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Assistant Nurse Managers Connecting and Engaging with Professional Peer Networks

Author
Finical, Gina

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Approved:

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Dr. Elena Siegel, PhD, RN, Committee in Charge 2021

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Dr. Susan Adams, PhD, RN, NP, CNS, Chair

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Dr. Julie Bidwell, PhD, RN, Chair

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Correspondence concerning this article should be addressed to Gina Finical, E-mail: ginafinical@gmail.com

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Introduction/Problem Statement

The nursing profession is the largest in the nation's healthcare workforce with over three million nurses, and nursing leadership is required across all levels and settings (IOM, 2011). This study focuses on one level of nursing leadership: Assistant Nurse Managers (ANM). This title, ANM, is most commonly used in the Sacramento, California area in reference to the permanent front-line nurse manager (i.e., not a relief or as needed position) with clinical and administrative duties for a specified shift on a specific unit. In contrast, the title *shift charge nurse* (CN) is most commonly reflected in the literature for this same position (i.e., front-line manager with clinical and administrative duties in the acute care setting) (Admi & Eilon-Moshe, 2016); however, both titles – CN and ANM – are found in the literature (Eggenberger, 2012). For the purpose of this thesis, CN and ANM will correspond with the title reflected in the respective cited literature. When specifically referencing the current study, the title ANM will be used.

The staff nurse, CN, and nurse manager (NM) positions are all varying frontline nursing roles, and it can be confusing to distinguish their different levels of authority and responsibilities (Admi & Eilon-Moshe, 2016). Charge nurses are the direct nursing leaders one step above the bedside nurse and are the frontline problem-solvers (Connelly, Yoder, & Miner-Williams, 2003). The CN is the entry-level management position on the frontline delivery of patient care (Connelly, Yoder, et al., 2003), responsible for all patients, all staff, and all operations within a unit for a particular shift (Admi & Eilon-Moshe, 2016; Cathro, 2016; Connelly, Yoder, et al., 2003; Eggenberger, 2012). Charge nurses operate under the direct supervision of a unit nurse manager (NM), an executive role with 24-hour responsibility for one or more units (Admi & Eilon-Moshe, 2016). Nurse leaders, including ANMs, are vital to the success of healthcare as

they connect organizational goals to patients (Omoike, Stratton, Brooks, Ohlson, & Storfjell, 2011) and improve patient outcomes (Eggenberger, 2012; Omoike et al., 2011).

Many CNs fulfill their role without any formal training, specialized education, orientation (Eggenberger, 2012; Flynn, Prufeta, & Minghillo-Lipari, 2010; Homer & Ryan, 2013; Morris, 2019; Platt & Foster, 2008; Sherman, 2005), or ongoing education to support their development of leadership skills (Eggenberger, 2012; Flynn et al., 2010; Platt & Foster, 2008; Sherman, 2005). A lack of formal training can lead to role stress, role confusion, and burnout (Platt & Foster, 2008), and CNs report they do not feel prepared for the role and have low self-efficacy (Morris, 2019; Platt & Foster, 2008). Once in the role, many CNs report receiving support from their direct supervisor (Flynn et al., 2010; Upenieks, 2003), and those who report a lack support from their direct supervisor express difficulty in role performance (Patrician, Oliver, Miltner, Dawson, & Ladner, 2012). Without formal training, CNs utilize their professional networks as their primary support and resource system (Morris, 2019). Professional peer networks offer opportunities for CNs to develop and strengthen leadership skills and provide support (Connelly, Nabarrete, & Smith, 2003; Flynn et al., 2010; Sherman, 2005); however, little is known about the extent CNs form professional peer networks and how networks are used by CNs for role support.

The purpose of this study is to examine the ANMs' experiences with and preferences for engaging in professional peer networks in the acute care setting. The insights gained from this study can offer a first step to better understand ways to develop ANM professional peer network opportunities and to support ANMs' advancements in this professional nursing leadership role. The findings can additionally serve as a beginning guide for organizations in developing innovative strategies that promote collaborative learning and support ANMs when leadership training, development, and support is limited.

Significance

The Institute of Medicine (IOM) 2020 goals calls for nurses to develop new partnerships, transition to a leadership style that fosters collaboration, and tap into their full leadership potential (IOM, 2011). The American Organization of Nurse Executives (AONE, 2005) stated excellent leadership is needed to have a high level of patient care and requires a leader to be proficient and competent. The AONE (2005) identified four core competencies for nurse leaders: communication and relationship management, professionalism, knowledge of healthcare environment, and business skills and principles. Charge nurses are the potential future nurse leaders, and therefore, it is imperative they have adequate professional development opportunities and peer support (Patrician et al., 2012). In order for CNs to perform at their best so they can positively impact the delivery of safe patient care, CNs need on-going leadership training and development, mentors, and support (Admi & Eilon-Moshe, 2016; Admi & Moshe-Eilon, 2010; Krugman, Heggem, Kinney, & Frueh, 2013).

Literature Review and Synthesis

Search Strategy and Results

The literature review and synthesis include data-based publications focused on the CN/ANM position in acute care settings. The citation dates included 1997 to 2020. The terms were searched separately, and searches employed combinations of terms using the Boolean terms AND and OR in the PubMed database. Terms included front line nurse leader (15) OR "nurse leader" (518) OR "charge nurse" (353) AND role (2624559) NOT "clinical nurse leader" (157) NOT "clinical nurse specialist" (2,918). Of the 234 articles found, 222 were excluded as they were not data-based (e.g., case studies, discussions, expert opinions), or the studies were not conducted in the acute care setting, resulting in 12 articles. Eight additional articles were

identified by hand search, resulting in a total of 20 articles. The 20 articles included 13 qualitative studies (Carlin & Duffy, 2013; Cathro, 2016; Connelly, Nabarrete, et al., 2003; Connelly, Yoder, et al., 2003; Eggenberger, 2012; Flynn et al., 2010; Homer & Ryan, 2013; Morris, 2019; Patrician et al., 2012; Platt & Foster, 2008; Sherman, 2005; Sherman, Schwarzkopf, & Kiger, 2011; Upenieks, 2003), six quantitative studies (Admi & Eilon-Moshe, 2016; Admi & Moshe-Eilon, 2010; Krugman et al., 2013; Omoike et al., 2011; Shirey & Fisher, 2008; Squires, Tourangeau, Spence Laschinger, & Doran, 2010), and one review (Shirey, 2004). The findings from this literature review are organized into four broad categories: (1) charge nurse role, (2) transitioning into the CN position and role training, (3) role stress, and (4) role support.

Charge Nurse Role

Twelve articles reported findings related to the CN role, including: (1) role competencies, job description, and position title; (2) roles and responsibilities; (3) CN role outcomes; and (4) role clarity (Admi & Eilon-Moshe, 2016; Carlin & Duffy, 2013; Cathro, 2016; Connelly, Yoder, et al., 2003; Eggenberger, 2012; Flynn et al., 2010; Morris, 2019; Patrician et al., 2012; Sherman, 2005; Sherman et al., 2011; Squires et al., 2010; Upenieks, 2003). The majority (11) included data collected through interviews (7) (Carlin & Duffy, 2013; Cathro, 2016; Connelly, Yoder, et al., 2003; Eggenberger, 2012; Morris, 2019; Sherman, 2005; Upenieks, 2003), observations (1) (Cathro, 2016), focus groups (2) (Flynn et al., 2010; Patrician et al., 2012), and survey comment sections (1) (Sherman et al., 2011). The quantitative studies used the CN Stress Questionnaire for data collection (Admi & Eilon-Moshe, 2016), the Interactional Justice Scale (Squires et al., 2010), Resonant Leadership Scale (Squires et al., 2010), Leadership-Member Exchange 7 Questionnaire (Squires et al., 2010), Safety Climate Survey (Squires et al., 2010), Perceived

Nursing Work Environment instrument (Squires et al., 2010), and the Maslach Burnout Inventory-The Emotional Exhaustion subscale (Squires et al., 2010). The majority of studies were conducted in the United States (U.S.) (10), with one study (Carlin and Duffy (2013) conducted in the United Kingdom, and another (Admi and Eilon-Moshe (2016) conducted in three countries: U.S., Thailand, and Israel.

Role Competencies, Job Description, and Position Title. There is not a nationally recognized standard list of competencies for the CN role (Admi & Eilon-Moshe, 2016), and job descriptions and/or stated competencies vary both within (i.e., across units) and across organizations (Flynn et al., 2010). In fact, not all organizations have a job description or set competencies for the CN position (Eggenberger, 2012). Furthermore, there is not a standardized title for the CN role as the same CN position in the United States is also termed ANM, shift CN, head nurse, and frontline nurse leader (FLNL) (Admi & Eilon-Moshe, 2016). This lack of standardization was highlighted throughout the papers included in this literature review. One article indicated the study participants in an acute care hospital in Florida, U.S. have the title CN or ANM, yet referred to the title as a "CN" throughout the article (Eggenberger, 2012). The Sherman et al. (2011) study conducted in the U.S. included acknowledgement of the title as CN or ANM, yet the authors referred to the participants and the role as CN throughout the article. Patrician et al. (2012) (U.S.) indicated participants' title as CN, while also noting they are considered clinical managers. Participants in the Admi and Eilon-Moshe (2016) study (U.S., Israel, Thailand) were titled shift CNs (SCN) and considered frontline managers. Four medical centers and one military medical center in the U.S. used the title CN (Cathro, 2016; Connelly, Yoder, et al., 2003; Flynn et al., 2010; Morris, 2019; Sherman, 2005). A U.K. study used the title senior CN (Carlin & Duffy, 2013). In one U.S. study, participants were collectively referred to as

nurse leaders, and specifically, assistant administrators, managers, and directors; however, these titles were not defined individually (Upenieks, 2003).

Role and Responsibilities. In the absence of a uniform job description, competencies, and position title; findings from several studies offered insights into the various roles and responsibilities of CNs. The CN is responsible for all patients, all staff, and all operations within a unit for a set shift (Admi & Eilon-Moshe, 2016; Cathro, 2016; Connelly, Yoder, et al., 2003; Eggenberger, 2012). Charge Nurses play an essential role in managing patient flow, staffing, patient and family concerns, and interdepartmental issues (Connelly, Yoder, et al., 2003; Eggenberger, 2012). The CN role includes clinical, administrative, and human relation responsibilities (Connelly, Yoder, et al., 2003; Eggenberger, 2012). The administrative responsibilities include disciplinary actions, coaching, education, and staff recognition (Cathro, 2016). Charge nurses are expected to make thoughtful and strategic patient assignments by fitting patients to nurses based on patient needs and nurses' skills, ensure staff follow policies and procedures, support the frontline staff, and assist frontline staff nurses with direct patient care (Cathro, 2016).

Charge Nurse Role Outcomes. Charge nurses are positioned to positively influence the culture of a unit, staff satisfaction, and the overall quality and safety of patient care (Carlin & Duffy, 2013; Cathro, 2016; Connelly, Yoder, et al., 2003; Eggenberger, 2012; Sherman, 2005; Squires et al., 2010) through monitoring, training, and supporting the nursing staff who deliver patient care (Cathro, 2016; Eggenberger, 2012). Good nurse leaders produce satisfied staff nurses who stay in their jobs and provide quality care to patients (Upenieks, 2003). Staff support was highlighted as an important part of the CN role by nurse leaders (Eggenberger, 2012; Morris, 2019; Patrician et al., 2012; Upenieks, 2003). The CN position was associated with staff

nurse turnover, emotional exhaustion, intent to leave, and medication errors; all of which impact patient outcomes (Squires et al., 2010). The watchfulness of the frontline care by the CN can ensure national healthcare benchmarks for quality measures are achieved, such as fall prevention, hospital-acquired pressure ulcer prevention, and hospital-acquired infection prevention (Cathro, 2016).

Role Clarity. Four studies included findings related to clarity of the CN role, revealing variations in understanding the CN role. Two studies found that staff nurses did not understand the full scope of the CN role (Carlin & Duffy, 2013; Patrician et al., 2012). In contrast, another study revealed CNs reported that they understood their role despite their organization (hospital) not having a CN job description (Eggenberger, 2012). Role confusion by staff and the CNs is common (Flynn et al., 2010). Unclear roles not only negatively affect those in the CN role, but a lack of clarity also negatively affects the staff they lead (Carlin & Duffy, 2013; Patrician et al., 2012). Role confusion contributes to role overload as staff nurses' expectations of the CN can be inappropriate (Patrician et al., 2012).

Transitioning into the CN Position and Role Training

Four studies included findings related to transitioning into the CN position. Nurses are usually hired into the CN role based on their strong clinical skills and are often promoted from the bedside nursing position (Flynn et al., 2010). In some organizations, it is mandatory for nurses to fulfill the CN role when needed (Flynn et al., 2010). One study reported findings that CNs felt unprepared, overwhelmed, unsupported, and fearful after transitioning into the role; with one participant indicating they sought medical treatment due to their negative role experience (Morris, 2019).

