be able to teach us how to manage. . . . Even though you're good at quality, you have to make sure you make money for the building.

In two of four chains, ongoing development also occurred in monthly district meetings, jointly attended by DONs and administrators. These meetings focus on "downloading information about marketing goals or new policies and forms" to be

implemented throughout the system. One corporation held monthly DON meetings for a few years, but these occurred infrequently over the past two years.

Apprentice roles: Four participants sited working in administrative roles with former DONs as part of their orientation to the position. Each believed being mentored and working with good DONs influenced their approaches to dealing with staff, making resident care improvements, and ensuring the "building is a better place to live and work."

Two participants recounted their experiences with a progressive DONs. Amy learned the importance of being passionate about care issues, developing teams, and creating a learning environment from her work as an ADON. "We worked together; he [DON] taught me things and at that same time we learned from each other. . . . It prepared me for this position." She believed that "every new DON needs a chance to work with someone who is really good in the role." Diana recalled the essence of her "apprenticeship" and the lasting effect it had on her development as a leader.

> We would talk about everything and figure out ways to help our residents and our staff. . . . He created a team and it was the best team ever in this building. We argued a lot, okay? I mean we questioned everything before we did it. New forms, again? New policies, like again and again, he helped us question him on all those things and I learned so much about how to be the DON. Not just the surveys, which is a big part of our job. No, we were seeing the job is more [than that].

Two participants credited their preparation to working "side-by-side" with more traditional DONs. Both felt well prepared for surveys, resident care situations, and maintaining a stable environment. One participant explained, "I didn't need any special training so that was good for the company and the building too. So we had stability."

These participants provided thorough oversight of their facilities and had success on annual surveys. Unlike Amy and Diana, neither described a vision beyond maintaining a "good and stable work team, and happy residents and families." One felt well-prepared to "carry on the good nursing tradition" by doing the same things her predecessor had done for years. "If it ain't broke, why fix it, right?"

Preparation from other settings: Two participants moved directly into ADON or DON positions from outside the nursing home system. Both held master's degrees and had management courses as part of their graduate programs. Further, both had nursing administrative experience in other practice settings and received formal, ongoing development in those positions. Neither thought that going through the ranks was beneficial or necessary preparation for the DON role.

Ellen was critical of the limitations of working only in nursing home settings. She believed that "too many DONs continue to do what they did as a staff nurse." A major problem for DONs, she said, was changing the care environment and skills of staff. "At least based on the RNs I have here, I think they need *a lot* more than experience here to take this kind of job." Helen presented a similar view.

> I think nurses do learn from going up the ladder. But honestly in nursing homes, I think nurses move up easy and fast because we can't find anyone else who's willing to work. . . . It's a catch-22. We can't find enough people to work here, so we keep raising up the ones who will to try to do the job whether they're best for it or not.

Summary: Participants were primarily prepared in on-the-job roles in the nursing home setting. Surviving "baptism by fire" and leading successful surveys with little to no preparation demonstrated their skills and tenacity and earned both facility and corporate recognition for their drive to meet standards. Those that had strong mentors or

experience outside the nursing home setting expressed values of communication, teamwork, and systems change as key components of their preparation. In contrast, DONs who worked with traditional mentors valued stability and regulatory compliance.

While there was uneven awareness of the consequences of their lack of professional preparation for the DON role, all dismissed this as usual practice in nursing homes. There was little evidence of participant or corporate attention to development of role competencies and skills beyond regulatory and corporate initiatives. Findings also revealed that DONs had no formal geriatric education and no performance assessment of their clinical competence in caring for elders. Further, participants did not see these limitations in knowledge and skills as problematic.

Role Responsibilities and Challenges

Responsibilities

Data revealed that DON role responsibilities were consistent across all nursing homes. Responsibilities fell into five broad categories: 1) leadership, 2) administrative, 3) clinical, 4) personnel, and 5) staff development. Leadership responsibilities included representing nursing in facility and corporate meetings, making or participating in facility decisions, resolving resident and family complaints, promoting quality of care programs, and maintaining staff morale. Administrative responsibilities included ensuring regulatory compliance, staffing, completing mandatory documentation, maintaining a safe environment, and managing equipment and supplies. Clinical responsibilities included reviewing resident assessments and care plans, coordinating admissions and discharges with families, physicians, and case managers, providing or supervising care, investigating incident reports, and identifying troubleshooting potential care problems.

Personnel responsibilities involved hiring, disciplining, and counseling employees. Staff development responsibilities included orienting facility staff, supervising nurses, and planning and teaching in-service education classes.

By spending blocks of time with participants, on different days of the week, I observed DONs carry out these responsibilities while responding to multiple demands emanating from three sources: 1) expected activities, 2) unexpected activities, and 3) staff-related activities. Participants identified staff-related responsibilities, a sub-set of expected activities, as a unique part of their work and as such were considered separately for analytic purposes.

Expected activities: Expected activities included the daily routines and meetings required by facility and corporate direction. While these responsibilities were standard across all nursing homes, one corporation had laminated 5x7 cards listing DONs' daily, weekly, monthly, and yearly duties. Although only one DON had a copy of her job description, all had ready access to the corporate checklist of tasks.

Administrative and clinical responsibilities listed above comprised the core functions of this category of activities and DON daily schedules were organized around completing these activities. Other groups of responsibilities were "worked in" as possible. Because of time constraints or other intervening factors, some tasks such as completing standardized reports on quality initiatives, were completed on evening or weekend shifts, or taken home for completion. Participants indicated this set of activities were mandatory, audited, measured, and rewarded. A satisfactory annual performance appraisal could include an annual bonus of up to fifteen percent of their base salary.

Unexpected activities: Unexpected activities demanded intermittent but time-sensitive responses form DONs. Two categories of unexpected activities were found; interruptions and filling in for absent team members. Interruptions included phone calls, emergent personnel issues, scheduling problems, resident care problems, ordering or distributing needed equipment and supplies, regulatory and Ombudsman visits, and handling family complaints.

As an example, during interviews with participants, phones rang, overhead announcements paged DONs, or staff came by in need of an immediate ear or a favor. I tallied these occurrences during the first hour of initial taped interviews. The range was from six to fifteen interruptions, and the median was eight. I did the same for the first hour of final taped interviews and the range was from five to twelve, with a median of seven interruptions. Response to interruptions and other unplanned activities was juxtaposed with highly structured tasks such as daily rounds, routine meetings, and completing time sensitive documentation.

A second category of unexpected activities, filling in for absent team members (from caregiver to administrator), often required DONs to forgo their planned tasks to assume crucial facility functions, again pushing their work tasks into evening and weekend hours. Tasks associated with filling in for others ranged from providing direct care to covering absences or vacancies for department heads. Coverage included social service tasks related to admission and discharge, educational tasks of providing mandatory and orientation trainings, and acting on behalf of the administrator to resolve budget and complaint issues, and participating in marketing tasks such as holding impromptu meetings with referral sources or giving tours to potential customers.

The DONs' job descriptions did not include filling in as described above. Three DONs however, recalled being told in initial interviews that covering for department heads was expected, and that filling in for the administrator was a major role function. While the need for participants to fill in for others varied from one DON to another, expectations of coverage for this wide range of functions was found as standard practice across all facilities. Two DONs had no DSD during the six month study period, and two others had no permanent administrator. Three of ten spent an average of sixteen hours per month in direct care, and one "covered the floor" at least once a week for almost two months. Consequences of this allocation of DON time to covering for others are presented as a part of leadership findings in chapter five.

Staff-related activities: Orientation and supervision of staff performance were identified as primary components of staff-related activities. These activities were predominately accomplished in individual conversations between the DON and staff. Often these interactions consisted of chance occurrences and one-on-one hallway dialogues during other activities. DONs utilized these conversations to impart important resident information, discuss performance issues, adjust scheduling, or provide clinical instruction. As Ellen said, "Every conversation, no matter how trivial, relates to how the work gets done, and how staff feels about me and the support I give them."

Role Challenges

Four major challenges emerged from the data. Common to all participants were problems associated with: 1) blurred work-home boundaries, 2) 24/7/365 responsibility, and 3) inadequate personnel, and 4) working in a "marginalized setting." The unrelenting

burdens led to feelings uncertainty, exhaustion, discouragement, and professional embarrassment.

Blurred work-home boundaries: Participants universally described being unable to separate work from personal and family time as their number one complaint. For each, the problem was greater than simply responding to emergencies. "It's my job to be on-call for an emergency and that's ok. But I take home work every night and I get staffing or simple resident calls maybe three times a week. That's stressful." The relentless intrusion of work at all hours created physical as well as emotional fatigue. "Some days I am completely exhausted from not sleeping. It's a wonder I don't make more mistakes."

One DON regularly completed resident documentation at home. In following up on this practice with others, it was considered acceptable and necessary. "We just have to do it that way. We protect the records [confidentiality], but if we didn't do this at home we would be living at work!" Another participant explained her rationale for completing forms and reports at home. "You can always do documentation at home, so you focus on the things you can't do at home during the day. Sometimes that means the RAPS [resident assessment] and sometimes working on care plans."

In addition to "leftover" paperwork, DONs had to be available for coverage and clinical troubleshooting. For DONs in larger facilities (>70-beds) this meant frequent phone calls, some of which required a series of follow-up calls to physicians or to state agencies to report outbreaks or incidents. Participants from smaller nursing homes experienced greater disruptions and more uncertainty in planning time away from work. Not only did work intrude on the participant's personal time, but often on family members as well. "Sometimes they are calling you and then of course you don't have a

sitter and you have a small kid, what do you do? Your kids come to work." One DON recalled that a friend's son often slept on his office floor when he had to cover sick calls on the night shift.

24/7/365 responsibilities: Not only did participants experience intrusion in their personal and family life 24/7/365, but the responsibility for practice errors and resident incidents on all shifts weighed heavily on them. For one participant, the pressure of knowing accidents could happen anytime was a "constant fear." Her staffing levels ranged from 3.36 to 3.72 HPRD for the prior three month period, but she considered them "still too low to meet all the resident's needs, especially at night." Another DON explained her concerns were two fold. "If staff makes a mistake, you're the one that's going to answer for it, plus them, but still you're the boss. I'm responsible." But when staffing exceeds budget targets to avoid a potential resident problem, they also face criticism. "I'm responsible. . . . I'm the one asked about it. Everything, if it's not done, it's on me. So it's the DON responsibility."

One DON said she routinely increased staffing to avoid problems with families she thought might sue the facility. "When something happens guess who it goes to? . . . I'm the DON so the bottom line is it [responsibility] goes to the position. . . . So I'm the one who has to go to defend us. Nerve-wracking." This DON had long tenure in her facility and was able to adjust staffing for circumstances such as avoiding potential liability, but was unable to make similar adjustments for other conditions that would benefit resident care.

Inadequate personnel: All participants described problems with having adequate numbers of staff. Two categories of staffing problems emerged: 1) staff vacancies

requiring DONs to fill in for direct care, or cover mandated functions, and 2) the need to hire staff that had more than one job. Both had an effect on resident care, staff morale, and the DON's ability to meet her goals and responsibilities.

Several DONs described the burden of covering vacant positions. Amy, who subsequently created a new MDS position in her facility, was required to fulfill both DON and MDS coordinator roles for almost half a year. This was permissible as the facility had less than 70 beds. She considered quitting because she was tired and dissatisfied.

> I was doing the MDS and doing everything else… I tried to meet different goals at the same time. After like five or six months of hard labor, I was not satisfied. I'd go home late and come back here in the middle of the night . . . because the charts are there and haven't been taken by everybody else. So that was really challenging for me and it was hard (laughs).

Another DON experienced similar problems after a long-tenured MDS coordinator resigned. She explained that her ADONs were also the MDS coordinator. Because there were no qualified applicants for the position, she hired a nurse with no long-term care experience. She decided to let her learn the basic job before adding MDS responsibilities. "I'm doing MDSs for 47 residents . . . annuals, change of conditions, and RAPs, that's a lot. . . . Most I bring home, but I can't be on the floor as much now I'm doing all this."

