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Transforming Self and Systems through Implementation of a Caring Coach Leader Program

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Abstract

Assistant nurse managers and nurse managers, often referred to as middle managers, have a direct impact on daily hospital operations, clinical work environments, delivery of high quality safe patient care, and patient outcomes. The stressful demands of this role have caused turnover rates to soar above the national average on some of the inpatient hospital units. Instability of nursing management oversight negatively effects staff job satisfaction and delivery of high quality safe patient care. In reviewing the organizations initial orientation program for transitioning middle managers into their new role, it was missing the supportive guidance of a coach. A Caring Coach Leader program was developed based on the foundation of transformational and caring leadership attributes aligned to the organizations theory-based culture. Transformational caring leadership attributes positively influence followers' engagement, builds trust relationships, and supports improvement of patient outcomes. Combined voluntary turnover rates of the assistant nurse managers and nurse managers, changes in caring attributes of program participants, and overall program appraisal were evaluated.

Keywords: nurse manager orientation, nurse manager turnover, preceptor programs for nurse managers, transformational leadership, quality and patient care outcomes.

Section II. Introduction

Within the United States, nurse manager turnover rates average 8.3%, as noted by the American Organization of Nurse Executives (AONE) (Zastocki & Holly, 2010). Currently, retention of assistant nurse managers and nurse managers has gained the attention of executive leadership, because current turnover rates for hospital middle management positions are exceeding the national average. Quality and financial oversight is provided by the managers accountable for unit operations, and turnover in these positions fragment implementation and monitoring plans of quality improvement initiatives. Today, given the focus on performance-based quality outcomes for reimbursement, as a result of the Affordable Care Act (United States Department of Labor, 2010), retention of middle management, assistant nurse managers, and nurse managers is critical to an organization's commitment to deliver value-based care.

Background Knowledge

When reviewing the current onboarding orientation processes within a large integrated not-for-profit health system located in Northern California, it was determined that there were inconsistencies amongst the medical centers with the initial orientation for assistant nurse managers and nurse managers, commonly referred to as middle management. The majority of the nursing orientation programs outlined in the literature focused on staff nurse orientation and preceptor programs, with limited reviews for nurse manager orientation programs. Based on review of the literature, orientation that is thoughtfully planned with nurse manager competencies, educational courses, resources, and supervisors as preceptors allows new middle managers to feel successful as they experience a smooth transition into their new role and the organization (Conley, Branowicki, & Hanley, 2007). Conley et al. (2007) identified potential solutions for organizations experiencing higher than average turnover rates.

Middle Management Turnover and Impact on Quality

Nurse manager retention and its impact on the quality and safety of patient care are critical as we transition to a pay-for-performance healthcare environment with reimbursement dependent on patient care outcomes. The turnover of nurse managers has departmental and organizational financial implications that include staff dissatisfaction, leading to increased staff turnover and loss of oversight for delivery of quality care that can affect patient outcomes and reimbursement (Dunham-Taylor, 2013). Nurse Manager role complexity including expectations to fulfill role duties, work as staff when needed, perform expanded duties to more than one unit, and substitute in the role of house supervisor when needed, further dilutes the effectiveness of the manager to oversee unit-based quality and safety (Dunham-Taylor, 2013). Role stressors that contribute to nurse manager turnover include resources and interactions with people, ongoing issues and tasks associated with the role, and ability to balance and affect performance outcomes. Dunham-Taylor (2013) noted that nurse managers are often hired into their role and provided an ineffective orientation that does not outline role expectations or facilitate socialization into the organization. Given the current economic environment's focus on performance outcomes, it is time to place importance on the nurse manager role and create a standardized orientation program.

Institute of Medicine and Patient Safety

The Institute of Medicine (2004) (*Keeping patients safe: Transforming the work environment of nurses*) report identified implementation of transformational leadership as an organizational action to harness the advantages of this leadership style's positive effect on transforming work environments to keep patients safe. The Institute of Medicine (IOM) report

recognized five successful management practices that had an impact with implementing change initiatives and achieving work environments focused on safety:

(1) balancing the tension between production efficiency and reliability (safety),

(2) creating and sustaining trust throughout the organization,

(3) actively managing the process of change,

(4) involving workers in decision making pertaining to work design and work flow, and

(5) using knowledge management practices to establish the organization as a '"learning organization"' (p. 108).

Nurse managers who implement the practices noted in the IOM report will influence change based on words, behaviors, and intellectual stimulation by encouraging nurses to engage in creative problem solving (Lievens & Vlerick, 2014). The transformational leader characteristics ultimately create a culture of safety, increase patient satisfaction, and improve the work environment and safety outcomes (Merrill, 2015).

Influencers of Change

Any identified gaps with current orientation programs for assistant nurse managers and nurse managers can be addressed by the system chief nurse executive (CNE) and medical center CNEs to ensure an evidence-based solution is implemented that aligns with the organizational strategy. The overall intent would be to ensure a thoughtful, evidence-based orientation program is designed based on the organization's expected competencies and leadership framework (see Appendix A for local competency and leadership model).

Local Problem

Currently, this large integrated not-for-profit health system located in Northern California is struggling with turnover of nurse leaders in the assistant nurse manager and nurse manager roles. Some medical centers have experienced turnover rates above 15%. Our organizational goal is to have a combined voluntary turnover rate below 6% for the assistant nurse manager and nurse manager positions; in 2015, our performance in reaching this goal was reported at 8%. No internal or external evidence was located to substantiate the selection of this goal; hence, the goal is an arbitrary target. Voluntary turnover rate excludes retirements, transfers, and terminations.

In 2015, the organization's executive leadership set a goal to recruit 150 nursing middle management positions due to high turnover rates. No formal exit interviews were conducted in the prior years, but some of the common complaints from current nurse middle managers include the stress of ever-changing work environments, competing priorities, implementation of multiple initiatives without additional resources, turnover of nursing leaders, and lack of support or understanding of their role. Multiple processes affect the retention of middle management nurse leaders. To identify root causes and select an intervention associated with turnover, the fishbone diagram was used (see Appendix B). Of note, no nursing management standardized orientation program, evidence-based competencies, or preceptor/coach program exists in this healthcare system (based on confirmation from regional leadership).

The personal and professional development pathway for becoming a nurse leader varies from person to person. What appear less variable and more common are responses from colleagues that their orientation into a new nursing leader role was limited or non-existent. Nursing middle managers, also referred to as frontline nurse managers in some hospital systems, are the *face of nursing* for our patients, families, physicians, direct care providers, ancillary staff,

and hospital administration. They work as patient and family advocates to safeguard delivery of quality and safe patient care within a complex system (DeCampli, Kirby, & Baldwin, 2010). They also oversee the organization's most precious resources – human beings and financial assets. (DeCampli et al., 2010). Given the challenges of their job previously outlined by Dunham-Taylor (2013) and the pivotal role with overseeing the hospital operations, it is imperative we prepare our middle managers to be successful by committing the necessary resources to support them as new assistant nurse managers and nurse managers.

Intended Improvement and Purpose of Change

This organization lacks a standardized orientation program for new assistant nurse managers and nurse managers that include evidence-based competencies as well as a formal preceptor or coach program to facilitate supportive onboarding. The proposed innovative solution is to design a coach program informed by Dr. Jean Watson's theory of human caring, commonly referred to as caring science, and the organizationally desired transformational leadership qualities to support the managers and directors in orienting new assistant nurse managers and nurse managers, as they transition into their new roles.

Aim Statement

The aim statement is: Create a Caring Coach Leader (CCL) program as a component of a thoughtfully organized orientation program that is focused on coaching and supporting middle managers as they transition into their new roles. This program will incorporate Watson's caring science attributes and transformational leadership qualities that are aligned with performance expectations for nurse leaders. The audiences for this program are nurse managers and directors who will oversee the orientation of new assistant nurse managers and nurse managers. The new CCL program was targeted for implementation in May of 2016 at two Northern California

medical centers. The outcome of the intervention is to decrease the combined turnover rates of assistant nurse managers and nurse managers to less than 6% and improve the caring attributes of nurse managers and directors who receive education through the CCL program. Based on the outcome of this intervention, a decision will be made on whether this program should be implemented at the remaining 19 medical centers.

Review of Evidence

The quality intervention for this project was initially influenced by the design of a structured orientation program outlined by Conley et al. (2007). A literature review was then conducted using the search words *nurse manager orientation, nurse manager turnover, preceptor programs for nurse managers, transformational leadership, and quality and patient care outcomes*. These key words were combined using the *and* technique within the search engines of the databases, CINAHL, Pub Med, and Fusion. The advanced search option was used to capture only academic journals in English and publications after 2000. Articles met inclusion criteria when (a) orientation programs were identified for nurse managers, (b) nurse manager preceptor-type programs were referenced, (c) nurse manager turnover and impact to quality safe patient care were discussed, or (d) nurse manager and transformational leadership skills influenced quality safe patient care outcomes.

The articles were reviewed using critical appraisal tools for quality and level of evidence. The Johns Hopkins Research Evidence Appraisal Tool for non-research studies was used to appraise the quality using a quality rating based on A for high, B for good, and C for low (Newhouse, Dearholt, Poe, Pugh, & White, 2007), and critical appraisal for level of evidence was conducted by applying an adapted tool from editors Melnyk and Fineout-Overholt (Fineout-Overholt, Melnyk, Stilwell, & Williamson, 2010) that outlined the level of evidence into seven

categories with 1 representing the highest level of evidence, systematic review or meta-analysis, and 7 being the lowest level, expert opinion or consensus (see Appendix C for evaluation table of the evidence).

Nurse Manager Orientation

Retention of managers to oversee and lead performance outcomes of quality and safety initiatives associated with hospital-based care is critical for a patient's healing and care experience. In reviewing the literature, the orientation programs primarily focused on staff nurses and preceptor programs associated with their orientation. A lack of effective orientation programs for nurse managers was identified, and only a few articles offered information on structured orientation programs to support nurse managers. Two articles dedicated to nurse manager orientation programs reported a positive outcome with development of mentorship relationships and supervisory preceptorship or peer coaching, as they transitioned into the organization and learned their new role (Conley et al., 2007; Hawkins, Carter, & Nugent, 2009).

Conley et al. (2007) designed, implemented, and evaluated a structured orientation program supported by newly redesigned role-specific competencies, supervisor preceptor model, and management development classes and resources. Two primary changes in the program focused on clarity with nurse manager competencies and changing preceptors from peer to supervisor. Conley et al. (2007) noted that orientation programs should be designed to enhance current knowledge and skills to promote learning, acquire new knowledge and skills for the job role, and support socialization into the organization's culture by building relationships and understanding the expectations of their leadership role. The orientation period was for six weeks and included weekly meetings with the preceptor. Conley et al.'s pilot program was implemented at a cancer institute that experienced low turnover rates with nurse managers

limiting the number of participants to five new nurse managers. The nurse managers who engaged in the new orientation program reported the competencies and supporting elements guided their learning and helped them quickly transition into the organization. Of note, the preceptor design with a senior nurse leader as the facilitator allowed them to quickly gain an appreciation of the organization's culture, values, and role expectations. This connection was intentionally designed to foster growth in the nurse manager's emotional intelligence. Preceptor evaluations were favorable, with emphasis placed on how the elements of the program guided their operational discussions with nurse managers. Nurse manager turnover or retention was not an evaluation element of this program.

Hawkins et al. (2009) acknowledged the need to extend the same value and importance of a structured orientation program to new nurse managers that is provided to nurse clinicians entering a new practice area. If we do not expect staff nurses to be competent without an orientation to their inpatient clinical unit, then this same principle should guide the role transition for a new nurse manager overseeing the operations of the hospital unit. Since nurse manager turnover creates gaps in leadership oversight and negatively impacts staff retention, a structured orientation program was implemented.

The program elements focused on performance within six domains: "leadership and retention, clinical management, coaching/mentoring, human resource management, financial management, and performance improvement and evidence-based practice" (Hawkins et al., 2009, p. 56). This program consisted of classroom education sessions, experiential learning, peer coaches to support application of learned concepts, nurse manager competencies, role clarity documents, progress check-in meetings, resource manual, and a bi-monthly support group to facilitate the new nurse manager's transition into their role and the organization. The support

group included the new nurse managers and their coaches, and has consistently been touted as one of the most valuable elements of the orientation program by the new nurse managers. This positive evaluation of the program validates research findings that new nurse leaders benefit by engaging in workplace socialization within a safe and supportive environment.

The authors of these two programs did not measure turnover retention as an outcome of their programs. Since many hospital systems experience high turnover rates for nurse middle managers, this would be important data to capture. No evidence of an expected voluntary baseline turnover rate for nurse managers was found, only a national turnover rate average for nurse managers was mentioned without any declaration of an acceptable target goal. Given the current rigor and challenges with the nurse manager's role in today's healthcare environment there is an opportunity to obtain this information. The current evidence primarily focuses on turnover rates of staff nurses.

Nurse Managers and Intent to Stay in Job

In Canada, Laschinger, Wong, Grau, Read, and Stam (2011) conducted a non-experimental study to determine if senior nurse leader practices could influence middle and frontline managers' perceptions of intent to leave their job, quality of patient care, organizational support, and empowerment. Data were collected through mailed surveys to 231 middle managers and 788 frontline managers working in acute care settings. The hypothesis tested was if nurse managers, who highly rated their senior nurse leader's use of transformational leader practices, would encounter more structural empowerment leading to a greater perception of organizational support, lowered intentions to leave current job roles, and elevated perceptions with quality of patient care. The researchers concluded that senior nurse leaders with transformational leadership practices empowered middle and frontline managers, decreasing

their intention to leave organizations and positively affecting their perception of organizational support toward quality patient care (Laschinger et al., 2011). When nurse managers feel supported by their leaders and organizations, it affects job satisfaction and decreases their intent to leave.

Warshawsky, Wiggins, and Rayens (2016) conducted a study that used secondary analysis of data from a 2012 survey completed by 355 nurse managers. This study used the Nurse Manager Practice Environment Scale to identify organizational aspects that contribute to nurse manager's job satisfaction and intent to leave their roles. Given the pivotal role of nurse managers with overseeing patient safety and quality care, along with being the foundation for future succession planning within organizations, it is important to understand what promotes job satisfaction and increases their likelihood of staying in their jobs. Transforming work environments to retain nurse managers is only a solution if the causes for action are known.

Analysis of the data revealed that three primary subscales were positive predictors for nurse manager job satisfaction: culture of generativity, patient safety culture, and constructive relationship between the nurse manager and the director (Warshawsky et al., 2016). These results suggest that nurse managers have more job satisfaction when executive leaders promote a culture of patient safety, directors encourage and empower decision making, nurse managers have time for mentoring and coaching activities with staff, and the workload is fair and manageable. As for intent to leave the job, two of the subscales for job satisfaction negatively affected intent to leave: culture of generativity and constructive relationship between the nurse manager and the director (Warshawsky et al., 2016). Nurse managers, who experienced a work environment of micromanagement from directors and no time for staff development activities, were more likely to explore other positions. Warshawsky et al. (2016) reported four

recommendations to support nurse manager job satisfaction and to improve the work environment: (a) establish an organizational culture of patient safety as the top priority, (b) decrease turnover rates by promoting career development opportunities, (c) encourage directors to coach and empower nurse manager involvement with decision making, and (d) evaluate practice environment to ensure fair and manageable workload. These findings reinforce the significance of relationships between nurse managers and directors and the need for hospital leadership to support cultures of patient safety, professional development, and manageable workloads.

Leadership Styles and Patient Outcomes

The IOM (2004) (*Keeping patients safe: Transforming the work environment of nurses*) report described transformational leadership as an organizational action item for adoption and implementation because of the impact of this leadership style's effect on transforming work environments for patient safety. As we prepare new hospital nurse managers for our current and future healthcare environment, it will be important to prepare transformational leaders who can engage their staff, implement shared decision making, be effective communicators and change agents, and build trust relationships. This leadership style has a positive effect on nurses' productivity, effectiveness, safety, and performance, and is negatively correlated with fear and stress (Lievens & Vlerick, 2013). Creating a work environment that decreases fear and blame promotes staff engagement and provides safe, high quality patient care (Merrill, 2015). Work environments void of unnecessary blame promotes staff to speak up regarding safety concerns.

Identification and selection of an organizational leadership style aligned with the culture is essential for supporting a performance outcome-based work environment. Three leadership styles have been noted in the literature: laissez-faire, transactional, and transformational.

Laissez-faire leaders often do not take responsibility or engage in decision making and are described as passive, with inactivity until problems are serious (Lievens & Vlerick, 2014; Merrill, 2015). Transactional leaders focus on rewarding performance. When employees receive rewards contingent upon performance, this does not support organizational commitment, engagement, or self-motivation, and lacks efficiency (Lievens & Vlerick, 2014; Merrill, 2015). As influencers, transformational leaders encourage and inspire employees to do more to ascertain higher performance. They act as role models, stimulate creativity, are respected, communicate a compelling vision, and create learning environments (Lievens & Vlerick, 2014; Merrill, 2015). Based on review of the literature, nurse managers that demonstrate the positive attributes of transformational leadership influence a safe working environment that, ultimately, leads to improved outcomes of patient safety and satisfaction.