Training. Charge nurses often fulfill their role in the absence of any formal leadership training (Eggenberger, 2012; Flynn et al., 2010; Homer & Ryan, 2013; Morris, 2019; Patrician et al., 2012; Platt & Foster, 2008; Sherman, 2005). Charge nurse role orientations are often inconsistent (Flynn et al., 2010; Homer & Ryan, 2013; Morris, 2019) and highlight the need for more formal role training (Connelly, Yoder, et al., 2003; Patrician et al., 2012). In addition, CNs often do not receive the ongoing education that is needed to continue to develop and strengthen their leadership skills for effective performance (Eggenberger, 2012; Flynn et al., 2010; Platt & Foster, 2008; Sherman, 2005). While some organizations offer CN training, Morris (2019) found classes were hard to access (i.e., limited openings) and were often taken weeks to years after transitioning into the leadership role.

With the lack of formal training for the role, CNs reported feeling unprepared and inefficient in the role (Morris, 2019; Platt & Foster, 2008). One study showed an association between a lack of formal leadership training for CNs and reductions in morale, increased absenteeism, and negative impact on the job performance of the frontline staff whom the CNs led (Platt & Foster, 2008). Unsupported CNs experience significant negative effects, and one participant reported seeking counseling because of it (Morris, 2019). Morris (2019) suggested a universal theme of "a cry for help" (p. 24) based on participants' reports of a lack of preparedness for the CN role and their interest in better role transitions for new CNs.

Study findings suggested CNs want ongoing leadership training (Krugman et al., 2013; Morris, 2019; Omoike et al., 2011; Sherman et al., 2011; Shirey & Fisher, 2008), and conflict management was identified as the top learning need (Eggenberger, 2012; Morris, 2019; Sherman et al., 2011). Charge nurses want to see change and do not want other CNs to share their negative

experiences due to a lack of adequate training (Morris, 2019). One author highlighted the need for CNs to receive ongoing support after role orientation (Flynn et al., 2010).

Leadership Workshops and Training. Thirteen articles were reviewed that evaluated nursing leadership training and program development, including nine qualitative studies (Connelly, Yoder, et al., 2003; Eggenberger, 2012; Flynn et al., 2010; Homer & Ryan, 2013; Morris, 2019; Patrician et al., 2012; Platt & Foster, 2008; Sherman, 2005; Sherman et al., 2011) and three quantitative studies (Krugman et al., 2013; Omoike et al., 2011; Shirey & Fisher, 2008). All studies were conducted in the U.S., except for the Platt and Foster (2008) study, which was conducted in the United Kingdom. Four of the qualitative studies collected data through interviews (Connelly, Yoder, et al., 2003; Eggenberger, 2012; Morris, 2019; Sherman, 2005) or focus groups (Patrician et al., 2012). Quantitative approaches included three studies examining pre- and post-program/workshop evaluation data (Connelly, Nabarrete, et al., 2003; Homer & Ryan, 2013; Omoike et al., 2011); a survey, as part of a workshop, to examine participants' experience as a frontline leader (Sherman et al., 2011); and a secondary analysis of data from a national survey (Shirey & Fisher, 2008). Four studies used data collected from participants who attended a nursing leadership workshop or program (Flynn et al., 2010; Krugman et al., 2013; Platt & Foster, 2008; Sherman et al., 2011).

The findings from these studies highlighted benefits of leadership workshops and training for CNs, including improved confidence and applied knowledge learned from peers, and more generally, the workshops/training provided a forum for leaders to get to know each other (Connelly, Nabarrete, et al., 2003; Flynn et al., 2010; Homer & Ryan, 2013; Krugman et al., 2013; Omoike et al., 2011; Platt & Foster, 2008). Conflict management that included reality-based scenarios was identified as the most common and valuable training for CNs (Sherman,

2005). Charge nurse participants in the Flynn et al. (2010) and Sherman (2005) studies benefitted from collaboratively working through scenarios with their peers in leadership training. Other benefits included renewed partnerships between the NMs and permanent CNs in units that provided coaching during their leadership program (Krugman et al., 2013); an expansion of the CN network with peers outside of their unit, which they reported was helpful to obtaining new information and insight in performing their role (Flynn et al., 2010; Platt & Foster, 2008); and improved perceptions of leading (Krugman et al., 2013). Connelly, Nabarrete, et al. (2003) and Homer and Ryan (2013) found CNs need help with applying their knowledge in handling real-life situations.

In one study, a sample return on investment was developed to show the cost of providing ongoing education to an organization's CNs was worth the benefits, including reduced staff absenteeism, increased job satisfaction, reduced overall complaints and grievances, reduced medical errors by staff nurses, improved patient flow process (admissions, transfers, and discharges), reduced employee turnover, and improved patient satisfaction (Sherman, 2005). Notwithstanding these benefits, Admi and Eilon-Moshe (2016) found CN training failed to provide adequate support that was needed for CNs to manage their role responsibilities and cope with the related stress. Another study focused on an administrative nurse leader program, and the results showed that the participants – nurse directors, nurse managers, and future nurse leaders – began to look for mentors and support from their peers after attending the program (Omoike et al., 2011), highlighting important connections that are possible from training opportunities. A mentoring program for CNs to improve their stress, support, and information sharing was associated with improved problem solving and coping (Admi & Moshe-Eilon, 2010).

Role Stress

Nine studies reported findings related to role stress (Admi & Eilon-Moshe, 2016; Admi & Moshe-Eilon, 2010; Carlin & Duffy, 2013; Cathro, 2016; Morris, 2019; Patrician et al., 2012; Platt & Foster, 2008; Sherman, 2005; Sherman et al., 2011). Four studies used a quantitative approach, with data collected from the CN Stress Questionnaire (Admi & Eilon-Moshe, 2016; Admi & Moshe-Eilon, 2010), a survey (Sherman et al., 2011), and a questionnaire (Platt & Foster, 2008), and five qualitative studies used data collected through interviews, observation, and/or focus groups (Carlin & Duffy, 2013; Cathro, 2016; Morris, 2019; Patrician et al., 2012; Sherman, 2005). Two studies involved data collected after CN participants attended a workshop (Platt & Foster, 2008; Sherman et al., 2011). Five of the studies were conducted in the U.S. (Cathro, 2016; Morris, 2019; Patrician et al., 2012; Sherman, 2005; Sherman et al., 2011), two in the United Kingdom (Carlin & Duffy, 2013; Platt & Foster, 2008), one in Israel (Admi & Moshe-Eilon, 2010), and one in Israel, Thailand, and the U.S. (Admi & Eilon-Moshe, 2016).

The responsibilities of the CN role are challenging and burdensome and are a common reason for stress (Admi & Moshe-Eilon, 2010; Morris, 2019; Patrician et al., 2012; Sherman et al., 2011). The CN role is perceived as exhausting (Sherman et al., 2011), and a lack of formal training for the CN can lead to role stress and burnout (Platt & Foster, 2008). The most common stressors in the role are conflict management, unclear job role, demanding job role, work overload, lack of resources, and lack of support (Admi & Eilon-Moshe, 2016; Admi & Moshe-Eilon, 2010; Sherman, 2005). Many CNs feel as if they are leading in chaos (Cathro, 2016). Patrician et al. (2012) found that managing the performance of staff was perceived as the most stressful aspect of the CN role. Interpersonal conflict with staff nurses was identified as a significant stressor (Morris, 2019).

Conflict happens daily with patients, families of patients, physicians, and the staff, and the CN is the one to respond (Morris, 2019; Sherman et al., 2011). Charge nurses commonly take on the stress of others in addition to their own role stress as they need to be able to identify and respond to others' stress (Cathro, 2016). In the Carlin and Duffy (2013) study, staff nurses did not see the CN position as a role they were interested in obtaining, and they viewed the CN role as demanding and stressful. One CN said that trying to support the staff was very difficult and the stress from it was carrying into their own personal life (Morris, 2019). CNs voiced their concern regarding how they are unable to adequately support staff nurses due to the overload of their responsibilities in another study (Patrician et al., 2012). Charge nurses need to be able to manage their own personal stress in order to be able to coach and mentor their staff (Sherman et al., 2011). Burnout can occur as CNs may have a hard time dealing with their own stress and struggle with personal coping skills (Morris, 2019). One study found that only 34% of participating CNs would consider a promotion to the NM role and the reasons they would not include an anticipated lack of support, role stress, not qualified, and no mentors (Sherman et al., 2011).

Role Support

Fifteen studies reported findings pertaining to mentors, support, or professional peer networks for the frontline nursing leadership role (Admi & Eilon-Moshe, 2016; Admi & Moshe-Eilon, 2010; Connelly, Nabarrete, et al., 2003; Connelly, Yoder, et al., 2003; Eggenberger, 2012; Flynn et al., 2010; Krugman et al., 2013; Morris, 2019; Omoike et al., 2011; Patrician et al., 2012; Platt & Foster, 2008; Sherman, 2005; Shirey, 2004; Shirey & Fisher, 2008; Upenieks, 2003). Of these studies, eight used a qualitative design (Connelly, Yoder, et al., 2003; Eggenberger, 2012; Flynn et al., 2010; Morris, 2019; Patrician et al., 2012; Platt & Foster, 2008;

Sherman, 2005; Upenieks, 2003), with data collected from interviews (Connelly, Yoder, et al., 2003; Eggenberger, 2012; Morris, 2019; Sherman, 2005; Upenieks, 2003), focus groups (Flynn et al., 2010; Patrician et al., 2012), and questionnaires (Platt & Foster, 2008). Five studies used a quantitative approach, with two using data collected from the CN Stress Questionnaire (Admi & Eilon-Moshe, 2016; Admi & Moshe-Eilon, 2010), two using pre-post surveys to evaluate leadership and CN programs (Connelly, Nabarrete, et al., 2003; Omoike et al., 2011), and one using a secondary analysis of a national survey (Shirey & Fisher, 2008). Other study designs included a quantitative action research design in the U.S., with data collected from the Leadership Practice Inventory and internal tools in a CN program (Krugman et al., 2013) and a review of studies from U.S., Canada, Australia, Japan, Israel, Finland, and the Netherlands (Shirey, 2004). Eleven of the studies were conducted in the U.S. (Connelly, Nabarrete, et al., 2003; Connelly, Yoder, et al., 2003; Eggenberger, 2012; Flynn et al., 2010; Krugman et al., 2013; Morris, 2019; Omoike et al., 2011; Patrician et al., 2012; Sherman, 2005; Shirey & Fisher, 2008; Upenieks, 2003), one was conducted in Israel (Admi & Moshe-Eilon, 2010), one in the United Kingdom (Platt & Foster, 2008), and one in U.S., Israel, and Thailand (Admi & Eilon-Moshe, 2016).

Mentorship and Support. The literature broadly suggested that mentors are needed for CN leadership development (Admi & Eilon-Moshe, 2016; Admi & Moshe-Eilon, 2010; Krugman et al., 2013) and support (i.e., emotional, performance) is needed for CNs for feedback, coping, and resilience (Admi & Eilon-Moshe, 2016; Admi & Moshe-Eilon, 2010; Flynn et al., 2010). Connelly, Yoder, et al. (2003) and Sherman (2005) discussed the importance of CNs receiving feedback from a supportive person. The support to CNs could lead to improvements in confidence, coping, and resilience (Admi & Eilon-Moshe, 2016). A review of 15 studies

identified a link between social support and stress at work, showing that support positively influences coping and well-being, affects burnout, absenteeism, job satisfaction, intent to leave, and organizational commitment (Shirey, 2004). Eggenberger (2012) suggested CNs could be utilized to their potential in ways that would align with their organization's goals if they were provided support that fosters leadership development.

Support from Supervisors. Five studies included various findings related to CNs and support from their supervisors. In one study, CNs reported receiving support from their direct supervisor as their daily resource person (Flynn et al., 2010). Another study revealed NLs obtained their informal power from alliances with others and commonly received support from their supervisors, which significantly impacted their growth and promotion (Upenieks, 2003). The CNs in the Patrician et al. (2012) study reported a lack of support from their NMs, and this caused a significant challenge for them in effectively performing their role. Krugman et al. (2013) linked supervisory support to the CN role in working with staff, finding CNs had trouble supervising and coaching their staff when the unit director was not available. As CNs are present for 24 hours a day and the CNs' direct supervisor works during the weekday hours (Admi & Eilon-Moshe, 2016), little is known about how nightshift CNs receive their supervisors' support.

Professional Peer Networks. Researchers conducting studies on the CN role acknowledged the need for CNs to have support from peers (Admi & Moshe-Eilon, 2010; Connelly, Nabarrete, et al., 2003; Connelly, Yoder, et al., 2003; Morris, 2019; Patrician et al., 2012; Upenieks, 2003). Due to lack of training, CNs utilize their professional networks as their primary support and resource system (Morris, 2019). Authors of one study concluded that steps should be taken to facilitate opportunities for peer support, given the support is needed to develop effective nurse leaders (Patrician et al., 2012). Professional peer networks can help CNs

develop and strengthen leadership skills, provide support, and information sharing (Connelly, Nabarrete, et al., 2003; Flynn et al., 2010; Morris, 2019; Sherman, 2005). A review of 15 studies found the size of the network is not as important as the presence, quality, and support from it; which has a significant positive impact on people and organizations (Shirey, 2004).