Participants also had to cover mandatory responsibilities for the director of staff development [DSD]. In one facility, the DSD position had been vacant for almost a year. In another the DSD was an LVN, which placed all responsibility for RN supervision, education, and evaluation on the DON. These responsibilities were considered "easier to cover because there is no timetable. You just have to have things done before the

surveyors get here." This strategy, though understandable, failed to meet the daily need for clinical oversight and staff development.

Filling direct care vacancies was the most taxing and disruptive challenge for DONs. One DON had no administrator and several licensed nurse vacancies. She was able to arrange for evening and night coverage so she could fill in on the day shift as needed. "What can I do? The district boss comes in and acts like I'm not doing my job. I feel like telling him it's true, but don't blame me." She elaborated on the effect it had on families. "You know they have complaints and I was always there to listen to them and try to solve them. Now I'm part of the problem!"

Direct care staff that had only one job was rare and considered "a cost of living problem." One DON understood the situation from the perspective of the staff but believed that "non- stop working" interfered with job performance and the quality of care. She said her most effective strategy was to try to give staff "their first shift of the day" at her facility so they would be "fresh." This meant she had to authorize "flexibility in the scheduling so people could get to their second job." Another DON said she sometimes covered the floor by herself to wait on staff leaving their day job to work evenings at her facility. When asked about the effect of resident care she shrugged her shoulders. "We all know this is the way it is. I try to make it work out the best for residents and staff. That's all I can do."

One dramatic example of a DON's intervention to keep a "really great CNA" involved finding the staff a second job in a nearby nursing home. "He had to move over two hours away. So I called my friend and got him hired over there. You can't afford to lose a good CNA!"

No participants thought problems with low pay were going to be solved during the course of their careers as DONs. In general they felt administrators and corporate office managers could do more, but would not unless new laws required them to increase wages and the number of staff. One DON believed her administrator, despite being good in many ways, did not understand the issue fully. "Who will take care of the residents? She [administrator] cannot. She does not understand how clinical is 24/7 all year long. She thinks our average is what counts. Not the everyday number of people."

Working in a marginalized setting: Two participants expressed deep passion about the effect the low status of nursing home practice had on them and their ability to improve care and conditions. Ellen described her concern.

> I'm finding other challenges besides my day to day work. . . .there's nothing positive about long term care. Nothing. So where families come in, you know, its, they come in suspicious. So something very simple could happen, but they say, "Your staff didn't do this." I feel as though I'm drowning in a sea of negativity and I have to get out, because then my whole outlook on life is turning negative.

Another DON reported her disappointment with the way nursing home staff was perceived by other nurses. "Some of my nurses tell me acute care nurses think we are not really skilled. And I feel bad about that and always defend them but in the back of my mind I know they're not." She saw the problem from two points of view. First, she believed there was a difference in perception because of the amount of technology used in acute settings--not the acuity of their patients. She elaborated saying that without technology, nursing home residents were very difficult to manage clinically. "We do everything the old fashioned way . . . . Most residents do not get a lot better. They get worse. Our job is to keep them as strong as possible for as long as possible. Then it's comfort, and even death."

Summary of Role-related Themes

Findings presented in this chapter included the reasons participants began working in nursing homes, conditions antecedent to entry into the position, preparation for the DON role, and the responsibilities and challenges of the role. These results underpin and set the context for leadership findings presented in chapter five.

CHAPTER FIVE

LEADERSHIP FINDINGS

Results presented in this chapter build upon findings describing the DON role and answer the study questions: 1) how do DONs define and enact leadership, and 2) what factors promote and impede DON leadership in everyday practice.

Results are reported in four sections. Section one presents DONs' definition of leadership, their approaches to accomplishing leadership tasks, and associated activities. Next, three profiles of DON leadership--the veteran, reflective, and beginning leader are presented and illustrated using concepts from transformational leadership theory. Section three reports the factors that promote or impede DON leadership. Section four concludes with a summary of leadership-related findings.

Leadership: Definition, Approaches, and Activities

DONs define leadership

Each DON was asked to define leadership in initial and final interviews. During participant observation they expanded upon their views and pointed out examples in their work. Amy captured participants' perspectives stating, "Leadership is the way you inspire people to reach a common goal, which in nursing homes is good resident care." Diana added, "For me, it's easy to define but difficult to do. Leadership is about inspiring people to work together; staff, residents, and families." Ellen described leadership as having "authority and influence in important clinical and facility decisions."

All participants identified themselves as leaders, and their DON position as a leadership role. Prompted by a question to describe their role as a DON, five (50%)

began their answer with a statement about being a leader. For instance one DON said, "My role? It's to be the leader for nursing and nursing care. I represent all of us and the work we do." Another said, "I am the leader and the voice of nursing in all our meetings. I speak for nursing in all our resident care decisions." Five others (50%) included being a leader as part of their initial answer. One DON said, "We have many responsibilities and leading is one of them."

Some tasks, such as completing reports, clinical paperwork, and ordering supplies were classified as purely management activities, but relational work such as interactions with staff, superiors, residents, and families was described as a leadership activity. Carol's statement reflects the conviction each participant held about being a leader.

> We are both. Manager and leader. But for staff we are their leader. Even when we are just going around the building we are leading by the way we relate to them and to their problems. They look up to us and follow us because we are the nursing director. Especially when it comes to people, everything we do is about leading.

The terms inspiration and motivation were used interchangeably and described as "the same thing" by seven of ten participants. Three others believed inspiration differed from motivation, or as Ellen said, "Inspiration is like when you start a dream in someone else and they know they can do better. It's more than motivating them to do what you want."

The process of inspiring others was considered the hallmark of being a leader, and all DONs claimed to use inspirational approaches in their work. Indeed, commitment to inspired practice was evident from observing DONs; however, data revealed differences in the ways DONs viewed and inspired staff. These discrete differences, when examined

in concert with leadership approaches presented below, led to the development of unique leadership profiles presented in section three.

Leadership approaches

Data from interviews and observations of DONs in clinical situations, meetings, and conversations with subordinates, peers, and superiors were analyzed to determine common leadership approaches. Being flexible, visible, and "hands-on" were universal themes. Flexibility referred exclusively to making schedule accommodations for staff to meet family or additional work obligations. Visibility was described as being either physically present or available by phone. Being hands-on depicted a range of activities employed to manage clinical or administrative situations.

Flexibility: As reported in chapter four, dealing with staffing problems was a major challenge for DONs. They believed their staffs were "like gold," and that "good staff equals good care." Some had success making small improvements in staffing but most believed their influence on increasing salaries or resident care ratios was negligible. Therefore, their leadership efforts were focused on creating flexibility in scheduling staff. "I cannot control everything like our budget or when [other] facilities pay more, but I can go the extra mile to keep my best staff."

Some DONs made adjustments to increase staff satisfaction on an individual basis, but most tried to develop teamwork. "Sometimes I sound like a broken record but I drum in the idea of teamwork and give-and-take." Amy was proud she had "never denied a staff request for time off in five years." She encouraged staff to "trade days off with each other," and encouraged compromises when staff had competing needs. "My bottom

line is having enough staff to give our residents their care. I'm flexible in agreeing to changes, but I try to get them to solve the problem."

Visibility: DONs spent the majority of their time on the resident units and in facility meetings. Their presence and participation in facility meetings was described as an essential leadership activity. Participants rarely missed or were late to daily meetings. Those that were unsure of their value and authority in the organization believed they could never miss a meeting. "I've fought too hard to let nursing's place slip away. When I'm not there I require a staff nurse to attend." In contrast, DONs in more supportive organizations experienced freedom to prioritize when necessary. "I have my routine meetings. If I'm late or have to miss one, I try to send a nurse in my place, but that can't always happen. Resident care comes first."

Completing "office work" at the nursing stations and making rounds were common approaches to remaining visible. As on participant said, "It's not just about being seen, it's about being around on bad days. It's letting staff see that problems don't get you down." Another added, "It's important for residents and families to see you around. They like knowing the 'big boss' is in the house."

Hands-on: Being hands-on depicted a range of activities employed to manage clinical or administrative situations. Two distinct approaches to being hands-on were identified. Some DONs intentionally went unit to unit asking, "What do you need me to do?" Inevitably they were assigned tasks such as retrieving linen, giving a medication, or calling a doctor for an order. Others approached being hands-on by observing the environment, "taking the pulse of the unit," lending a hand to assist a resident, or

inquiring about a care issue. These DONs did not pursue tasks, but rather briefly pitched in as needed or initiated clinical conversations.

Being flexible, visible, and hands-on allowed DONs to stay in close contact with staff, observe care, and troubleshoot problems. As Irma said, "Leadership for DONs happens while we are doing all of our responsibilities." Differences in the ways DONs enacted approaches were considered in the analysis of leadership styles and effectiveness and integrated in descriptions of DON profiles later in this chapter

Leadership Activities

DONs characterized their work as "putting out fires" and as a "juggling act." They moved from one task to the next addressing moment-to-moment issues. As reported in chapter four, I observed DONs respond to a multitude of demands emanating from expected, unexpected, and staff-related activities. These categories provided a structure to observe and analyze actions and approaches to leading in everyday practice. Reported previously, these activities were typical across all nursing homes.

Expected activities included completing the multitude of daily routines such as rounds, scheduling, paperwork, meetings with staff, resident and families, and attending facility and clinical meetings. While participants organized their days around this set of activities, they also used them as a platform to communicate and instill their vision and values in care and administrative decisions.

Unexpected activities were juxtaposed with highly structured expected activities described above. This set of activities included handling interruptions and filling in for others. They demanded intermittent but time-sensitive responses from DONs and often constrained their ability to lead. DONs that incorporated unexpected activities into their

schedule rather than simply respond to a series of unrelated demands were better positioned to accomplish longer term goals.

When filling in for absent team members (from caregiver to administrator), DONs experienced disruptions but also found opportunities to incorporate their values in practice. For instance one DON said, "When I cover for staff, like for the med nurse, it keeps me in touch with the problems they have. So, then I can help them solve the problems rather than hide them." Covering for an administrator "sent a signal to others" that nursing had a position of authority in the facility.

Staff-related activities included orientation and supervision of staff performance. These activities were predominately accomplished in individual conversations between the DON and staff. Often interactions occurred during chance meetings during other activities. These interactions, though often unplanned, allowed DONs to impart important information, comment on performance and care issues, and engage in personal conversations with staff.

Leadership Profiles

Three DON profiles--the veteran, reflective, and beginning leader are described and theoretically analyzed in this section. Profile descriptions were constructed from actual transcripts, observations and conversations recorded as field notes immediately following participant observation sessions with DONs. Descriptions use like examples from previously described categories of expected, unexpected, and staff-related activities to reveal variances or similarities in leadership styles. Representative examples were drawn from data that typify each profile. Transformational leadership theory (TLT) provided the conceptual framework for description and analysis. Three dimensions of

TLT include transactional (TA), transformational (TF), and laissez-faire (LF) leadership approaches, described in chapter two, are briefly reviewed.

TA relationships, in the tradition of exchange theory, are based on principles of give and take, or the "transaction between a leader and follower" (Burns, 1978; p. 4). TA leadership style is characterized by the exchange of negotiated rewards contingent upon meeting minimal standards, and use of active and passive management-by-exception approaches (Bass & Avolio, 1994; Burns, 1978).

TF leaders are change agents who recognize personal needs of followers, look for ways to engage with individuals, and appeal to followers' "better nature and move them toward higher and more universal needs and purposes" (Bolman and Deal 1997; p. 314). TF leaders use idealized influence, intellectual stimulation, inspirational motivation, and individual consideration (Bass & Avolio, 1994). LF leadership "represents a non-transaction" (Bass & Avolio, 1994, p. 4) and is characterized by avoidance of issues, delays in decisions, lack of communication, and short-range planning.

The Veteran Leader

Veteran approaches to leadership reflected the archetypical image of a traditional, task-oriented nursing manager (Kerfoot, 1999). That is, they focused their attention on stability and maintenance of routines. Monitoring and surveillance were the primary approaches used to audit the work environment and staff compliance. In the following illustrations, veterans focused their attention on select care practices while others went unnoticed, were accepted without questioning the effect on care, or rationalized as unavoidable.

Expected activities: Early morning rounds with Bella revealed her approach to monitoring and "running a tight ship."