Wong, Cummings, and Ducharme (2013) conducted a systematic review from May 1, 2005 to July 31, 2012 that focused on studying the relationship between nurse leader practices and patient outcomes. Studies were included if aspects of leadership were identified as styles, practices, behaviors, or competencies and were described or observed by self or others. Nurse leaders were broadly defined within the healthcare organizations, but were required to have supervision over nurses. Only articles published in English were accepted, and studies were only included if direct observations were reported or data were obtained from administrative databases that focused on the intent of the systemic review. This systematic review yielded 20 studies, with 13 studies obtained from this timeframe and seven previous studies obtained between 1985 and April 30, 2015 using the same relationship variables. The majority of the studies reviewed were conducted in organizations where transformational leadership characteristics were the organizationally accepted leadership style. Wong et al. found a positive

correlation between nursing leadership practices and enhanced quality outcomes measured by patient satisfaction, reduction of medication errors, usage of restraints, infections acquired during hospitalization, and lowered patient mortality rates.

A literature review completed by Verschueren, Kips, and Euwema (2013) between January 2000 and September 2011 yielded 10 articles with diverse patient outcomes. The review identified leadership styles and actions from head nurses that positively influenced patient safety and quality care outcomes. In this review, patient outcomes (patient satisfaction), clinical outcomes (pressure ulcers, mortality, infections), and process outcomes (medication errors, restraint usage) were used to measure quality and safety outcomes. Transformational leadership was the most predominant style. Trustful relationships, built on the foundation of integrity and fairness, were observed; a trend was noted between head nurses and nurses that had trustful relationships and their positive impact on patient outcomes (Verschueren et al., 2013). Trust is an important aspect of transformational leadership and is needed to promote a culture of safety and to build relationships.

Positive patient outcomes were noted when measuring medication errors that were the result of trust and use of standardized clinical pathways. Trust as a relationship-based aspect of leadership (transformational) and pathways as a task-based method for standardizing care (transactional) highlights the benefits of combining both leadership styles to be an effective leader focused on improving patient care (Verschueren et al., 2013). Additionally, both transformational and transactional leadership had a positive outcome with patient satisfaction by application of contingent awards for performance. Given the demands on head nurses, limited resources, focus on efficiency, and task-focused activities, applying relational leadership behaviors can be challenging. Hospital leadership committed to supporting nurse managers

overseeing direct care providers is necessary to reap the positive benefits associated with transformational leadership (Verschueren et al., 2013). Verschueren et al. (2013) suggested that application of both distinctive leadership styles should be considered to maximize leader's effectiveness with achieving outcomes. Providing and improving safe quality care requires effective nurse managers/leaders to be flexible, use the desired leadership styles to get results and not view them as mutually exclusive.

Preceptor, Mentor, or Coach

During the literature review process, the words preceptor, mentor, and coach were often used interchangeably, making it difficult to comprehend the differences between these supportive roles. What is the difference between preceptors, mentors, and coaches? Clarification was sought in the literature to ensure the program nomenclature was accurately aligned with the organization's culture, leadership's expectations, and intended outcomes of this quality improvement intervention.

The desired process to support this quality improvement intervention needs to allow time for facilitating the initial onboarding orientation and socialization into the organization's culture, assist with applying the newly acquired knowledge and skills into practice, instill confidence, increase another person's self-awareness through self-discovery, and promote leadership development. Accomplishment of these objectives can be achieved through people who embody various roles. Preceptors, historically, complete a preceptor education program and are assigned to a preceptee during the course of their unit or department orientation. Their time is purposeful, limited to the onboarding to assist with socialization into the unit and organization, and the goal is a completed orientation (Conley et al., 2007). Preceptor relationships can be peer-to-peer or employee-to-supervisor. When peer or internal managers are used as preceptors, often their

ability to provide the required time is interrupted due to their own unit-based operational duties (Conley et al., 2007; DeCampli et al., 2010).

Mentors are typically self-selected individuals who are trusted and respected by the mentee that act as a guide or counselor (DeCampli et al., 2010). The relationship is informal, not time limited, and grows more over time. Korth (2016) highlighted the "art of compassion, communication, and nurturing" (p. 210) as primary skills of nurse leaders that are not learned through textbooks, but rather acquired from observing and learning from successful leaders. When asked, most nurse leaders can easily acknowledge the healthcare mentors that impacted their professional development in their formative years. Conley et al. (2007) found that using the supervisors of new nurse managers as mentors was beneficial with learning from their knowledge and developing a mentoring relationship that extended past their orientation phase. A mentor is someone you connect with for professional counsel, career guidance, and maneuvering through professional dilemmas (Funari, Feider, & Schoneboom, 2015). These relationships are genuine, honest, candid, and built on trust (Funari et al., 2015). The roles of preceptor and mentor can both add value for the new employee, assistant nurse manager, or nurse manager.

Coaching promotes professional development by helping others find the answers through facilitative and explorative learning activities that invoke empowerment, and this can be a contributing factor of an organization's success. Coaching is less pronounced in nursing because it is often categorized as mentoring or part of a supervisor's duties (Narayanasamy & Penney, 2014). Coaching implies that a formal relationship has been established that is not self-selected by the learner and frequently happens in real-time to enhance the learning experience (DeCampli et al., 2010). Formal coaches can be resources internal to the organization or contracted through outside sources (DeCampli et al., 2010). Bottom line, nursing leaders have ample opportunities

to engage in coaching or mentoring activities with their employees, but the barrier remains for finding the time amid the workload and competing priorities associated with job roles (Korth, 2016). The coach asks questions exposing the learner to new ideas, skills, and strategies that foster new behaviors, attitudes, and ultimately new ways of knowing, doing, and being (DeCampli et al., 2010). The relationship should have a strong foundation built on mutual respect, trust, openness, reflective learning, honesty, reassurance, and positive communication (DeCampli et al., 2010; Narayanasamy & Penney, 2014). The outcome of a coaching relationship during job role transitions is twofold. One outcome is to encourage growth and development of the learner by innately motivating their desire to learn and to meet their own individual needs. Another outcome to help the learner meet organization's needs by aligning coaching with behaviors and strategies required for meeting performance expectations.

Coaching can transform individuals and organizations by supporting the middle manager working in today's complex environment fraught with increased role responsibilities. Coaching is formal, not time limited, builds respectful trusting relationships, motivates self-achievement, and nurtures competence and confidence. Given these characteristics and the organization's expectation that all nurse leaders attend local *coaching for excellence* courses to obtain coaching skills, the caring leader program will be named coach program and not preceptor program. At this time, the supervisor of the middle managers will be the coach for the assistant nurse manager and nurse manager roles based on the Conley et al.'s (2007) preceptor model, and role responsibility with prioritizing time for a supportive onboarding with direct reports will be emphasized.

Statement Based on Literature Review

Based on a review of the literature and the current organization's culture, a CCL program was created using the attributes of transformational leadership and Watson's nurse theory (2008). As previously mentioned, the goal is to decrease turnover rates of assistant nurse managers and nurse managers, resulting in retention and oversight to ensure delivery of high quality safe patient care. Using the intervention of a CCL program to retain middle management allows healthcare organizations to identify and create coaches who role model transformational caring leadership skills, which positively impacts patient outcomes. This quality improvement intervention is in alignment with the organization's mission, values, and nursing leadership practices.

Theoretical Framework

The theoretical frameworks of Watson's (2008) theory of human caring and transformational leadership (Bass & Riggio, 2006) guided the design and study of this quality improvement intervention. Alignment of these two theories in the creation of the Caring Coach Leader program for nurse managers and directors was intended for them to connect the value of caring with their practices as nurse leaders, integrate these attributes into daily practices, and experience the beneficial outcomes for patients, employees, and new middle managers. The blending of these two theories allows for the emergence of *transformational caring leaders*.

Watson's Theory of Human Caring

Watson's (2008) theory of human caring is built on core aspects that include the 10 Caritas processes, previously called carative factors, developed to support the nursing discipline by informing the professional practice of nurses toward delivering quality care and fostering authentic healing relationships. These practices are:

> One: Practicing loving kindness and equanimity within the context of caring consciousness. Two: Being authentically present, enabling, and sustaining the deep belief system of self and one-being-cared-for. Three: Cultivating one's own spiritual practices and transpersonal self, going beyond ego-self. Four: Developing and sustaining helping-trusting authentic caring relationships. Five: Being present to, and supportive of, the expression of positive and negative feelings as a connection with deeper spirit of self and one-being-cared-for. Six: Creatively using self and all ways of knowing as part of the caring processes; engaging in artistry of caring healing practices. Seven: Engaging in genuine teaching-learning experiences that attend to unity of being and meaning, attempting to stay within another's frame of reference. Eight: Creating healing environment at all levels (physical as well as non-physical, subtle environment of energy and consciousness) whereby wholeness, beauty, comfort, dignity, and peace are potentiated. Nine: Assisting with basic needs, with an intentional caring consciousness; administering "human care essentials," which potentiate alignment of mind-body-spirit, wholeness and unity of being in all aspects of care. Ten: Opening and attending to spiritual-mysterious and existential dimensions of one's own life-death; soul care for self and the one-being-cared-for (pp. 282-288).

These caring practices express the behaviors we see daily from our direct care nurses as they transform themselves and the work environment to create caring healing relationships with self, patients, families, members of the healthcare team, and the community they serve.

Relational caring and mindful and intentional presence occurs when a nurse chooses to engage in an authentic transpersonal caring moment with another person (Watson, 2008). This allows people to be open to experience and connect one's spirit and energy with another human

being. The transpersonal nature of this caring healing relationship is life changing for the nurse and patient that is not forgotten. The nurse grows from these experiences and becomes more responsive, intuitive, and able see the patient from their frame of reference (Watson, 2008). With time, this transpersonal caring consciousness informs the professional practices and relationships as he/she evolves into a Caritas nurse, experiencing all ways of knowing, doing, and being (Watson, 2008). This informed place of authenticity and caring consciousness positively affects nurses' ability to form caring healing relationships with self and others.

Transformational Leadership Theory

Transformational leadership has gained momentum in the healthcare industry over the last decade due to the positive influence noted by this leadership style's effect on improving patient care outcomes and proclamation from IOM (2004) that adopting this leadership style can transform clinical work environments by positively influencing a culture of safety. Multiple transformational leadership resources are available in the literature and frequently these resources cite Burns (1978) as the founder of transformational leadership theory. Transformational leaders engage with followers to find their motives for gratifying higher needs and this allows each other to mutually "raise one another to higher levels of motivation and morality" (Burns, 1978, p. 20). Burns is frequently credited for establishing the foundation that shaped the development of future transformational leadership theorists. For example, Bass and Riggio (2006) confirm the value of transformational leadership's compelling effect on follower's attitudes and commitment towards the leader and organization. They emphasize the importance for transformational leaders to gain the trust of their followers, demonstrate fairness, and enable empowerment.

Four moral components compliment the foundational framework of Bass and Riggio's (2006) transformational leadership theory and will be described below.

Idealized influence. Transformational leaders act as role models for their followers and the followers want to emulate their leaders. The leaders are trusted, respected, revered, and viewed as gifted individuals that demonstrate the capabilities, resilience, and focus to get the job done.

Intellectual stimulation. Transformational leaders encourage their followers to seek innovative and creative solutions by challenging the status quo to find new ideas and approaches.

Individualized consideration. Transformational leaders act as mentors or coaches by paying close attention to the individualized learning development and growth needs of their followers. They encourage communication and are effective listeners to ensure followers reach their potential. A supportive learning environment is created that welcomes individuals diverse needs and recognizes their unique talents.

Inspirational motivation. Transformational leaders motivate and inspire their followers by helping them find purpose, enthusiasm and new opportunities within their work. They create compelling visions that encourage followers to partake in the work as a team to accomplish the future goals.

Leaders that possess these qualities influence and transform followers. They are authentic leaders that are true to themselves and others that focus on developing their followers, stimulating follower's intellect, and building a better future together. The transformational leaders who possess the attributes noted by Bass and Riggio (2006), trust, honesty, integrity and other qualities, create loyalty amongst their followers.

Transforming Self and Systems through Caring Leadership

Nurse leaders, middle managers, directors, and nurse executives can transform themselves, their work environments, and systems by developing and demonstrating caring practices. Caring fosters positive team behaviors and builds collaborative relationships amongst the team, which influences a respectful, caring healing environment focused on quality and safe patient care (Sellars, 2011). When nurse managers demonstrate benevolent practices, employees are more likely to trust them, build working relationships, and engage in the work. Engaged managers are perceived as advocates for ensuring quality nursing care; and when employees feel supported and heard by their managers, they in turn role model advocacy and seek opportunities to improve patient care outcomes (Sellars, 2011). Hence, leaders that form these authentic, caring, respectful relationships promote nursing relational-centric caring practices and healing environments (Watson, 2006; Watson, 2009b). These new authentic caring environments promote true transformational shifts with people's actions and hospital systems by integrating caring modalities, practices, and processes as a *way of being*.

Dr. Jan Nyberg is an experienced nurse administrator who was guided early in her career by caring theory. Nyberg (1998) created a caring nursing administrator model that was informed by Watson's theory of human caring and administrative theories. The development of this model led to two roles for caring solutions – leader of caring profession and facilitator of caring within a healthcare organization. Nyberg characterized caring as a feeling and viewed it as a commitment to facilitate growth in others by allowing them to experience and internalize satisfaction through caring relationships. Caring now becomes a personal philosophy, way of thinking, and outlook to life that perpetuates an individual's behaviors and actions, making them more intuitively aware of the importance of relationships. As wisdom is gained through

knowledge, nurses apply this knowledge to their areas of specialty practice. For nursing leaders, Nyberg acknowledged five caring attributes that consistently facilitate expression of caring behaviors: "commitment, self-worth, ability to prioritize, openness, and ability to bring out potential" (p. 30). Her Caring Assessment Scale was designed based on these caring attributes.

For nursing manager, leader, or executive roles, caring is a responsibility when tending to the needs of nurses, employees, and others within the organization. Nyberg (1998) outlines three principal responsibilities for the nursing administrator:

> 1) To understand caring as philosophy and ethic to be established by organizational processes and structures; 2) to develop skills related to caring behaviors that are utilized in formal relationships with individuals and groups; 3) to be alert and responsive to opportunities to participate in situations involving nurse managers, nurses, administrative colleagues, and patients or families who have specific needs that allow the nurse administrator to behave as a caring person (p. 36).

The goals for caring are development of meaningful relationships and support for the growth of people within the organization. Patients benefit by being a recipient of the caring behaviors' positive effect on healing, and employees benefit by finding meaning and purpose in their work (Nyberg 1998). The current healthcare business environment requires a value-based focus on financial, quality, and service performance that is stressful and calls upon the nurse administrator to lead by ensuring the core of human caring is not lost and remains the philosophical priority for the organization. As a result of this responsibility, nursing administrators lead transformation of professional practice from the inside out by transforming practices and influencing others to engage in caring healing practices that transform selves, clinical work environments, and systems. As more nurse leaders assimilate the qualities of

transformational leadership, trust, integrity, respect, engagement, empowerment, and effective communication into their *way of living and being*, the emergence of transformational caring leaders may be witnessed.

Section III. Methods

Ethical Considerations

Dr. Jean Watson: Caring Theory and Ethical, Value-Based Care

Hospital institutionalized care is predominantly driven by business models directed by economics, organizational theory, medical science, and technology that reduces the human presence to that of body physical (Watson, 2006). Human beings become objects moved through the hospital stay and system to meet level of care payer realities and efficiency throughput metrics without regard for the person. The sacred act of *holding space* for another person as our hands touch, tend to authentic healing practices during times of sickness is lost. These current practices dishonor the human being for their wholeness of mind, body, and spirit and inhibit nurses from practicing to the fullness of their profession, the art of caring fostered by professional theory-guided nursing care. Human-to-human relationships and people-centric care is absent with caring reduced to hospitality that measures the service experience as a commodity. Impersonalized care without regard for humanity and void of caring and human relationships, represents an organization not guided by a values-based theory approach. Watson (2006) delivered the following message regarding value-based care: “Any profession that loses its values becomes heartless; any profession that becomes heartless becomes soulless. Any profession that becomes heartless and soulless, becomes worthless” (p. 49).

Nursing care implies nurturing others to recover or achieve a state of optimal health; curing cannot occur without caring. The nursing professional cares for and about the patient, with the intent to bring about a positive change in their welfare. Nurses apply their knowledge and skill when tending to the physical care of human beings, but they also establish respectful individualized relationships. When caring for someone, nurses must use their intuitive self to

sense the person's potential and need to grow, but they must also believe in one's own ability to assist with this growth (Nyberg, 1998). Nyberg (1998) stated "Caring is an ethic that affects all of life's relationships" (p. 36); it is how we relate to other human beings and are open and responsive to meeting the needs of others.

Caring should not be the marketing phrase to attract customers, consumers, or end users. Instead, genuine caring comes from within and is demonstrated by allowing us to express loving kindness and compassion, knowing that healing involves our authentic self to *see* the wholeness of others and *be* the environment. Authentic caring healing practices must be enculturated into the processes of the organization and behaviors of the people to create caring healing environments and relationships that express our humane model for spiritualizing and tending to the health of our patients, families, and communities. As hospitals seek Magnet status for nursing, they are discovering the need to resurrect conscious practices that embody the wholeness of the person and integrate healing and human caring practices into the clinical environment to generate life altering transpersonal relationships for patients and nurses (Watson, 2006; Watson, 2009b). This requires professional nursing care to be guided by theory-based, authentic caring practices that value and support caring healing environments, where relationship-based nursing care can be delivered. Watson's work allows for the artistic expression of caring (nursing model) within curing (medical model) and hospital economic driven models to honor the patient's mind, body, and spirit and give them what they seek and need for an authentic caring healing environment. When organizations publicly announce Watson's theory as their ethical guide for nursing care, then nursing leaders must ensure professional nursing caring practices are indeed being practiced, so we obey our commitment to humanity.