CNs reported they need their own formal peer group that can connect them with other CNs within their organization – and across units – with the benefit of ultimately helping patients (Patrician et al., 2012). Other reported benefits of networking include learning from each other as new perspectives and ideas emerge from sharing their experiences (Flynn et al., 2010; Sherman, 2005), providing a safe way to collaborate, and working through challenges (Flynn et al., 2010). After CNs connected through a 16-week CN development program offered by one organization, participants reported in their post-program evaluations that the flow of patients throughout the organization improved (Platt & Foster, 2008). In addition, findings indicated an increase in peer networks, with participants reporting improved self-esteem, confidence, autonomy, and alignment to the organization; which led to the transformation of handling issues from a problem-solving approach to solution-focused (Platt & Foster, 2008).

Commonly, CNs within organizations do not know each other, highlighting the need for organizations to prioritize activities that connect leaders (Platt & Foster, 2008; Sherman, 2005). A secondary analysis of two national surveys found that 65% of organizations did not recognize staff for memberships to professional associations (Shirey & Fisher, 2008); the study authors discussed that organizational support is important as these memberships can provide networking outside of the organization that can give an awareness to national and global issues related to the improvement of patient care. These data revealed that promoting and providing methods for CNs

to connect with each other is one approach organizations can take to create a culture of collaboration, learning, and support.

Limitations

Further research is needed to examine the CN role and ways it continues to evolve over time. The scope of the role and responsibilities, regardless of the title, remains unclear in the literature. There is inconsistency across the literature in CN training and on-going leadership training, and little is known about ways to best deliver training (e.g., formats, duration, etc.) to maximize CN role effectiveness and CN wellbeing. There was not much known about the extent CNs form professional peer networks and how these networks are used by CNs as there were no studies found that directly examined the impact, influence, learning, or quality of the professional support CNs receive from their peer networks. The current literature did not examine the differences of support available across the varied shifts, such as dayshift and nightshift.

Theoretical Basis for Professional Peer Networks

Two theories provided the theoretical basis for this study focused on ANM professional peer networks and the support ANMs receive by connecting with peers: the social learning theory (Bandura, 1978) and social exchange theory (Homans, 1958).

Social Learning Theory

In the social learning theory, Bandura (1978) stated people learn by interacting with others. According to Pedersen et al. (2018), as "a concept, leadership (by its very nature) must be social in order to be effective" (Pedersen et al., 2018, p. 173). ANMs have a variety of knowledge and rich experiences that can be shared with their peers. Professional peer networks can be a valuable resource for social learning that may be underutilized and untapped.

Notwithstanding the value of formal ANM training (initial and ongoing), organizations can provide opportunities for nurse leaders to meet and learn from one another.

Social Exchange Theory

The social exchange theory (SET) is useful for understanding people in their work place (Cropanzano & Mitchell, 2005). This theory explains that social exchange is a relationship between people in which material goods and non-material goods (i.e., prestige) are exchanged in an influential process (Homans, 1958). According to the SET, there are unlimited possibilities when the relationships are high quality (Cropanzano & Mitchell, 2005). The SET is grounded by the norms of the exchanges, the resources exchanged, and the relationships that emerge (Cropanzano & Mitchell, 2005; Homans, 1958). In the healthcare setting, the resources exchanged can be material goods, such as supplies, equipment, and services (i.e., staff and clinical assistance for patient care and administrative duties), and non-material goods such as information, status, and prestige. The exchange norms of nurse leaders often lie in the reciprocity of the relationships as they serve as resources and support to each other, and this is a common organizational culture (Cropanzano & Mitchell, 2005). When the exchanges are frequent, there is greater perceived organizational support (Cropanzano & Mitchell, 2005). Resource exchanges can have economic outcomes, such as related to performance; and socioemotional outcomes, such as feeling valued and having dignity (Cropanzano & Mitchell, 2005). Relationships that emerge in the workplace have advantages. When the relationships are strong, they can lead to nurse leaders who look out for one another, which can lead to positive organizational outcomes and a positive organizational culture (Cropanzano & Mitchell, 2005). The SET can be applied to and valuable in understanding the professional peer networks of nurse leaders within their

organizations. Understanding the SET allows organizations to realize the benefits of connecting its nurse leaders across an organization.

Methods

Design

A qualitative descriptive, cross-sectional design was used for this pilot study. Data were collected through in-depth interviews. The qualitative descriptive design is used to describe experiences in which the researcher can offer a low-inference interpretation and understanding of the facts (Sandelowski, 2000).

Sample

A convenience sample of eight individuals participated in this study. This sample size was adequate for the pilot nature of this study and provided saturation (i.e., information obtained was repetitive) to yield high-level themes that could be explored further in future studies. Saturation was reached when new data were not being discovered and adding a participant was not expected to reveal new information or themes (Guest, Bunce, & Johnson, 2006).

As titles for the ANM role vary across organizations, participants were recruited who self-identified as having a current or previous position as an ANM based on the following position description: a permanent frontline nurse leader (FLNL) role that is hired into and responsible for a unit for a particular shift in the hospital setting. In the greater Sacramento area, the term CN commonly refers to the relief CN role, which is not a permanent position. To assist participants in self-identifying as an ANM, the inclusion criteria specifically listed titles that fit the description in the greater Sacramento, California area (e.g., Assistant Nurse Manager [ANM], Nurse Services Supervisor 2, Administrative Nurse II [ANII], and Nurse Shift Manager [NSM]). The following criteria were used for recruitment:

Inclusion criteria:

1. A registered nurse
2. Current or previous (within the last 5 years) full-time, permanent employment in one of the following positions in an acute care setting: ANM, Nurse Services Supervisor 2, ANII, and NSM.

Exclusion criteria:

1. Individuals who work in the same unit as the PI
2. Individuals in the same graduate program cohort as the PI
3. Relief positions/individuals that support the permanent ANM, Nurse Services Supervisor 2, ANII, or NSM positions; such as relief CNs

In addition to the sample of eight participants, three other individuals expressed interest in the study. One was excluded during the screening process as their job title (based on a position in Southern California) was not reflected in the inclusion criteria. The other two individuals expressed interest in the study after the sampling goal of eight participants was achieved.

Recruiting Procedures

Two approaches were used to recruit study participants, as needed to achieve sampling goals. First, the PI obtained a Memorandum of Understanding (MOU) with UC Davis Health to use the UC Davis Health listserv for the ANIIs (one of the titles used for CN positions in this institution) and to post flyers. The listserv was used to send electronic mail messages for advertising of the study and recruiting study participants at UC Davis Health (Appendix A). All correspondence took place during non-work hours as the request was within the context of the student role completing a thesis. Second, the PI distributed flyers through networking by sending an electronic mail message, including to colleagues at the Betty Irene Moore School of Nursing,

with requests to post and share the study flyer (Appendix B). Study flyers included (1) an advertisement of the study and invitation to participate and (2) printed on the back of the flyer was the Letter of Information (Appendix C) required for consent. Those who responded to the flyer were sent detailed study information by electronic mail (Appendix A and C).

Development of the Interview Guide

The PI drafted a semi-structured Interview Guide and pilot tested the questions to ensure clarity prior to finalizing. Pilot testing occurred with two colleagues of the PI who were currently or previously in the ANII/ANM role and by members of the thesis committee. These individuals were not study participants and their responses were not included in the study data. Feedback from the pilot testing was incorporated into the final version of the Interview Guide (Appendix D). The Interview Guide also included general demographic questions, such as age, gender identity, race, highest level of education, job title, years in current or previous job role, unit they worked in, the shift they worked, and professional organizational memberships.

Data Collection

The study was conducted during the COVID-19 global pandemic when social distancing was recommended. Individuals who provided verbal consent participated in an interview by telephone, which was consistent with recommended social distancing guidelines. The interviews were recorded using a digital audio recorder. Interviews lasted 24 to 54 minutes. The PI served as the data collection instrument and conducted all interviews. As an incentive to participate, the participants were given a $15 gift card at the end of the interview in appreciation for their time. One participant declined a gift card.

Data Analysis

Data analysis began after the first interview. The digital recorded files were uploaded to Otter.ai for automated transcription. The transcripts were reviewed for verbatim accuracy and corrected as needed. The transcriptions were manually coded by reading the transcripts several times and making notes about the data. The general impressions based upon the notes were discussed with thesis chair throughout the process. Key data (i.e., transcript excerpts) were copied to one column of a three-column table in a separate document. The data were reviewed again and then summarized in a second column. The summaries were reviewed for themes and patterns across participants. The third column was created to keep track of the high-level coding related to similar concepts across all participants (e.g., role training). The coded data were then highlighted and color-coded by similarity. The summarized data and coding were reviewed, and sub-codes were identified that reflected the data (e.g., want future role training). The interview data were analyzed using inductive thematic analysis. Thematic analysis was chosen to identify patterns and understand their meaning in an area where there is minimal research (Braun & Clarke, 2006).

Trustworthiness

Several steps were taken to ensure the trustworthiness of the data collection and analysis processes. The PI was an ANM at UC Davis Health. To address potential bias, the PI kept a reflection journal to identify any subjective elements that may be brought into the study and discussed the reflections with the thesis chair. A subjective element was related to understanding the role. The PI was expecting to hear from participants opinions and views on the role that were similar to the PI's views. The PI and thesis chair discussed distinguishing self from the role as an ANM and focusing on the role of the researcher. This helped the PI to remain grounded in the

role of the researcher and curious and open to the data that were received. This assisted in minimizing expectations of data. The PI used the prompts, such as "can you tell me more about that," rather than assuming to know the participant's intended meaning. The samples of raw text, coding definitions, and practices were reviewed with thesis chair and revised as applicable. An audit trail was created that documented the process of coding, including the coding definitions, decisions made about coding, and revisions to the analysis process. Methodological rigor was maintained by using reflective journaling and debriefing procedures with thesis chair. These processes were also used by the PI to search for biases and explore how personal feelings towards the research may have impacted interpretation of the data. The exploration of truth was the focus of this study. Data were analyzed by the PI and excerpts of data and analysis approach were reviewed with thesis chair.

Sensitivity

The PI, in her current role, had a certain level of sensitivity to the topic of this research, which placed her in a position of understanding as a data collection instrument. This position also provided an advantage since terminology, etc., that participants might use could be easily understood. This can be a strength in analyzing the data. However, this may also create bias. To address sensitivity and related bias, the following approaches were used.

The PI asked interview questions that were focused on specific experiences and had an openness to learn from the participants. The PI's experience as an ANM gave insight and a level of knowledge and understanding (i.e., sensitivity) of the phenomenon of interest and into what the participants shared, and it motivated her to understand the experiences and perceptions of other ANMs. The PI understood the terminology and the role differently than someone who had not had any exposure to the role. With this experience and insight, rapport was able to be

established and relevant follow-up questions and prompts were asked. The PI was considered a peer to the participants; however, most of the participants were not aware of the PI's background. Some of the participants were known to the PI and knew the PI to be a peer and not in a position of authority or power over the participants.

With the benefits of PI sensitivity, inherent bias also increases. To proactively address this bias, the PI wrote in a reflection journal to identify any subjective elements that might have been brought into the study and those reflections were discussed with the thesis chair. For example, the PI knew two participants, and based on knowledge of some of their experiences, the PI explored her own expectations about how the participants would respond to some of the interview questions. In addition to writing in a reflection journal and discussing with her thesis chair prior to the interviews, the PI maintained the same interview format as for the rest of the interviews, followed the research questions, remained open to learn and hear what the participants chose to share, and did not guide the participants to respond in any manner that supported the PI's expectations.

Protection of Human Subjects

The PI submitted the study protocol to the UC Davis Internal Review Board (IRB) and received an exempt determination. An MOU was signed with UC Davis Health. Recruitment began only after IRB deemed the study exempt and the MOU was fully executed. Written consent was waived. Consent information was provided by email (Appendix C). Consent was verbal after giving participants verbal and written information about the study and participation. Participants were informed their participation was voluntary and they had the right to discontinue their participation at any time and could choose to not answer any of the questions.

A potential risk was the breach of confidentiality. The list of participants was kept separate from the data (audio recordings and transcriptions), and participant information was not linked to the data. Data are stored on the PI's password protected computer. Only the PI and thesis chair had access to the data. Participants' contact information was not documented or recorded. The identity of the participants was known only to the PI. The PI will not disclose to anyone the identity of the participants and will maintain confidentiality in protecting their identities.

Results

Sample

The sample was primarily female. The majority of participants had master's degrees and worked the dayshift. To further protect the confidentiality of the participants, the interview guide did not include any questions about the organizations where the participants worked. The sample reflects variations in participant characteristics, including age, race, and length of time in the role. The demographic data are summarized in Table 1.

Table 1

Participant Demographics

		N = 8
Gender Identity (n)	Male (1) Female (6) Not answered (1)	
Age, years (n)	30-39 (4) 40-49 (3) 50-59 (1)	Median age 40.5 Range 32-53
Race (n)	White (4) Hispanic/Mexican (2) African American (1) Asian (1)	

Highest level of education (n)	Bachelor's (2) Master's (6)	
Unit (n)	Labor & Delivery/ Mother & baby (1) Medical/Surgical (3) ICU (4)	
Shift (n)	Days (6) Nights (2)	
Years' experience in role (n)	<1 (1) 1-3 (0) 3-5 (5) 5-10 (2)	Median 5 years Range 7 months–8 years
Professional organization memberships (n)	• American Association of Critical Care Nurses (AACN) • Sacramento Sierra Nurse Leaders (SSNL), Chapter of • Association of California Nurse Leaders (ACNL) • Sigma Theta Tau International Honor Society of • Nursing • National Association of Orthopaedic Nurses (NAON) • Association of Women's Health, Obstetric and • Neonatal Nurses (AWHONN) • Postpartum Support International (PSI) • National Association of Hispanic Nurses (NAHN) • Nursing Leader Management • Oncology Nursing Society (ONS) • Other	Membership in one professional organization (4) Memberships in two professional organizations (3) Memberships in three professional organizations (1)

Six of the eight participants indicated their official role title as ANM, and two indicated one of the other role titles reflected in the inclusion criteria (i.e., ANM, Nurse Services Supervisor 2, ANII, and NSM).