> At 7:10 a.m. Bella began her first rounds of the day. As we walked the floors, she casually surveyed each area. Passing Roger who was buffing the floor, Bella pushed an extension cord from the middle of the hall with her foot. He looked up, nodding that he understood. "Don't forget to watch behind you," she instructed, "Residents are coming out for breakfast and we don't want accidents!" She stooped to pick up a piece of paper and threw it in a waste can in a resident's room. She waved to the CNA helping a resident transfer from bed to wheelchair, hesitated momentarily to watch the transfer, and commented, "They're fine."

Bella's approach to observing the environment and interacting with staff and residents indicated a predominately transactional style. She efficiently conducted routine rounds and paid selective attention to potential issues. Her proactive vigilance of observing a resident transfer, and checking on potential safety issues were examples of active management by exception (MBE-A). In both cases, Bella's approach alerted staff to her expectations and provided direction for their practice. She spoke infrequently to staff, an indication that rounds were undertaken for monitoring purposes only.

> "Jo san," Bella greeted Mrs. Fong, a monolingual resident sitting in her usual hallway spot, just outside her room. Bella sweetly touched her sweater, face and hair saying, "Pretty, pretty today, momma." We slowed our pace to maneuver through the corridor crowded with medication, dietary and cleaning carts. We passed residents swaddled in blankets waiting for showers to be given after breakfast. When a CNA set a tray in front of one resident, I asked Bella how he was going to eat. "They're all fed by staff."

While Bella had proactively instructed Roger about hallway safety, she paid no attention to the clutter of the unit corridor which posed equal safety issues, and impeded residents from moving freely through the unit. Bella's inattention to actual and potential resident care issues demonstrated passive management by exception (MBE-P), or a "wait and see" approach of correcting problems after the fact rather than trying to prevent them.

In some instances, Bella's approach to handling difficult issues indicated an absence of leadership; a laissez-faire approach. For example, when asked how residents swaddled in bath blankets would eat breakfast, Bella said, "They're all fed by staff." Her response was surprising in contrast with her caring interaction with Mrs. Fong. Not only were these residents swaddled in full public view, but their restricted mobility could be considered a restraint, and the quality of their mealtime experience was diminished.

Bella failed to demonstrate her stated value of "providing excellent care to our residents." Her tacit acceptance of this routinized practice sent a signal to staff that she approved of their disengaged approach to resident care. Not surprisingly, staff moved mechanically through their arduous morning tasks. In fairness, even with a ratio of one CNA to eight residents it was difficult for staff to complete their work, but by extricating values from actual practice, Bella failed to engage or inspire staff to develop new ideas and routines to address these difficult conditions.

Unexpected activities--managing interruptions: The preponderance of unplanned activities in a DON's day required a response to routine and emergent needs of others. When I met Josie for a midday appointment, she had spent the entire morning handling a medical emergency for a resident's son. I joined her for lunch with other department heads. During the half hour lunch period she answered three overhead pages, jotting reminders for follow up after lunch. "Here's my afternoon agenda."

Lunch conversation was a pleasant mix of personal and work-related discussions, which added three more items to Josie's list. After lunch she telephoned four staff to fill an evening shift sick call. She finally agreed to exchange a weekend shift to replace the imminent vacancy. "I can fix that tomorrow. There goes the overtime." She explained

she didn't "have the heart to have pm's work short since the residents were so good about us being 'a little stretched' on days."

These illustrations demonstrate the veterans' passive and reactive approach to managing interruptions and indicated a TA style of leadership. Josie described her overarching philosophy of leadership as "handling one day at a time." Always visible, upbeat, and efficient in helping out and completing tasks, she expected each day to unfold with a new set of tasks to be accomplished. This left Josie with little time to focus on other than resolving moment-to-moment clinical issues.

Josie negotiated the sick call replacement with an exchange that rewarded the staff but created a budget problem and an additional vacancy she would "fix" later. In her decision to exceed her staffing budget, she recognized the effect of the day's events on residents. The true cost and clinical consideration of her decision is unclear as staffing was at the minimum 3.2 HPRD for the day. The intent of her action was primarily an exchange, or show of reciprocity to re-establish clinical stability and pre-existing balance in the relationship between provider and patient (Homans, 1958). Both illustrations demonstrated the give-and take approach characteristic of TA leadership.

Unexpected activities--filling-in for others: Josie was also covering as the only RN on duty. Meaning she had to complete all professional tasks, including contacting physicians on all clinical issues. We went to one unit to renew a medication order. She checked the chart, called the doctor's office, and waited for almost five minutes to get the verbal order. She handed the chart to an LVN, "All done. You doing okay all by yourself?" She also asked about Lucy's children before leaving the unit.

She repeated the process on another, this time handing me the phone to wait on hold while she took a call from a resident's daughter to explain a new medication. She obtained the order and completed the call with the family member. She continued to check item after item off her list throughout the afternoon.

Josie's approach to amassing and completing tasks was well suited for days when she needed to cover direct care responsibilities. In fact, on two of the four observational days with Josie, she had some responsibility for direct care coverage due to a recent LVN resignation. Two other days she did not have coverage responsibilities, but her approach showed little variation.

Josie had no overarching plan for evaluating or improving care. In fact, she commented that the Federal guidelines for the DHS State survey were her goals for the nursing department, and that surveys had been very good for many years. Her lack of vision and responsibility for establishing more than minimal goals for resident care and workforce development indicated a lack of leadership, or an LF style.

Though somewhat more engaging and personable than Bella, Josie also demonstrated primarily TA leadership approaches. Her interactions with staff indicated personal interest, but did not inspire greater professional commitment. Josie was task oriented and efficient as she managed interruptions and filled in for others. She, like other veteran leaders did not view the process as disruptive or overwhelming. Her view was, "It never ends. But this is my job; this is how I know what needs to be done."

Staff related activities: The following illustrations describe veteran approaches in two key areas of staff-related responsibilities, developing professional staff and intervening in ongoing performance problems.

Staff development: Helen was excited to have a new ADON. Janie recently moved to the area and had been in her position for about a month. She had no long term care experience but had been a head nurse on a medical-surgical unit where, according to Helen, "she must have had a lot of older patients." Janie's week of orientation included two days of classroom instruction on corporate policies and forms and facility routines, a partial day with Helen attending meetings and "learning how I do things," and two days working side-by-side with another ADON. Helen believed Janie had a lengthy and "comprehensive" orientation but had not yet attended the company's MDS class. She said it would take Janie about six months to "really learn" the MDS but added, "I can't push her too fast. I just hope she stays!"

Helen had almost daily contact with Janie in meetings and on the phone, but had no ongoing orientation or supervisory sessions with her. "I am in constant touch with her and she is getting a lot of experience. I never give her an assignment without telling her what she needs to do." I listened to one phone conversation Helen had with Janie.

> We're getting an admission with a stage two sacral pressure ulcer and maybe a problem on his left heel, so do the *whole* skin assessment right away. Check on the mattress; he's Medicare. Put him in one of Ben's rooms; he's good with skin. I'll start the paperwork and do the care plan tonight. Any questions?

Helen's clear but directive approach with Janie, gave Helen no chance to develop a mentoring relationship with a new RN. By issuing a series of instructions, she also missed the opportunity to assess Janie's knowledge or capabilities in order to teach or develop her skills. Given her desire to support Janie in her new role, Helen did not invite or nurture mutual commitment likely to inspire and retain Janie. The TA nature of the leader-follower learning relationship was evident. Helen also invested little time in

meeting with Janie to see how she was adjusting--to work or to her move from another state.

Janie's orientation represented a clear improvement from the "baptism by fire" Helen received. Helen was justifiably proud of the week long orientation program she created for staff. She had even been asked to consult with other DONs in the corporate chain on setting up similar programs at other facilities. The program was a good start to improving initial competence, but was not "comprehensive" as Helen described. The program lacked clinical and supervisory content beyond survey and regulatory compliance. Helen described the major benefits of orientation. "Staff feels they have time to adjust and they go to the floor with knowing what they have to do … having a 'floor buddy' makes a big difference!" At the end of orientation, staff was "checked off" on a standardized list of skills and information. This checklist was kept as part of the employee's file and served as regulatory evidence of competency.

Staff performance: I sat with Bella at the nursing station while she completed an assessment on a new resident. She shook her head as she read a care plan that did not meet her approval. "I guess this is next for me to do." She was frustrated that staff "kept making the same mistakes." She had no explanation for why they were overwhelmed in their jobs. "Most of them only pass meds and do their treatment and maybe a little paperwork." She believed most considered their work "just a job" and were uninterested in learning, lacking the 'head and heart' to make needed changes. Further, she believed staff was unmotivated to improve. "I cannot teach them." She believed her only option was to correct the mistakes herself. This was necessary to "keeps charts ready for the State." Bella rarely disciplined or terminated staff for performance problems. "Unless

they make a *major* mistake they know we won't let them go." A major mistake was considered coming to work drunk or abusing residents.

Bella's exchange relationship with staff rested on the assumption that leaders have authority to issue directions that followers must obey. Such compliance leads to specific rewards, approval, and avoidance of sanctions. Bella's failed attempts to 'reach' her staff were rooted in her negative views of staff capabilities which led to repetitive and futile attempts to modify their performance. While these approaches are consistent with TA leadership, her acceptance of poor performance indicates a lack of leadership or an LF approach. She avoided dealing with staff that resisted her interventions. Further, she failed to assess the consequences of poor staff performance on resident care. Bella corrected documentation by monitoring charts and "doing it" herself, but took no action to protect residents from staff whose performance was poor but fell short of resident abuse. Her avoidance of staff problems until they reached an extreme level of concern, such as being intoxicated while on the job, indicates a lapse in leadership as any level of poor performance jeopardizes the care of residents.

In sum, veteran approaches to leadership were primarily TA. In situations viewed as hopeless or inevitable, avoidance of action resulted in a lack of leadership, or a LF approach. Veteran leaders focused their attention on stability and maintenance of routines. Leadership approaches endorsed task-oriented and habitual nursing practices, promoted compliance, and prompted staff to maintain the status quo.

Monitoring and surveillance were the primary methods used to audit the work environment and staff compliance. This style of leadership privileged stability and predictability over change and improvement.

The Reflective Leader

Reflective approaches to leadership indicated minimal reliance on formal monitoring. The leader-follower relationship was based, in part on agreed upon values and ideals of caring. The reflective style was characterized by connecting with others, recognizing staff contributions, expressing core values, sharing information, and accountability, characteristics of TF leadership.

Leadership tasks were associated with building expertise and creating a trusting environment. Reflective leaders also used TA approaches such as exchanging benefits for expected levels of service, or in monitoring routine compliance. Underlying TA actions however, were TF values of idealized influence, intellectual stimulation, individual consideration, and inspirational motivation.

Expected activities: Morning rounds with Diana began at 8 a.m. Diana arrived at work between seven and eight o'clock each morning. She liked to give staff time to "get their morning started" before going to the units. She used rounds to "get a good idea of how the day is going to go." Staff expected her to make rounds each day, but on occasions when she could not, she called units. "I let them know and then my ADONs will give me a verbal report."

As we toured the units, Diana took her time and scanned each area. She moved a chair from hall to alcove commenting, "It's hard to keep the hallways clear in the morning, but we try. Staff is so busy at this time so I don't mention it right away because they will feel bad. I think you know how it is." The units were busy and staff darted in and out of rooms, paying only slight attention to the physical environment. Sensing Diana's embarrassment, I agreed it didn't look like a good time to intervene and asked

when the best time was. "Oh, we have staff meetings. I bring treats and people like to come." Diana was one of only two participants who held nursing staff meetings.

Like veteran leaders, this reflective leader also had to deal with difficult to manage clinical situations. She scanned the environment for gaps and opportunities rather than ignoring or excusing problems. She discussed ongoing issues with staff. Further, she demonstrated a sense of timing and sensitivity to her staffs' pride in their work. Diana also created a formal meeting structure with direct care staff to maintain social and professional connections, promote open communication, and address care and practice improvements. These approaches mitigated her TA actions of taking selective or delayed action to discuss or correct unrelenting problems that occur during peak activity times like AM care.

