HOLDING THE FRONTLINE: THE EXPERIENCE OF BEING A CHARGE NURSE IN AN ACUTE CARE SETTING

by

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This dissertation was prepared under the direction of the candidate's dissertation advisor, Dr. Rose O. Sherman, the Christine E. Lynn College of Nursing, and has been approved by the members of her supervisory committee. It was submitted to the faculty of the Christine E. Lynn College of Nursing and was accepted in partial fulfillment of the requirements for the degree of Doctor of Philosophy.

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ABSTRACT

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Within the current context of the healthcare environment, the charge nurse role has become very important for safety and positive outcomes. There is little known about the role from the perspective of the charge nurse. This qualitative descriptive exploratory study examined the experience of being a charge nurse in acute care practice, and describes how charge nurses live caring in their support of nurses and patients. Ray's (1989, 2006) theory of Bureaucratic Caring, Swanson's (2008) caring attributes and leadership, and Boykin and Schoenhofer's (2001) theory of Nursing as Caring provided the theoretical lenses through which study findings were viewed.

Semi-structured interviews were conducted with 20 charge nurses in 4 acute care facilities. Eight themes emerged from an inductive analysis of the data describing the experience of being a charge nurse in acute care practice: *Creating a Safety Net, Monitoring for Quality, Showing the Way, Completing the Puzzle, Managing the Flow, Making a Difference, Putting Out Fires,* and *Keeping Patients Happy*. Participants also

were asked questions about how they provide support to staff nurses and patients. Themes that reflected how charge nurses live caring in their support of staff and patients were: *Jumping in the Trenches, Nurturing Staff Growth, Offering Authentic Presence,* and *Looking after Nurses*. Additionally, the researcher used methods of narrative inquiry to get the participants to share stories of how they lived caring in their support of nurses and patients.

Recommendations included the need to elevate the visibility of the charge nurse role and its importance to the organization, and provide support for leadership development. Job descriptions and competencies for charge nurses must reflect the complexity of the environment. Charge nurse participants did not dialogue explicitly about their functions in terms of communication and intraprofessional team building. Since charge nurses have an increasing involvement with mentoring novice nurses and new staff, they would benefit from developing coaching skills. Given the current environment, their responsibilities in these areas may need to be better articulated so that they can focus on increasing these abilities.

DEDICATION

To my mom who has always celebrated my being a nurse and believed in me and my dreams.

To my husband Jan, my constant source of strength and support.

To my children, Jaime, Jessica, Justin, and Jordan, you are indeed my greatest blessings.

You have all shared in allowing “My Ship to Sail,” and for that I will be forever grateful.

HOLDING THE FRONTLINE: THE EXPERIENCE OF BEING A CHARGE NURSE IN AN ACUTE CARE SETTING

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CHAPTER ONE. THE PHENOMENON

Introduction

The fragmentation of the U. S. healthcare delivery system has been described as "the greatest barrier to patient safety" (Shortell & Singer, 2008, p. 445). Adverse events and errors are resulting from the increasing complexity of the work of healthcare providers, mounting workloads, and a lack of coordination of care delivery (Kosnik, Brown, & Maund, 2007). The implementation of effective work processes is complicated by various threats to patient satisfaction and safety such as increasing patient acuity, decreased time for monitoring patients, frequent interruptions and turnover of patients, staff turnover, use of temporary workers, and reductions in support staff (Page, 2004; Vahey, Aiken, Sloane, Clarke, & Vargas, 2004). Without strong clinical leadership, these factors can lead nurses to take the focus off responding to the needs of individual patients, and can result in nurse burnout.

Decreased reimbursements in Medicare and Medicaid payment systems have driven the implementation of health care system cost containment initiatives, which are forcing higher patient ratios and resulting in greater demands on the Registered Nurse (RN) (IOM, 2004). Simultaneously, new changes in reimbursement, such as pay for performance, are stimulating the development of protocols and interventions to reduce the potential for hospital-acquired conditions. Tasks associated with monitoring these initiatives have been added to the nurse's duties. Core measures, hospital-acquired

conditions, never events, National Patient Safety Goals (NPSG), and Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) have become the mantras in this highly regulated environment (Hines & Yu, 2009; Shaffer & Tuttas, 2009). These new regulatory requirements have added to the data collection and documentation responsibilities of nurses. The end result is that nurses at the point of care often experience difficulty pulling together all the information they need to coordinate their patient's care efficiently (Parker, Giles, & Higgins, 2009; Skillings, & MacLeod, 2009). This environmental complexity also is inhibiting the ability of these same nurses to do the right things and is creating errors of omission because of physical barriers, systems barriers, and time constraints (Kalisch, Landstrom, & Williams, 2009).