Three key themes emerged from this study: (1) ANM role training is inconsistent and sometimes inadequate; (2) the ANM position is considered complex, challenging, lonely, and ANMs feel siloed in their units; and (3) ANMs value meaningful connections and engagement with their professional peers. The findings are organized in five sections centered around these three themes, beginning with a section - as context - that describes ways participants transitioned

into the ANM role. The next section - *role training experiences* - provides findings to support the first key theme related to adequacy and consistency of training for the ANM role. The third and fourth sections - *middle management role complexities* and *resources utilized* - summarize findings that support the theme related to role-specific activities and ANMs' perspectives about the role. The final section - *professional peer connections* - summarizes findings related to participants' perspectives about professional peer connections and the values and attributes associated with these connections.

Transitioning into the ANM Role

Circumstances leading to attaining the ANM position varied. Some participants suggested their transition stemmed from recommendations and support from others (e.g., peer ANMs, nurse managers, nurse educators). In contrast, others said they were intentional about attaining the position, seeking opportunities to prepare for the role by asking what could be done, taking leadership classes, and acquiring skills by watching current leaders. One participant's recount of their transition suggests that they fell into the role, while another said they accepted the role as it was suggested they at least try it out. One participant highlighted the professional development support they received from their unit management and spoke about their interest in the role was a way to "*give back*" to the unit.

Some participants spoke about how their experiences in other specific roles and activities contributed to their transition, such as serving as a relief charge nurse, resource nurse, temporary nurse manager, chairperson and member involvement on committees and councils, preceptor, teaching classes, and attending courses in their nursing graduate education program. For example, a couple of participants spoke about their experiences as a relief charge nurse or a resource nurse. They stated it eased their role transition as well as supported their level of

comfort and role preparation even though the roles are completely different. Four participants spoke about the role transition as difficult and challenging, citing their lack of preparation for what to expect in the role, staff not always accepting them in the role, and the surprise to "*suddenly lose all your peers.*" Once in the role, participants spoke about expectations to lead regardless of whether they were trained or if they knew how. One participant shared a challenge in the role transition related to people knowing them as a staff nurse first. Another participant spoke about staff resistance when they took over the role, with a range in acceptance and some level of competition by others who were also interested in taking on the role.

Role Training Experiences

Several participants stated they were inadequately trained for the role, and the training they received was inconsistent, infrequent, lacking administrative and conflict management elements, or not often required on an ongoing basis after taking on the role. One participant indicated different training for ANMs within their unit, and thus, there was inconsistency in the ways ANMs carried out their roles and responsibilities, which was one of the biggest complaints from the staff. A participant described the training experience as "*in some respects it went okay, and in some respects it went badly … and I had to fail in a lot of ways.*" One participant spoke about the training ANMs received as unit-specific and dependent upon the importance the NM placed on the training. While some NMs encouraged and supported their ANMs to go through training, other NMs preferred their ANMs focus on tasks in the unit. This participant raised questions about what the role is like in other units in their organization. In response to questions about training for the ANM position, the participants described their experiences, including (1) pre-role training; (2) orientation, on-the-job training, and classes; (3) mentoring/coaching; (4) ongoing role training; and (5) recommendations for training future ANMs.

Pre-Role Training. Three participants stated they completed leadership training courses/modules that were specific to the ANM role before they held the position. Reasons for taking the program/course varied. For example, one participant spoke about their NM prompting them to take the classes, envisioning a future leadership role for the participant for a seamless role transition even before the participant recognized their potential, stating: "*I don't think I recognized what I was doing was a leader, who I am. It was others who recognized what I was doing.*" In contrast, another participant highlighted an intentional approach to seeking out leadership training, noting their preference to develop leadership skills before holding the position. This same participant shared that they used their own professional development time off for course offerings. The three participants who had pre-role training did not describe their role training negatively and did not discuss feeling unprepared for their role as mentioned in sections below.

Orientation, On-the-Job Training, and Classes. Four participants spoke about an orientation process for their role with a range in duration from one day to five weeks. Two participants indicated they did not receive an orientation or training for the role. One participant stated they were "*thrown into the job*," and the other indicated their one-day orientation was "*not a real orientation.*" Two participants said their role training included shadowing someone else (e.g., peer ANM, nursing supervisor).

Most participants indicated on-the-job training was the primary way of learning their role and described the process as "*having to learn on my own,*" "*trial and error,*" "*slowly and painfully,*" getting advice from a lot of people, and a "*rocky*" process. Most of the participants indicated they learned their role from others already in the role and one indicated learning from their nurse educator as well.

Specific training for the ANM position varied, and most participants indicated it was both inconsistent for ANMs across their organization, inadequate, and "*unorganized.*" Some of the comments included:

> "*I got handed doing this schedule … without any training on how to do the schedule*"; and *"I feel like I've been under fire for a few things because I just got kind of put into that role, but not ever trained on it."*

> "*There wasn't a guidebook, there wasn't mandatory training, there wasn't expected training. There was an expectation for you to lead, but not an expectation for somebody to show you how. So, it was just like a trial-and-error kind of thing that you kind of did. But no, there was no official training at all.*"

> *"It's just literally learning as I go. Which was a little difficult, 'cause I felt a little lost at times, not knowing exactly what my position was or what I was responsible for."*

One participant described the situation as scary despite how long they have worked in their unit, with "s*o many things you don't know the answers to,*" and in terms of timing, stated *"… it would be great if there was classes that were taught before I got five years in."* Six participants stated they received role training through leadership classes; however, several participants noted the leadership classes were not taken early in the role. One participant described some of the leadership classes as helpful, but general, and lacking information on the administrative part of the role.

Mentoring/Coaching. Three participants reported having mentors; one was a NM in another unit and the others were peers. In addition, two participants indicated they were paired with another ANM for about 30 minutes in a leadership meeting when they were new to the role, and they shared differing perspectives about the value of this pairing. While one said the pairing was "*kind of nice*" they did not stay in touch with the mentor after the meeting, and they expressed interest in having a regular mentor who works outside of their unit. The other

participant indicated the pairing was helpful and they would often reach out to this person to ask questions or run things by them. One participant hired a professional coach for a year to help with having difficult conversations that occur in the role and indicated it was somewhat helpful.

Ongoing Role Training. Beyond the more general role training, the participants revealed varied opportunities for leadership training once they were in the position. The ongoing leadership training was described as self-driven, not mandatory, not fully structured, and without many options available. Two participants said they had not had any ongoing training for their role. One participant stated: "*The opinion that I got was kind of once you're up and going, you're kind of up and going.*" Only one participant indicated they have mandatory quarterly leadership training. Other participants spoke about gaining leadership training from various sources, including a nurse leader program tailored for preparing staff nurses for a future potential leadership role, a leadership workshop, retreats held for their organization's leadership, a master's program in leadership, or self-taught. One participant said:

> "*I think becoming a leader is a continuous process. I don't think it just happens and then you are and then you're done learning.*"

Some participants raised questions about whether they had learned how to lead despite being in their role for years. For example, one participant said they are still working on how to be a leader, while another asked, "*did I learn to be a leader*?" In contrast, one participant said despite not having official leadership training:

> "*I didn't really need like a set guidebook to lead me to lead because half of that was natural anyway … it wouldn't have probably hurt to have some like little tid bits here and there, but I think I did pretty good.*"

Recommendations for Training Future ANMs. Several participants emphasized the importance of training and their desire for future ANMs to have a formal, standardized, consistent, and structured training that aligns across their organizations. Two participants

highlighted communication and dealing with conflict management as content areas for training. One participant suggested training similar to the training new staff nurses receive as their training is formal, expectations are clear, and role resources are shared. Some participants also spoke about wanting mentorships for new ANMs. An idea was to cross orient new ANMs on another unit to give them a well-rounded perspective of the rest of the organization to understand more than just their unit. Leadership classes before being in the role were wanted, such as a class that gives the basics of the role. One participant commented:

> *"They need to have a standardization of how they train new leaders, because there currently is not one in place and every department does it differently."*

Middle Management Role Complexities

Participants' descriptions of the ANM position reveal varied responsibilities and role characteristics. The role was described as unexpectedly challenging, "*very stressful*," taken for granted, and requiring a lot of information to keep up with "*fairly high stakes,*" difficulties with managing people, overwhelming role responsibilities, issues with managers, and unique difficulties on nightshift. More than half of the participants reported feeling overwhelmed, stressed, scared, lost, lonely, and unprepared for the responsibilities and issues they faced. The role was perceived as being stuck in the middle of the hierarchy between the frontline staff nurse and upper management. Some participants reported feeling siloed in their units as they were often the only ANM on a shift.

Although participants were not asked questions specific to role responsibilities, several participants offered general information about aspects of the role, including staff discipline actions, staff assignments, supporting the NM, and covering other job roles (e.g., having to also be the lunch relief nurse and the unit secretary). One participant spoke about it as a fast-paced and challenging role that requires a multitude of responsibilities from providing patient care to

managing people to administrative work. One participant said the role included "*a lot of checking the boxes*" but also required a lot of thought process. Some participants said it is hard to complete all the job responsibilities as they have so much to do and they get behind. A situation was described where a NM told the ANMs they need to be better about rounding on the patients, and the participant stated, "*I don't think I can add just one more thing in there,*" as they are not only the ANM but also frequently the unit secretary and the lunch relief nurse. Some participants wondered about what the role is like in other units, whether they are having the same issues, and what the role entails for others.

Engaging with Staff. Communication, including crucial conversations, conflict management, and disciplining staff, were mentioned as crucial yet difficult skills to acquire despite being in the role a long time. Some participants indicated they want to have a good relationship with the staff they oversee, they want the nurses to feel valued, and they do not want to make anyone unhappy; although, the latter was known to be an unreasonable goal. One participant spoke about wanting the role to be understood and appreciated by having the staff nurses trained for the role.

Managing people was said to be "*really hard to do*" as there are a multitude of staff issues to be dealt with: regular sick calls, outward disobedience, poor practices, resistance, and scheduling. One participant spoke of people wanting you to have solutions to their problems. Another described an experience of walking into the unit and having someone say, "*everyone is so pissed off at you today*" and "*if you don't make very good assignments and your nurses are miserable, they will make you miserable for 12 hours.*" The role was also said to be like a mom and dad role, whereas if a staff person is told 'no' by one ANM then staff goes to the other ANM

trying to get a 'yes.' One participant said everyone is trying to hold it all together and everyone in every unit is burned out in the COVID-19 pandemic.

Nightshift. The only two participants who worked the nightshift spoke about the nightshift as especially difficult and frustrating, with fewer resources and people available (e.g., NMs, social workers, case managers), variations across organizations in use of leadership huddles at night, and not all units are included in the huddles. One participant indicated varying levels of access to NMs at night. Participants spoke about the challenges and frustrations with running out of supplies that could only be replenished during the dayshift and things happening that must wait until dayshift to be resolved.

Role Isolation. Five participants spoke about role isolation, describing the position as unexpectedly lonely and isolating, "*siloed in your unit,"* and not having anyone else to talk with about issues as they arise when you are the only ANM in the unit. A participant described how "*phenomenally isolated*" the role felt when starting in an unfamiliar department. Another participant said:

> "*nobody tells you … the lonely position you just stepped into and that people that you've been … friends with and coworkers with for 20 plus years are now going to treat you at an arm's length and that when you walk into a room everybody's going to stop talking*" and "*you are no longer their friend that they hung out with and had lunch with … I was no longer the same person I was the day before.*"

Another participant discussed they were warned to expect people to stop talking when they walked into the room and were recommended to not take it personal as "*that's just how it is.*"

Stuck in Middle Management. Three participants spoke about challenges with serving in a middle management role. One participant recounted feeling and being seen as "*stuck in the middle*" in terms of placement in the organizational hierarchy; one step departed from clinical work but not fully stepped away. The role for some ANMs involved working on the frontline

doing patient care alongside the staff nurses they managed as part of their job. Sometimes they functioned like a staff nurse, and sometimes they were in charge managing the unit. The unique part of this role was its position of still being directly connected to the patient on the frontline and being connected to upper administration in a hospital. Participants said:

> "*We're stuck in the middle. We're not a manager, we're assistant nurse managers, but I'm not quite staff"* and described it as "*we get hit the most by everything*" and "*they [staff] kind of like me as staff, but not really.*"
>
> "*You're no longer the nurse taking the doubles [two patients], you're taking a single [one patient] or you're out of the count [not taking any patients]*."