As we continued on rounds, Diana stopped to greet each staff we encountered. She introduced me to staff by sharing something personal and professional about each person. "Ruby's been here for how long, eleven years? Wow, that's great. She is so good with our demented ladies; she knows all their special secrets to make them happy." We stopped at each nursing station for Diana to review the change of shift reports. She asked RNs and CNAs about resident conditions. "Anything I need to know? How did Mrs. Lui sleep last night?" She listened, thanked them, and added, "Good, she got her sleep at last!"

Diana's approach was primarily transformational. She recognized individuals both personally and professionally. She showed special recognition of the ways that staff infused values in their practice with residents. She initiated clinical discussions with staff, listened and engaged them in purposeful dialogue. She used questions to elicit

information, and demonstrated the importance to their contributions by telling them how their work and information helped her do a better job.

Unexpected activities: The majority of unstructured or unplanned activities were related to emergent needs of others. Reflective DONs considered interruptions as symptoms of bigger issues occurring in the environment. Three categories of unexpected activities are discussed below

Unexpected activities--managing interruptions: During a thirty minute midday office conversation with Ellen, the number of calls and pages were exceedingly high. After handling one staff request to leave work early, four calls and one page, Ellen appeared frustrated. "What's going on today? Let me get this call and we'll do rounds. Maybe that will help!" When she finished the call, I asked if she used that strategy frequently.

> Of course! Sometimes they just need to share their problems with someone in charge. And other times it's like just keeping me informed. It's a double-edged sword. I want and need to know. But it keeps me from really concentrating on anything else but what's right in front of you.

Other DONs closed their doors and did not answer phones for brief periods. "I have to get some relief. But if they really need me, they knock." I observed Carol use this strategy on several occasions. During these times she checked e-mail, opened mail, completed reports, and reviewed medical records for current clinical issues or auditing purposes.

Unexpected activities--filling in for others: Carol covered responsibilities of the vacant administrator position for several months. This meant one of her first duties of the day was to lead the morning team meeting. "I do the same to prepare whether I'm covering as the administrator or just there as the DON." When the team was late, she

paged the department heads. Within minutes the room was filled and pleasantries were exchanged. Carol asked Joy, the social worker, to update the clinical and quality charts posted around the room. She began the meeting, "OK folks, I'm Bob [the administrator] again today. Ready to start? Linda [RN], go ahead for nursing." As Linda reported resident changes, Joy recorded the information. Carol was careful to summarize, highlight issues for the group, and explain care concerns for non-clinical staff. "Ralph, I know it's going to be hard on your staff, but we can't have people eat together in the west dining room yet. We still have norovirus symptoms. Have you talked to your people about getting trays out?"

Interruptions and filling in for others seemed to take a toll on reflective DONs. As Diana said, "I make a list every night just in case I can stick to." DONs who demonstrated a reflective approach developed strategies, like Ellen's or like Carol's, to ensure they could focus on their work without ignoring or over-responding to situations in a moment-to moment fashion. In this way, reflective participants were able to have some control over the environment rather than simply react to each demand as it occurred--bringing a higher level of consideration to their work and daily organization. They stayed connected with staff as well as with the larger organizational demands, leant a helping hand when needed, and remained more focused on core responsibilities.

Staff related activities: Several participants discussed dilemmas associated with managing staff performance. The following illustrations describe reflective approaches to develop staff and correct performance problems.

Ellen explained issues that surfaced while developing an inexperienced LVN who was working many shifts in the 69-bed facility.

> Lena was my CNA and just finished LVN school. Brand new, so you can expect some mistakes, not big ones but we're working everyday to get her use to all the orders. She was my only LVN a lot of the time. So guess whose name kept coming up on incident reports? Well she's the only LVN *and* she's working extra … so my boss and the upper people were saying you need to fix her right away or write her up. I said I'm not going to. I kept on working with her and she is doing good and really appreciates my help.

Amy also found directives to sanction rather than develop staff unacceptable. "Write them up? Exactly how does that help? It's one thing if it's like being late. But when staff is trying to understand their job, you keep trying too." She recognized that "no one likes being called on the carpet," but believed it was her responsibility to point out areas for improvement. "As I see it, people try their best but when they don't, that's where I step in to help." She developed a method for listening to staff explain their point of view about a problem then used their explanations to suggest changes. "I always try to give them a few days to make a change and I check back. Most of the time this works to some degree, and then you can go from there."

Reflective approaches to performance problems were primarily TF. DONs demonstrated a sincere commitment to develop staff rather than impose disciplinary measures "coming down from the top." Both Amy and Ellen took a professional stance with superiors to support and advocate for staff. Reflective approaches were rooted in values and professional standards, rather than based on compliance or avoidance of problems. Amy's positive yet thorough approach helped staff make changes in practice behaviors. Her approach to staff development and performance improvement advanced her transformational agenda to ensure good resident care.

Carol described an ethical dilemma DONs frequently faced when dealing with staff performance issues.

> Sometimes I don't know what's the right thing to do. Like when staff makes mistakes more than once. Maybe they did not turn people right or get someone out of bed or to the bathroom in time. These are bad things. You know in your heart if it's an accident or a bigger problem. So if they are good in general, do you let them work or send them home? Both ways can be really bad for our residents. It's not easy because you have to assess if the mistake is worse than having nobody at all. Our catch-22!

Carol was aware of the ethical underpinnings of her decisions. Other DONs shared similar dilemmas and talked about "trying to figure out the greater good." Their delays in taking a definitive action however, differed from the ongoing avoidance and cynicism expressed in Bella's earlier statement, "Unless they make a *major* mistake they know we won't let them go."

In sum, reflective leadership approaches were characterized by connecting with others, recognizing staff contributions, expressing core values, sharing information, and accountability. Reflective DONs were primarily TF leaders but also used TA approaches as a secondary style of leadership. These DONs recognized the personal needs of followers and found ways to engage with them and inspire them to become better clinicians which contributed to resident care improvements. Reflective leaders acted as change agents in their organizations. Leadership tasks were associated with building expertise, acknowledging difficulties and facing challenges, and creating a trusting environment.

The Beginning Leader

Three of ten participants were relatively new to the DON role (6 - 11 months). Two had worked exclusively in clinical and administrative positions in nursing homes. One had extensive supervisory experience in acute settings and brief experience as a DSD and MDS coordinator in a nursing home. Antecedent conditions for accepting a

DON position, presented in chapter four, set the stage for these beginning DONs. Frances demonstrated a TA or veteran orientation in her early work as a DON. Two others with mentored experience in leadership roles showed evidence of TF, or reflective approaches.

The beginning leader--veteran approaches: Frances stepped into a DON position mid-survey when the former DON was terminated. She saw her major responsibility as bringing the facility into compliance and focused her efforts on directing and monitoring staff performance. Her job was to keep the staff in "survey mode" for a series of inspections over the next year. She spent most of her time on units auditing documentation and correcting mistakes. Her approach with staff was matter of fact and directive. "I know what my job is here and we'll accomplish it even if I have to do it myself."

In fact, besides district and regional corporate representatives dropping in to audit facility progress, Frances was essentially on her own. She had no administrator the first four months on the job, no ADON, no DSD, and she had to fill in as the charge nurse two to three times a month. Her district nurse consultant was frequently in the facility but had little contact with Frances. When asked about the role of the consultant, she replied

> Let's put it this way. She was here every day before the last bad survey and it didn't help. She said the DON wouldn't listen to her so I try to. I mean she knows her stuff, and that's a big help because she can audit us and give me her list and I can work it out with my staff. I'm not happy when she goes straight to my staff. That should be me…we need new ways to get this place working right.

Having no DSD, Frances recruited outside experts such as a wound care specialist from a nearby hospital to provide staff in-services. Using outside professionals was both "a survival strategy" and a way to provide "the latest information" for her staff. She was

proud that staff recognized her efforts to improve their skills. Frances demonstrated a mixed style of TA and TF leadership. While she recognized and was dissatisfied with the "interference" and "corporate attempts" to improve clinical practice, her interactions revealed nominal connections with others. Her approach to regimented monitoring was indicative of a TA style used by other veteran leaders. Frances was cognizant of a need to infuse new clinical knowledge into practice by using professional experts.

Her ability to develop TF approaches, particularly in connecting with staff rather than continuing her "survey mode" was constrained by the overarching need to pass the series of upcoming surveys. Her statement, "I know what my job is here and we'll accomplish it even if I have to do it myself." This constraint on leadership is presented later in section three.

The beginning leader--reflective approaches: Gail was promoted to DON when her predecessor left to consult in another corporate chain. Gail felt well-prepared and confident to assume the DON position. "As the ADON I did all the tasks with my supervisor. So I know the job responsibilities completely. The difference is I never did it alone." Two factors helped Gail transition into the DON role successfully--continued mentorship with her former DON and the support of the facility administrator.

Despite failing to negotiate an assistant for herself, she created part-time as-needed positions to complete mundane clerical duties previously assigned to nursing staff. She considered the trade of an assistant for "direct care help" a worthwhile exchange in that it improved efficiency and allowed nurses to focus on residents, infusing meaning in their work and improving attention and care for residents.

Gail demonstrated TF behaviors in assessing many facets of the environment to create a new work flow system for her department. She was able to work within the budget constraints while showing her value of increasing nursing time with residents. She filled her need for help and mentorship by continuing a professional relationship with her former DON. Gail's thoughtful and creative approach indicated her potential to develop as a TF leader.

Contextual Factors

Contextual factors call attention to task and performance expectations, environmental conditions, and the nature of relationships which influence leadership style. Factors found to influence leadership enactment included: 1) facility size, 2) facility generated revenue, 3) regulatory compliance and standardized care, and 4) DON-facility administrator relationships. A description, including illustrations and themes related to DON leadership enactment is presented for each set of factors. Poor staffing in nursing homes and the effect on resident care has been well-researched. In this study, staffing adequacy and the effect on DON leadership was examined within two contextual categories facility size and facility generated revenue.

Facility size

Four of ten DONs worked in small facilities with less than 70 beds. These facilities had flat nursing organizational structures and limited numbers of professional staff. That is, the DON had no assistants at the management level and few RNs in key professional roles such as charge nurse, ADON, DSD and MDS coordinator. As Carol said, "There are fewer resources to start with so you don't have much leeway to organize them."

Ellen said the flat infrastructure at her 69-bed facility affected her work on a daily basis. Further, she believed it limited opportunities for staff to develop clinically and professionally. Other DONs gave examples of "pulling the DSD" out of teaching to complete regulatory paperwork and surveillance for programs like infection control and TB and flu screening. "We have no unit clerks to do the forms and no RNs except as floor and MDS nurses." DONs in small facilities used the DSD to provided basic orientation and … "mandatory in-service classes like sexual harassment, abuse, and annual updates. That's all we can do, but I think we are missing the most important part--the clinical." In one small facility, the DSD was an LVN which shifted the responsibility of education and supervision of RNs to the DON.

Others compared their roles with DONs in acute settings who did not have the same burden of 24/7 of coverage. Participants pointed out the negative effects of having few or no professional colleagues to share their workload, develop collegial relationships, or consult on clinical or administrative issues. "They can delegate, and depend on, and share that presence with another RN. Especially in small buildings we don't have anybody that does this…I have no one to help me or to really talk to.

Amy believed that having few professional nurses on her staff impeded her ability to develop staff and improve the image of working in nursing homes. "Acute nurses would tell me, long term care nurses really are not skilled. And I feel bad about that and I always defend them but in the back of my mind I know they're not." Amy knew she could not develop her staff and help them advance professionally.

Conversely, facilities with more than 99-beds had more RNs in direct care as well as in supervisory and educational positions. For example, these facilities were mandated

to have a fulltime RN educator [DSD] and DONs were protected from working as the charge or in direct care. Therefore larger buildings had at least one nurse supervisor for between forty and sixty beds. In addition, there was a MDS coordinator, plus staffing for medical records, data entry, reception, in some cases, staff scheduling. Diana expressed her thoughts about the importance of having depth of resources.

> DONs prefer the larger buildings because you have support people you could just move around where you need them. One big benefit, aside from the resources is you can have a team…we can talk and have conversations. I think for the DONs that makes it less stressful. It's really hard to find a nurse for a smaller facility.