Systems can be improved by identifying and developing the leadership capacities of key personnel who can improve quality and prevent errors. Researchers (Vahey et al., 2004) found that giving nurses at the point of care more administrative support was one of the factors that can contribute to positive patient outcomes and safety, including lower risk-adjusted Medicare mortality (Swearingen, 2009). Page (2004) made recommendations for better systems designs to reduce human error, including providing back-up support to recover from or eliminate mistakes and improve coordination and communication within teams, as well as providing interdisciplinary team training programs. Leadership support at the unit level also can facilitate nurses' clinical decision-making. When staff nurses perceive that leadership support is present on the unit, there is a decrease in nurse burnout, an increase in nurse satisfaction and retention, and an increase in patient satisfaction (Fransson Sellgren, Ekvall, & Tomson, 2008; Vahey et al., 2004).

Traditionally, nurse managers have provided support to staff at the point of care, but increasingly this responsibility is being placed on charge nurses. In today's environment, managers are being called away to address global systems issues (Porter-O'Grady, 2003; Shirey, Ebright, & McDaniel, 2008; Wieck, 2005), or often have responsibility for more than one patient care area (Lucas, Spence Laschinger, & Wong, 2008; Page, 2004; Shirey et al., 2008; Wieck, 2005). The American Organization of Nurse Executives (AONE) 2004 survey found that staff nurses were not as satisfied with their relationship with their nurse manager as the nurse managers and administrators thought they were (Ulrich, Buerhaus, Donelan, Norman, & Dittus, 2005). In their study, Schmalenberg and Kramer (2009) sought to identify the nurse manager behaviors that staff nurses found to be supportive and discovered that results were affected by how the nursing staff felt the charge nurse role was defined within the organization. If charge nurses essentially are responsible for the "day-to-day management of the unit" (p. 65), then staff do not find it supportive when nurse managers assist with these functions. These researchers also called for additional studies to identify the leadership or management competencies that nurse managers can delegate to the charge nurses. Suggestions were made that it would be easier to delegate management competencies than it would be to delegate leadership competencies. Other surveys have indicated that staff feel a lack of support and leadership from management in responding to constant challenges and change (Parker et al., 2009). Nurse managers in at least one study acknowledged that building relationships with their staff so that they feel "engaged and supported" often was sacrificed because of "time required away

from their units" (Shirey et al., 2008, p. 129). As a result, Buerhaus (2009) has identified a need to develop better relationships between nurses and management.

Lacey et al. (2008) suggested nurse leaders can create "targeted interventions of support" to "promote professional practice environments" (p. 336); yet, the authors acknowledge that there are no "standard administrative practices" (p. 339) that are associated with quality outcomes, and that nurse leaders must determine best practices by developing indicators and measuring improvements. Factors that influence nurses feeling supported in their endeavors to produce good clinical outcomes must be explored. Caring, promoting teamwork, and resolving conflict were among the supportive manager behaviors identified by Kramer et al. (2007). Indeed the staff nurses interviewed in the Kramer study said that charge nurses, rather than the nurse managers, provided the support for "managing the unit" (p. 337), which included patient flow and bed assignments, "day to day direction of unit activities", the provision of direct patient care in emergencies, and the orientation of new nurses (p. 332). McGilton (2003) found that in the long-term care setting, charge nurse support was more critical to a nurse's relational ability with patients than nurse manager support because the charge nurses had more interactions with the staff, while the nurse managers frequently were called away. When a Charge Nurse (CN) position exists between the nurse manager and staff nurse in the organizational structure, the charge nurse may be one "tangible" source of support for staff nurses at the unit level (p. 339).

Overview of Research Problem

Staff nurses have described charge nurses as being "the eyes of the unit" (B. D. Noval, personal communication, December 9, 2008). Ironically, charge nurses have

been both understudied and underprepared (Burns, Eagleton, Golden, & Thompson, 2009; Connelly, Yoder, & Miner-Williams, 2003; Fulks & Thompson, 2008). These authors describe charge nurses as often performing without a job description and formalized competencies, although many assume that they impact financial outcomes and patient and physician satisfaction. In addition, due to their contact with nursing staff, they may have a greater impact on staff satisfaction than other nursing leaders. Charge nurses have received only modest economic support for professional development, despite the fact that turnover is "higher among first-level leaders such as charge nurses" than among senior-level leaders (Swearingen, 2009, p. 108). Little is known about the type of preparation they require, the scope of their role, the kind of ongoing support they need, and their impact on staff retention and patient and safety outcomes.