Some participants said the staff did not understand the ANM role. One participant spoke about nursing administration, saying those higher on the organizational chart did not readily recall that the ANMs "*are the only people that connect upper administration to bedside, really, and middle management is really hard.*"

Resources Utilized

In response to questions about the resources or people they rely on when facing ANM job challenges or questions, participants described a variety of resources they used to support their clinical needs, including care to patients and their families, managing staff and staff role support, and role-related administrative duties. All eight participants referred to people as a resource and reaching out to their NM and/or peers. Participants described using peer ANMs for advice, guidance, questions, concerns, information, obtaining supplies, and clinical questions, such as policies and patient care, and administrative role questions, such as staff hiring and disciplines, leading in a union environment, and daily responsibilities. When patients needed specialized care requiring unit-specific expertise, some participants reached out to their peers in another unit. Even though participants spoke about their peers as very approachable and responsive, and they shared a willingness to help their peers when asked, some of them discussed they are more

willing to help out when there is a personal connection and discussed a reciprocal relationship of giving and receiving. The NM was described as a person that is heavily relied on and a great resource. The nursing supervisor (i.e., oversees the patient and nursing operations in an organization for a shift) was the next common resource person used for the role when needed, such as when the issues were related to the hospital as a whole as opposed to unit specific issues or for needs that arise on weekends. Other individuals identified by participants as a resource included mentors, doctors, executive leaders, human resources staff, nursing staff, unit nurse educator, and labor relations.

One participant described a wealth of resources available to them with *"in a hospital as big and as busy as ours and a patient population as diverse as ours, there are an infinite number of people and resources that I reach out to and utilize all the time."* Two participants identified printed information as a resource, including a personal, self-made, resource book for future reference and the California Nurses' Association manual. One participant stated they learned about the different resources in the hospital through a nurse leader program. This same participant emphasized the importance of having sufficient resources to do their job well and have the best patient outcomes, including knowing who to turn to as a resource: *"I just want to reiterate how important it is, when you're new to leadership, that there be enough resources."*

Professional Peer Connections

Participants' responses to questions about professional peers are organized into three primary categories: (1) peer connection logistics, (2) professional peer connections during the COVID-19 pandemic, (3) peer connection benefits, and (4) preferences for future professional peer connections.

Peer Connection Logistics. Professional peer connections are formed in a variety of ways. Some participants took a more proactive approach to making connections than others. The reported value of connecting at in-person leadership meetings held by their institution varied. Two participants described these meetings as an opportunity to mingle, talk, and put names to faces; while two others suggested the meetings did not create a genuine atmosphere for networking or they had difficulty connecting with peers, stating, "*we would just kind of sit in our chairs and not really get to know other people very well"* and *"[you] had to feel your way through wherever you are.*" One participant described these leadership meetings as their only opportunity to connect with peers, "*or if you made yourself come out of your unit to go visit another unit just to have a conversation.*"

Several participants spoke about forming peer connections during times in the past when they worked together. Two of them said they connected with peers by reaching out to another unit for help. A few participants described meeting their peers through school. Several participants identified their unit-level monthly leadership meetings as another way of connecting with peers. One participant stated they did not get to see their peers within their own unit as much unless one of them came in to do their administrative duties and they missed seeing them, while another said they all have lunch together after their unit meetings. Other than classes and monthly unit leadership meetings, one participant indicated there were few opportunities to connect, and some participants indicated most connections occurred within their own unit as highlighted by the following comment:

> *"I would start by saying I don't know a whole lot of my peers only because I don't think there is opportunity to get to meet everybody very often. We're all very kind of siloed in our unit."*

Other ways participants spoke about connecting with each other included organizational huddles, working on committees or projects together, facilitating classes, and attending leadership retreats or training held by their organization. While one participant said the five- to ten-minute huddles were their main exposure to peers outside of their unit, they also noted these huddles are just an opportunity to be familiar with names and faces of people and not an opportunity to connect as it is not appropriate. Another participant said the huddles are a way to connect, and that by talking after the huddles, they have made great relationships.

Two participants indicated making peer connections through the Sacramento Sierra Nurse Leader organization, describing these events as the best way they have made connections. They also noted that it was nice seeing everybody outside of work to talk, network, and discuss professional topics, and it was a way to re-connect with old work contacts who have left their organization through these events.

Three participants explained connecting by "*happenstance*" or just in "*passing*" in the hospital. Only two participants described making peer connections comfortably by their own initiative. One indicated they learned early on the importance of connecting, but they said it is not easy to do. Others said that making peer connections is difficult when they are siloed in their unit, and they do not have frequent opportunities for connecting. Getting together with peers outside of work was another way two participants said they connect, including meeting up with people they had a relationship bond with and they would discuss work related things, attending happy hour after a leadership class which encouraged networking on a more interpersonal level, and opportunities to get "*to know people for being people and not for just their role that they play.*"

Once connections were established, participants described connecting with their peers by text, phone, email, Microsoft Teams, a core text system, and OneNote. One participant said they use multiple methods to connect with professional peers to stay in the information loop across their organization and with those in sister facilities of their organization (Microsoft Teams, core text, email, huddles twice a shift, mandatory annual organizational wide leadership training). This was the one participant who indicated feeling effectively connected to professional peers. The core text system was described as all ANMs from all hospitals within their organization use the system, the system shows who is on shift presently working, and so they are able to find out who is available to call for any needed expertise. The participant said these connections and constant conversations are appreciated and help to identify people when you see them in the hospital and "*our connecting with each other is natural, because we're always connecting with each other … one way or another.*" Another participant discussed using OneNote with peers within their unit to regularly connect and maintain current communication as a running shift dialogue, offering consistency in the management of their staff, for follow-up, to keep a record of the information, and have updates at the start of a shift.

Professional Peer Connections during COVID-19. Six participants spoke about ways the COVID-19 pandemic negatively affected peer connections. Some participants described missing out on networking in 2020 due to cancelled meetings, classes/trainings, conferences, events, and hospital huddles. Other participants described forming alternative ways to hold meetings (e.g., phone, video); although, there was mention by some those connections have been harder to create and sustain when not in person. Two participants spoke about the shift to virtual connections, with quarterly leadership meetings held by Zoom, and leadership huddles that discuss staffing needs are now held on Microsoft Teams as phone calls via the computer. One

participant said about using the open forum email where all ANMs in the organization respond, they "*may not be able to identify you by your name because now we're all not together like we used to … we still get lost*." One participant said they reached out pretty frequently to peers when the pandemic occurred, while another said due to the pandemic, making connections was hard as there was not a lot of connecting and "*that ability has been impacted heavily by all the limitations placed on us during the COVID-19 pandemic*." A participant said they missed getting together with peers, learning from each other, leaning on peers for guidance, and relating, because they did not get that on their shift unless they reached out.

Peer Connection Benefits. Participants emphasized the importance of networking, knowing their peers, and forming peer relationships within their organizations, across organizations, and nationally. Participants described peer connections as important, especially to those new in the role, including peer connections within and outside their unit. As one participant described:

> *"but when you kind of poke your head up from your immediate surroundings and you meet other people from other places, and you hear their experiences, and you network, and you make those connections, I think it makes your patient's experiences better, I think it makes your patient outcomes stronger, and I think it makes your job, whole job and career satisfaction better."*

Several participants said they like to be well connected with each other, to know who people are, and put a name to the face of those in other departments as it makes a difference in the ANMs knowing they can call on them. One participant said getting to know more ANMs would be building a sense of team on a greater whole hospital level as "*we're all on the same team, ultimately*" as they are not connected with peers who are outside of their unit, and it is important to not overlook the benefit of having interpersonal relationships where right now some of them are struggling to engage and maintain them from a distance. Participants said it made a

difference to be well connected with each other. There were also indications that connections offered a certain comfort level since having a familiar relationship facilitates information and communication when they need to go to a peer in another unit as the more familiar and comfortable they are with other ANMs, the more likely they are to reach out for resources or assistance. A participant said it was hard to reach out when they did not know people on other units, and they loved reaching out to their trusted peer to coordinate care for a patient as they know the patient is in safe hands. Statements by participants are:

> *"The more you have familiarity and comfort with other [ANMs], the more likely you are to reach out to them for resources or assistance. You might be more reluctant to ask a question or reach out … if this is just another person of a name that you don't know on a personal level."*
>
> *"I like to make connections with people, because if I need something, they know me, they're more … willing to help me out and vice versa."*
>
> *"We work at a wonderful facility and we accomplish a lot here at our hospital, but I always think of how much more could we accomplish? How much stronger could we be if we were a little bit more unified and in sync and not so siloed?"*

Three primary themes emerged from participants' comments about networking with professional peers and benefits: (1) serving as a resource: giving and receiving assistance; (2) learning from peers; and (3) emotional and psychological support

Serving as a Resource: Giving and Receiving Assistance. Peer connections are relied on as a resource by all ANMs for various reasons, especially those with expertise in specialty units as ANMs reach out to each other for help when there is a need, such as getting supplies, equipment, or help for their unit. Peer connections were also seen as helpful when they needed information that could aid in decision making. All the values attached to peer connections resulted in making the job easier, improving teamwork, and perhaps improving their departments overall. Participants spoke about everybody benefiting from ANMs giving and receiving

assistance from their professional peers as the assistance they give and receive supports the nursing staff in their provision of patient care. The rapport and relationship built with peers provides the comfort, security, and trust to know they will get the help they need; they will get the help easier, quicker, the equipment they lend will be taken care of and returned, and supplies they give will be reimbursed.

Peers within their own unit were often discussed as a resource as they help in completing job responsibilities, making decisions, sharing knowledge, and sharing information. Discussions included how important it was to know who their resources are as it is helpful when they need something. Several participants said that knowing a peer in another unit made it easier to go to them for help and they were more willing to help when there is a personal connection. Others said their peers are willing and automatically jump in and help when asked, offering comments such as: "*we will all pull each other together*," figure things out together, and "*you need it, I got your back.*" When anything was needed, it was their peers who were relied upon and they went to for help. One participant described feeling good that their peers knew they were dependable and reliable as there were a lot of times that others did not ask them for their help because they did not know them. A participant said they had to establish trust with other units to know they could call if they needed something.

In terms of reaching out to peers for their expertise before and during the COVID-19 pandemic, one participant described a situation during the COVID-19 pandemic when their unit took in some ICU patients due to an ICU bed shortage and reached out to an expert, an ICU ANM, who came to their unit, evaluated the patient, told them what was missing in the care with feedback, made recommendations, advocated for the patient, supported the staff, and improved the patient by getting them moved to the appropriate unit (the patient required specific training

only few ICUs have). Another participant discussed challenges due to the specialty of the unit they work in (e.g., ICU expertise) as giving the support is almost expected, yet the support they can receive is limited. This participant talked about a time they asked for help and the individual was nervous as the request was out of their skill set, but they came anyway and helped. This participant said it did not bother them to help another unit because "*if you need me and I'm there, I will help you. It doesn't matter what it is. It could be the silliest thing.*" A participant described having an eye-opening experience when they were new in the role: they received support from a peer in another unit when it was needed as well as the ongoing willingness of this peer to lend a hand and said "*as a result of this I will go to the ends of the earth if I could do anything for*" them.

Learning from Professional Peers. Participants said they learned much from peers, appreciating their peer's insights, seeing how they interact, watching how they do things, bouncing ideas off them, being able to "*pick the brains*" of their peers, and their various ideas that help them to see the bigger picture and form new perspectives, and ultimately, improve patient safety. One participant spoke about all their peers who have been in their roles for 15 plus years, saying they see a lot of experience they want to learn from, soak up, and lean on for guidance. This same participant noted how nice it is to see the amount of time others have been in their roles, stating: "*through all the ups and downs … they're still here, they're still trying to do better, they're still trying to make that change.*"

Peer connections also helped them to learn what was happening around their organizations, find out about projects on other units, and learn about issues other units are addressing and how they are resolving issues. Participants discussed bringing ideas and strategies that actually worked for others back to their units, such as showing staff nurses they are valued,

approaching a difficult nurse, and having crucial conversations. With the COVID-19 pandemic, one participant noted that they have lost out on some networking that could have given them information about how other organizations are handling patient needs. Another participant said they learned through their peer connections that things were not done the same across their organization when they should be.

Two participants noted that knowledge sharing and learning happens with a peer when they know them and feel comfortable with them, someone with the same role, same responsibilities, same expectations, as one individual stated:

> "*I think there's a lot more communication and sharing of knowledge and resources that would happen if you were comfortable enough to talk to somebody because you had more of a personal relationship.*"

Emotional and Psychological Support from Peers. Participants said they support each other with issues they are having and go to peers talk, express their frustrations/vent, discuss stressors/challenges, give and receive feedback, discuss role expectations, lean on, confide in, serve as a sounding board, share successes, get encouragement, and get advice. One participant said, "*I feel very supported,*" in having peer connections and another said it's important to have a peer to talk to about things that can't be discussed with the staff. Participants said it is important and preferred to have peer connections with someone they know and feel safe with, who understands what they are going through, understands it is a private conversation, can give feedback, and can guide or support them on a personal or professional level. One participant said, "*I like that I know that they're there if I need them for feedback,*" and another said they do not go to peers outside of their unit for support. One participant said having peers definitely made them better at their job, because if there was not someone listening and giving feedback, they would burn out quickly as the frustration would be too great. Another participant said what

they liked the most was everybody comes with their own background story and once they are in that moment where they need each other, they are there for each other, they are there for "*12 hours and anything can happen in those 12 hours,*" and it is appreciated when someone they know is there.