Even the mundane, repetitive task of answering the phone was related to facility size. In all facilities, outside calls came through a central number. Larger facilities had a receptionist that answered and triaged calls. In small facilities, floor staff had to answer incoming calls which meant they stopped their work with residents to take messages, page staff, or transfer the call to an internal number. Frequently, staff placed a caller on hold and returned to resident care responsibilities. If unanswered, callers had to phone again requiring constant involvement by many staff. Additionally, only four participants had voicemail. All others had to accept or avoid calls as they came in. Initially, setting up an appointment with a DON took hours and sometimes days to reach them. Families trying to contact the DON encountered this same delay. To address this problem, DONs gave out their personal cell numbers to streamline the process for them and for callers, and reduce the burden on staff. Rather than make costly changes to the facility phone systems, corporation authorized reimbursement for work-related cell phone charges. Some DONs routinely applied for reimbursement but others said the amount of paperwork "wasn't worth the trouble."

Summary of leadership issues related to facility size: Small facility size (< 70 beds) influenced DON leadership in several ways. Themes of professional isolation, uncertainty, work overload, and inability to meet staff development goals emerged. As participants pointed out, it was not easy to recruit a DON for a small building. These DONs were unable to build an adequate infrastructure, had few collegial relationships, and had to shoulder the bulk of the workload alone. This resulted in consequences for other staff as well. As Amy pointed out, staff had few opportunities to improve their skills or stay current with technology and practice changes. DONs felt badly about their inability to improve staff competencies.

Facility-generated revenue

Facility revenue was generated from the payer-mix of residents in each facility. Those with high numbers of Medicare, private pay, and rehabilitation days earned significantly more than facilities with a high percentage of Medicaid residents. For many facilities, the ability to generate revenue was dependent on corporate decisions. Two of four corporations (7 nursing homes) had centralized referral and placement services. As such, facilities had little ability to improve their earning capacity, yet budget allocations were based on annual earnings of each facility, not on district net earnings. Accordingly, the earning power of each facility influenced DON leadership enactment.

Despite differences in facility revenue, all DONs were expected to "meet the bottom line" while ensuring successful annual surveys and "keeping families happy." Bella explained that 99% of her residents had Medicaid. As a result, the facility revenue did not support improvements in the physical plant or purchase of new equipment. She

was frustrated and unable to "demand money to improve the place or get things for residents." Many essential items were requested year after year.

> We don't have lockers, so staff put their belongings in residents' closets. That's not allowed. But they keep doing it and we keep putting it on our list. We want suction machines for the bedside because we have 32 tube-feeders and should have this. And the combo vital sign machine, like this one [shows me the equipment which is actually not the newest available], would make CNA's work easier--but that's money too.

The failure of corporate support to purchase essential clinical equipment placed residents at risk, eroded staff morale, and impeded the DON's ability to enforce policies. In some instances, failure to purchase simple items actually cost the facility money. One example was the lack of iron-on labels for residents' clothing. Josie said, "It's a big issue for families, and we always end up paying." I observed staff looking for resident belongings by sorting through laundry baskets in the clothing room and asking their coworkers to "be on the lookout" for a special item. Reimbursement for lost items was taken from the facility's "bottom line" but approval for the iron-on equipment and supplies required district approval.

Amy's facility was funded totally by private pay or Medicare revenue. She admitted that the company allowed her more "leeway" in staffing and "put more into the environment so families would feel satisfied." She explained the higher payer-mix gave her "more latitude than other DONs to use overtime." Since revenue was based on thorough MDS documentation, Amy frequently allowed the MDS coordinator or other RN staff to work extra hours to complete the documentation. She also had more autonomy to increase staffing for difficult resident situations. "We have families who pay out of pocket for their parents. So, I can sometimes add a CNA if we are really

busy." She said the "business position" made her uncomfortable and over her five year tenure, had experienced "ups and downs in company support."

> The bottom line is what they care about. If you have a good year…you get your leeway. But if the next year's bad, they take it away…it is a conflict for me, so I just try to focus on nursing. I don't educate myself on the business side or else I will get jaded. I don't want money to interfere with the way I make my decisions.

In all facilities, the daily staff meeting began with a review of the resident payer-mix, potential private and Medicare admissions, and a checklist of residents receiving speech, occupational, and rehabilitation therapies. Each category represented opportunity for higher reimbursement. When residents were no longer eligible for Medicare or private insurance reimbursement, families were contacted immediately. They had to decide whether to have therapy services discontinued or pay for rehabilitative services beyond basic care. When the decision was to discontinue therapy services, comments from therapy and non-nursing team members included statements like, "it's time for nursing to pick this up," or "we'll have to show you nurses how to assist," seemed to ease the discomfort staff felt in reducing services to the residents. Sometimes staff proactively ordered medical equipment for residents while they were still eligible for Medicare reimbursement.

The influence of mandates to maximize revenue on DON clinical leadership became clear as I observed an event during one staff meeting. A nurse reported that a resident's antibiotic was changed from IV to oral due to problems with the infusion on the night shift. An immediate flurry of activity ensued. The DON instructed an ADON to call the unit to ensure the morning dose had not been given. A social worker called the physician to reinstate the IV order. I was amazed at the swift, coordinated response from all members of the administrative team. There was no discussion about the

resident's need for IV therapy, nor the risks or discomfort of restating the infusion. As I accompanied Helen to the floor to restart the IV she explained the situation.

> The IV makes this resident Medicare and not just skilled--that's about $600 a day and with five more days to go, that's a big difference for us. I'll have to see what went wrong last night and why I didn't get called on this. This is a *big* mistake and we're lucky we caught it in time. I'm the bottom line on this one.

Summary of leadership issues related to facility-generated revenue: Facility revenue played a major role in funding resident care equipment, making improvements in the physical environment, and facilitating a safe environment for residents and staff. DONs were expected to "meet the bottom line" while ensuring successful annual surveys and "keeping families happy." Inadequate financial support constrained their ability to accomplish these goals.

Facilities that provided care to the Medicaid population were financially disadvantaged and leaders had less autonomy to make decisions about allocation of capital and personnel resources. Lack of financial support for essential clinical equipment placed residents at risk, eroded staff morale, and impeded the DON's ability to enforce policies.

The need to maximize facility revenue was dramatically illustrated by the reinsertion of an IV without discussing clinical or ethical considerations. Staffs were not unsympathetic toward residents. They attempted to replace therapies with nursing care and tried to make sure expensive medical equipment was ordered during periods when residents had access to reimbursement. DONs acknowledged the effect revenue had on resident care and working conditions, but had little authority to change the situation. As reported earlier, DONs that used reflective and TF approaches were able to create an

environment promoting creative approaches to resident care and clinical work despite infrastructure and fiscal constraints.

Regulatory compliance and standardized care

Every DON reported that her number one priority was to pass the state survey. Linked to the need for facilities to pass regulatory inspections, parent corporations developed sets of standardized policies, procedures, and clinical initiatives. One long tenured DON said that this was a new process, originating perhaps within the last five to seven years. Each nursing home received all policies, procedures, and forms from the corporate office. The benefit and burden of this standardized approach emerged from interview and participant observation data.

Ellen believed it was getting harder every year to "please the State." She added that company forms were designed specifically for survey success and that, "If you fill them out right, and there's no negative outcome to alert surveyors of a problem, the forms can get you though a survey in good shape." When I asked her about the effect on care and staff practices, she laughed and said. "Now there we're the same as before. At least as far as policies goes. The good change has been in our QIs [quality initiatives] for pain, pressure ulcers, falls, restraints, and psychotropic use." Ellen believed that the corporate focus on standardizing policies and forms helped improve the care by providing a structure that satisfied State inspectors. She did not believe better forms were linked to improved care, but thought corporate initiatives to improve resident care outcomes had a positive affect on the quality of care. "QIs give us good standards of care to implement, and staff gets mandatory in-services on care. Before, it was all about basic procedure and legal issues. Now we have mandatory clinical content."

Ellen's views represented those of 50% of the participants. That is they were pleased to have the majority of the policy development done by corporate experts. One participant disagreed. She thought one problem of being part of a national chain was that "Problems anywhere, are suddenly your problems too." She wasn't alone in thinking that the corporate initiatives were not sensitive to "local problems." Four DONs mentioned that the QI initiatives were good, but also artificially limited their clinical direction and ability to decide what was most important in their facilities:

> They [corporate initiatives] take up all our energy. It's all we do. You can only give the staff so much to think about or it's overload for them. All ideas come from outside and they're not always our biggest problem to solve. So really a lot more could happen if we had a mix of their ideas and mine. The other problem is they pay for their ideas to get done and you have to do yours on your own!

Two other problems were universally identified, the lack of DON input into the implementation of new policies or procedures, and in designing documentation forms. Josie commented, "You can see that the company puts a lot into all the material, but they don't know our work and our staff." Others complained about the complexity and time-consuming nature of documentation and the amount of auditing expected to ensure compliance. New policies and standards were established without clinical or operational input from DONs. The establishment of new policies and standards followed along the lines described by Frances in all nursing homes:

> Essentially we have a meeting where we get everything--the training, the binders and forms to bring back, and sometimes we get new artwork if it's a big national program. Then we take it all back and start doing it. They always give us a new tool to fill out…the audit always comes with the new program.

Amy believed that the auditing process was based on corporate mistrust and showed a lack of understanding of the staff or the "real work" at the facility level.

She thought the corporate forms were complicated, and while comprehensive from a regulatory perspective, they were not designed for easy use by CNAs or licensed nurses with English as a second language. "The company thinks oh, this is a great policy; this is how it should be. But it's not really. We need to be practical to help our staff."

> Policies need to emerge. I think there should be a trial where they send it out and we see if it will work. No, there is none of that. It's like commands, 'this is what you will do.' So, I have to come up with my own way to make it work for us.

To promote staff acceptance of changes in their practice, Amy developed a system of implementing part of the overall policy "one step at a time." This required extra work on her part and agreement of her administrator to "give me support with the district." But she found it made a long term difference "because staff really get it and have input into making it work."

Irma was also critical of corporate mandates that emphasized routinized care over individualized approaches. "I know it's all about making the survey easier to pass, but it doesn't let me help staff learn to think. I tell them to answer the question, 'What's best for my resident?' Then go to the policy."

Summary of leadership issues related to regulatory compliance and standardized care: Corporate support of improving clinical standards and disseminating clinical programs for implementation of quality initiatives served a positive purpose. This support of providing new information, developing policies and forms, and providing marketing tools for promoting awareness was mediated however by the institutional way the process was carried out. Mandates to implement standard forms and programs focused on improving survey success. The focus on compliance and creating an audit climate constrained DONs' ability to make decisions, plan interventions sensitive to the

needs of their residents and staff, and limited both the knowledge and the practice of nursing home staff. The distance between corporate intent to improve care and their mechanistic approach to the work widened the gap between staff and residents by creating artificial remedies for problems.

DON - Administrator relationships

The relationship between the DON and the facility administrator influenced DON leadership style and effectiveness. During the course of the six-month study, three DONs (30%) had no administrator. Of these one was assigned a "temporary corporate float administrator" for one week. Another had an administrator who stayed briefly and left the system. And one had a "brand new" administrator assigned to the facility "without even asking my opinion."

Seven participants had stable administrators. Three DONs said they started at approximately the same time as the administrator. One was recruited by a former administrator to the DON position in his new facility. And one participant resigned during the study to become the DON at the same facility her administrator moved to. Three DONs in this group were appreciative of the administrator's longevity, but had mixed regard for their interest in primarily maintaining the budget and achieving good surveys. Two others were extremely satisfied with the commitment and the passion their administrator had for the work and the nursing home environment.

As reported and illustrated in chapter four, support of facility administrator at the time DONs entered a facility influenced their ability to change practice, build teams, and improve resident care. Ellen identified her biggest challenge to establishing better care and nursing was her administrator's desire to control and speak on behalf of nursing.

Helen received initial and ongoing conditional support from her administrator. When surveys were good, facility benchmarks met, and annual bonuses certain, Helen had freedom to make and implement autonomous decisions. Periodic mandates from the administrator changed Helen's decisions which led to problems in resident care and staff morale. Her organizational effectiveness was compromised during these periods she identified as "cyclical."