Institutional Review Boards

Prior to moving forward with this quality intervention, it was necessary to submit preliminary documents for joint approval from the Heathcare Leadership and Innovation Department, within the School of Nursing and Health Professions at the University of San Francisco and the healthcare system employer to validate that the proposed project did not meet the regulatory imposed definition of research involving human subjects. The outcome of the reviews confirmed no research on human subjects was being performed with implementation of this quality improvement intervention.

Disclosure to Participants of Caring Coach Leader Program

Before the start of this evidence-based quality improvement program, attendees were asked if they would participate in the completion of a demographic survey and Caring Assessment Scale that assesses individual's caring attributes through a self-assessment. It was emphasized that this request was voluntary, and attendees could still attend the program regardless of their decision to complete the surveys. They were informed that the information would be used to evaluate the attendee's perception of their caring attributes prior to the start of the CCL program, and results would be compared with the same follow-up surveys that will be sent post-completion of the program. All participants received notice that answers would be kept confidential because the survey results have no identifying information linked to individual identities. There was no individual benefit or reimbursement and no financial costs for partaking in the quality improvement intervention.

Setting

The setting for this quality improvement intervention occurred within a large integrated not-for-profit health system located in Northern California. The system includes 21 hospitals

ranging in size from small (less than 100 hospital beds) to large (greater than 200 beds), which deliver diverse specialty services at the different campuses. Some of the specialty services are Level II trauma centers, cardiovascular surgery centers, Joint Commission certified comprehensive stroke centers, Ebola centers, and neuroscience centers. Sixteen of the 21 medical centers were listed on the 2016 U.S. News & World Report for Best Hospitals based on analysis of clinical specialty care, procedures, and medical illnesses. The health system has approximately 74,000 employees, with approximately 18,000 registered nurses. In 2010, the executive leadership announced that the healthcare system was embracing Dr. Jean Watson as the nurse theorist, and the system became a National Caring Science affiliate of the Watson Caring Science Institute.

Within this integrated healthcare system, one system CNE and 19 CNEs oversee the delivery of quality patient care from nurses involved in direct and indirect care within the licensed and accredited hospitals. In 2015, all CNEs, chief operating officers, and area managers selected AONE as the competency model for developing nurse leaders in assistant nurse manager, nurse manager, director, and CNE positions. This conscious macrosystem decision was based on concern with middle manager turnover rates and lack of consistency with orientation, professional development, and competencies for individuals hired into these critical operational roles. Two CNEs from middle and large sized hospitals were selected to co-create the role-specific AONE competencies for assistant nurse managers, nurse managers, and directors to support professional development and onboarding orientation. This request also included integration of caring science behaviors to ensure alignment with nurse leader performance expectations. The role-specific competencies for assistant nurse managers, nurse managers, and directors for the first six months in the role were finalized in the second quarter of

2016, along with the CCL program. The two CNEs engaged in this work were asked to pilot the CCL program at their medical centers. The targeted audience was nurse managers and directors who would oversee the onboarding orientation of new assistant nurse managers and nurse managers.

Planning the Intervention

Buy-in for a standardized orientation program built on the AONE evidence-based competencies for managers and leadership development through education courses was established in 2015. The third element of a standardized orientation program outlined by Conley et al. (2007) would be implementation of a preceptor program to support application of new knowledge and skills into one's practice and socialization into the organization's culture. The proposed quality improvement intervention was discussed with facility preceptor/advisor in the fourth quarter of 2015 to obtain support and approval for implementation. As noted earlier, the intervention was named the CCL program based on the literature review and alignment with current coaching culture. In the first quarter of 2016, the progress with the AONE competencies was presented to the CNEs during their peer group meeting. At this meeting, the CCL program was introduced as a supportive program that was in development to assist with the onboarding orientation of new nurse leaders.

Alignment to Organization's Mission and Strategy

The core concept of this quality improvement innovative solution is to create a Caring Coach Leader program that is in alignment with the organization's mission, vision, and strategic initiatives for nursing. The goal of this program was to support a standardized onboarding orientation for new nurse leaders in middle management positions (see Appendix D).

Assessment with the Five P's

The five P's framework was chosen to help guide and define the scope of this project form a microsystem perspective (Nelson, Bataldne, & Godfrey, 2007). They will now be defined in detail below.

Purpose. Nurse manager turnover rates have increased within this integrated healthcare system, and some clinical inpatient units are experiencing nurse manager turnover rates higher than the national average of 8.3% (Zastocki & Holly, 2010). The purpose of this quality improvement intervention is to implement an evidence-based CCL program to compliment the assistant nurse manager and nurse manager orientation program that recently implemented AONE evidence-based manager competencies with a preexisting learning and development pathway. The goal is to decrease voluntary turnover rate with middle managers to less than 6%.

Patients. The patient population is hospitalized patients who receive patient care within the inpatient setting.

Professionals. The affected professionals are registered nurses in nursing middle management roles defined by the organization as assistant nurse managers and nurse managers. The audience for the caring coach program is their immediate supervisors, nurse managers, and directors.

Processes. Multiple processes affect the retention of middle management nurse leaders. To identify the root causes and select an intervention associated with turnover, the fishbone diagram was used, and the primary categories of causation were people, processes, materials, and work environment (see Appendix B).

Patterns. Measurements to evaluate improvement included assistant nurse manager and nurse manager voluntary turnover rates and changes in nurse manager and director perceptions of their own caring attributes using the Caring Assessment Scale by Dr. Jan Nyberg.

Aim Statement

The aim statement is to create a CCL program as a component of a thoughtfully organized orientation program that is focused on coaching and supporting middle managers as they transition into their new roles. This program will incorporate Watson's caring science attributes and transformational leadership qualities that are aligned with performance expectations for nurse leaders. The audiences for this program are nurse managers and directors, who will oversee the orientation of new assistant nurse managers and nurse managers. The new CCL program was targeted for implementation in May of 2016 at two of the Northern California medical centers. The outcome of the intervention is to decrease the combined turnover rates of assistant nurse managers and nurse managers to less than 6% and improve the caring attributes of nurse managers and directors, who receive education through the CCL program. Based on the outcome of this intervention a decision will be made on whether this program should be implemented at the remaining 19 medical centers.

Organizational Readiness

Change is not a new concept within this integrated healthcare system because change is the only constant noted in the healthcare industry today. Key concepts from Kotter's (1996) model with leading change have guided implementation for several quality improvement initiatives within this healthcare system, and this project is no exception. Kotter's model was developed to provide organizations with a process to successfully implement change, decrease the number of failures associated with change, and support sustainability of the change. Kotter's

foundation is based on the concept that major change is not easy, and processes need to be in place to address internal and external barriers. The eight steps of Kotter's change model are:

> Establishing a sense of urgency, creating the guiding coalition, developing a vision and strategy, communicating the change vision, empowering broad base of people to take action, generating short-term wins, consolidating gains and producing even more change, and institutionalizing new approaches in the culture (pp. 21-22).

The urgency for this project was the loss of assistant nurse managers and nurse managers required for overseeing the ongoing hospital operations to ensure high quality safe patient care through people and systems. Retention with this role is required to provide efficient, dependable quality care that is not further disrupted by staff turnover from job dissatisfaction given the loss of their immediate supervisors. Based on the value-based care focus of financial reimbursement changes with the Affordable Care Act, stability of this role is critical.

Budget and Resource Requirements

A two-year budget was created outlining both costs incurred and costs not incurred, because some expenses were already budgeted and some costs were incurred from expenses that were not budgeted (see Appendix E). The primary resources required for this project are time from the subject matter experts (SMEs) to assist with identifying and developing the content of the CCL program, time for the managers and directors to attend the program, and resources associated with hosting an education event. The SMEs time used for development of this program is part of their current role, which does not incur additional expenses. Education time for the managers and directors is already included in operational budget, along with administrative support resources, and does not incur additional expenses or backfill. The biggest challenge will be local nursing leadership allowing the time away from their daily operations to attend education. Travel expenses are already included in current budget processes. The

incurred costs consist of food, beverages, Survey Monkey fees, and materials. In 2016, the caring leader program will cost $5,003 to implement at five hospitals, compared to $15,688 to implement at 16 hospitals in 2017. An inflation rate of 1% was applied to all expenses in 2017.

Cost Avoidance and Return on Investment

The CCL program is not a revenue source, but rather a cost avoidance endeavor that has a return on investment if one less middle manager leaves their position (see Appendix F). Within the second and third quarter of 2016, the cost to implement the program at two medical centers is $2,001, and if one less person leaves their job, this will avoid the interim middle manager expense of $104,766, yielding a total cost avoidance of $102,765. In order to reach the organizational goal of less than 6% for voluntary turnover rate, eight middle managers need to not resign from their positions. If this goal can be accomplished, the total cost avoidance will be $838,128. Based on the low cost of this program and the projected returns on investment, this program has been supported for implementation.

Implementation of the Project

Work Breakdown Structure

The primary deliverables of development, implementation, and evaluation have been outlined in a work breakdown structure, which also includes corresponding sub deliverables (see Appendix G). Development includes the plan and design phases, with inclusion of SMEs integrating the expected leadership foundation into the program. Implementation involves creating a strategic communication plan and registration process leading to a well-attended event. Lastly, evaluation focuses on collection and analysis of the data for monitoring outcomes.

Program Design

The CCL program was created for the organization by the regional facilitator and educator of the program, with consultation from internal SMEs. There was six performance objectives: 1) create genuine caring moments, 2) apply attributes of caring and trust when building relationships, 3) practice reflective listening and asking open-ended questions to assist the orientee to find answers and ways of knowing, 4) integrate reflective practices into daily activities to guide self and team development, 5) illustrate shared decision making by engaging staff in department quality improvement activities, and 6) design a personal vision as a CCL leader.

The program was designed using the desired organizational transformational leadership qualities referenced in the 2004 IOM report, Watson's (2008) caring science theory, and caring attributes from Nyberg's Caring Assessment Scale for nurse leaders (Watson, 2009a). The program was built on the premise of building trust relationships first and foremost to create followers, who can then engage in the work, share decision-making activities, and participate in effective communication (see Appendix H). The nurse managers and directors will coach their new direct report nurse leaders, assistant nurse managers, and nurse managers on the behaviors and actions needed to successfully transition into the culture and their new role. This education supports their professional growth and, ultimately, contributes to their successful performance and retention – train plus support equals perform and retain.

The four core building blocks of the program are trust relationships, staff engagement, shared decision making, and effective communication. Authentic conversations, experiential learning activities, and reflective practices were incorporated into the program. The participants worked individually, with partners, and within small and large groups (see Appendix I for

facilitator lesson plan). Case scenarios and open-ended questions were used to stimulate critical thinking and emphasize the caring attributes required of a nurse leader who oversees inpatient care. These attributes are in alignment with Watson's theory, transformational leadership expectations, and Nyberg's Caring Assessment Scale (see Appendix J) for nurse leaders (Watson, 2009a).

Key Stakeholders

The primary customers of this program consisted of the decision makers and approvers (CNEs) for nurse leaders to attend the CCL program, the individual receiving the education (nurse managers and directors) who would be coaching their new assistant nurse manager and nurse manager, and the new nurse leaders (assistant nurse managers and nurse managers) who would benefit from the coaching from their immediate supervisors. Similarities, dissimilarities, and shared needs are noted amongst the stakeholders, with all stakeholders benefiting from this program from the train, support, perform, and retain perspective (see Appendix K). Increased retention is the outcome for all three of the stakeholders. However, the other three categories have some dissimilarity that is reflective of their sender or receiver roles.

Communication and Messaging Plan

The overall strategic messaging plan focuses on the role-specific benefits of the program for train, support, perform, and retain to answer the *why* for the targeted audiences. The content of the program's four building blocks of trust relationships, staff engagement, shared decision making, and effective communication aligned to caring science. Transformational leadership answers the *what* and emphasizes what is needed to transform self and systems. The communication strategy reaches out to the targeted audiences who benefit from this program.

The *when*, *where*, and *how* benefits from this program requires communication assistance from the CNEs to the individuals selected to attend the educational program.

For the pilot, email communication and phone calls were the primary method of communication. An email identifying who, what, and why was sent to the CNEs who volunteered to implement the CCL program (see Appendix L). Local communication to the targeted participants was overseen by the CNE. Ongoing email and phone call communications assisted to confirm when, where, who, and how. Post the pilot and approval for multi-campus spread, internal communication will be branded and emails will be used for communication and marketing of the program, along with various in-person and virtual meetings. Websites, flyers, brochures, calendars, and testimonials will act as tools to facilitate communication to targeted audiences about the new CCL program. Summary of the full-scope communication strategy includes methodology, purpose, audience, and frequency (see Appendix M).

The CCL program was to be piloted in two medical centers in the North Valley of California. The regional facilitator/educator was responsible for implementing the program and communicating the purpose, content, and audience for the education to the CNEs. The local CNE would then send out communication to his/her team regarding the CCL leader program and determine how many education days were required to ensure attendance of the key stakeholders. Recommended group size was ten to twelve individuals, but smaller medical centers could send five to six for the 8-hour education session.

Once this was completed, the local administrative support staff secured the education dates, conference rooms, and confirmed availability of the regional facilitator. Communication prior to the program was sent to the CNEs by the regional facilitator for communication to the attendees answering who, what, and why potential questions about the program. Additionally,

local administrative support staff arranged for the food, beverages, snacks, flipcharts, markers, and calendar appointments to attendees and obtained LCD equipment for the presentation. Regional administrative support obtained the journals, folders, presentation, pins, pens, and printed handouts for the education day. Local resources provided support service assistance needed on education day.

Planning the Study of the Intervention

As previously mentioned, the first quarter 2016 voluntary turnover rate for middle managers was 6.8%, and the organizational goal is to be less than 6%. Based on review of the Fishbone Diagram (see Appendix B) several issues with people, processes, materials, and work environment could be contributing factors for the current turnover rates. Currently, the organization is focused on standardization and has requested the initial orientation processes be reviewed for performance improvement opportunities. The ideal state is to have a standardized initial orientation program that includes evidence-based competencies, education courses to support the competencies, and a coach program to facilitate the successful transition into their new job role and the organization. The current state does not have standardized competencies or a coach program to support the desired transition outcome. Given these findings, and knowing work was already initiated to standardize competencies for initial orientation, the CCL program became the intervention to support the concept of a thoughtful orientation.

The regional facilitator, Caritas coach, and educator led planning the study of the intervention. Implementation of caring science education programs for nursing management and leadership roles is not a new concept for this healthcare organization. A *Leading with Care* series was designed five years ago that emphasized the importance of building relationships with self, patients, families, members of the healthcare team, and the community. A core group of

nurse leaders, primarily the Caritas coaches, were selected to attend the regional education sessions, with the intent to educate all nursing management and leadership personnel at their medical centers. This education taught the nurse leaders the theory, language, knowledge, actions, and behaviors required to implement caring science within their departments and medical centers. Selecting a coach program built on the foundation of caring science principles would, hopefully, not be new information for the requested participants and would be welcomed education. However, turnover from early retirement benefit packages, normal retirement departures, and voluntary and involuntary turnovers left many unknowns about the presence or absence of caring science integration into the professional nursing practice of staff nurses and nurse managers/leaders at the medical centers. Conducting an initial self-assessment of the participants caring attributes, using Nyberg's Caring Assessment Scale, was an important step to understand the participant's baseline prior to receiving the CCL education program. The anticipated outcome was that this new program would positively influence their behaviors and be reflected by changes in their follow-up self-assessments of their caring attributes.

Prior to implementation of this quality intervention, discussions and decisions were needed on the process for obtaining the caring assessment information and whether to include a demographic survey. Nyberg's scale and use of a demographic survey was discussed with adviser and preceptor; the decision to use Nyberg's scale was endorsed, and development of a demographic survey was recommended. When discussing processes for delivering the surveys, it was decided to use paper for the initial survey prior to the start of the education program and the Survey Monkey tool as the methodology for the follow-up survey. This allowed the facilitator to explain that participation in these surveys was voluntary, confidential, and connected to an evidence-based quality improvement intervention. Since the majority of the

attendees had no relationship with the facilitator, this conversation was important to engage the participants, answer questions, and build credibility. Another important step for planning the study of this intervention was to develop a program evaluation tool for participant feedback on the benefits and applicability of the program to their role and to receive recommendations on changes to the program. These steps for planning the study of the intervention were necessary to inform the evaluation phase of this quality intervention.

Key Milestones – Planning, Development, Implementation, and Evaluation

Successful projects require strategic planning and timeline management to ensure the program is developed according to design, implemented timely, and evaluated for outcomes (see Appendix N for GANTT Chart).

Planning started in July 2015 with identifying the innovative solution for decreasing turnover rates of middle managers. The project then entered into the development phase in February 2016 by creating the name of the program, learning objectives, and outline of curriculum using the desired attributes of transformational leadership and caring science. During the development phase, it was important to engage key stakeholders (CNEs) in the concept of the program and to get their buy-in. Once this was achieved, SMEs were identified, AONE competencies were finalized for initial orientation, CCL program was communicated to the CNEs, and budget was finalized. The development phase ended in May of 2016.

The initial phase of the implementation plan started in February 2016, as implementation dates were communicated and availability of potential education assistance was sought. Other key deliverables included selection of medical centers for initial implementation; confirmation of conference rooms; and finalization of food, beverages, handouts, and registration process.