Participants spoke about the benefits of relating to a peer, including reducing loneliness and isolation, knowing other ANMs feel the same, and validating their own feelings. They spoke about the importance and value of knowing their peers are having similar issues and struggles no matter which unit they work in (e.g. staff and management problems, burn out due to COVID-19 pandemic), talking to peers to "*just relate with each other,*" talking to peers from other facilities, knowing they are all trying to hold it together during the pandemic, and knowing they were not the only one confused about the role. One participant described forming a buddy system with another new ANM as they started the role at the same time and their connection helped them to feel less alone and not as if they were learning on their own. Some comments are:

> "*I think it validates some of our … questions or issues that we're having, that we're not the only ones. We're not isolated …[when] something happening.*"
>
> "*It's not just an issue that I'm having, it's universal … knowing that they're how other people are feeling as well … makes me feel less isolated.*"
>
> "*A lot of it is the confidence to know that I'm not an absolute and utter failure. It's the confidence to know that other people have been there, the ways that you've been tested by staff … are not just being applied to me.*"

One participant recounted telling a new ANM "*you're not alone. You're not the only person who's felt this. I've felt it before.*"

Beyond social support from peers, a few participants spoke about the role of peers in advancing their own professional goals, including learning about leadership classes or webinars, reputation building, pursuit of a higher education, obtaining information about other nursing

roles, and job opportunities (e.g., new jobs in different organizations). One participant said when peers went back to school for a master's degree it "*gave me some ideas or thoughts about going back to school after I said I would never go back to school after my bachelor's.*" A participant discussed their professional goal of a future executive nursing position, and they looked at forming relationships with people and their interactions with them as a means for building their reputation of a person people want to work with. One participant said peer connections did not relate to their professional goals while another said, "*we've never really discussed what our professional goals are*" (e.g., applying to schools for a family nurse practitioner program). This same participant said that a big challenge for an ANM is figuring out what their professional goals are.

Preferences for Future Professional Peer Connections. The majority of participants expressed preferences to network, connect, and engage with each other, to relate, and to receive support (e.g., role, psychological, and discuss professional topics with each other). They shared their interest in wanting to learn with each other and from each other (especially from those in their role for a long time and those deemed successful). They expressed wanting to use each other as a resource to help out in their units, wanting functional professional peer relationships, and wanting interpersonal connections, such as peer camaraderie (e.g., know peers on an interpersonal level, develop personal relationships). They indicated interest in knowing what different units and hospitals were doing (e.g., to make their unit better, show they value their nurses, prevent staff burnout, hear the challenges they are facing and how they are handling their issues. One participant discussed wanting to meet others in the role nationwide and said, "*I have no idea what they do, but I would like to learn, I would love to learn.*" One participant mentioned wanting a peer mentor.

Participants described preferences for a variety of methods and options to connect, including professional events and opportunities for social engagement, such as professional leadership events and group gatherings, leadership classes and conferences, nursing leadership retreats, and connections with peers within their organization. Some participants expressed interest in leadership classes and conferences that include topics on "*premium leadership skills,*" information to achieve executive certifications, and conflict management and human resource issues.

Participants shared various preferences for ways to connect, with mixed perspectives about connecting virtually, and several participants said they want to connect in person. Preferences included wanting formal and informal conferences, separating into work groups, and time to socialize.

Some participants said they want to connect with peers across their organization in different units as it is believed that increasing peer networks would strengthen their leadership capabilities. Another participant shared their interest in a networking group in their organization and all-management events more often that involve interactive activities, encouraging casual acquaintances, and networking opportunities, such as monthly meetups, a leadership focused book club, a fun event, and alternating monthly themes (e.g., one month an educational focus, another month purely fun and networking, and another month structured on ideas related to the organization's goals). Three participants shared their preference to connect with peers at a location outside of their hospital, indicating the value in in seeing people outside of work as being at work has a "*basal level of stress*" as one participant described:

> *"One: better food, two: … getting out of the hospital confines… when you're in the hospital it's like you have these like walls that are around you, I mean, physically and kind of emotionally. You have the stress of the hospital; you see all the people that we work around, around us. And when you're outside of the hospital … we're not*

> *surrounded by coworkers, we're not surrounded by patients, … we're in a … lower stress environment…there's something about … the hospital, they all have this sort of taupe-colored walls and the offices are all kind of … drab, but when you can get out of the hospital … it's an environment that harbors relaxation."*

In addition to sharing preferences for connecting with their peers in the future, the majority of participants also spoke about wanting future ANMs to receive formal, structured, and standardized training across their organization.

Discussion

The findings from this study tell a story about ANMs who are not adequately trained for their roles, have a challenging job, are lonely in their roles, and feel siloed in their units. Participants shared the difference their professional peer networks made for the role, and they expressed interest in meaningfully connecting and engaging with their professional peers for the multitude of benefits those connections bring, which include serving as a resource (giving and receiving assistance), peer learning, and emotional and psychological support.

ANM Role Transition and Training

The findings are consistent with the literature indicating ANMs/CNs feel unprepared, overwhelmed, and fearful after transitioning to the role (Morris, 2019). This study provided insights into the value of other experiences prior to transitioning into the ANM position, such as serving as a relief CN, and various supportive factors once in the role, such as receiving information about the requirements of the role, expectations about relationship changes that may occur with staff, resources available to reach out to for role support, and early mentorship. These findings align with the current literature as mentors (Admi & Eilon-Moshe, 2016; Admi & Moshe-Eilon, 2010; Krugman et al., 2013) and support (i.e., emotional, stress, feedback) are needed in the role (Admi & Eilon-Moshe, 2016; Admi & Moshe-Eilon, 2010; Flynn et al., 2010).

In this study, it is interesting to note that the participants who reported having pre-role training did not describe their role training negatively and did not discuss feeling unprepared for their role. This finding is consistent with the current literature as those who received training had positive results, such as improved confidence (Connelly, Nabarrete, et al., 2003; Flynn et al., 2010; Homer & Ryan, 2013; Krugman & Smith, 2003; Omoike et al., 2011; Platt & Foster, 2008) and a better perception of leading (Krugman et al., 2013). This study matches the current literature in that the ANM/CN role is often fulfilled without formal leadership training (Eggenberger, 2012; Flynn et al., 2010; Homer & Ryan, 2013; Morris, 2019; Patrician et al., 2012; Platt & Foster, 2008; Sherman, 2005), the orientation is inconsistent (Flynn et al., 2010; Homer & Ryan, 2013; Morris, 2019), formal role training is needed (Connelly, Yoder, et al., 2003; Patrician et al., 2012), and a lack of formal training leads to feeling unprepared in the role (Morris, 2019; Platt & Foster, 2008). Also similar to the literature, CNs/ANMs who were offered training had difficulty getting into the classes, and frequently, these courses were taken up to 18 months or longer after getting into the role (Morris, 2019).

This research additionally identifies the inconsistency in role training. ANMs did not know what the role was like in other units in their organization, and this may contribute to role confusion. The existing literature highlighted that the role was unclear and confusing due to inconsistent and unstructured CN role training that varied by unit (Flynn et al., 2010). If ANMs are confused about their roles, then the staff they lead may be as well. This is important as the literature shows that unclear roles negatively affect those in the role and the staff they lead, as well as contributes to role overload (Carlin & Duffy, 2013; Patrician et al., 2012).

When participants were asked about what they would like to have in the future for connecting with their peers, their responses were not only about peer connections. Rather, the

majority spoke about wanting consistent and effective training for future ANMs. This aligns with current research in that ANMs want future nurse leaders to have better experiences than they did (Morris, 2019). It was said that once they start the role, they were expected to effectively lead others regardless of whether they were trained. This study highlighted ANMs' interest in performing their job well. Organizations could provide formal ANM training early in the role and in a consistent manner across the organization (i.e., rather than at the discretion of individual units or NMs). Adequate role preparation and training can offer ANMs comfort and confidence in their ability to lead. They do not need to be surprised about the role dynamics, nor do they need to learn by failing. ANMs can be prepared to serve in their role the moment they begin working in the role.

Only one participant in this study said leading others was natural for them. This indicates those who do not believe leading is natural are relying on training. The only participant who said they felt effectively connected to their peers was the only participant who said they have mandatory ongoing role training, suggesting the value of ongoing role training and the effectiveness of their connections. In this study and in the literature, ANMs/CNs are often not receiving adequate ongoing leadership training after being in the role to further develop and strengthen their leadership skills (Eggenberger, 2012; Flynn et al., 2010; Platt & Foster, 2008; Sherman, 2005). As leading is said to be a continuous learning process in this data and in the literature (Kouzes & Posner, 2017), ANMs could have ongoing leadership training to empower, value, and support them in carrying out their roles.

ANM Role

The role as described in this study is consistent with the current literature as a nursing management position on the front-line delivery of patient care that includes clinical,

administrative, and human relation responsibilities (Connelly, Yoder, et al., 2003; Eggenberger, 2012). The participants in this study used a variety of titles to refer to their role, which was consistent with the current literature (Admi & Eilon-Moshe, 2016; Sherman et al., 2011; Upenieks, 2003). Despite their official job title, throughout several interviews participants referred to themselves by other titles (e.g., Charge Nurse). This is consistent with the existing literature in that there was not a nationally recognized title for this role. Further, even though the role has evolved into having administrative responsibilities, the term charge nurse is still commonly used, and this contributes to role confusion (Admi & Eilon-Moshe, 2016; Eggenberger, 2012; Sherman et al., 2011; Upenieks, 2003), including lack of clarity between the position as permanent or a relief role.

Role Complexities and Need for Ongoing Training and Development

The findings from this study match the literature describing the role as complex and those in this role as have difficulty managing role responsibilities due to role overload (Patrician et al., 2012). This study aligns with the current literature indicating CNs/ANMs need on-going leadership training and development, mentors, and support in order to perform at their best and positively impact the delivery of safe patient care (Admi & Eilon-Moshe, 2016; Admi & Moshe-Eilon, 2010; Krugman et al., 2013). Findings from the current study make new contributions to the literature with this middle management role described as "*stuck in the middle*" – sometimes functioning like a staff nurse taking a patient assignment and sometimes managing the unit. Yet since the ANM is a permanent role, they are always one of the ANMs even when not assigned as such on a particular shift. This may be a contributor to role confusion for the ANM and for the staff, yet there may be some value for the ANM to provide direct nursing care at the level of a staff nurse to maintain their skills.

Despite this potential benefit, the reported feeling of "*stuck in the middle*" sounds as if the role is one in limbo and is not in a good position. The role may be seen as in the middle as the responsibilities and relationships that are attended to go above, below, and across the role spectrum. They go above as they report to a NM and upper management, below as they manage the staff and the patients, and across as they utilize their peers as a means for fulfilling role duties and obtaining role support while sometimes performing the role of the staff nurse as they do patient care. Un-sticking this middle management role may be one of the keys to empowering the role and transforming the role into one that is a strong middle link between upper nursing administration and the bedside. The ANM role is unique and very important as it is the one role that directly connects upper nursing management to the frontline nurse and the patient. Consistent with the literature, participants in this study spoke about a positive link between this frontline management position and patient outcomes (Carlin & Duffy, 2013; Cathro, 2016; Eggenberger, 2012; Sherman, 2005; Squires et al., 2010).

The findings from this study also suggest variations in ANM peer connections based on their specific unit or shift. For the ANMs who work in units that are not included in the leadership huddles or who work nightshift, they are likely further disconnected than the average ANM to their peers. Nightshift ANMs are more disconnected as there are fewer people available, fewer resources available, and no leadership huddles at night for some ANMs. This is important as the huddles were one of the primary ways participants said they connected with each other. As NMs are not commonly on site at night or on weekends, it is possible that ANMs are not reaching out at these times (e.g., middle of the night). With NMs being a primary support and resource person for the ANM role, as is found in the current literature (Admi & Eilon-Moshe, 2016; Flynn et al., 2010), it is possible that the nightshift ANMs are much less connected and

supported than those on dayshift. This is important as the literature showed a lack of resources and support are among the most common stressors in the role (Admi & Eilon-Moshe, 2016; Admi & Moshe-Eilon, 2010; Sherman, 2005) and the literature showed CNs/ANMs have trouble supervising and coaching their staff when their direct supervisor is not available (Krugman et al., 2013).

The lonely and isolated feelings in the role – as revealed in this study – highlight the emphasis that can be placed by organizations to connect ANMs across their organization and to teach them how to build peer connections. ANMs are further isolated as they discussed being siloed in their unit and having staff treat ANMs differently once they are in the leadership role. ANMs do not have to be surprised with the loneliness and isolation as organizations can prepare ANMs for this possibility and can provide them tools, resources, and support when they experience these feelings. The current literature does not discuss the loneliness and isolation in the role; however, there are findings that CNs/ANMs do not have contact with their peers in their organization and many have never even met (Platt & Foster, 2008; Sherman, 2005). CNs/ANMs connecting with each other has not been adequately studied.