Summary of leadership issues related to DON - Administrator relationships: Strong partnerships between the DON and the facility administrator supported DON efforts to sustain and initiate improvements, mitigated organizational resistance to change, and established expectations for teamwork and better care. Poor or inconsistent support from administrators constrained DON authority and effectiveness, permitting only incremental changes in the overall culture of the facility and resident care over time.

Summary

This chapter reported study findings related to DON leadership. DONs defined leadership as a process of inspiring and bringing people together to reach a common goal--good resident care. Key approaches to providing leadership were being flexible, visible, and hands on. Three DON profiles, the veteran, reflective, and beginning leader were described, illustrated, and analyzed using transactional (TA), transformational (TF), and laissez-faire (LF) dimensions from transformational leadership theory. Contextual factors and their influence DON leadership enactment were presented. Discussion of findings and implications for practice and future research are presented in chapter six.

CHAPTER 6

DISCUSSION

> There are days when I feel I'm just managing whatever is thrown my way. On these days I'm not very satisfied and I definitely don't *feel* like a leader. But even on these days, I see my staff, and my residents, and my families still looking up to me to do my best--to provide some leadership to make this a good place for them.
>
> Carol, Study Participant

This final chapter proceeds with an eye to the future. The momentum for study of DON leadership has been growing for decades and as this study concludes, professional and industry attention is once again turning toward the DON to resolve persistent care and workforce problems. Findings from this study are timely and significant as they advance our knowledge about DON practice and leadership in nursing homes.

This chapter begins by revisiting the study's purpose, aims, and methodological considerations. Key findings are situated within the larger empirical context and discussed theoretically and pragmatically. Limitations of the study and implications for practice are presented. Directions for future research to refine and expand upon study results are proposed.

Purpose, Aims, and Methodology Revisited

The purpose of this research was to investigate the leadership role of nursing home DONs. Specific aims were to explore, describe and analyze: 1) DON perceptions, definitions, and approaches to leadership, and 2) contextual factors that influence DON leadership. Ethnographic methodology allowed observation of DONs in everyday practice and access to their perceptions, personal musings, ideas, and self critique. Therefore, I was able to describe and analyze the dimensions of DON practice, as well as the critical individual and corporate agency gaps that influenced leadership enactment.

Empirical Findings

The DON role

Findings presented in chapter four included the responsibilities and challenges of the role, reasons participants began working in nursing homes, conditions antecedent to entry into the position, and preparation for the DON role. Five responsibilities were consistently reported: 1) leadership, 2) administrative, 3) clinical, 4) personnel, and 5) staff development. DON tasks fell into three categories of expected, unexpected, and staff related activities. Common role challenges were identified as: 1) blurred work-home boundaries, 2) 24/7/365 responsibility, and 3) inadequate personnel, and 4) working in a "marginalized setting." These unrelenting burdens led to feelings uncertainty, exhaustion, discouragement, and professional embarrassment.

Interestingly, there is little change in the activities or burdens of the DON role identified in this study from those reported over the past twenty seven years (Abedzadeh & Heine, 1992; Aroian, Patsdaughter, & Wyszyski, 2000; Carroll & Byers, 2001; Giordano & Panfil, 1987; Heine, 1995; Lodge, 1985; Lodge & Pietraschke, 1986; Simms, Price & Pfoutz, 1985; Simms, Pfoutz & Price, 1986). These prior studies reported that DONs were most involved in daily operations and human resource management and least involved in professional and leadership activities.

Results of this study differed from previous findings in that DONs conceptualized leadership as a core responsibility distributed across their many tasks. As Carol said:

> …for staff we are their leader. Even when we are just going around the building we are leading by the way we relate to them and to their problems. They look up to us and follow us because we are the nursing director. Especially when it comes to people, everything we do is about leading.

The DON as leader

Chapter five reported three major findings related to leadership: 1) DONs identify as leaders and their position as a leadership role; 2) their leadership style had an effect on staff performance and resident care, and 3) nursing home contextual factors influenced DON leadership in positive and constraining ways. DONs universally identified relating effectively with others as a core responsibility of their leadership role.

Three antecedent conditions existing at the time participants entered a DON position shaped the organization's expectations for leadership as well as the entry and ongoing leadership experiences of DONs. Those filling long standing vacancies (n = 2) had to re-establish the influence and authority of the DON role. Those replacing failed DONs (n = 3) confronted serious problems of regulatory compliance, poor resident care, and low staff morale. In contrast, DONs who followed successful predecessors (n = 5) felt confident in their abilities and experienced support to improvement staff and resident programs.

Mentored preparation, strong DON-administrator partnerships, adequate nursing infrastructure, and professional connections beyond the nursing home setting promote DON confidence and competency. Conversely, lack of nursing infrastructure, reliance on corporate standardization, and constraints on creativity and risk-taking fundamentally impede DON leadership.

Despite participants' identification as nurse leaders, few opportunities for professional networking or formalized mentoring existed. Some attended corporate, regional, and district meetings. One corporation initiated district DON meetings that occurred inconsistently, likely due to heavy DON workloads at their facilities.

While no participant was active in the National Association Directors of Nursing Administration/ Long Term Care (NADONA), each corporation paid for DON's membership in the organization. Again, the unrelenting workload made it impossible for DONs to attend without further relinquishing personal and family time. The result was DONs who remained tethered to daily responsibilities, were isolated from colleagues, and had limited access to new clinical and administrative evidence to guide their practice and improve resident care.

Building the DON workforce

Recruitment of qualified RNs into nursing home practice is constrained by the negative image of the industry and the perception of limited professional opportunities. As a result, DONs have primarily been promoted from within the nursing home ranks (Cheah & Moon, 1993; Reif & Estes, 1982; Heine, 1995; Lodge, 1985; Lodge & Pietraschke, 1986; Wunderlich & Kohler, 2001). Prior studies report that caring for elders has been the primary reason DONs chose to practice in nursing homes (Abedzadeh & Heine, 1992; Aroian, Patsdaughter, & Wyszyski, 2000; Lodge, 1985; Lodge & Pietraschke, 1986; Tellis-Nayak, 2005).

In this study, only three of ten participants indicated their desire to work with elders as the primary reason for accepting a nursing home position. For several, nursing homes provided an opportunity to re-enter practice after relocating or being unemployed for a period of time. For others, nursing homes provided an opportunity to achieve their career goal of becoming a nursing administrator. These DONs described the importance of working in different settings and in a variety of positions--from staff to leadership roles to their work in nursing homes. To fill current and projected DON vacancies, this

study suggests the potential exists to recruit talented RNs into DON roles from outside the current nursing home workforce.

DON role preparation

In spite of successful efforts to ensure the addition of geriatric content in nursing academic programs across the country, little change has occurred in the preparation of the top leader in nursing homes. Every study conducted over the past quarter century has identified a need for better prepared DONs yet the problem still exists.

Participants in this study were prepared primarily in on-the-job roles. By surviving "baptism by fire" and leading successful surveys, DONs earned facility and corporate recognition. Those that had strong mentors or experience outside the nursing home setting expressed values of communication, teamwork, and systems change as key components of their preparation. In contrast, DONs who worked with traditional mentors valued stability and regulatory compliance.

Unlike findings from prior studies, over half of participants (n = 6) held baccalaureate degrees in nursing (BSN) and two had a master's degree in public administration. Except for one DON educated in the US, all other BSN prepared DONs attended nursing school in the Philippines where basic education is at the BSN level. The educational level of this group of participants may be explained by the geographical location of the study on the west coast. While unusual, this finding may allow nursing homes with similar demographics to promote DON participation in advanced practice programs at the master's level.

Despite the high educational level of the sample, no participant had formal preparation in gerontology or geriatric nursing. This continued lack of gerontological

nursing preparation is concerning, especially in light of the rising complexity of resident acuity, the reliance on unlicensed staff to provide care, and the unrelenting problems of meeting the most basic of regulatory care standards. Additionally, the formal education of DONs in administrative and leadership content was almost non-existent.

All participants were aware, but accepting of their educational deficits. Most utilized industry and regulatory resources to improve resident care and staff performance. Even reflective leaders however, stopped short of seeking professional or academic consultation to improve their practice, and only one participant considered returning to school. These factors suggest that without advanced education in administration and leadership theory and without knowledge of gerontological nursing theory and practice, while enthusiastic and willing, DONs may be unable to effect meaningful change in their organizations.

The DON: manager or leader?

While organizations and services can be managed, a workforce must be led and inspired to accomplish organizational objectives (Hesselbein, 1999). Leaders must engender followership, which is not guaranteed simply because one holds a management title (Drucker, 1999). The empirical literature is replete with examples of the debate about who leads, who manages, and who is vested with the responsibility for either or both. Recently, literature trends toward the view that today's manager must balance management and leadership responsibilities, and possess both sets of skills (Kouzes & Posner, 1993). This type of manager is portrayed as one who is comfortable with change and focuses on developing the people who make organizational goals achievable (Bass, 1990; Bennis, 1999; Curran, 2002; Kerfoot, 1999; Kotter, 1996; Zaleznik, 1977/1992).

DONs in this study considered inspiring others as the hallmark of being a leader, and all DONs claimed to use inspirational approaches in their work. Indeed, all were passionate however; I observed key differences in their approaches to inspiring others. DONs held differing views of staff capabilities that influenced their approach to staff supervision and development. They also approached environmental and resident care challenges differently. These discrete differences, when examined in concert with their leadership style led to construction of the unique leadership profiles described and illustrated in chapter five.

DON profiles of leadership

Veteran, reflective, and beginning leader profiles were constructed from interview and observational data. Transformational leadership theory (TLT) was used to examine the tasks, approaches, activities and processes associated with leadership enactment. TA approaches were reflected in promotion of work norms and rules. TF approaches focused on connecting with staff and fostering cooperative processes. LF leadership was identified as the absence of attention to both norms and rules, as well as to interactions with others (Burns, 1978; Bass, 1985).

According to Mintzberg (1983), leadership matters. This study suggests that a leader's style also makes a difference by influencing staff performance and ultimately, the quality of resident care. For instance, veteran leaders monitored staff compliance methodically, overlooked clinical situations that seemed to have no solution, used minimum regulatory standards to set expectations for resident care, and avoided conflict and sanctions for poor performance. As a result, staff mechanically completed resident care and often failed to comply with documentation standards. Conversely, reflective

leaders maximized staff creativity in dealing with difficult issues. Their emphasis was on teamwork, shared goals, and staff involvement in solving problems and suggesting system improvements.

Leadership style has a cascading effect throughout an organization, similar to the image of dominoes falling in sequence (Bass & Avolio, 1995; Leach, 2005; McDaniel & Wolf 1992, Stordeur et al. 2000). Thus the behaviors and values at the top of organizations "cascade" downward to influence staff at all levels. The influence of the cascading effect DON leadership on staff was observed to influence the quality of attention staff gave to residents and to the living environment.

The theoretical literature reports the positive cascading effects of TF leadership in organizations (Bass & Avolio, 1995; McDaniel & Wolf 1992, Stordeur et al. 2000) but there are no reports of the consequences of TA or LF leadership. Further, the cascading effect beyond the leader-follower dyad had not been reported. In this study, TF and LF approaches of veteran leaders, and the TF and TA approaches of reflective leaders were observed to affect the clinical effort of staff, as well as the care they gave to residents. The cascading effect of all leadership styles on staff performance and resident care may provide concrete interventions for developing DONs' leadership awareness, self-knowledge, and supervisory skills.

Veteran leadership was characterized predominately by TA leadership behaviors. That is, attention was focused on stability and maintenance of routines. Monitoring and surveillance were the primary approaches used to audit the work environment and staff compliance. Veteran relationships, in the tradition of exchange theory, were based on principles of give and take (Burns, 1978). Veterans' selectively attended to staff and

practice issues. Others went unnoticed, were accepted without question, or rationalized as unavoidable. This behavior, often mirrored in the attention staff gave to resident care issues, created a cascade of concern for compliance rather than a concentration on caring.