Developmental programs that have been designed for charge nurses frequently address the need for them to understand organizational culture, be able to facilitate staff assignments, delegate appropriately, build teams, resolve conflict, and communicate effectively (Sherman & Eggenberger, 2009). Charge nurses also need to understand cultural and generational differences, promote assertiveness, be knowledgeable regarding ethics, and foster patient, physician, and staff satisfaction (Swearingen, 2009). These programs have been designed based either on expert opinion or on charge nurse surveys of educational needs. The importance of this study is that it will allow for the development of educational programs for charge nurses based on the actual experiences of charge nurses within the current acute care setting.

Given the proposed shortage of nurses and the need for healthcare workforce redesign to respond to that shortage, it is not clear what levels of leadership support will exist or what role charge nurses will play in acute care facilities in the future. Nursing leadership will be challenged to predict what occurrences will take place within the healthcare environment, and standards and protocols will need to be formatted for each situation. Competencies that reflect the evolving role of the charge nurse in responding to these changes will need to be developed. Charge nurses often are called on to make decisions within unexpected circumstances. Tools and resources should be made available which the charge nurse can draw upon in complex decision-making situations. Because of these factors, some facilities have begun work to standardize the role of the charge nurse in their hospitals (Lillis, 2009). "The complexity of care in facilities today warrants a unit-based coordinator of care- the charge nurse- who has the pulse of the status of the unit" (Federwisch, 2008, para. 5). Charge nurses are positioned uniquely not only to fix the immediate problem, but to address the underlying cause if they are empowered to do so (Page, 2004). Frequently, the "charge nurse may be the constant in the center of all activities" (Hughes & Kring, 2005, p. 16).

Charge nurses, who often are the clinical experts, will need to oversee the orientation and competency validation of new nurses and staff nurses, and make patient assignments accordingly (Kramer et al., 2007). Historically, in times of downsizing, supportive systems personnel are eliminated (Walker, Urden, & Moody, 2009). Resource positions in education and administration become expendable (Long, 2004) and leave open the question of who at the unit level will be able to mentor the nurses who are in various stages of development. Buerhaus (2009) predicted that with

economic recovery, many older experienced RNs will leave the workforce, and positions once again will become available for new registered nurse graduates who will require coaching and ongoing mentorship. These new graduates will need additional support if they are to be retained in the workforce and not burnout (Buerhaus, Donelan, DesRoches, & Hess, 2009; Kovner, Brewer, Greene, & Fairchild, 2009; Spence Laschinger, Finegan, & Wilk, 2009). Simultaneously, budget cuts are resulting in flatter organizational structures that make it challenging for nurse managers to support staff nurse professional development (Lucas et al., 2008).

Projected shortages of registered nurses now are expected to reach 260,000 by 2025 (Buerhaus, Auerback, & Staiger, 2009). With potential decreases in health care reimbursement as the system moves to pay-for-performance models (CMS, 2005), accompanied by the current economic decline (AHA, 2009), administrative teams are focusing heavily on reducing patient hours per day to contain costs. The American Hospital Association (2010) statistics report that “more than 80 percent of hospitals have cut administrative expenses and just over half have reduced staff” (p. xii). Team nursing, or variations of this model of care delivery, has become the logical alternative to replace the RN intensive requirements of primary care, while reducing labor costs through the use of ancillary personnel (Cioffi & Ferguson, 2009). But team nursing may result in an increased focus on tasks and a subsequent fragmentation of care (Page, 2004; Skillings, & MacLeod, 2009), especially if organized around tasks instead of utilizing a patient-centered approach (Cioffi & Ferguson, 2009). Effective teams and supportive professional practice environments require strong leadership (Cioffi & Ferguson, 2009; Sherman, 1990; Spence Laschinger et al., 2009). When present, charge

nurses are positioned to provide that leadership at the unit level on every shift, and can provide support for clinical decision-making (Cioffi & Ferguson, 2009; Tiedeman & Lookinland, 2004). Charge nurses also must delegate effectively within the team and understand the legal responsibilities related to scope of practice and supervision of novice nurses (Sherman & Eggenberger, 2009).