Resources

The participants in this study who stated they rely on their NMs the most were those who worked on dayshift. This makes sense as, anecdotally, NMs work the dayshift. Since peers are the other most common resource relied on by ANMs, this highlights the importance for ANMs, especially nightshift ANMs, to be connected to each other. Since some participants said they are more likely to reach out for help and more likely to learn from peers if they know who they are, it is important for ANMs to have opportunities to meet each other. It was interesting that participants said that they quickly help another ANM when they are asked, they liked knowing

peers will lean on them for help, and they knew their peers will help them when they reach out to them. At the same time, they said they were more likely to ask for help from a peer when they knew them and had a relationship with them.

It was unexpected that participants focused on people as their primary resource for support. Only two participants discussed using resources other than people. It was expected they would discuss the use of resources other than people, such as current research, policy and procedure, and books. It is possible they do use these resources and they did not discuss this as they were not specifically asked. Further research is needed to explore ways to support ANMs in this regard.

ANMs Connecting with Peers

Study participants indicated that when they are effectively connected, they are stronger, their organizations are stronger, and patient outcomes are improved. As found in the literature and in this research, CNs/ANMs are an invaluable resource for support and learning to each other (Flynn et al., 2010; Morris, 2019; Sherman, 2005). The current study findings and the current literature highlighted the need for this group of nursing leaders to connect with peers in their organizations as a way to ultimately help their patients (Patrician et al., 2012). The ANM role directly affects patients as the support they provide to each other is often for the purpose of providing patient care. The current literature corresponded to this finding as peer supportive networks positively impact the people and the organizations (Shirey, 2004). ANMs seem to facilitate growth in each other through encouragement, knowledge sharing, and understanding. Participants in the current study associated the help peer ANMs provided to each other as directly affecting the quality of patient care, further highlighting the significance of connecting ANMs with their peers across their organization early in the role. Since they suddenly lose their

peers when they transition into the role, they are novice in the role, they learn from their peers, peers are an important resource, and peers provide support; this reveals how providing networking opportunities early in the role may better support and strengthen their role performance and well-being.

The two most common ways the participants formed connections with their peers were through classes offered by their organizations and at quarterly ANM-specific leadership meetings held by their organizations. The findings highlight the value of networking opportunities provided by their organizations as participants indicated that was when the connections were primarily formed. Participants said they had difficulty forming peer connections on their own as they do not have adequate opportunities to form these connections. Organizations were shown to affect the peer connections of ANMs and provide the opportunities used the most for networking. Organizations cannot force connections; however, they can bring ANMs together and help them initiate the connections through opportunity. The Sacramento Sierra Nurse Leader organization offers opportunities for ANMs to connect with local peers in other organizations. Since only two participants indicated they were members of this organization, there is question as to whether others were aware of this organization, especially since several participants indicated interest in connecting with peers outside of their current organizations. The professional organizations ANMs are members of were also not mentioned as a means for connecting with peers. Social media forums were not mentioned by any participants in connecting with others in their role. It is not known if they connect with peers through social media forums or not as participants were not directly asked. Participants described various ways to connect with peers, and the participant who reported feeling effectively connected indicated they used multiple methods to connect – more methods than the other participants.

Descriptions of ways of forming professional peer connections reflected either passive or intentional approaches. The participants who reported making peer connections intentionally said it was difficult to do. It is not known why ANMs do not connect intentionally. ANMs may not realize how important the peer connections are, how much of a difference they can make in their roles, and may not know how to connect with their peers. Merely putting names to faces is important; however, this seems to be the minimum. It is also important that ANMs engage in more meaningful ways. This could be explored in further studies.

The findings from this study highlighted the importance of using multiple methods for ANMs to connect and maintain their connections and emphasized the desire ANMs have in forming more personal and meaningful peer connections. Since organizations have cancelled meetings, events, and gatherings due to COVID-19, networking and connecting opportunities have not been available. This research has shown ANMs are reliant on their organizations' networking opportunities for making peer connections.

It is interesting that participants did not discuss their peers having anything to do with their professional goals, yet they described peers as motivating them to transition into the ANM role, or attend graduate school, and serve as a resource to build their reputation for career advancement, and they are a source to learn about job opportunities. It is possible ANMs may positively influence each other's professional goals and assist in career advancement if they discuss their goals with each other as ANMs have mentioned how helpful idea sharing with peers has been in generating new ideas.

Convoy Model of Social Relations

The findings from this study support the convoy model of social relations (Kahn & Antonucci, 1980), which depicts the relationship between personal characteristics and situational

characteristics. Together, personal and situational characteristics affect the requirements for professional support, which in turn, affects the convoy structure, then quality, and then outcomes, such as performance and well-being. See Figure 1 for application of the model to this study, which is based on an adaptation of Kahn and Antonucci's convoy model of social relations (Kahn & Antonucci, 1980). The adaptation used in this model was validated and approved by the original framework's author, Antonucci for the Rao, Evans, Mueller, and Lake (2019) study. The adaptation substituted references to *social* networks and support with *professional* networks and support (Rao et al., 2019). The PI in this study focused on the professional support provided by a professional network. The findings relate to the convoy model and support the framework. The personal characteristics include personal characteristics, experience, education, professional memberships, and possibly, social personality trait (introvert or extrovert). This study did not explore whether participants were introverts or extroverts, yet personality traits may be a factor in whether they take initiative to connect and engage with professional peer connections. The situational characteristics are the role expectations, role training received, the unit type, the shift they work (i.e., day or night), unit culture, organizational culture, and opportunities for connections.

Figure 1
Convoy Model of Social Relations

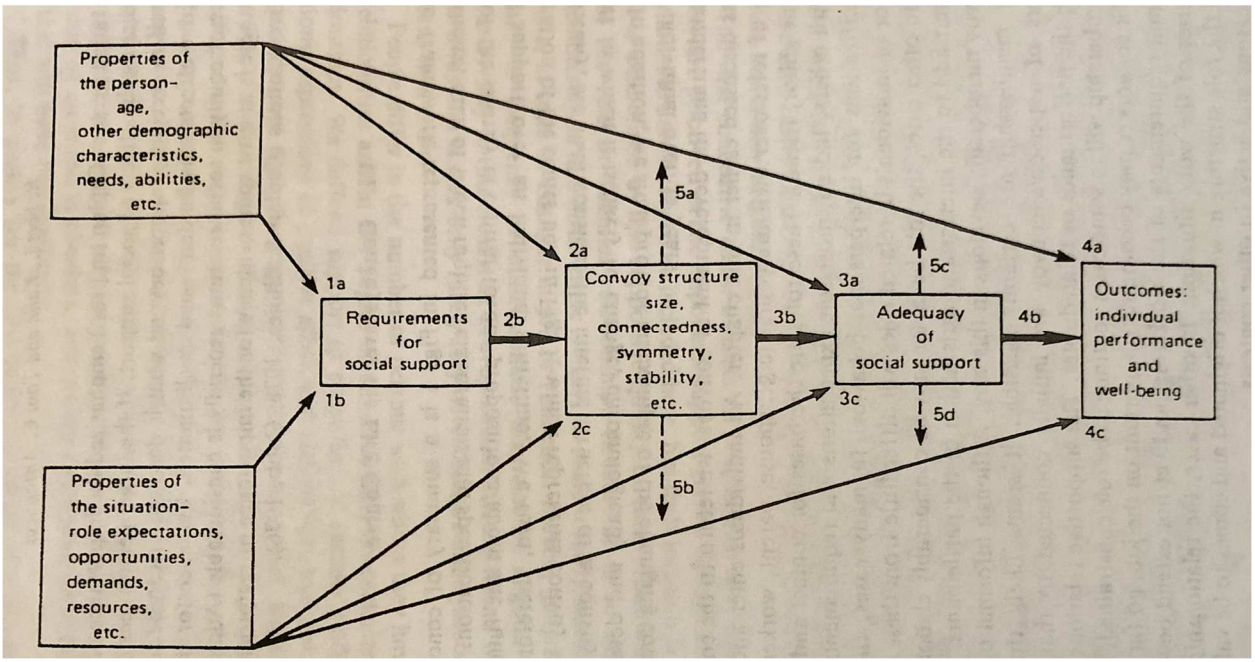
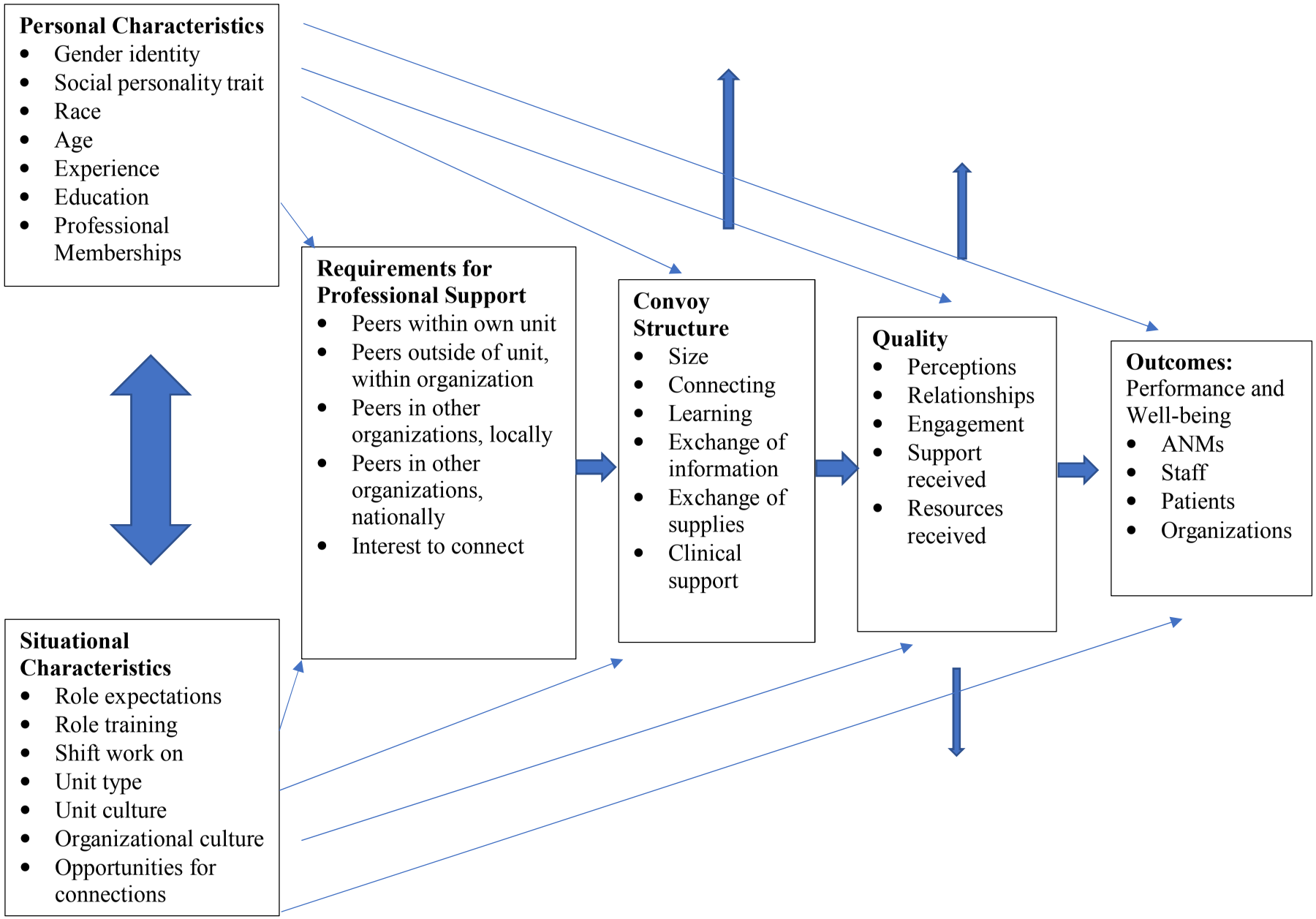


Figure 2
Adapted Convoy Model of Professional Relations



Limitations of the Study

The small sample size limits generalizability of the findings. However, the sample size was adequate for the purpose of a pilot study using a cross-sectional design. The sample reflects variations in participant characteristics working in select acute care organizations in one geographic region (greater Sacramento area). The findings may not be transferable to other geographic areas, larger more varied samples, or to other organizations with a different hierarchical structure. Further research is needed to expand the sample size, range of acute care organizations, and geographic representation.

Timing may also have served as a study limitation. The study was conducted during a global pandemic. It is possible the participants were feeling less connected with people, more lonely than usual, and more stressed due to the social isolation and social distancing. They may have been stressed over experiencing a more challenging work environment during an ongoing pandemic. However, the findings provided a credible reflection of reality, even in a global pandemic. It is a possibility the current COVID-19 global pandemic is bringing to light issues that already exist in the role and are revealing how important it is to connect ANMs and provide them effective role training. Resilience and coping skills have become crucial for nurses during the pandemic, and these are leadership skills that can make a difference in times of stress. Acute care hospitals should always be prepared for a disaster or an event. The pandemic can be shedding light on the need to better support this role as it is the ANMs who set the example for the staff who provide the frontline patient care.

Future research – during a time when people are no longer socially isolating and when there is not a global pandemic – will be an important next step. Participants were not directly asked about each group of peers, such as those within their unit, outside of their unit yet within

their organization, from other local organizations, and nationally. Separating the groups of peers would be useful to understand and explore further. A comprehensive examination of the ANM role was beyond the scope of this study; the data obtained about the role related specifically to the resources used and people relied upon when facing job challenges and the perceptions of the role in this study are merely the data that emerged. Future research focused on all aspects of the ANM role is needed.