Between February 2016 and May 2016, barriers with implementation timelines were communicated and adjustments were made based on needs of end users.

The evaluation phase started when the first CCL program was implemented in May 2016 and it ended in September 2016. Survey results were collected and analyzed during this time for the two medical centers that volunteered to implement the CCL program. Based on the outcomes of the evaluations, a recommendation will be made on whether to implement the CCL program at the other medical centers within this Northern California healthcare system.

Methods of Evaluation

SWOT Analysis

Given the ongoing issues with middle management turnover rates, a SWOT analysis was conducted to identify the organization's strengths, weaknesses, opportunities, and threats to assist with finding a solution to stop the loss of talented middle managers from the organization (see Appendix O). As a reputable organization known for being an employer of choice and given our focus on quality, caring science, care experience, and people, we attract knowledgeable and experienced middle management recruits, but are struggling to retain them. From the SWOT analysis, the weaknesses highlight the challenging work environment based on stress, workload, strained relationships lacking trust within a fear-based culture, an initial orientation that lacks a preceptor or coach program, and standardization of leadership competencies.

Currently, competitors are learning from us, focusing on outperforming us, and becoming Magnet organizations. If we want to continue to lead, then we need to implement an innovative solution quickly to facilitate retention of our middle managers. This innovative solution is the creation and implementation of a CCL program for managers and directors that is built on the

foundation of caring science and transformational leadership attributes. The intent of the program is to stress the importance of the leader instilling caring behaviors and actions as transformational nurse leaders to build trust relationships and facilitate the role transition of new middle managers.

Quantitative and Qualitative Evaluation Plan

The evaluation plan for the CCL program consists of formative and summative evaluation criteria and a methodology for analysis of the data. The evaluation phase was implemented in May 2016 and continued through September 2016. Outcomes from caring attribute self-assessments, demographic information, program evaluations, and turnover data were gathered and analyzed (see Appendix P for detailed Evaluation Plan).

Initial Evaluations

Prior to the start of the CCL program, a paper version of the demographic survey and Nyberg's Caring Assessment Scale (see Appendix Q) were completed. The demographic survey included age, gender, years of experience as a RN, years of experience in management and/or leadership, highest education degree, number of direct reports in current role, and if they ever had the support of a mentor or coach during their career. Nyberg's Caring Assessment Scale is a 5-point Likert scale with 20 questions developed from the five primary caring attributes (previously referenced) Nyberg believes contribute to caring behaviors in nurse leaders. The Likert scale responses range from *cannot use in practice* to *always use in practice*. These completed paper surveys were entered at a later date into a Survey Monkey tool by the facilitator and educator for the program.

Program Evaluation and Follow-up Surveys

At the completion of the program, a post-course evaluation was conducted and collected real-time, which included a 6-point Likert scale asking participants to select their level or agreement or disagreement based on specific questions (see Appendix R). This evaluation followed the standard process of receiving feedback from attendees on meeting the learning objectives of the program, presentation of content, what went well, what could be changed, and suggestions for improvement. Approximately eight weeks after the completion of the CCL program, follow-up Caring Assessment Scale and demographic surveys via a Survey Monkey tool were sent through email to the nurse managers and directors who attended the program. Survey Monkey completion rates were tracked and reminders were sent to the attendees over the course of the 2-week completion deadline. Arrangements will be made to present final results of the program to the participating CNEs, nurse managers, and directors in fourth quarter of 2016.

Analysis

The analysis consisted of quantitative and qualitative information from organization voluntary turnover rates, program evaluations, and pre- and post-program Caring Assessment and demographic surveys that were collected from the CCL program participants by the regional facilitator. Program evaluation results were entered into an Excel spreadsheet to obtain individual and aggregate mean scores on the 6-point Likert scale questions and to capture the qualitative responses from open-ended questions. The initial paper Caring Assessment 5-point Likert scale and demographic survey results were manually entered into a replicated pre-program survey that was built into Survey Monkey software. Similarly, the post-program surveys were built into Survey Monkey software, and the link was sent through email to the participants. The

Survey Monkey software calculated the data, and results from initial and follow-up surveys were exported into Excel spreadsheets for aggregate and comparative analysis.

Section IV. Results

Program Evaluation and Outcomes

The original pilot for implementation of this CCL program was supported by two CNEs at two different medical center locations. An unexpected outcome was the inability for one of the CNEs to identify implementation dates for the CCL program due to conflict with other competing priorities, anticipatory quality regulatory survey, vacations, and a pre-scheduled nursing practice education program that were happening during the program's implementation phase. The timing of these events only allowed one medical center to implement the CCL program.

Turnover Rates

In 2015, the year-end combined voluntary turnover rates for assistant nurse managers and nurse managers was 7.8%, previously reported at 8% due to rounding up practices. First quarter of 2016, prior to the implementation of the first CCL program, the combined voluntary turnover rate was annualized at 6.8%. This quantitative outcome remains above the organizational goal of less than 6%. During the second quarter of 2016, the first CCL program was implemented, and the second quarter ended with a combined voluntary turnover annualized rate of 6.1%.

CCL Program Evaluation and Outcomes

Overall, the verbal comments of those who attended the CCL program taught at the one medical center were positive, and the program evaluations supported this perception. The program was taught on two days to 16 nurse managers and directors, with six individuals in attendance on the first day and 10 individuals present on the second day. The participants turned in fourteen program evaluation surveys to the regional facilitator after completion of the program (see Appendix S for program evaluation results). Descriptive questions about the course used a

6-point Likert scale survey, ranging from *strongly disagree* (1) to *strongly agree* (6), with mean responses ranging from 5.3 to 5.7. In descending order, ratings of 5.7 were given to teaching methodology and adequacy of facility while ratings of 5.6 and 5.5 were allocated to applicability of education to role, content meeting the objectives, and clarity of the stated objectives. The lowest scores of 5.3 included pace of course being appropriate to material presented and learning methods to perform job more effectively. The lowest ratings were also supported by responses from the qualitative questions.

Presenter ratings of the regional facilitator/educator used the same 6-point Likert scale survey noted above, and the mean responses ranged from 5.6 to 6.0. In descending order, communicating effectively was rated 6.0 and being knowledgeable on the subject and responding well to questions were both allocated ratings of 5.9. The lowest rating was a 5.6 for maintaining the participants' interest. This result aligns with responses from the qualitative survey questions.

The qualitative survey had three open-ended questions: (1) What aspects of the course were most beneficial to you? (2) What would you like to change? and (3) Additional comments or suggestions for improvement. The beneficial aspects of the program included time for reflection and introspective work, gaining insight from colleagues through purposeful dialogue, renewal and mindfulness with caring science, reconnecting to our purpose as nurses, and comparing Caritas processes to transformational leadership attributes. The suggested areas for change ranged from changing nothing to overlapping discussion points that most likely contributed to comments of slow pace and recommendations to change class to four hours. These comments support the lower Likert score results for pace of course appropriate to material being presented and ability to maintain interest of participant.

Some additional changes for program redesign included providing more time to debrief on open-ended questions exercise, spending more time connecting the learning's to application within the work environment, and improving communication of program's purpose and objectives prior to day of arrival. Other comment changes were requests to offer more programs with this type of content, so nurse leaders can re-engage with this valuable work and re-energize themselves and each other. The additional comments section gave positive accolades about the day – inspirational, thankful, great day, all leaders can benefit from this program, hopeful assistant nurse managers can attend, and positive accolades for presenter. Some additional program suggestions were offered in this last section: add a better definition of transformational leadership and give more tools to teach staff.

Some unexpected and beneficial changes occurred during implementation of the program. The original CCL program agenda proposed 7.5 hours for this educational offering; however, it was delivered in 6 hours. Nurse managers and directors felt comfortable engaging in conversations about the ongoing stressful situations that contribute to job dissatisfaction and ability to care for self and others. These conversations were genuine and presented opportunities for the teams to gain insight from each other. During the morning session, the participants learned about relational leadership styles, building caring relationships, coaching, and how to ask meaningful open-ended questions. During one of the lunch hours, a nurse manager used the information learned to conduct a conversation with one of her staff. She verbalized that she used the skills she just learned and the conversation went well. Summary of morning session: **P**ause, acknowledge caring coachable moment; **A**uthentically be present, look, listen, and feel; and **R**eflective inquiry, ask questions

Demographic Surveys

Demographic surveys were administered to 16 participants prior to the start of the CCL program and post-completion of the CCL program (see Appendix T for comparative demographic survey results). Sixteen pre-surveys were completed representing a 100% response rate and 11 post-surveys were completed equaling a 69% response rate. In both surveys, the participants were primarily between the ages of 36 to 45 years of age, were female, had obtained a masters' degree in Art or Science, and support from a mentor was more common than support from a coach during their management or leadership career. The majority of the participants had 11 to 25 years of experience as a registered nurse.

Two of the demographic questions had dissimilar response numbers when comparing the pre- and post-survey results: years of experience in management or leadership role and number of employees as direct reports (span of control). For years of experience in management or leadership, the pre-survey identified two responses for 1 to 5 years and one response for 11 to 15 years, but the post-surveys showed higher response rates in these two categories. This question may have been confusing, since it did not specify nursing experience only, and during the post-survey, participants might have included years in non-nursing managerial or leadership roles. The number of employees as direct reports to demonstrate span of control also had incongruent results between pre- and post-surveys. When the pre-survey was conducted, questions were asked about this data element and clarity was provided. The pre-survey showed zero for 11 to 15 employees, but the post-survey results showed one for 11 to 15 employees. Any future surveys will require modification of the two questions with inaccurate comparative results.

Caring Assessment Surveys

Nyberg's qualitative pre- and post-Caring Assessment surveys were combined with the demographic surveys; hence, the response rates were the same as the demographic surveys with 100% for the pre-survey and 69% for the post-survey. The anticipated responses between the participants' pre- and post-surveys would be increases in the caring attributes mean score post-completion of the CCL program; however, the results did not completely validate this assumption (see Appendix U for comparative Caring Assessment survey results).

Twelve of the 20 caring attributes showed an increased mean score, while eight showed a decrease in the mean score from the pre-survey results. Reviewing the 12 positively influenced responses, nine caring attributes had an increased mean score of .11 or greater, with four showing an increase that ranged from .20 to .34. The higher scoring caring attributes, in ascending order, included: (1) *understanding that spiritual forces contribute to human care*, (2) *allowing time for caring opportunities*, (3) *understanding thoroughly what situations mean to people*, and (4) *basing decisions on what is best for the people involved.* Of note, the verbal and written responses from the participants acknowledged appreciation for reconnecting with caring science, reflecting on our purpose as nurses, allowing time for them, and feeling reenergized. This was also reflective with an increased post-survey mean score of .14 for the caring attribute of *taking time for personal needs and growth*.

In reviewing the eight negatively swayed responses, two caring attributes stood out more than the others with a decreased mean score of .11 for *focusing on helping others to grow* and decreased mean score of .60 for *remaining committed to a continuing relationship*. These results are puzzling, since the CCL program was focused on the importance of building trust relationships and coaching others to assist with their growth and development. Yet,

communicating a helping, trusting attitude toward others, *having deep respect for the needs of others, remaining sensitive to the needs of others*, and *implementing skills and techniques well* all had elevated mean scores based on the pre-survey results.

Section V. Discussion

Summary

Key Successes

Voluntary combined turnover rates decreased to 6.1% at the end of second quarter 2016. Although, I would love to take credit for this positive progressive decline, implementation of one CCL program at one medical center during the second quarter is not the only influencer of these results. The healthcare system actively engaged in a recruitment strategy to fill additional assistant nurse manager and nurse manager positions based on turnover needs and upcoming retirements. This competing priority occurred at the same time as the CCL program. An additional 34 recruits were hired, increasing the denominator that positively affected the voluntary combined turnover rate. No harm was incurred with implementation of the CCL program.

Based on the evaluations, the CCL program was a worthwhile endeavor reconnecting nursing managers and leaders to their purpose and allowing them an opportunity to connect caring practices and attributes with their leadership roles. Feedback from the evaluations also recognized opportunities to enhance the participants' learning by spending more time on skill development with open-ended questions and providing applicable skills and tools to support a caring environment in the workplace. Additionally, more knowledge on transformational leadership was requested. The CCL program will be modified to include these recommendations, along with decreasing the program time to four hours by removing redundancies.

Another successful outcome was observed between pre and post Caring Assessment Scale surveys. When comparing pre and post survey results for Nyberg Caring Assessment, the majority (60%) of caring attributes had an increase in mean scores. This was positively

perceived; one caring attribute for *remaining committed to a continuing relationship* was significantly lower from the baseline than the other 40% of caring attributes which had decreased. During the program, discussions transpired that reflected on the presence of distrust and non-caring behaviors from some individuals within the work environment and its interference with building trusting relationships. Perhaps, the nurse managers and directors acknowledged the need to redirect their emotional energy away from the negative influencers and chose to develop caring moments, practices, and relationships with self and other members of the team, as noted by the positive increase for *allowing more time for caring opportunities*, along with *basing decisions on what is best for all the people engaged in the work.*

Key Findings and Lessons Learned

A key finding was discovery that caring science inspirational courses were not being taught locally, and the theory of human caring was not being connected to caring healing practices of the nurse leader. During and after the CCL program, the immediate feedback was the need for regular ongoing programs to reconnect nurse leaders with the art and purpose for why they entered the nursing profession. Another interesting finding was the request to share this program with the assistant nurse managers, as it was not viewed as an exclusive program for nurse managers and directors only. The coaching techniques and connection with transformational caring attributes was deemed valuable for a broader audience and not limited to initial orientation.

Lessons learned from the pilot include the need for a back-up plan when a selected facility pulls out of the implementation plan. Proactively acquiring the potential schedule for the Joint Commission surveys would have been beneficial to better estimate the barriers to implementation and allow for identification of other CNEs as potential implementation sites. In

the future, creating a Survey Monkey assessment to obtain information from the CNEs about local events and initiatives will be considered. Another lesson learned was not to rely solely on the CNE, with their busy schedules, to communicate the purpose and objectives of the program to the attendees. The full communication strategy was not implemented for the pilot, so this issue will be mitigated with future implementations. An additional learning was to proactively inform host site of conference room requirements for conducting the CCL program so small workgroup activities can be accommodated. The scheduled conference room posed a few challenges for the small group interactive sessions. Lastly, this program is worthy of Board of Registered Nursing (BRN) continuing education units (CEUs), and future plans will include completion of the BRN application to grant participants CEUs.

Implications for Nursing Practice

Creating *Caring Coach Leaders* among nurse managers and directors to facilitate initial orientation has the potential to support newly hired middle managers as they transition into a new organization's culture, as noted by the positive change with increasing the perceptions of participants' caring attributes. However, this program does not need to be limited to initial orientation only nor to just nurse managers and directors. Other nursing manager and leader positions would benefit from receiving this education program, as it can renew and reconnect them with the purpose of why they chose nursing and inspire them to continue leading and facilitating caring into their practices as nurse leaders. Spreading this program to others would be beneficial to create a culture of caring observed by changes in nurse manager and leader caring attributes and behaviors that become a *way of life and being*. Caring coach moments could occur in daily activities to sustain a purposeful culture that values human caring through ethical theory-based practices.

As nurse managers and leaders, it is our duty to ensure the core of human caring is not lost from nursing, but rather that it is flourishing to create caring healing practices within all nursing team environments in honor of people and our profession. The *leading with care* courses that were previously offered to nurse managers and leaders will resume with new content as part of the overall regional strategy to support Caritas literacy and transformational leadership behaviors for the emergence of *transformational caring leaders*. Opportunities to explore formal coaching models and coach certification will be included in the overall strategy as a path for sustaining a culture of Caritas Nursing.

The reality of today's healthcare environment requires leaders to adapt their leadership style based on the audience and operational objectives. The literature review supports the need to use a combination of transactional and transformational leadership qualities to oversee the day-to-day operations that are often task-based (transactional), while embracing the behaviors of transformational leadership to inspire, engage, and empower followers. The art and science of these two styles are a necessity for the current metric-driven clinical work environment. Both of these styles will be added to the CCL program; however, the beneficial impact noted in the literature of transformational leadership leading to improvements in job satisfaction, turnover, trust, empowerment, and patient outcomes will continue to be emphasized within this educational program's learning activities.

Trust, a word found in the literature for caring and transformational leadership, is something that should not go unnoticed. Without trust, a leader will have no followers. Without trust, patients will not connect with another person to create a transpersonal caring healing relationship. Without trust, employees, peers, and leaders will not engage in the work or build relationships. The attributes of integrity, ability or competence, benevolence, and justice affect

the ability to build trust with another person (Zhang & Surujlal, 2015). People can forgive lack of ability when new in a role, but they will not forgive lack of kindness or genuine caring (benevolence). The important message is that you cannot capture the hearts and minds of followers until you show them you care and they can trust you. Transformational caring leaders have the ability to build caring healing trust relationships with all members of the healthcare team.

Dissemination Plan

Based on the positive accolades from this program, the minimal financial cost, high potential to positively impact the return on investment, and ability to connect nursing theory to caring healing practices of nurse leaders, a recommendation to implement the CCL program at the remaining 20 medical centers will be made. The results of the CCL program will be shared with local and regional key stakeholders to obtain buy-in and to solicit additional feedback prior to redesigning the CCL program. Upon final approval, the previously mentioned communication plan will be activated, and an assessment of local events or initiatives will be conducted prior to creation of a rollout plan. Also, a train the trainer course will be created to instruct the local Caritas coaches on how to teach this program to their nursing management and leadership teams.