The Institute of Medicine (IOM) (2001) called for six essential enhancements to improve healthcare: safety, timeliness, efficiency, effectiveness, equity, and patient-centeredness. Healthcare institutions have been delinquent in responding to the implementation of these improvements (Buerhaus et al., 2007). Nurses have identified the shortage of nurses as affecting the IOM aims, particularly "patient-centered care, effectiveness, safety, and efficiency" (Buerhaus, Donelan et al., 2009, p. 295). The IOM (2001) has recommended redesigning care processes to meet these goals with the development of effective teams. Productive team processes require effective communication, conflict management, interdisciplinary collaboration, adequate resources, and rewards. The IOM suggested reducing human error by providing back-up support at the unit level to eliminate or assist with recovery from mistakes. Page (2004) proposed the charge nurse as one alternative to providing this support as well as building in redundancy or double checks to increase safety. Buerhaus et al. (2007) encouraged the development of "team communication and collaboration to improve patient care and patient safety" (p. 860). Charge nurses can promote the use of communication strategies, such as SBAR (Situation-Background-Assessment-Recommendation) (Monroe, 2006), and tools for effective handoffs (Haig, Sutton, &

Whittington, 2006), and they can initiate and foster the use of team briefings and huddles to impact patient outcomes (AHRQ).

Leaders must be available at the frontlines to listen and provide direction for managing the changes to support implementing these recommendations. Charge nurses are expected to have direct knowledge of the situations that place patients at risk. Since the charge nurse interacts and communicates with patients, families, nurses, physicians, and interdisciplinary team members and provides resources as well, they also may have control over or input into the conditions, such as delays in resuming medication and transcribing orders or administering treatments, which contribute to subsequent adverse events.

Fostering appropriate and effective communication among healthcare providers leads to effective coordinated care. Providing support to see that services such as diagnostic tests, procedures, and consults are integrated ensures that the right information always is available at the appropriate time for the healthcare team. Charge nurses are situated uniquely at the frontline where they can identify and respond to any system failures and provide this support.

Charge nurses appear to play a key role in providing nursing support, coordinating the team, mentoring staff, and promoting communication functions (Connelly, Yoder et al., 2003; Kramer et al., 2007). Although there is literature about the charge nurse role, there have been no studies about the experience of being a charge nurse from the perspective of those in the role. It is crucial to be aware of this point of view as members of the healthcare team redesign systems to reach the IOM's (2001) goals for improvement and the delivery of safe quality care within the current economic

and regulatory constraints. If the charge nurse role is crucial in making progress toward meeting these goals within this complex healthcare environment, then the role must be preserved and strengthened. The level of support that charge nurses provide for staff nurses and patients must be understood clearly in any planning for future models of healthcare delivery.

Description of the Research Question

The purpose of this study is to explore the experience of being a charge nurse in acute care practice and to gain an understanding of how charge nurses live caring in their support of nurses and patients.

Research Question

The research questions of this study were: What is the experience of being a charge nurse in acute care practice? How do charge nurses live caring in their support of nurses and patients?

The two objectives of the study were to:

1. Describe the experience of being a charge nurse in acute care practice.
2. Discover how charge nurses live caring in their support of staff nurses and patients.

Definition of Terms

For the purpose of the study, the researcher used the following definitions:

Charge nurse. The National Labor Relations Board (NLRB, 2002) defined permanent charge nurses as supervisors who "assign and responsibly direct" overall duties or tasks to an employee (p. 1); are "held accountable for the performance of their unit staff" (p. 14); do not typically take a patient care assignment, or "do substantially

less patient care than they assign" to staff nurses (p. 16); and exercise "independent judgment" in non routine circumstances without detailed instruction (p. 27). Charge nurses previously have been defined as taking "ownership for all unit activities during their shift" (Connelly, Yoder et al., 2003, p. 298) and as "nurses assigned to a particular unit designated by the head nurse to coordinate nursing activities on a particular shift" (Connelly, Nabarrete, & Smith, 2003, p. 204). While charge nurse is the title most often used for the role between the nurse manager and the staff nurses, some organizations designate this role as the assistant nurse manager. Charge nurses within this study will be defined as registered nurses holding the title of charge nurse or assistant nurse manager in an acute care hospital and having shift accountability for the overall performance of their unit.