Notwithstanding the study limitations, the findings in this study build on findings of previous studies in providing additional insight into ways to connect nurse leaders. Furthermore, the participants provided a variety of experiences and insights into how professional peer networks matter and what ANMs want in future connections, offering important preliminary data for future studies to examine the professional peer connections of ANMs. Several questions emerged from the findings, warranting further research. For example, how important is it for ANMs to have an experience in the relief CN role prior to becoming an ANM? How did the global pandemic affect the results? How many ANMs still perform patient care as part of their role and how often?

Research Implications

The insights gained from this pilot research offer an initial understanding of the experiences of the ANM role, attributes of their professional peer connections, and ways to develop opportunities to connect them to each other and support their advancements in this professional nursing leadership role. The findings provide preliminary data for future studies of ANM professional peer networks and ways to best support ANM role performance, including initial and ongoing training. These findings can serve as a beginning guide for organizations in developing innovative strategies that promote collaborative learning and support to frontline

nurse leaders where leadership training, development, and support are needed. Organizations that create opportunities for nurse leaders to connect would show their employees that they value nurse leaders as they invest in their role, empower the role, and promote their professional advancement. The findings can be used by ANMs and acute care organizations as a starting point to support and strengthen this important role and unify the organizations in which they lead. Some suggestions for further study include the implementation of training programs that incorporate intentional networking and methods for supporting and connecting ANMs. Exploring the ANM nightshift role in the acute care setting would be useful in determining their unique challenges and needs.

Conclusion

The findings from this study are consistent with the last two decades of research highlighting CN/ANM lack of role preparedness as a long-standing issue and there does not seem to be significant wide-spread advancements in role preparation. If ANMs feel lost, lonely, overwhelmed, and unprepared in their roles, how effectively are they leading their staff? This is something that can be improved by simply preparing them and developing them for their roles through consistent and ongoing training, encouraging mentors, and connecting them with each other. It is difficult for ANMs to have time to make connections while at work. Due to the fast-paced role, they are often the only ANM on shift, and their presence is needed in their units. When the most common ways ANMs are connecting are at events held by their organizations, organizations can use this information to connect their nurse leaders on a regular basis. Since there is a lack of leadership training, ANMs want more training as they see themselves as continuously learning, and they connect with each other in classes; this is also an opportunity for organizations. If organizations offered more leadership classes and required ongoing leadership

training for the role, they would not only be supporting the role through training and learning, but also by providing opportunities for their ANMs to network, connect, and engage. Organizations can also use these findings as an opportunity to teach its ANMs the importance of forming and maintaining professional peer connections and teach them effective networking methods.

This research can also provide information to ANMs to fully realize the importance of forming and sustaining professional peer connections. ANMs can take the initiative to increase the size and quality of their networks to better support them in their roles. The Sacramento Sierra Nurse Leader association is a local chapter to which only two ANM participants belonged. Joining a local nurse leader chapter is one method ANMs can act upon into increasing their own professional peer connections outside of their organizations. Other ways they can increase their peer connections are by seeking out leadership conferences, classes, joining professional organizations, and stepping out of their units to build relationships with ANMs in other units. This is difficult for them to do as they have so many role responsibilities.

Looking ahead, opportunities can be explored to support organizations in their investments in ANMs, as this role is a critical link connecting upper management to the frontline delivery of patient care and can directly affect the quality and safety of patient care. Organizations can incorporate intentional networking strategies and opportunities for their nurse leaders. ANMs need ongoing opportunities to strengthen their leaderships skills through training and development and sustained professional peer connections. This data revealed a variety of preferences for what ANMs want in connecting and engaging in professional peer connections. This data also recognized that some may need more structured opportunities to help them facilitate the connections for those who do not initiate the connections. This study's results

indicate a variety of connection options can be made available to ANMs by their organizations. The professional peer networks of ANMs should be seen as a resource with multiple benefits that are not fully available or tapped into.

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Appendix A: Email Script

Script for email and in-person or phone discussions about the study

Dear ---,

I am recruiting participants for a study I am conducting with Assistant Nurse Managers/Nurse Services Supervisor 2/Administrative Nurse II/Nurse Shift Managers as part of my master's program. This email includes information about the study and participation.

I am a student at the University of California, Davis in the Nursing Science and Health-Care Leadership Master of Science — Leadership Track.

The purpose of the study is to examine Assistant Nurse Manager/Nurse Services Supervisor 2/ Administrative Nurse II/Nurse Shift Manager experiences with and preferences for connecting and engaging with peers in your same role in the acute care setting (hospital).

Attached is a Letter of Information that provides details about the study and participation.

The findings from this pilot study will provide directions for further research to develop evidence-based opportunities for Assistant Nurse Managers/Nurse Services Supervisors 2/Administrative Nurses II/Nurse Shift Managers to build their professional peer networks and to promote collaborative learning and professional nursing leadership within organizations.

Please contact me either by email or text/phone to schedule an interview. At the start of our session, we will review the attached Letter of Information and I will answer any questions you have about the study, eligibility, and participation. If you would like to talk first and address any questions you have, we will schedule a time convenient for you.

Please feel free to share this email and attachment with anyone you think might be interested in this study.

I thank you for your time and I look forward to talking to you.

Best regards,

Gina Finical, RN, BSN, CCRN
Master of Science in Nursing Science and Health-Care Leadership student
Betty Irene Moore School of Nursing
University of California, Davis
Cell (916) 903-3653

2nd Follow-up email if no response

Dear ---,

In follow-up to an earlier email, I'm reaching out to share information about a study I am conducting and to invite you to participate.

I am a student at the University of California, Davis in the Nursing Science and Health-Care Leadership Master of Science — Leadership Track.

I am recruiting Assistant Nurse Managers/Nurse Services Supervisors 2/Administrative Nurse II/Nurse Shift Managers to participate in a pilot study I am conducting for my thesis. The purpose of the study is to examine Assistant Nurse Manager/Nurse Services Supervisor 2/Administrative Nurse II/Nurse Shift Manager experiences with and preferences for connecting and engaging with peers in your same role in the acute care setting (hospital).

Attached is a Letter of Information that provides details about the study and participation.

The findings from this pilot study will provide directions for further research to develop evidence-based opportunities for Assistant Nurse Managers/Nurse Services Supervisor 2/Administrative Nurse II/Nurse Shift Managers to build their professional peer networks and to promote collaborative learning and professional nursing leadership within organizations.

Please contact me either by email or text/phone to schedule an interview. At the start of our session, we will review the attached Letter of Information and I will answer any questions you have about the study, eligibility, and participation. If you would like to talk first and address any questions you have, we will schedule a time convenient for you.

I thank you for your time and I look forward to talking to you.

Best regards,

Gina Finical, RN, BSN, CCRN
Master of Science in Nursing Science and Health-Care Leadership student
Betty Irene Moore School of Nursing
University of California, Davis
Cell (916) 903-3653

Script for email and conversations with MS-L graduate cohort

Dear MS-L students,

I am recruiting participants for a study I am conducting with Assistant Nurse Managers/Nurse Services Supervisor 2/Administrative Nurse II/Nurse Shift Managers as part of my master's program. This email includes information about the study and participation.

Please feel free to share this email and attachment with anyone you think might be interested in this study. If you would be willing, I will drop off printed flyers to you for posting in your units in the hospital setting. As a member of my graduate cohort, you are not eligible to participate in this study.

I am a student at the University of California, Davis in the Nursing Science and Health-Care Leadership Master of Science — Leadership Track.

The purpose of the study is to examine Assistant Nurse Manager/Nurse Services Supervisor 2/ Administrative Nurse II/Nurse Shift Manager experiences with and preferences for connecting and engaging with peers in your same role in the acute care setting (hospital).

Attached is a Letter of Information that provides details about the study and participation.

The findings from this pilot study will provide directions for further research to develop evidence-based opportunities for Assistant Nurse Managers/Nurse Services Supervisor 2/Administrative Nurse II/Nurse Shift Managers to build their professional peer networks and to promote collaborative learning and professional nursing leadership within organizations.

Please contact me either by email or text/phone to schedule an interview. At the start of our session, we will review the attached Letter of Information and I will answer any questions you have about the study, eligibility, and participation. If you would like to talk first and address any questions you have, we will schedule a time convenient for you.

I thank you for your time and I look forward to talking to you.

Best regards,

Gina Finical, RN, BSN, CCRN
Master of Science in Nursing Science and Health-Care Leadership student
Betty Irene Moore School of Nursing
University of California, Davis
Cell (916) 903-3653

Appendix B: Recruitment Flyer

Appendix C: Letter of Information

University of California at Davis
Letter of Information

Title of study: Assistant Nurse Managers Connecting and Engaging with Professional Peer Networks

Investigator: Gina Finical, Student,
Nursing Science and Health-Care Leadership Master of Science — Leadership Track, Betty Irene Moore School of Nursing, University of California, Davis

Introduction and Purpose

The purpose of this study is to examine Assistant Nurse Manager/Nurse Services Supervisor 2/Administrative Nurse II/Nurse Shift Manager experiences with and preferences for connecting and engaging with peers in the same position.

Assistant Nurse Managers/Nurse Services Supervisors 2/Administrative Nurses II/Nurse Shift Managers who meet the following criteria are invited to participate:

1. A Registered Nurse working in the acute care setting (hospital)
2. Currently or previously (in the last 5 years) employed full-time as a permanent Assistant Nurse Manager, Nurse Services Supervisor 2, Administrative Nurse II, or Nurse Shift Manager

If you meet the criteria and you consent to participate, you will be asked to participate in a telephone interview that will last up to 60 minutes. The interview will include questions about:

- Tell me how you became an Assistant Nurse Manager/Nurse Services Supervisor 2/ Administrative Nurse II/Nurse Shift Manager (as applicable)
- Training received for the role (at start and ongoing)
- Resources/individuals you rely on when you have challenges and questions about your job/role
- Ways you connect with others in your same role
- Your recommendations for future opportunities for peer connecting, peer learning, and/or peer support to you and to others in this role

The telephone interview will be audio recorded. At the start of the interview, I will ask that you not use your name, name of others, or name of your organization during the recording. The recording will be transcribed; your name will not be included or linked to the transcription. As a token of appreciation for your time, you will receive a $15 gift card to Amazon, Starbucks, or Peet's Coffee after the interview.

Participation in research is completely voluntary. You are free to decline to take part in the project. You can decline to answer any questions and you can stop taking part in the project at any time. Whether or not you choose to participate, or answer any

question, or stop participating in the project, there will be no penalty to you or loss of benefits to which you are otherwise entitled.

Questions
If you have any questions about this research, please feel free to contact the investigator at (916) 903-3653 or grfinical@ucdavis.edu.

Appendix D: Semi-Structured Interview Questions

Introduction
Before beginning the interview, the researcher will review the Letter of Information with the participant and answer any questions about the study or participation.

Demographic Questions:

Gender Identity: Age: Race:

Highest level of Education: Diploma Associate's degree Bachelor's degree Master's degree Doctorate PhD degree

Type of unit you work on: Shift you work:

Current job title: Years of experience in role:

If current job title is not Assistant Nurse Manager, Nurse Services Supervisor 2, Administrative Nurse II, or Nurse Shift Manager: How many years were you in an Assistant Nurse Manager, Nurse Services Supervisor 2, Administrative Nurse II, or Nurse Shift Manager position?

What Professional organizations are you a member of?

Interview Questions:

1. Tell me about how you became a (insert job title).
    a. (possible prompt) How did you learn to be a leader?
2. Tell me about the training you received for the (insert job title) role, both when you were first in the position and ongoing.
3. I know (insert job title) face lots of challenges every day. Please tell me about the resources or people you rely/relied on when you are/were addressing challenges or job questions?
    a. For example, if you're having difficulty handling a situation, where do/did you go for decision making support?
    b. Can you provide an example of a situation this occurred?
4. Tell me how you connect/connected with other (insert job title).
    a. (possible prompt) Tell me some examples of the support you receive/received from other (insert job title)
    b. Tell me some examples of the support you give/gave to other (insert job title)

   c. Describe the support you've looked for from other (insert job title)
   d. (possible prompt) How did you form these connections?
   e. (possible prompt) How does/did connecting with your professional peers affect you?
   f. (possible prompt) What do/did you like about those connections?
   g. (possible prompt) What about any downsides?
   h. (possible prompt) Tell me how connections with other (insert job title) relate/related to your professional goals.

5. Now I want to switch gears and think about if there were opportunities for additional networking with your professional peers. In an ideal world, with all of the resources or time available, what would you like to have/(have had) in future opportunities for peer connecting, peer learning, or peer support?

*As applicable, prompts with similar variations will be used throughout the interview to follow-up on points mentioned by the participants, for example: 1) tell me more about that, 2) how does that make you feel? 3) how so? 4) why is that important? 5) could you give me an example? 6) tell me about the last time you did that.

At the end of the interview, the researcher will thank the participant for their time and ask about their preference for the $15 gift card (e.g., Amazon, Starbucks, Peets). The researcher will let the participant know that the gift card will be sent electronically to their preferred email (confirm email address they want for the gift card). If a participant expresses interest in the final study report, the researcher will tell them they can access it from the ProQuest database once the thesis is filed and published.