Relation to Other Evidence

The coach and mentor survey responses, with more participants enlisting the support of mentors rather than coaches, supports the literature finding from Narayanasamy and Penney (2014) that coaching is a newer concept within the nursing profession. Even though this program was renamed coach program rather than preceptor based on the benefits of coaching, there is still a place for mentors in healthcare. Mentors are people you meet during your lifetime that are present when you need them, always ready to give you honest feedback, and you can call

upon them whenever there is a personal or professional need. They are informal relationships that are not always restricted to work. Like all things in life, balance can be achieved with supervisors as formal coaches and self-selection of mentors for personal and professional growth. At some point the formal coaching relationship with the supervisor evolves into a mentoring relationship that was also noted by DeCampli et al. (2010).

Barriers to Implementation and Limitations

The primary barriers for implementing the pilot CCL program were dealing with interference from other facility and organizational priorities and current established cultures. The pilot site that implemented the program had three nurse leaders from one department decline the invitation due to a previously scheduled event with their regional service line and outside presenters. The second confirmed pilot site was not able to finalize dates due to their Joint Commission survey window and another education program was scheduled because of a local initiative to support nursing professional practice. As previously mentioned, future plans for spreading the CCL program will include an assessment of local events and initiatives by the CNE to avoid scheduling conflicts.

This healthcare organization was established during the industrialized era and built on the foundation of a medical model supported by labor unions. The hierarchical metric driven business structure and integrated medical model is present that continues to support the organization's success with delivering high quality care and maintaining financial stability. In today's healthcare environment, with value-based care driving payment, this model has served the organization well; however, the expression of nursing through the art of human caring tends to be overshadowed and suppressed within a medical model and task-driven environment. Caring, as the core and art of nursing, needs to be resurrected, because when this is missing, the

work of nursing is lifeless and meaningless. During our discussions, the nurse managers and directors voiced the need for more support and tools to assist with managing barriers within the work environment that negatively affects their ability to promote trusting caring relationships. Comments from the program evaluations also validated what was verbalized. Conflict management skills are a necessity to be an effective nurse leader and are included in the AONE competencies. Internally, professional development courses are offered to advance our leaders knowledge and skills with conflict management. However, an assessment of these course offerings, inclusive of supporting resources, is warranted because skill proficiency with conflict management is essential to redirect disruptive behaviors that interfere with the goal of achieving a culture of caring.

Limitations with this pilot included small sample size, lower than anticipated return rate, and room layout for interactive activities. The inability to schedule another site and cancellation from three scheduled participants contributed to the decreased sample size. These limitations will be mitigated with future implementations, because planning and implementation schedules will be based on the outcome of the local CNE assessment. The room layout required some modification with the coaching experiential learning activities when creating and asking open-ended questions. Based on the evaluations, participants wanted more time for application of this activity, and the original plan would have met this need. Future discussions for room reservations will include space needs for partner and small group discussions.

Interpretation

The most significant change was an increase (from pre to post survey) in 60% of caring attributes, such as *understanding that spiritual forces contribute to human care* and *allowing time for caring opportunities.* One surprising finding was attendees' self-assessed perception of

one caring attribute *remaining committed to a continuing relationship* that decreased, which seemed rather counterproductive to the program's core message of building trust relationships. During the interactive program, discussions were open, and expression of both negative and positive feelings was encouraged. A few comments mentioned the daunting challenges within the clinical work environments with the presence of distrustful non-caring behaviors; thus, one of the requests for improvement included providing more applicable skills and tools to promote caring practices within their departments. The caring attributes with the greatest positive changes in mean scores were *comprehensively understood what situations mean to people* and *basing decisions on what is best for all the people involved*. As the nurse managers and directors returned to their work environments, perhaps, there was a realization that too much time was spent dealing with the negative behaviors of non-performers and more attention was required to understand the needs of all their staff to make decisions for the good of the whole and not the few. Hence, the commitment to spending time engaging with negative relationships was severed and time was shifted in a more positive direction, allowing time to promote caring interactions for the betterment of all people within the work environment. As more CCL programs are implemented, it will be important to evaluate and compare the qualitative results for similarities and dissimilarities that may or may not support this statement.

With the discovery that courses are not being taught to keep Caring Science alive in the hearts and minds of our nurse managers, leaders, and staff, it appears that this is not a priority or has fallen by the wayside due to management turnover. Further implementation of the CCL program will not reap the positive benefits of increasing and sustaining caring attributes in our nurse leaders if this issue is not addressed. As nursing middle managers and leaders leave the organization, the current work of Caring Science is not being sustained; hence, current nursing

managers are not receiving ongoing education to keep them connected to the core of our noble profession. Thus, the Caritas culture will not be thriving in the future and this negatively affects our goal for human caring to be a *way of living and being*. An outcome of this project is the development of a regional strategy to bring Caritas literacy into nursing daily practices for staff, managers, and leaders that will involve local Caritas coaches. Qualitative nursing caring indicators will be implemented to bring the voice of nursing forward in this metric-driven environment.

Conclusions

Although program participants were limited, the increase in their caring attribute perceptions is promising for creating caring coach leaders and spreading the CCL program to support new assistant nurse managers and nurse managers with role transitions in the hope of decreasing turnover rates. An added benefit was hearing the desire for this program to not be limited to nurse managers and directors or for orientation only. The positive accolades with this program has stimulated the development of a regional strategic plan that includes spreading this CCL program, refreshing the leading with care sessions for managers and leaders, reigniting the passion and purpose of the current Caritas coaches, adding more Caritas coaches, and reconnecting with the medical center caring circles. The intent is to ensure the culture of human caring is present in the daily caring healing, trusting practices of nurse managers, nurse leaders, staff nurses, and members of the healthcare team. This culture must be sustainable regardless of turnover in managerial and leadership positions. All new nurse managers and leaders must receive education on Caring Science and transformational leadership upon entry into the organization to meet the expectations of *being Transformational Caring leaders*.

Section VI. Other Information

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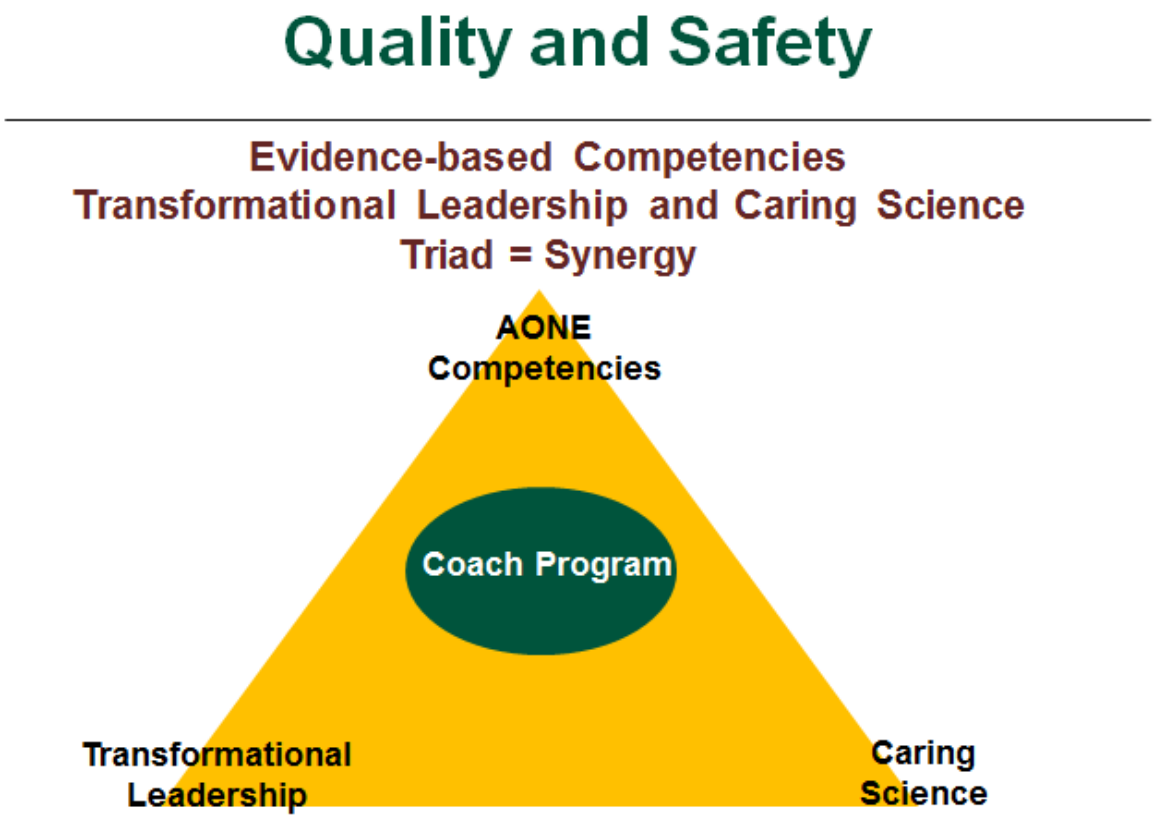
Section VIII. Appendices

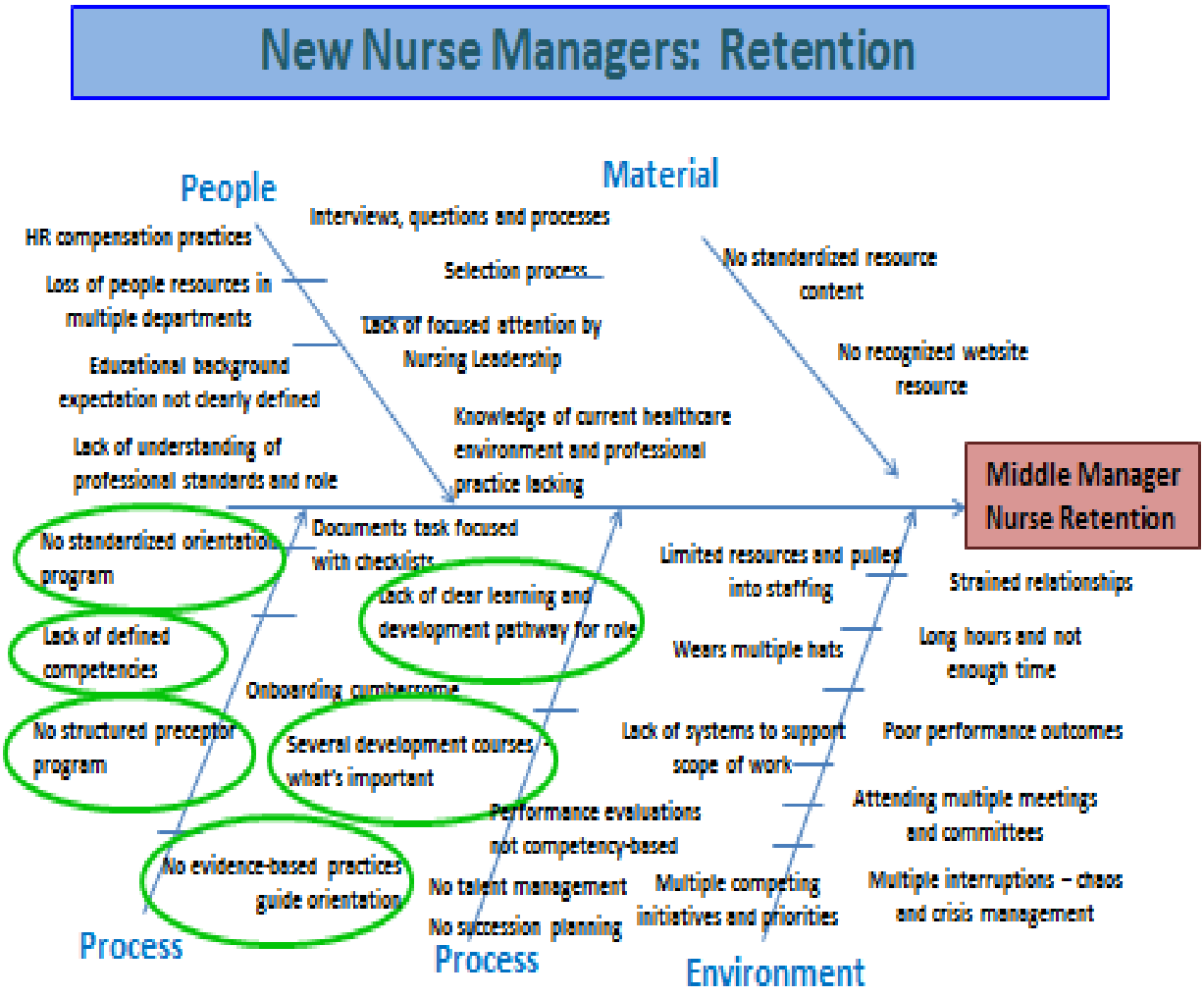
Appendix A

Competency and Leadership Model



Appendix B

Fish Bone Diagram



Appendix C

Evaluation of Evidence Table

Citation:	**Conceptual Framework**	**Design/ Method**	**Sample/ Setting**	**Major Variables Studied and Their Definitions**	**Measurement of Variables**	**Findings**	**Appraisal of Worth to Practice; Level = L; Quality = Q**
Conley et al., (2007)	Andragogy (Knowles) and emotional intelligence (Goleman). Synergy model used for competencies.	Needs assessment completed with 10 nurse managers to inform the design. New nurse manager orientation program be practical and effectively orient small numbers of managers; relevant to leadership problems; assist with acquisition of knowledge and skills; support socialization and institutional intelligence; appreciate adult learner needs. Program consisted of identified competencies, education classes with written resources, supervisor preceptors, and weekly meetings with preceptors.	A comprehensive cancer center in Boston, Massachusetts. New nurse manager orientation program was piloted with five new nurse managers.	New orientation program 6 weeks - consisted of preceptors (nurse manager's supervisor), nurse manager competencies, and education classes, resources. Evaluations from preceptors and new nurse managers.	Not clearly identified	Program was positively received by new nurse managers. They had a clear understanding of the organization's expectations and required learning, skills. Preceptors helped them to quickly acclimate into organization and understand the culture. Preceptors also gave positive accolades because the resources gave clear direction on what skills, experiences, and knowledge were essential for new nurse managers. Preceptor and new nurse manager met weekly at a minimum.	Limitations, small sample size and measureable outcomes. L: 6 Q: B

Hawkins et al., (2009)	Transformational Leadership (Kouzes and Posner's) Organization's six domains of performance expectations: clinical management, human resource management, leadership and retention, coaching/mentoring, fiscal management, and performance improvement.	Designed structure orientation program for nurse managers based on leadership values of organization. Guiding principles of program: 1) facilitation of professional development through coaching relationships, 2) learning environment as safe space, 3) learning viewed as continuous, lifelong commitment, 4) commitment to orientation process, 5) sufficient organizational resources, and 6) organizational systems to support new nurse manager. Program consisted of education sessions with written resources, competency checklist, peer coach as preceptor, periodic check-in meetings, and bi-monthly nurse manager support group meetings.	Hospital setting for University Health System located in Virginia. No sample size provided.	Evaluation feedback from preceptors and nurse managers in new orientation program.	Not clearly identified	Lessons learned: Commitment required to follow the orientation plan; coach check-ins promoted trust, feeling of being cared for; teaching moments acknowledged when nurse managers shared their priorities, schedules, and problem-solving ideas; important for coaches to ensure nurse managers adhere to check-in meetings and not cancel them; promote importance of nurse managers prioritizing attendance at management meetings to keep current on organizational directives and avoid downhill spiral with isolation and job dissatisfaction; and connecting nurse manager's unit work with organizational initiatives, committees. Implementation of support group for one year was positively perceived from nurse managers.	Limitations, no sample size and clear measurable outcomes. L: 6 Q: B

Laschinger et al., (2011)	Transformational Leadership (Kouzes and Posner's)	A secondary analysis of previously obtained data that used non-experimental, predictive mailed survey process. The hypothesis tested that nurse managers who rated their senior nurse leaders use of transformational leadership practices would encounter positive effects with structural empowerment, organizational support, quality of patient care, and lower intentions to leave their positions. The hypothesis was tested with two groups, first-line managers and middle nurse managers.	Final sample size was 788 front line managers and 231 nurse managers. Setting was 10 Canada provinces with responses from nurse leaders at 38 community hospitals and 28 academic health centers with greater than 100 beds.	Standardized self-report evaluates five elements of the hypothesis for leadership practices, structural empowerment, intentions to leave position, and perceptions with organizational support and quality of care.	A demographic survey and the Leadership Practices Inventory (LPI) was used. LPI is a valid and reliable tool that consists of 30-items with six components for each of the five leadership practices. Conditions of Work Effectiveness Questionnaire II (CWEQ-II) is composed of 19-items that measures six areas of structural empowerment. Shorter 8-item version was used from original 36-item Survey of Perceived Organizational Support (SPOS) with Likert scale ranging from 0 to 6. One item (question) from the International Survey of Hospital Staffing and Organization of Patient Outcomes (ISHSOPO) was used to measure nurse manager's perception with quality care provided. One question from ISHSOPO was used to measure nurse manager's intent to leave their current job.	Senior nursing leadership practices positively empowered first-line and middle nurse managers by influencing their perceptions of organizational support and quality care along with decreasing their intent to leave their job.	Limitations, potential common method bias with self-report study and non-response rate bias. Future studies using objective multisource ratings of quality patient care and turnover data is needed. L: 6 Q: A