Acute care practice. Most acute care today in the United States is delivered in hospital environments. Nurses who work in acute care practice engage in their professional endeavors in environments designed to provide treatment for brief or episodic illness. The goal in these facilities is to promote health and a return to maximum function in order to transition the patient to the next level of care.

Significance of the Research Study

Few research studies have been conducted that explore the role of the charge nurse in this rapidly changing healthcare environment (Connelly, Yoder et al., 2003). All positions that are not direct patient care remain vulnerable to elimination to meet the bottom line (Suby, 2009). Studying the charge nurse role may have implications for improving patient safety. Redesigning care delivery roles for efficiency and effectiveness may promote the retention of charge nurses and staff nurses. Charge

nurses have been a consistent presence on whom the physicians, nursing staff, and patients rely in the chaos of the current healthcare environment. There are important questions that still need to be answered to provide information about how the role of charge nurse is being used in acute care settings today and about what type of support charge nurses provide. How does the charge nurse perceive her/his role of supporting the staff nurses? Do they make decisions regarding resources, staffing, and patient status that are crucial to unit function and patient care? The charge nurse leadership role must be explored both in terms of economics and coordination of care.

Medical errors are the "fifth leading cause of death in the United States" (Edwards, 2008). Fifty-eight percent of adverse events or injuries due to medical management are due to preventable errors, and 27.6 percent are due to negligence. These preventable errors present a great opportunity for nurses to intervene and advocate on behalf of the patient. Inefficient care coordination and a lack of complete clinical information and accountability contribute to the environment being ripe for errors to occur. Charge nurses may play a pivotal role in reducing these errors by promoting a more timely response to changes in patient conditions and a reduction in the number of failure to rescue events due to their proximity to the situations.

If it was known how charge nurses spend their time and what decisions they make, then recommendations could be made for education and practice. Better understanding of the charge nurse role will provide insight into how to provide more effective leadership development for the charge nurse. Recent IOM (2010) recommendations call for promoting leadership at the point of care, involving those leaders in system improvements for healthcare, and developing leadership competencies

and mentoring for all levels of nursing leadership. Ultimately, if charge nurses are to be used for coaching and mentoring new nurses for retention in greater capacities (Buerhaus, Donelan, DesRoches, & Hess, 2009; Kovner et al., 2009; Spence Laschinger et al., 2009), they will need to be educated and mentored in performing this essential function.

New roles, such as the Clinical Nurse Leader (CNL), also may necessitate revisions in the charge nurse role, as the justification for the CNL role overlaps with many of the aspects of the charge nurse role (AACN, 2007; Sherman, 2008). CNLs are educated at the graduate level but do not function in an administrative capacity, although there is a leadership competency component to their role in terms of team manager, which specifies that they delegate and supervise to direct outcomes in patient care (AACN, 2007). Charge nurses do have a supervisory component to their role as defined by the NLRB (2002), are "held accountable for the performance of their unit staff" (p. 14), and have overall accountability for unit performance on their shift (Connelly, Yoder et al., 2003). One distinguishing difference that has been suggested between the two roles in facilities that have both roles is that the "CNL manages the patient" and the "CN manages the flow of the unit" (CNL Personal Communication, July 24, 2010). The most significant practice implication of this study might be role redesign at the unit level, which could promote retention of the charge nurse role. Identifying areas where charge nurses are needed to provide consistent support to staff nurses may lead to systems redesign. Knowing how charge nurses make a difference in practice also may have implications for how care is organized in the future. For

example, from a leadership perspective, does it take a nurse to do what charge nurses are doing and are charge nurses performing an essential nursing function?

Theoretical Lens

With the complexity of the current healthcare environment, it was important for this study to select nursing leadership theory that has been written within the context of understanding that nursing is a blend of "human science and the art and science of human caring" (Ray, 1989, p. 31). Ray viewed organizational culture from this caring lens. Providing support has been linked to caring in nursing. Support was among the 27 caring constructs identified by Leininger (1978). Caring persons implement actions "directed toward assisting, supporting, or enabling another individual (or group) with evident or anticipated needs to ameliorate or improve a human condition or lifeway" (Leininger, 1988, p. 156). Swanson (2008) adapted her caring processes for leadership and leadership support at the unit level has been recommended (Page, 2004; Porter-O'Grady, 2003; Vahey et al., 2004). The position of the charge nurse is conceptualized as the support role for staff, caring for, with and about staff. Boykin and Schoenhofer (2001) called for nursing administrators to create an environment in which nurses are supported in "living and growing in caring" (p. 24). Caring charge nurses must be able to provide this level of support to nurses and patients, while complying with administrative mandates in the performance of their role. Each of these nursing theorists has linked both leadership and caring in their work.