TA leadership can be a useful management approach to create or maintain a stable environment. Sole reliance on TA approaches however, signaled the veteran's tacit acceptance of routinized, habitual practices and set a tone for disengaged approaches to resident care. Reflective DONs also used TA approaches to maintain ongoing standards or stabilize problems. Different than their veteran colleagues however, reflective leaders augmented maintenance approaches with leadership that engaged staff personally and professionally.

The reflective leader's style was characterized primarily by TF behaviors of connecting with others, recognizing staff contributions, expressing core values, sharing information, and accountability. Reflective DONs provided individual attention and recognition of care successes. These approaches contributed to staff attending to residents in personal ways.

Reflective approaches relied infrequently on formal monitoring, an interesting finding in light of the highly regulated nursing home environment. The leader-follower relationship was based, in part on agreed upon values and ideals of caring. Leader tasks were associated with building expertise and creating a trusting environment. The domino effect was observed in personal attention, and as Carol said, "A difference in the *feel* of the building."

Beginning DONs used both TA and TF approaches. In particular, one with a strong mentor relationship with a past DON, and a good relationship with her facility

administrator, made significant changes in the organization of care to residents. Another participant hired to bring her facility back into compliance, was strongly oriented to TA approaches as evidenced by monitoring, and vertical patterns of communication (Bass, 1990). These approaches were mediated by her attention to infusing intellectual stimulation into the organization by using expert educators from outside the nursing home system, to improve the conditions of care and develop staff (Bass & Avoilio, 1985).

Laissez-faire leadership: Laissez-faire (LF) leadership is characterized by avoidance of transactions, delays in decisions, lack of communication and feedback to followers, avoidance of new ideas and directions for organizational improvement, and lack of long-range planning (Bass & Avolio, 1994; Northouse, 1997). While this leadership style has not been reported as a dominant style of nursing leaders, LF behaviors have been associated with practice situations that are either uncomfortable or unvalued (Northouse, 1997).

Laissez-faire leadership was used by veteran DONs with some frequency, and by reflective DONs on occasion. When decisions were difficult, conflictual, or perceived to be inevitable, DONs delayed or avoided taking action. For example DONs with a veteran profile would "give up" on poor performance if it was not a serious infraction or was deemed to be beyond a staff's capacity, like completing documentation correctly. The cascading message that poor care was acceptable created an atmosphere of hopelessness and cynicism. This was evident in DON-follower communication and spilled over into staff interactions with residents.

One additional feature of LF leadership is avoidance of contact with superiors or subordinates, remaining isolated from both reality and new directions (Northouse, 1997). This type of behavior was not observed or described in this study.

TLT and nursing leadership studies

While no nursing home studies using TLT have been conducted with DONs, several studies of nurse leaders in acute settings exist. Notwithstanding contextual differences between settings, findings provide a lens to view results of this research. In general, while this body of research reported TF leadership as the dominant style of nurse leaders, findings from two studies, Dunham and Klafehn (1995) and Stordeur and Vandenberghe (2000), found that leaders used mixed TA and TF styles. This result was found in studies of leaders in other fields (Bass, 1990) and is congruent with the three DON profiles described in this study.

Several studies found a significant positive relationship between TF leadership and staff retention (Kleinman 2004), job satisfaction (Dunham-Taylor & Klafehn, 1995; Medley & Larochelle, 1995; McDaniel & Wolf, 1992; Morrison, Jones & Fuller, 1997) and increased work effort and group effectiveness (Dunham-Taylor, 2000). Other studies examined the cascading, or domino effect of TF leadership in organizations (Leach, 2005; McDaniel & Wolf, 1992; Stordeur & Vandenberghe, 2000).

Of particular relevance were findings from the 1997 study conducted by Morrison and colleagues in an Alabama medical center (Morrison, Jones & Fuller, 1997). The descriptive survey study examined the relationship of leadership style and empowerment to the satisfaction of licensed and unlicensed staff. Sixty-four percent of staff (n = 442) participated in the study. Interestingly, empowerment affected job satisfaction of

licensed and unlicensed staff differently. Empowerment, an approach used exclusively by TF leaders, was linked to satisfaction of licensed but not unlicensed staff. Recognition and personal consideration were the key measures of satisfaction for unlicensed staff and these approaches are common to both TA and TF leadership.

Since nursing homes employ mostly unlicensed staff, DON leadership that emphasizes fair exchange, clear messages, and active management by exception may be appropriate and appreciated by direct care staff. On the other hand, to attract strong and competent RNs into nursing home practice, developing DONs to understand and use TF approaches that promote empowerment is essential.

Contextual Factors

Factors found to influence leadership enactment included: 1) facility size, 2) facility generated revenue, 3) regulatory compliance and standardized care, and 4) DON-facility administrator relationships.

Small facility size (< 70 beds) influenced DON leadership in several ways. DONs were unable to build an adequate infrastructure, had few collegial relationships, and had to shoulder the bulk of the workload alone. This resulted in consequences for other staff as well. As Amy pointed out, staff had few opportunities to improve their skills or stay current with technology and practice changes. Other participants pointed out, it was not easy to recruit a DON for a small building even though smaller facilities are often described as more home-like settings for residents.

Facility-generated revenue was the primary funding source for resident care equipment and physical environment improvements. Inadequate financial support constrained DONs' ability to accomplish these goals. They were expected to "meet the

bottom line" while ensuring successful annual surveys and "keeping families happy." While important business goals, neither have been empirically linked to the quality of resident care. DONs acknowledged the effect that limited revenue had on resident care and working conditions, but had little authority to change the situation. As reported earlier, DONs that used reflective and TF approaches were more likely to engage staff in developing creative approaches to resident care and clinical work despite infrastructure and fiscal constraints.

Every DON reported her highest priority was to pass the state survey. To ensure their facilities passed regulatory inspections, parent corporations developed sets of standardized policies, procedures, and clinical initiatives. This support however, was compromised by institutional processes that focused on compliance. Institutional mandates created an audit climate that constrained DONs' ability to make decisions, limited the infusion of new clinical evidence, and reinforced routinized staff practice. The unintended consequence of this mechanistic approach to care widened the relationship gap between staff and residents by creating artificial remedies for problems.

Poor or inconsistent support from administrators constrained DON authority and effectiveness, permitting only incremental change in the overall culture of the facility and resident care over time. Strong partnerships between DONs and facility administrators supported DON efforts to sustain and initiate improvements, mitigated organizational resistance to change, and established expectations for teamwork and better care. Strong partnerships promote TF leadership which has been strongly correlated with above average organizational behavior (Aditya & Ram, 1997; House & Aditya, 1997; House, Aditya & Ram, 1997).

Leadership research has focused primarily on individual characteristics or qualities of a leader. Bass (1990) however suggested that variances in leadership were related to the interaction between the leader and the organizational context. It is widely accepted that leader behaviors differ between types of organizations. Nursing homes are characterized as stable and mechanistic organizations. In these organizations, TA leadership that provides adequate exchange rewards, clear direction, and efficient monitoring of outcomes is thought to be the most effective style (Jacques, 1996).

Stability, harmony, and efficiency are seen as necessary for organizational survival. As such, TA leadership is expected to satisfy organizational needs for stability and predictability. The job of such leaders is to manage established routines or make incremental adjustments in norms to ensure efficient organizational functioning. As demonstrated in multiple illustrations provided in chapter five, TA leadership had negative consequences on care and staff performance. Similar observations have been described in other mechanistic organizations as well (Katz & Kahn, 1978).

This study found variation in DON leadership profiles, and this variation influenced the work of staff and the delivery of resident care. Differences in leadership style had an effect on the meaning infused into staff work and whether resident care was habitually constructed, individualized, or thoughtfully routinized to meet regulatory and workforce needs.

Contextual factors were found to either encourage or impede enactment of leadership. For example, corporate expectations for regulatory and fiscal compliance called attention to the nature of authority relations, performance goals, and environmental monitoring. Veteran leaders were more likely to pass along corporate expectations

without question, audit compliance, feel discouraged when staff failed to meet the standard, and intervene personally to "get it done right." This cycle led to unspoken allowances for mistakes, marginal or deficient staff performance, and ultimately to minimal improvements in care.

Literature suggests that TF approaches, which engage people in their work is a more effective leadership style (Vance & Larson, 2002). Reflective DON leaders looked beyond the fiscal and compliance mandates to promote the secondary goals of corporate nursing homes--better care and workforce satisfaction. They found corporate mandates insufficient to assure regulatory or clinical compliance, and expressed concern over their inability to suggest alteration in standardized practices. Overwhelmingly, DONs wished for a stronger voice in decision-making at the facility and district levels to better serve the needs of residents, staff, their local environment, as well as the corporation's goals.

This study brings into light the question of whether TA leadership, purported in the literature as the most effective style of leadership for mechanistic organizations, is indeed appropriate to advance the clinical and culture changes needed in nursing homes. TA and LF approaches demonstrated by veteran leaders failed to engage staff in the intrinsic value of their work. While their goal was to inspire staff to give better care, they missed opportunities to infuse meaning into the caring practices of staff by focusing on monitoring, correction, and "giving up" on those that failed to meet standards. In poorly resourced nursing homes, compliance and acceptance of marginal staff performance may have a heightened negative outcome of stagnation and reinforcement of institutional approaches to care.

Nursing home ethnographies have long reported that nursing leadership is needed to improve staff attention to the human conditions of nursing home elders (Foner, 1994; Gubrium, 1975; Kayser-Jones, 1981/1990). Of particular interest is Kayser-Jones' (1981/1990) finding that routinized care is associated with depersonalization of elders. In this study, corporate mandates for DONs to implement standardized procedures and monitor compliance promoted routinized care. Standardizing procedures may improve documentation of regulatory criteria, but lead to depersonalization of residents by reinforcing negative ways staff view and respond to residents. Study findings suggest that DON approaches that value order over individual consideration, monitoring over engaging with staff in clinical discussions, and maintaining the appearance of compliance over addressing staff performance dilemmas, may be at the root of persistent problems in improving marginal or deficient care.

Limitations

Limitations of the study are considered in this section. Here, I reflect on the questions left unaddressed in this research, and the shortcomings associated with the questions pursued and methods used. This ethnographic research represents a unique first attempt to explore, describe, and analyze the dimensions of DON leadership in the nursing home setting. The design privileged the voice and perceptions of DONs and thus relied heavily on their subjective views. DONs selected the days and events for participant observation activities so consequently a full range of role and leadership behaviors may not have been observed. The study design included multiple periods of participant observation that provided many opportunities for triangulation of data, thus

enhancing the possibility for precision in representing DON views and analytic accuracy in describing leadership approaches and activities.

By focusing on leadership, an inherent risk was the possibility of overlooking how much of the DONs' work involved managing the status quo. While examining the effect of management on leadership was beyond the scope of this study, it is possible that management proficiency could, in and of itself, facilitate or constrain leadership.

Study findings are naturally bounded by the small sample, inclusion of only one type of nursing home setting, and limited geographic location. Findings are not intended to be generalized to the larger population of nursing home DONs, but carefully considered as important factors in designing and implementing future studies.

Direction for Future Research

The gaps in our knowledge about the nursing home DON role are many, but the need to continue exploring the leadership component of the role is crucial if we are to make and sustain improvements in resident care and the working conditions of nursing home staff. Most research over the past twenty-five years has lacked a strong conceptual basis to frame and guide discourse about leadership, and thus has been insufficient to catalyze significant change in DON practice. This research builds upon and extends previous research by describing and testing theory about the leadership role of DONs.

Findings point to the need for a current national profile of DONs that describes their demographic characteristics, wages and benefits, geographic distribution, and levels of geriatric and administrative education. Moving beyond descriptive surveys, we also need a program of nursing home research to study the relationship between nursing leadership and facility characteristics, types of ownership, cost, and clinical outcomes.

This study suggests that a leader's style also makes a difference by influencing staff performance and ultimately, the quality of resident care. This study found variation in DON leadership profiles, and this variation influenced the work of staff and the delivery of resident care. Larger studies are needed to confirm and understand the cascading effects of DONs' leadership style on staff satisfaction and performance, and on the care staff provide to residents.