Lievens and Vlerick (2013)	Transformational Leadership (Bass)	Cross-sectional research design tested two hypotheses focused on transformational leadership, safety compliance, safety performance, and knowledge related job characteristics	All nurses in large Belgian hospital; 498 approached and 152 completed questionnaires	Nurses perceptions of head nurse's transformational leadership style. Knowledge-related job characteristics. Safety performance and Safety compliance. Control variables were relationships with gender, age, and personality trait conscientiousness.	Transformational leadership style used the Multifactor Leadership Questionnaire (MLQ) a 20-item subscale 5 point Likert scale. Knowledge related job characteristics used the Work Design Questionnaire (WDQ) a 20-item subscale. Safety compliance was determined using four-item Safety Compliance Scale with safety performance using the four-item Safety Participation Scale.	Head nurses scoring high with transformational leadership have nurses who comply and engage more with work place safety. Demonstrated transformational leadership had positive outcomes with safety performance and compliance.	Limitations, small sample size, low response rate of 30.5%, and use of self-reported measures. L: 6 Q: A
Merrill (2015)	Leadership theories: Transformational, transactional, and laissez-faire. Bass one of the references.	Descriptive correlational study: purpose was to study the relationship between nurse manager leadership styles and climate of patient safety. Also, to explore if leadership styles promote a climate of patient safety.	Adult hospital inpatient units from 9 nonprofit hospitals within 1 healthcare system from 1 state. Survey Monkey was sent via email to 1,579 registered nurses working within 41 inpatient departments. Response rate was 29.5% with 466 responses received.	Patient safety climate measured using subscales of Hospital Unit Safety Climate (HUSC) survey for manager support, training/socialization, emphasis on safety, blameless system, usage of safety data, support from pharmacists, and worker safety. Also, staff nurses rated the presence of their nurse manager leadership styles (transformational,	Two validated tools: HUSC survey (5-point Likert scale) and Multifactorial Leadership Questionnaire (MLQ-5XS) a 4-point Likert scale. Also, demographic information was obtained. HUSC is a 33-item survey that measures 6 safety measurements and 1 worker safety measurement. The MLQ-5XS contains 45 items measuring the leadership styles of transformational,	Transformational leadership style positively influenced the department's patient safety climate that included 1) socialization into an environment that identified cultural norms of what is permissible and supported speaking up; 2) blameless system to help team members see errors as learning opportunities to improve patient safety and build a culture of trust; and 3) inter-professional teamwork	Strengths, positive correlation between transformational leadership style and promotion of patient safety. Limitations, small sample size, sample from 1 healthcare system in 1 state, and poor response rate. L: 6 Q:B

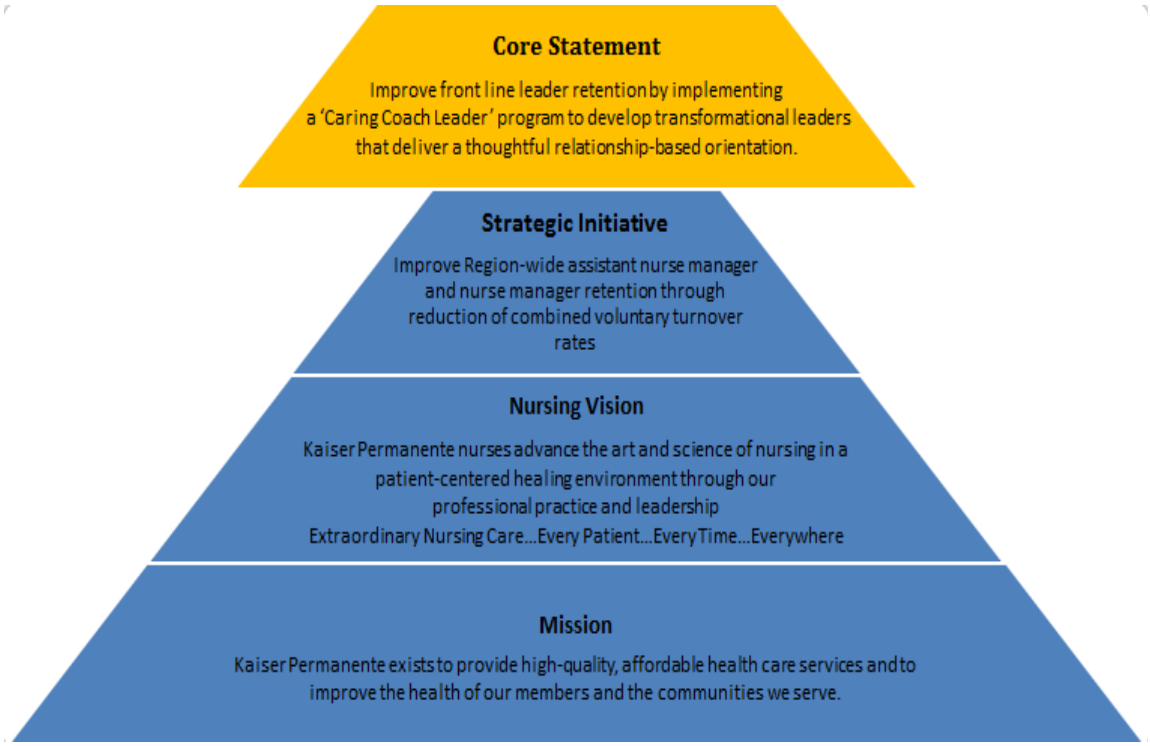
				transactional, and laissez-faire).	transactional, and laissez-faire.	that fostered alliances with pharmacy.	
Verschueren et al., (2015)	Conceptual framework of the studies was very different: multiple leadership theories, e.g. transformational, full-range leadership model; work environment e.g. complexity science, nursing outcome models, motivation theories for management.	Systematic review to explore what leadership styles of head nurses positively affected patient outcomes for safety and quality of care. Majority of studies used a cross-sectional exploratory correlational design.	Using authors search and inclusion criteria 10 articles were found. The studies took place in the U.S. or Canada. The care settings included academic medical centers, hospitals, long-term care centers, or nursing homes.	Associations were reviewed to determine what leadership styles and behaviors lead to better outcomes of patient safety and quality care.	Diverse leadership measurement tools were used with Multiple Leadership Questionnaire (MLQ) from Bass & Avolio and Leadership Practices Inventory (LPI) from Kouzes & Posner representing examples for leadership theories. Nursing Work Index Revised and Work Environment Scale were used to measure factors of the work environment. Five Practices of Exemplary Leadership was used to measure motivation. These are a representative sample of the measurement surveys.	The predominant leadership style in the studies was transformational leadership. Linkage noted between head nurse leadership and patient outcomes. Trustful relationships between head nurse and staff nurse is an important driver of for improving patient outcomes and is linked to a positive recognition of the department's quality and patient safety climate. Trust is a necessity to obtain commitment from the nurses to engage in behaviors that support a climate of quality and patient safety. Trust is a critical element of leadership behaviors and is accelerated when supporting processes are in place e.g. adequate staffing, clinical pathways.	Limitations, the diverse studies used a variety of styles, practices, and outcomes along with models and measures making it challenging to present a general conclusion. L: 5 Q: A
Warshawsky et al., (2016)	None noted	Secondary analysis of cross-sectional data from previous electronic survey to study the relationship between job characteristics,	Convenience sample of nurse managers from 25 hospitals in 9 different healthcare systems with a	The primary variables studied were the practice environment of nurse managers and effect on job satisfaction, intent	Forty-four elements from 8 subscales of the Nurse Manager Practice Environment Scale (NMPES) were used to evaluate quality practice	Nurse manager job satisfaction is higher in work environments associated with executive leader's ability to form organizational culture	Limitations, primary was the cross-sectional survey design since cause and effect could not be established,

		practice climate of nurse manager and job satisfaction and their intent to leave.	total of 356 nurse managers completing the surveys.	to leave, and intent to stay.	environment. Likert 1 to 6 scale was used with higher score reflecting greater agreement. Job satisfaction was measured using 2 questions from previous studies with a Likert scale ranging between 1 to 6 with higher score very satisfied/likely. A 3-item scale was used to measure intent to leave through the completion of 3 questions with a 3-point Likert scale with higher score noted as agree. Intent to leave, one question only for years planning to remain in job role.	of patient safety, directors empower nurse managers to be decision makers, workload is manageable and fairly distributed amongst peers, and there is time for coaching and mentoring employees. Nurse managers intent to leave their job was more likely when they lacked time to develop their employees, were micromanaged by their directors, and perceived inequities with workload distribution.	self-administered surveys may have slanted the responses, and variable response rate may have resulted from group-level phenomenon. L: 6 Q: B
Wong et al., (2013)	Donabedian's framework with structure-process-outcome	Systematic review to check for potential relationships between patient outcomes and nursing leadership practices. All articles applied a cross-sectional design.	Eight bibliographic databases were searched using key words and this yielded 15,180 papers but only 121 were reviewed based on criteria and 13 met the final selection criteria. These were added to a like previous	Examination of the relationship between nursing leadership styles (transformational, transactional, relational, participatory, consensus, task-oriented, relationship-oriented, resonant, leader ability along with support, trust of leadership, and perceptions of	The studies used multiple measurement tools. Leadership: Nursing Work Index Revised with subscale used that focused on manager ability and support, Patient Safety Climate in Healthcare Organizations, Safety Attitudes Questionnaire, Job Content Questionnaire, or Organizational Assessment Scale.	The majority of the articles used Transformational leadership as their theory. Positive relationship noted between relational leadership styles and patient outcomes for satisfaction and improved patient safety. Patient safety outcomes were described as reduction in medication errors, use of restraints, occurrence with	Strengths, implications for leadership theory, future research, and practice. Majority of the studies used valid and reliable tools, were conducted at various healthcare settings, adequate sample sizes, and correlations were noted using several effects.

			study that resulted in 7 articles done by authors for a final size of 20 studies. The care settings included inpatient units within hospitals, nursing homes, emergency departments, dialysis centers, or home health organizations located in U.S., Canada, or Norway.	leadership) and patient outcomes (satisfaction, mortality, safety, complications, adverse events, and utilization of healthcare services).		hospital acquired infections, and lowered patient mortality.	Limitations, variety of leadership and outcome measures prohibited meta-analysis; grey literature and unpublished dissertations were not included so all relevant work may not be accurately reflected, only English language studies may also excluded informative studies, L: 5 Q: A

Appendix D

Alignment to Organization's Mission and Strategy



Appendix E

Budget

Caring Coach Leader Program			
Expense Type	**Details**	**2016 Amount**	**2017 Amount**
Program Development	• Subject Matter experts time 80 hours X $130 – Literature review and development • Consultation with key stakeholders average $120 X 3hrs X people 3	$10,400 $1,080	None
Attendees time based on number (#)	6 hours on one day • Managers 6hr X $120 X # • Directors 6hr X $128 X #	5 hospitals* $28,800 $13,824 Managers 40 Directors 18	16 hospitals $93,082** $46,904** Managers 128 Directors 60
Travel for Educator per number of sessions	• Hotel $250/night X # days • Parking $20/night • Breakfast $20/meal • Dinner $50/meal • Mileage – average $100/round trip	$2,500 $200 $200 $500 $1,000 2 sessions per hospital	$8,080** $647** $647** $1,616** $3,232** 2 sessions per hospital
Education session • Food • Beverages	• Lunch/Beverages $30/attendee • Snacks $5/attendee • Educator added to #'s	$1,770 $295	$5,727** $955**
Survey Monkey Account	• Annual Fee	$300	$303**
Materials	• Journals $10/person • Handouts/Folders $10/person • Pins $15/person • Pens $6/person • Flipcharts, markers	$580 $580 $870 $348 $260	$1,899** $1,899** $2,848** $1,139** $788**
Total Additional Dollars		**$5,003**	**$15,688**

Note Gray Area: Expenses not incurred - Time for developing program and attendance to training are included in normal budget plans.

*Assumes initial program evaluations from the 2 pilot hospitals demonstrates need for 2 additional implementations in 2016

**Assumes inflation rate of 1% (McMahon, 2016)

Appendix F

2016 Return on Investment (ROI) and Break-Even Analysis

Middle Management

Per hour rate (estimated salary & benefits)	Daily 8 hour rate	Interim Daily 8 hour rate	Daily Difference	Average days of coverage by interim	Additional expense/person
120.04	$960.5	$1,525	$564.5	178	$100,481

Total Cost Avoidance Calculations for System (761 Total Assistant Nurse Managers and Nurse Managers)

Voluntary Turnover Numbers	Change in Numbers	Voluntary Turnover Goal < 6%	Cost Avoidance Salary	Cost Avoidance HR cost $4,285/hire*	Total Cost Avoidance
52 people/year	Baseline	6.8%	Baseline	Baseline	Baseline
44 people/year	8**	5.8%	$ 803,848	$ 34,280	$ 838,128
36 people/year	16***	4.7%	$1,607,696	$ 68,560	$1,676256

Cost Avoidance Guidelines

Cost Avoidance Salary = $100,481 X Number of people
Cost Avoidance cost/hire = $ 4,285 X Number of people
Total Cost Avoidance = Cost Avoidance Salary + Cost Avoidance cost/hire

Break Even Analysis – Cost Avoidance

	Second Quarter 2016	Third Quarter 2016	Fourth Quarter 2016
Cost	$2,001	0	$3,002
Benefit	No change	1 less person leaves job $104,766	2 less people leave job $209,532
ROI	($2,001)	$104,766 – loss of $2,001 = $102,765	$209,532 – loss of $5,003 = $204,316

Second Quarter Cost assumes implementation at 2 medical centers
Third Quarter Cost assumes implementation at 0 medical centers during evaluation phase of program
Fourth Quarter Cost assumes implementation at 3 additional medical centers
Cost assumes food, beverages, and materials based on attendees, portion of Survey Monkey annual fee, and portion of flipcharts, markers. See budget
Benefit assumes total cost avoidance of $100,481 + $4,285 per Interim Middle Manager
ROI of program noted if 1 less Middle Manager resigns

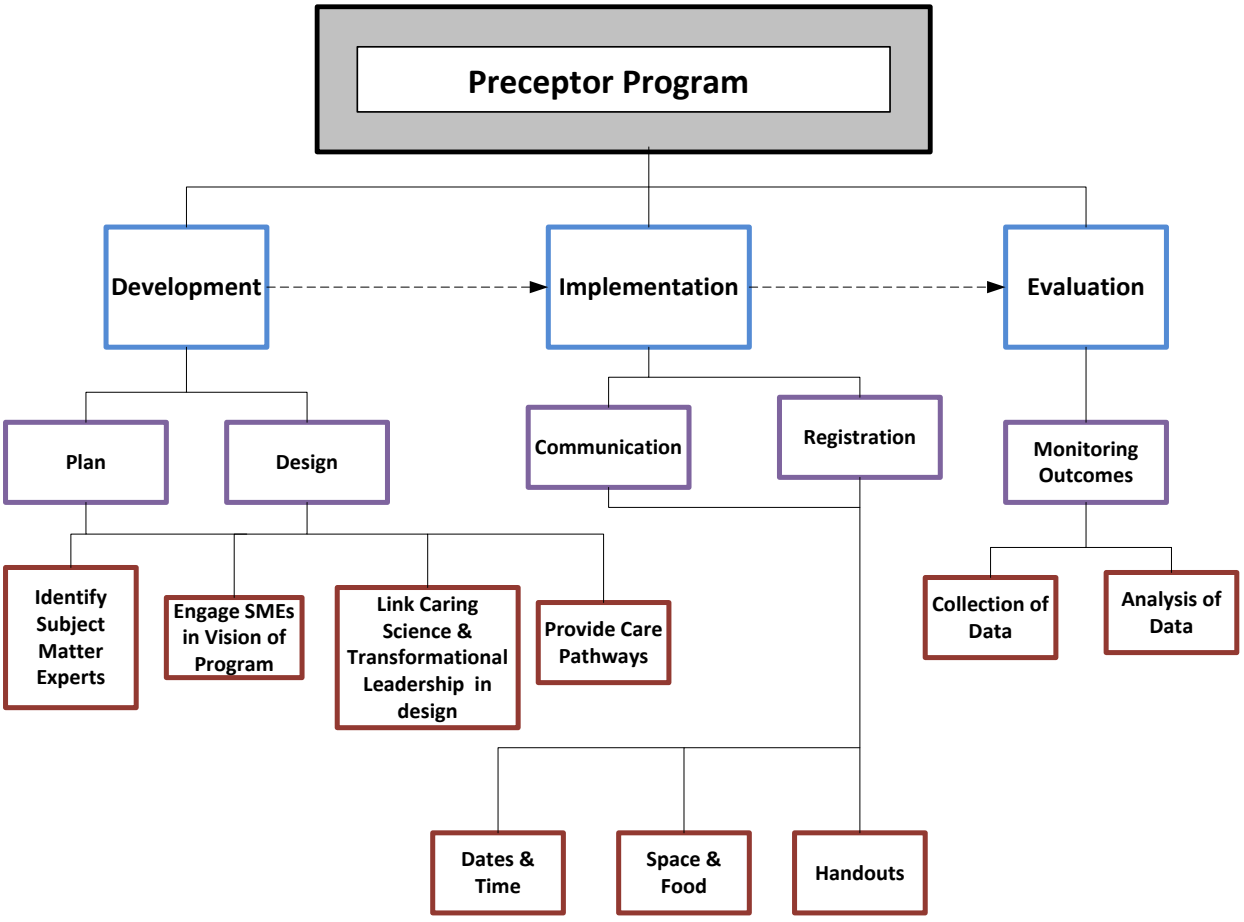
*Based on Organization Size from Source: 2011-2012 SHRM Benchmarking Database; includes advertising fees, recruiter pay/benefits, travel costs, relocation costs, and agency fees.

****** Assumes decrease of 8 less people leaving their job roles

*******Assumes decrease of 16 less people leaving their job roles

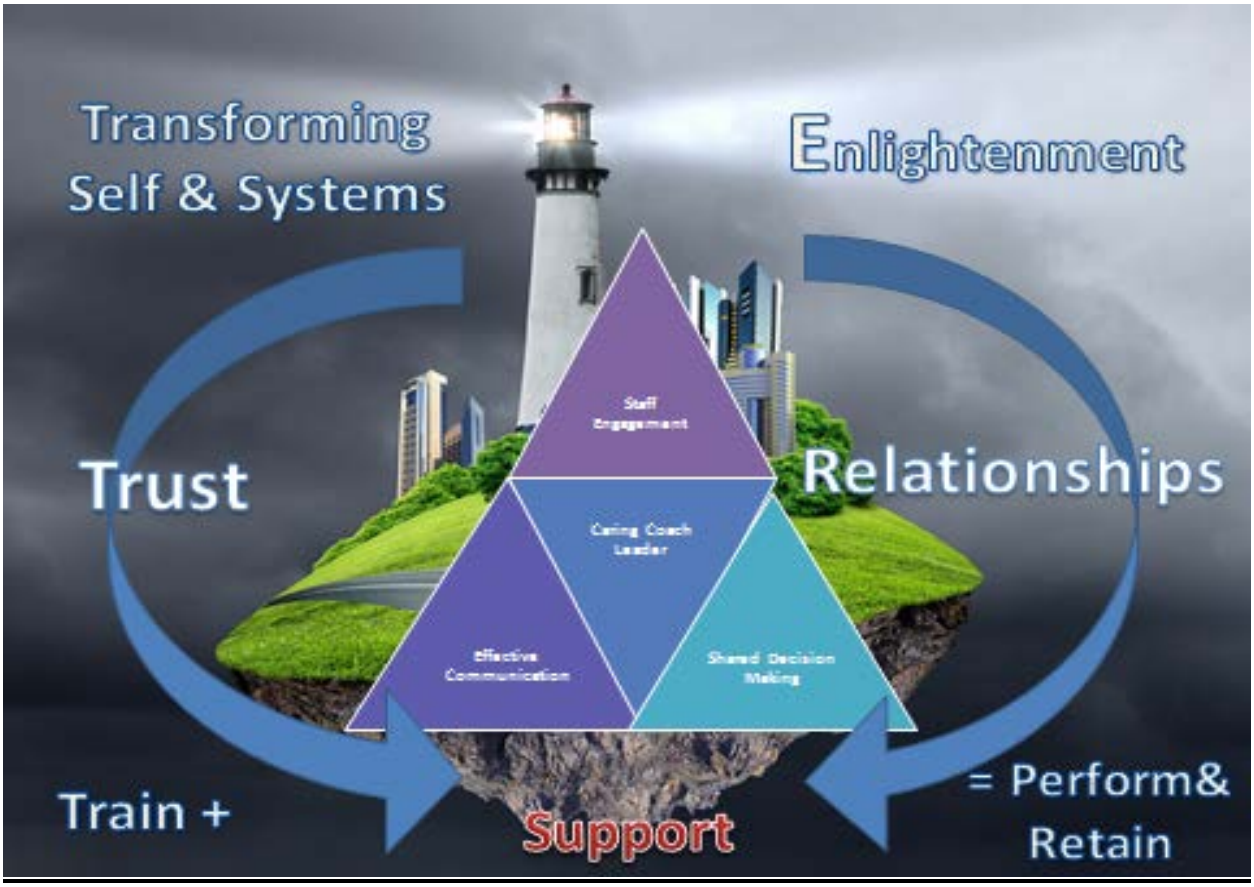
Appendix G

Work Breakdown Structure



Appendix H

Concept of Caring Coach Leader Program



Appendix I

Caring Coach Leader Program Facilitator Learning Plan

Program Objectives:

1. Create caring moments with direct reports and employees.
2. Apply attributes of caring and trust when building relationships.
3. Practice reflective listening and asking open-ended questions to assist orientee to find answers and 'ways of knowing'.
4. Integrate reflective practices into daily activities to guide self and team development.
5. Illustrate shared decision-making by engaging staff in department quality improvement activities.
6. Design a personal vision as a Caring Coach Leader.

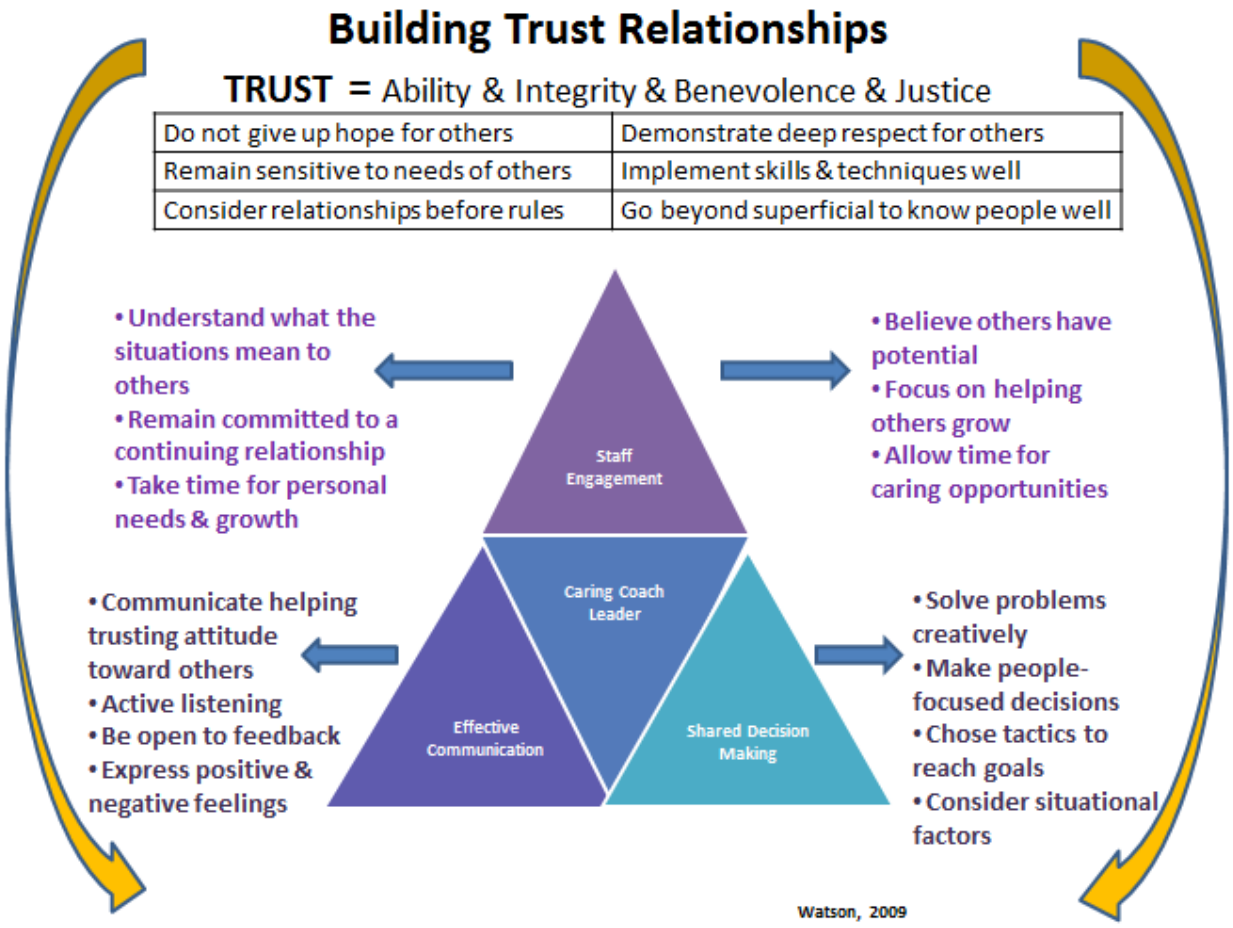
Time & Topic	Content	Delivery Method
Welcome/Introductions/ Housekeeping 30 minutes	Housekeeping: Deliverables, agenda, folders, handouts, surveys initial and follow up with paper and Survey Monkey, program evaluation, follow up reminders	Power Point slide Handouts
Objectives 5 minutes	Review Program Objectives	Discussion
Why are we here? 10 minutes	Emphasize why is this important based on literature review with preceptor program, IOM transformational leadership and Caring Science, relational leadership, and nurse manager satisfaction and retention	Discussion
Initial Caring Assessment Scale survey 30 minutes	Each attendee completes the demographic and Caring Assessment scale survey (self-awareness opportunity) After completion review strengths and areas of opportunities for self-development with partner	**Exercise:** Discussion with partner on self-reflection of strengths and opportunities for development based on own survey results. **After Sharing**: Have individuals use one word to describe themselves as a caring leader and flip chart the responses
Caring moment 20 minutes	Video for reflection	Laptop CD/DVD **Group Exercise:** Answer questions of what aspects of your work do you value most and what makes it so rewarding?
Break 15 minutes		
Caring Leaders as Coaches 45 minutes	Nurse Leader Touchpoints Coach vs Mentor vs Preceptor Coaching Unlearn our programming	Discussion **First Activity:** Discuss with a partner

	Asking Questions Building relationships takes time Pearls of Wisdom	• What are 1-2 attributes about a previous leader, coach, or mentor that inspired you? • How has this person positively impacted your leadership? • What are 1-2 attributes about someone that let you down? **Second Activity:** • Write open-ended questions • To learn what people value • To help someone learn from an experience • To assist direct report with asking staff questions to identify a solution on a quality of care fallout • To engage direct reports on seeking a solution with disruptive behavior affecting teamwork • To establish a culture of patient safety • To establish unified set of team values
Lunch 30 minutes		
Debrief of morning session 15 minutes	What were your learnings? What were your "ah-ha" moments? Anything we need to revisit?	
Trust Relationships 2 hours 35 minutes with 15 minute break	What is Trust? Starts with Self-awareness Trust attributes Building Trust Caring Assessment and 4 Attributes Reflective Practices	Discussion: **Exercise:** What are your Values? Share responses Caring Moment: Kindness **Exercise** What is your Elevator speech? What are 1 to 2 reasons why people can Trust You?

		Exercise: Trust Relationships Wisdom….what would like to re-do from your past? Based on the 4 attributes……. What is your strength? What is your opportunity for improvement? What do you need to do differently? **Exercise Group:** Review the Caritas Processes and Transformational Leadership Attributes What speaks to You?
Caring Coach Leader Vision 25 minutes	• Leading with purpose as a coach • What is your Vision? • What is your Personal walk away from the Day?	Pen and paper, Discussion and Reflective Practices Exercise: What is your Vision as a Caring Coach Leader? **Exercise Group:** Share your vision How will you implement this Vision? Share thoughts from the Day

Appendix J

Four Core Building Blocks of Caring Coach Leader Program



Appendix K

Description of Targeted Customers

	Assistant Nurse Managers & Managers	**Managers & Directors**	**Chief Nursing Officers**
Role	Receiver of new orientation from trained 'Caring Coach Leader' program	Receive leadership development and become trained 'Caring Coach Leader'	Decision maker & approver for training time
End User Benefits	***Train*** • Oriented to new role to support transition ***Support*** • Increased job satisfaction, promotes feeling valued, cared for, and develops sense of belonging ***Perform*** • Coached for successful performance ***Retain*** • Increased retention	***Train*** • Attend 'Caring Coach Leader' program to learn and coach new nurse leaders as role models ***Support*** • Develop relationships with self & others • Create followers through trust relationships ***Perform*** • Lead & align department/organization performance ***Retain*** • Increased retention	***Train*** • Implementation of standardized, orientation plan and leadership development program ***Support*** • Leadership development ***Perform*** • Delivery of role-based performance expectations ***Retain*** • Increased retention

Appendix L

Email Communication to CNEs

Good morning! Thank you for your interest and engagement with being the first to implement this new program. I am reaching out to secure some dates from both of you so I can teach the Caring Coach Leader program at your medical centers for your Nurse Managers and Directors. This new program will also support the roll out of the AONE competencies.

Core Statement – Improve front line leader retention by implementing a 'Caring Coach Leader' program to develop transformational leaders that deliver a thoughtful relationship-based orientation.

The "Caring Coach Leader" program is built on the attributes of transformational leadership skills from the 2004 IOM report and attributes from Dr. Jan Nyberg's caring assessment tool for leaders. The program is designed and based on the premise of building trust relationships first and foremost to create followers who can then engage in the work, share decision making activities, and participate in effective communication. The managers and directors will coach their new direct report nurse leaders on the behaviors and actions needed to successfully transition into the culture and their new role. This training will support their professional growth and ultimately contribute to their successful performance and retention; train plus support equals perform and retain.

The four core building blocks of the program are trust relationships, staff engagement, shared decision making, and effective communication. Authentic conversations and experiential learning activities will be incorporated into the program as attendees work individually, and within small and large groups. Case scenarios will be used to stimulate critical thinking and emphasize the caring attributes required of a nurse leader that oversees inpatient care within KP Northern California medical centers. These attributes are in alignment with Dr. Jean Watson's theory and Dr. Jan Nyberg's caring assessment tool for nurse leaders.

Grateful for your Leadership, Priscilla

Appendix M

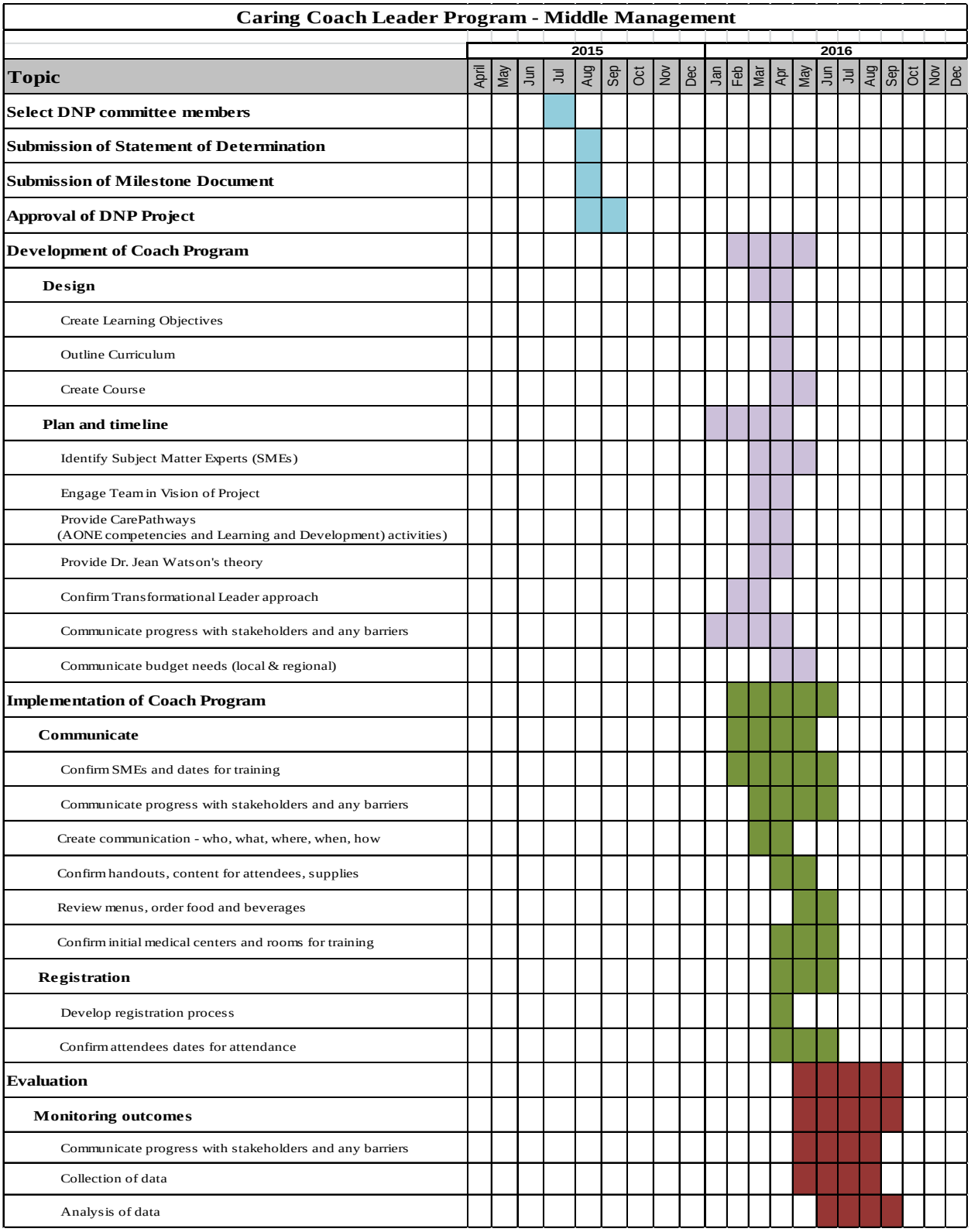
Communication Strategy

Methodology	Purpose	Audience	Frequency
NCAL Patient Care Services WIKI site	Place information about the new program along with updates, dates/times/place for training and registration process	Assistant Nurse Managers, Nurse Managers, Directors, Chief Nurse Officers	Monthly
Nurse Scholar's Academy website	Place information about the new program along with updates, dates/times/place for training and registration process	Assistant Nurse Managers, Nurse Managers, Directors, Chief Nurse Officers	Monthly
Regional Peer Groups	Give initial presentation to attendees about the program using the 'why', 'what', and 'who' messaging tactics. Allow for questions and answers. Gain buy-in.	Chief Nursing Officers Service Line Directors	One time initial and updates variable
Regional Webex sessions	Provide information on the program about the 'why', 'what', 'who', 'when', 'where', and 'how' to targeted audiences • individuals who did not attend director or CNO peer group meetings • managers and directors who will attend the training • new nurse leaders - assistant nurse managers and managers	Assistant Nurse Managers, Nurse Managers, Directors, Chief Nurse Officers	Monthly