From this study, two hypotheses that require empirical study have been identified. First, we need a better understanding of constraints and facilitators that regulatory and corporate mandates actually place on leadership and thus, on resident care. I hypothesize that corporate constraints, and poor DON-administrator relationships reduce DON autonomy and impede enactment of TF leadership, thus decreasing organizational effectiveness, resident care improvements, and workforce performance and satisfaction.

Second, the problems identified in small facilities need to be studied. In light of the desire to create smaller, home-like settings for long-term care, the burdens associated with fewer and less skilled resources are concerning and require further explication. I therefore hypothesize that an administrative structure that employs nurses with advanced, specialized education in gerontology and administration in both DON and facility administrator roles would increase DON satisfaction, improve retention and development of professional nurses, and contribute to sustainable improvements in resident care.

Implications for Practice

Building the workforce: In light of existing problems attracting RNs into the nursing home workforce, this study suggests new strategies to recruit qualified RNs and potential nurse leaders. The pool of nurses interested in working in nursing homes may

be larger than expected. Marketing leadership opportunities to RNs looking for career advancement or to re-enter practice may promote RN interest in nursing home positions as well as attract RNs with a range of experience and skills.

Improving workforce preparation: While filling current and projected DON vacancies is an important issue, this study also underscores the need for gerontological and administrative competence. Qualified candidates must possess or develop essential skills and a current fund of knowledge to make and sustain needed improvements in long-standing care issues.

Six of ten participants in this study had BSN degrees; two others held a master's degree. These nurses, enthusiastic about their work and contributions to nursing home practice, would be good candidates for graduate education. It is not known if the high level of DON education is unique to this study however; to improve care and retain dedicated DONs, corporate facilities with similar DON demographics could create incentives for nurses to complete education at the master's level.

Creating new partnerships: Academic investment in developing this cadre of nurses is essential to change the landscape of nursing home practice. Opportunities exist for development of faculty practices and nursing internships in local nursing homes. Too often, academics and scientists enter and leave the field without bringing participants with them into public arenas or academic settings.

To decrease the professional isolation of the nursing home leaders, programs to support advanced education of RNs need to be developed, funded, and made accessible to the current workforce. Schools of nursing must initiate partnerships with local nursing homes and the larger nursing home industry. While strides have been made to increase

geriatric content in academic nursing programs, nursing administration programs have not embraced the nurses providing leadership and care to the vulnerable nursing home population. These programs need to recruit existing practitioners and prepare them for major facility and corporate roles.

Improving professional ownership: Nursing needs to accept O'Neil's (1998) challenge to include long term care nurses within its' professional embrace. Minimum standards for professional practice must be enforced in all settings where nurses work. With the same commitment given to improving caregiver staffing ratios in nursing homes, advocates, scientists, and consumers must work to extend these gains to achieve the minimum requirements for administrative staffing set forth by the National Citizen's Coalition for Nursing Home Reform over a decade ago (NCCNHR, 1995; Harrington et al., 2000).

Conclusion

The leadership role of DONs is central to clinical and organizational success. Almost thirty years ago, Kayser-Jones (1979) discussed the importance of nursing leadership to improve resident care. Soon after, Harrington and Cruise (1984) identified the need for nurse leaders in gerontology to use their power to direct policy and make structural changes for the care of elders. While there is little debate about the need for DONs to have additional education and mentorship to sustain workforce and resident care improvements, very few studies have shed light on the DON leadership role in addressing intransigent nursing home problems.

A need exists for development of a strong national research agenda to promote effective nursing leadership in nursing homes. Findings from this study point to three

inter-related factors to improve nursing leadership. First, the expectation of leadership must be established and memorialized in DON position descriptions and in corporate procedures. Second, a framework for ensuring ongoing DON leadership development needs to be designed by professional, consumer, and industry stakeholders. Third, DON rewards--fiscal, professional, and personal must be commensurate with the position responsibilities and challenges.

The need for academic and professional oversight of nursing home practice cannot be minimized. These professional groups must recognize, support, and develop the nursing talent that serves our nation's elders. Professional standards can not be left in the sole purview of individual facilities or proprietary nursing homes. When institutional policies and practices contribute to marginalizing, isolating, and de-professionalizing nurses who practice in nursing homes, then academics, scientists, and professional organization leaders must step forward to actively intervene or provide necessary consultation and support to DONs. They must also take a clear public position that promotes awareness of the need to maintain a healthy work environment for nurses as well as a safe and humane residence for people living in nursing homes.

In sum, this ethnographic study investigated leadership from the perspective of DONs. Findings, presented as a rich description constructed from the stories, thoughts, and observed actions of participants, drew on transformational leadership theory to explicate how DONs perceive and enact leadership. This study extends the theoretical literature by contributing a conceptual description of DON leadership in the nursing home context. Findings improve our ability to recruit and retain DONs, develop their leadership capacity, and provide a foundation for subsequent research.

Appendix A

Initial Interview Guidelines

Introductory statement:

As you know, my research focuses on the role and responsibilities of nursing home DONs. I am specifically interested in learning about the experience of being a DON from the perspective, or point of view of DONs. Thank you for agreeing to participate in this study and spending time with me today.

Grand tour questions:

To begin, I would like to hear about your nursing background and how you became interested in nursing home care.

Can you please tell me about your decision to accept this DON position? How did that come about for you?

Can you please tell me about your work as a DON?

How would you describe your approach to your work?

What is a typical day like for you?

In-depth/focused probes:

How would you describe your experience as the DON?

What are your major responsibilities?

What do you consider to be the major challenges of your job?

- Can you give me an example of a time when (*use an example from the DON's story*) occurred?

Are there times when it's difficult to finish your work?

- How often would you say this occurs?
- What is your approach to this/these situations?
- How do you decide what to focus on in those situations?
- Whom do you count on for help?

What do you find most rewarding in your role as a DON?

- Can you give me an example of a time when (*use an example from the DON's story*) occurred?

What preparation did you receive for the DON position?

What DON development activities or classes have you participated in?

Who do you talk with about:
a) your development as a DON?
b) problems you encounter?
c) successes you have?

Can you please tell me about your goals for professional development?

What supports do you:
a) have?
b) use?
c) need?

What do you consider to be the characteristics of a successful leader in the nursing home setting?

How do you define leadership?

How do you define DON leadership?

What do you consider to be the major leadership challenges of your job?
- Can you give me an example of a time when (*use an example from the DON story*) occurred?

If you could change one thing about the DON role, what would that be?
- Are there other things you would change as well?

21. What aspect of the DON role would you say should not be changed?
- Are there other things you would not change as well?

Thank you for spending this time with me and sharing your views on the DON role.
- Do you have other thoughts or reflections on your role, or on leadership that you'd like to add at this time?
- Is there anything else you would like to share that I should know to better understand your experience as the DON?

General Prompts:
- Could you give me an example of that?
- Could you explain that a bit more?
- Tell me more about that.

TABLES

Table 3.1 Characteristics in the Study Sample

DON Characteristics[1] N = 10	Range	Mean	Standard Deviation
Age	33 - 62	45.60	9.20
Yrs as an RN	8 - 40	20.80	8.12
Yrs in NH practice	4 - 34	12.60	9.60
Yrs as DON	1 - 14	4.90	4.35
Yrs in other settings	0 - 22	8.30	7.57
Nursing Education	**Diploma**	**AD**	**BSN**
	1	3	6

[1] data rounded to nearest whole number

Table 3.2 Investigator's Data Collection Summary of Activities

	Total	Range	Mean	Standard Deviation
Initial Interview [Hrs]	15.75	1.00-2.00	1.58	0.41
Follow-up Interviews [# - Hrs]	N = 26.00 Hrs = 28.50	N = 1.00-4.00 Hrs = 1.00-6.50	N = 2.60 Hrs = 2.85	N = 0.97 Hrs = 1.99
Participant Observation Conversations [# - Hrs]	N = 40.00 Hrs = 22.75	N = 2.00-9.00 Hrs = 1.00-6.00	N = 4.00 Hrs = 2.28	N = 2.40 Hrs = 1.63
Participant Observation Sessions [Hrs]	164.25	8.00-33.50	16.43	8.18
Total Visits [#]	43.00	3.00-7.00	4.30	1.42

FIGURES

Figure 4.1 Reasons for Entering Nursing Home Practice in Study Sample

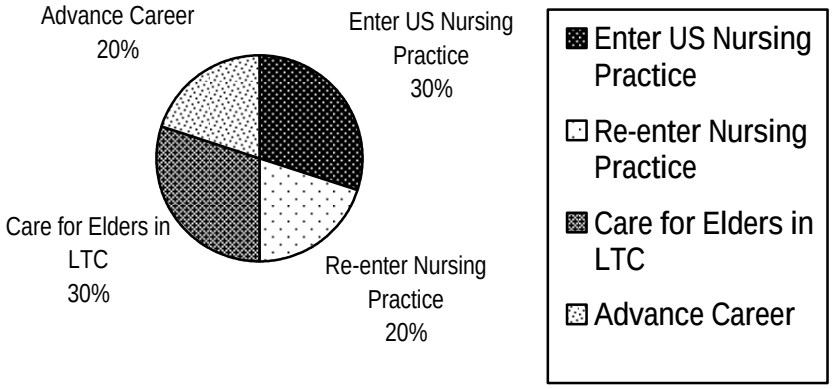


Figure 4.2 Antecedent Conditions to Becoming a DON

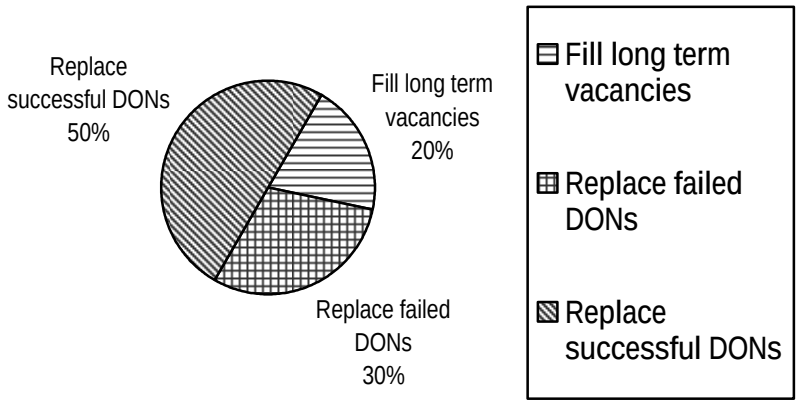
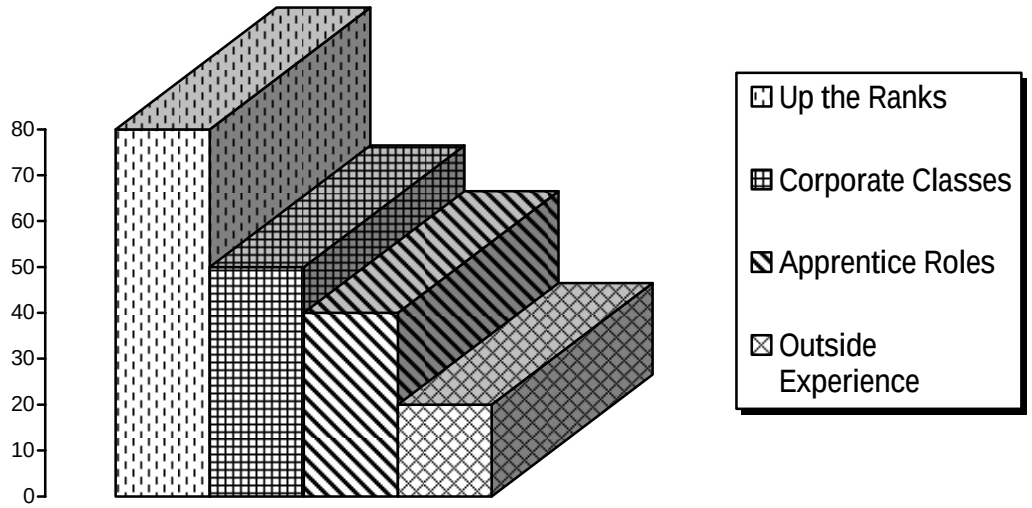


Figure 4.3 DON Role Preparation in Study Sample



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