Local meetings at medical centers	Conducted by CNOs informing managers and directors of new program and who will be attending the training. Brochures/flyers to be distributed.	Nurse Managers, Directors, Chief Nurse Officers	Initially group meeting Ongoing one-on-one or group communication via email
Local meetings at medical centers	Communication from trained managers and directors to new nurse leader attendees on • benefits of programs • What to expect during initial orientation • Ongoing coaching	Assistant Nurse Managers, Nurse Managers, Directors,	Initial meet and greet then weekly during orientation with monthly post orientation
Brochure/flyers	Develop focused messaging to the targeted audiences in written distribution format that supports the 'why', 'what', and 'who' and when appropriate the 'where', 'when', and 'how'.	Assistant Nurse Managers, Nurse Managers, Directors, Chief Nurse Officers	Initial with monthly updates based on need
Branding of Program	Color schemes, pictures, and verbiage will be branded for internal and external communication using the 'lighthouse' as our guide to enlightenment.	Assistant Nurse Managers, Nurse Managers, Directors, Chief Nurse Officers, Human Resource Recruitment team	Initial only
Training Calendar	Provides visual in calendar format for dates, times, and locations of the 'Caring Coach Leader' program. Registration process will be included. Calendar to be placed	Assistant Nurse Managers, Nurse Managers, Directors, Chief Nurse Officers, Human Resource Recruitment team	Monthly

	on WIKI and NSA websites		
Email	Informational, invitational	Assistant Nurse Managers, Nurse Managers, Directors, Chief Nurse Officers, and general communication to other departments e.g. HR, learning and development, executive leadership	Initial and Ongoing communication
Reports	Provide ongoing communication regarding • Attendees • Retention by medical center for ANMs and NMs	Chief Nursing Officers	Monthly
Testimonials	Communicate positive accolades from attendees to support marketing of the program	Assistant Nurse Managers, Nurse Managers, Directors, Chief Nurse Officers	Quarterly

Appendix N
GANTT Chart



Appendix O

SWOT Analysis

Strengths	Weaknesses
• Employer of Choice • Strong foundation of Caring Science • Ongoing support for implementation of Caring Science strategies • Current position supports the spread of Caring Science and competencies for nursing staff, management, and leadership • AONE competencies declared as foundation for nursing leaders • Organization focused on quality, safety, and care experience • Quality oversight/Quality improvement is embedded in our culture • Integrated model for healthcare, health plan, and physician group practices	• Turnover rates have increased for nursing middle management • Job dissatisfaction present with nursing managers • Lack of standardized, supportive competency-based orientation for middle management • No preceptor/coach program for onboarding new middle managers • Transformational leadership skills are not openly discussed • Culture of fear and blame is pervasive • Middle managers faced with role dilution, lack of role clarity, and work long hours • Demands from executive leadership for performance have increased stress of middle managers • Multiple competing initiatives demanding more time and resources • Relationships are strained and trust is lacking • Challenges with finding work life balance in current work environment
Opportunities	**Threats**
• Develop standardized onboarding orientation using the AONE competencies for middle management roles • Create and implement a preceptor/coach program for nurse leaders who are onboarding assistant nurse managers and managers • Provide role clarification for the assistant nurse managers, nurse managers, and directors • Improve job satisfaction and trust relationships • Use the language of transformational leadership and Caring Science to build our nurse leaders of the future • Prepare our leaders to meet the expectations of Magnet hospitals	• Healthcare systems have learned from us, are focused on implementing our model and outperforming us • Other systems are competing with our wages and our employees are being recruited • Hospitals are becoming recognized for Magnet status while we are not pursing this recognition

Appendix P

Detailed Evaluation Timeline 2016

Caring Coach Leader Program – Middle Management																		
Topic	**Details**																	
2016	5/23	5/30	6/06	6/13	6/20	6/27	7/04	7/11	7/18	7/25	8/01	8/08	8/15	8/22	8/29	9/05	9/12	9/19
Program Training Dates	X		X															
Initial Caring Assessment Scale self-assessments	X		X															
Program Evaluations completed day of training	X		X															
Program post evaluations summarized (2 wks)			X		X													
Program post evaluations aggregated (2 wks)							X											
Follow up Caring Assessment Scale self-assessments (6- 8 wks)							X	X	X X	X	X							
Caring Assessment surveys/demo info summarized per med center (2 wks)											X		X					
Caring Assessment surveys/demo info aggregated (2 wks)															X			

	First Quarter 2016			**Second Quarter 2016**			**Third Quarter 2016**			**Fourth Quarter 2016**			**2017**	
Turnover rates Obtained for 2016				X			X			X			X	

Appendix Q

Nyberg Caring Assessment Scale and Demographic Survey

Nyberg Caring Assessment Scale*

Are these caring attributes things you actually use in your day-to-day practices?

Instructions: For each statement below, please circle the number for how often you think you demonstrate these practices in the work situation.

	Cannot use in practice	Occasionally use in practice	Sometimes use in practice	Often use in practice	Always use in practice
1. Have deep respect for the needs of others.	1	2	3	4	5
2. Not give up hope for others.	1	2	3	4	5
3. Remain sensitive to the needs of others.	1	2	3	4	5
4. Communicate a helping, trusting attitude toward others.	1	2	3	4	5
5. Express positive and negative feelings.	1	2	3	4	5
6. Solve problems creatively.	1	2	3	4	5
7. Understand that spiritual forces contribute to human care.	1	2	3	4	5
8. Consider relationships before rules.	1	2	3	4	5
9. Base decisions on what is best for the people involved.	1	2	3	4	5
10. Understand thoroughly what situations mean to people.	1	2	3	4	5
11. Go beyond the superficial to know people well.	1	2	3	4	5
12. Implement skills and techniques well.	1	2	3	4	5
13. Choose tactics that will accomplish goals.	1	2	3	4	5
14. Give full consideration to situational factors.	1	2	3	4	5
15. Focus on helping others to grow.	1	2	3	4	5
16. Take time for personal needs and growth.	1	2	3	4	5
17. Allow time for caring opportunities.	1	2	3	4	5
18. Remain committed to a continuing relationship.	1	2	3	4	5
19. Listen carefully and be open to feedback.	1	2	3	4	5
20. Believe that others have a potential that can be achieved.	1	2	3	4	5

Upon completion of Survey:

1. Circle any statement you rated 3 or below – your areas for growth
2. Star any statement you rated 4 or 5 – your current strengths
3. Discuss your results with assigned partner

*Permission to Use was granted by Dr. Jean Watson on behalf of Dr. Jan Nyberg

Dear Attendees,

The purpose of this letter is to ask you to take part in an evidence-based quality improvement project that implements a Caring Coach Leader program as an intervention to support onboarding orientation of middle management. I will be using the Caring Assessment Scale by Dr. Jan Nyberg that assesses individuals caring attributes via a self-assessment. Demographic information will also be included as part of the evaluation process for this project. I am interested in learning about attendee's perception of their Caring attributes prior to the start of the Caring Coach Leader program and compare these results to a follow up survey that will be sent via email in 6-8 weeks after the completion of this program.

All of your answers will be kept completely confidential. The survey results will have no identifying information on it and no individual identities will be used in any reports or publications that may result from this work. There is no benefit to you for participating in this study and there will be no reimbursement provided. There will be no financial costs to you as a result of taking part in the project.

If you agree to participate, please complete the attached Demographic and Caring Assessment Scale surveys. The follow up survey will be sent as a Survey Monkey in 6-8 weeks post completion of this program. Together, the surveys should take approximately 10-15 minutes to complete. Sincerely, Priscilla Javed, RN, MS

Facility: _____ **Date:** _____

Age: ☐ 18 - 25 ☐ 26 - 35 ☐ 36 - 45 ☐ 46 - 55 ☐ <56

☐ Male ☐ Female

Years of Experience as RN:

☐ 1-5 ☐ 6 -10 ☐ 11 - 15 ☐ 16 - 20

☐ 21 - 25 ☐ 26 - 30 ☐ 31 - 35 ☐ > 35

Years of Experience in Management/Leadership Role:

☐ 1-5 ☐ 6 -10 ☐ 11 - 15 ☐ 16 - 20

☐ 21 - 25 ☐ 26 - 30 ☐ 31 - 35 ☐ > 35

Number of Employees as Direct Reports:

☐ < 10 ☐ 11 -25 ☐ 26 - 50 ☐ 51 - 75

☐ 76 - 100 ☐ > 100

Highest Degree obtained:

☐ AA/AS ☐ BA/BS ☐ MA/MS ☐ DNP

☐ PhD ☐ Other_____

Have you had a Mentor support you during your management/leadership career?

☐ Yes ☐ No **Comments:**

Have you had a Coach support you during your management/leadership career?

☐ Yes ☐ No **Comments:**

Appendix R

Caring Coach Leader Program Evaluation

Your evaluation of this presentation will help us improve our education program. *Your input is important to us!* Please indicate your responses to the questions below by completely filling in the sections.

Please indicate the degree to which you disagree/agree with each of the following statements.	**Strongly Disagree**		**Agree**		**Strongly Agree**	
The course objectives were clearly stated.	1☐	2 ☐	3 ☐	4 ☐	5 ☐	6 ☐
The course content met these objectives.	1☐	2 ☐	3 ☐	4 ☐	5 ☐	6 ☐
The facilities were adequate-*room, lighting, temperature, A/V, etc.*	1☐	2 ☐	3 ☐	4 ☐	5 ☐	6 ☐
Overall, teaching methods were appropriate to the content.	1☐	2 ☐	3 ☐	4 ☐	5 ☐	6 ☐
The course was applicable to my role.	1☐	2 ☐	3 ☐	4 ☐	5 ☐	6 ☐
I learned methods/principles to perform my job more effectively.	1☐	2 ☐	3 ☐	4 ☐	5 ☐	6 ☐
The pace of the course was appropriate to the material presented	1☐	2 ☐	3 ☐	4 ☐	5 ☐	6 ☐

Presenter: Priscilla Javed, RN, MS Program	**Topic: Caring Coach Leader**					
Was knowledgeable on the subject.	1☐	2 ☐	3 ☐	4 ☐	5 ☐	6 ☐
Communicated effectively.	1☐	2 ☐	3 ☐	4 ☐	5 ☐	6 ☐
Maintained my interest.	1☐	2 ☐	3 ☐	4 ☐	5 ☐	6 ☐
Responded well to questions.	1☐	2 ☐	3 ☐	4 ☐	5 ☐	6 ☐

What aspects of the course were most beneficial to you?

What would you like to change? *(add or delete)*

Additional Comments *(suggestions for improvement)*

Appendix S

Program Evaluation Results of Caring Coach Leader Program

Questions 6-point Likert scale ranging from Strongly Disagree to Strongly Agree	**Mean** Completed surveys (n = 14)
The course objectives were clearly stated	5.5
The course content met these objectives	5.6
The facilities were adequate (room, lighting, temperature, A/V, etc)	5.7
Overall, teaching methods were appropriate to the content	5.7
The course was applicable to my role	5.6
I learned methods/principles to perform my job more effectively	5.3
The pace of the course was appropriate to the material presented	5.3
Presenter	
Was knowledgeable on the subject	5.9
Communicated effectively	6
Maintained my interest	5.6
Responded well to questions	5.9
What aspects of the course were most beneficial to you? ▪ Reinvigorating Caring Science, centering around Caring Science, renewed mindfulness, powerful, refreshing, inspirational, great review of Caring Science, information good ▪ Helped me get back to my purpose, reconnect, found opportunity to care more, opportunity to revisit our purpose and reason for being here ▪ Time for Self-reflection, reflective practices, permission to take time for introspective work, dialogue most beneficial, gaining insight from others ▪ Transformational Leadership attributes, comparison to Caritas processes ▪ Exercise for asking open-ended questions, presenter able to 'go with the flow' when difficult questions asked	
What would you like to change? ▪ Nothing, very good presentation ▪ More time for debrief with open-ended questions ▪ Some discussion points overlapped, change to 4 hour class, pace a bit slow ▪ Spend more time connecting the dots between the principles and learnings, and how to apply it within work environment, need more tools to help us not only survive but thrive and help others do the same ▪ Attend and engage in more programs with this type of content, need ongoing opportunity to re-engage, energize ourselves and each other ▪ More clarity on the purpose and take away of course, knowing purpose and objectives prior to day of program.	
Additional comments (suggestions for improvement) ▪ Presenter best person to teach this course, inspirational, great day, loved it, several responses filled with thankfulness ▪ Add definition of Transformational Leadership, more tools to teach staff ▪ Highly recommend program and hopeful ANMs are given the opportunity to attend, all leaders can benefit from this program	

Appendix T

Results of Demographic Pre- and Post-Program Surveys

	Pre-Program Survey N = 16		Post-Program Survey N = 11	
Age				
18 - 25	0	0%	0	0
26 - 35	0	0%	0	0
36 - 45	7	43.75%	6	54.55%
46 - 55	4	25%	2	18.18%
56 or > 56	5	31.25%	3	27.27%
Gender				
Female	14	87.5%	10	90.91%
Male	2	12.5%	1	9.09%
Years of Experience as RN			1 Skipped	
1 – 5 years	0	0%	0	0%
6 – 10 years	0	0%	0	0%
11 – 15 years	2	12.5%	2	20%
16 – 20 years	5	31.25%	3	30%
21 – 25 years	5	31.25%	2	20%
26 – 30 years	1	6.25%	1	10%
31 – 35 years	1	6.25%	0	0%
> 35 years	2	12.5%	2	20%
Years of Experience in Management/Leadership role				
1 – 5 years	2	12.5%	3	27.27%
6 – 10 years	7	43.75%	2	18.18%
11 – 15 years	1	6.25%	3	27.27%
16 – 20 years	3	18.75%	2	18.18%
21 – 25 years	2	12.5%	0	0%
26 – 30 years	1	6.25%	0	0%
31 – 35 years	0	0%	0	0%
> 35 years	0	0%	1	9.09%
Number of Employees as Direct Reports (span of control)				
< 10	2	12.5%	2	18.18%
11 – 25	0	0%	1	9.09%
26 – 50	1	6.25%	0	0%
51 – 75	0	0%	0	0%
76 – 100	3	18.75%	1	9.09%
> 100	10	62.5%	7	63.64%
Highest Degree Obtained				
AA/AS	1	6.25%	0	0%
BA/BS	6	37.5%	5	45.45%
MA/MS	9	56.25%	6	54.55%
DNP	0	0%	0	0%
PhD	0	0%	0	0%
Other	0	0%	0	0%
Mentor support during Management/Leadership career			1 Skipped	
Yes	9	56.25%	7	70%
No	7	43.75%	3	30%
Coach support during Management/Leadership career				
Yes	7	43.75%	4	36.36%
No	9	56.25%	7	63.64%

Appendix U

Results of Nyberg Caring Assessment* Pre- and Post-Program Surveys

Caring Attributes	Pre-Program Survey Results N = 16 Mean Score	Post-Program Survey Results N = 11 Mean Score	Increase (+) or Decrease (-)
1. Have deep respect for the needs of others	4.44	4.55	+ .11
2. Not give up hope for others	4.19	4.18	- .01
3. Remain sensitive to the needs of others	4.44	4.55	+ .11
4. Communicate a helping, trusting attitude toward others	4.38	4.45	+ .07
5. Express positive and negative feelings	4.19	4.18	- .01
6. Solve problems creatively	4.06	4.18	+ .12
7. Understand that spiritual forces contribute to human care	4.25	4.45	+ .20
8. Consider relationships before rules	3.31	3.36	+ .05
9. Base decisions on what is best for the people involved	3.75	4.09	+ .34
10. Understand thoroughly what situations mean to people	3.94	4.27	+ .33
11. Go beyond the superficial to know people well	4.19	4.18	- .01
12. Implement skills and techniques well	4.19	4.36	+ .17
13. Choose tactics that will accomplish goals	4.44	4.36	- .08
14. Give full consideration to situational factors	4.13	4.09	- .04
15. Focus on helping others to grow	4.38	4.27	- .11
16. Take time for personal needs and growth	3.13	3.27	+ .14
17. Allow time for caring opportunities	3.56	3.82	+ .26
18. Remain committed to a continuing relationship	4.31	3.91	- .60
19. Listen carefully and be open to feedback	4.50	4.55	+ .05
20. Believe that others have a potential that can be achieved	4.50	4.45	- .05

*Permission to Use was granted by Dr. Jean Watson on behalf of Dr. Jan Nyberg