Ray's Theory of Bureaucratic Caring

Ray's (1989) grounded theory qualitative study has the added value of having taken place in acute care hospitals and of having included interviews with

administrators, nurses, physicians, and other interdisciplinary health care professionals. The researcher described the paradox that nurses and other professionals struggle with of "serving the bureaucracy and serving human beings, especially clients, through caring" (Ray, 2006, p. 364).

Ray (1989, 2006) contended that bureaucracy allows for the understanding that hospitals, as organizations, are founded on certain principles, such as equality, demonstration of competency for role, standards of practice, policies and procedures, and documentation. Although many leadership theories such as transformational, transactional, authentic, and servant leadership (Failla & Stichler, 2008, Kleinman, 2004; Neill & Saunders, 2008; Shirey, 2006) have being expounded that move away from this focus on management and hierarchical bureaucratic systems, the current acute care environment still is based on these principles from a regulatory and economic perspective. To provide the necessary support to staff nurses, clinical leaders must have an understanding of this environment. Organizational caring and human caring are seen as interconnected (Ray, 2006). Ray (1989) understood that to grasp the dichotomy between bureaucratic principles and caring nursing practice, it was essential to study how all of the participants viewed the meaning of caring and its importance in acute care.

Ray (1989) defined the essential categories of bureaucratic caring as political, economic, legal, technological/physiological, educational, social, spiritual/religious, and ethical. Political caring includes regulatory factors, definitions of roles within the organizational structure, and competing for scarce resources. Relationships of power within the context of the system have implications here. Team processes that must occur

include communicating, decision-making, negotiating, and resolving power struggles and conflict. In healthcare systems, a flat structure is not possible because a leader takes over whether formally or informally. At the unit level, that individual often is the charge nurse. Quality initiatives led by the charge nurse represent political caring. Economic caring equates to rendering goods and services, remaining economically viable, and allocating scarce resources. Charge nurses continuously assess staffing as it relates to patient volumes and acuity. Hospitals exist for nursing care and systems have to be efficient and effective. Economic caring also applies to the process of interpersonal exchange. Charge nurses coordinate many of the interdisciplinary components of care delivery, which can lead to efficiencies; any delays in care equate to economic deficits. Legal caring factors included right to privacy, informed consent, patient rights, external safety standards, rights of healthcare workers, standards of practice, policies and procedures, liability, and malpractice. Charge nurses often are selected based on the fact that they are the clinical experts and masters of the technology on their unit. Technological caring, or the use of machinery in the support of the patient's physiological needs, would be expanded today to include digital phones and bedside computers. Educational caring is the importance of lifelong learning, teaching others, and the exchange of information. The role of charge nurses in mentoring and developing staff cannot be overstressed. Social caring is engaging in effective communication and interdisciplinary care, maintaining a unit culture where this is appreciated, and coming to know what patients and colleagues value. Charge nurses know that patient, physician, and staff satisfaction are critical to patient outcomes. Spiritual/religious caring involves the relationships of healthcare workers with the

patients as they engage in matters of life and death, and includes “acts of brotherly love” (p. 36). Finally, ethical caring includes doing what is right according to ethical standards, or focusing on the good to be achieved and avoiding negative consequences to the system. Charge nurses often are consulted to guide staff nurses through these complex situations.

In her revised version of the model, bureaucratic caring is represented as a complex holographic model, in which Ray (2006) postulated that all caring has spiritual-ethical components woven throughout, including the processes of bureaucratic caring that are political, economic, technological, and legal. This change calls for the reinvention of work from the perspective of patient outcomes. According to the literature, charge nurses have been called upon to respond with all forms of bureaucratic caring in a supportive role.

Current changes in the health care environment lend themselves to questions regarding how these administrative caring processes can be promoted at the unit level, and how leaders can be supported in developing a lens that looks at the global components of caring. Moreover, how does caring exist on both the nurse to patient level as well as on the unit and organizational level? Therefore, Ray’s Theory of Bureaucratic Caring (1989, 2006) provides a framework to understand the experience of being charge nurse in acute care practice.

Swanson’s Caring Attributes and Leadership

Swanson (2008) also projected a need to create conditions for caring, which she referred to as the “healing trinity” of caring, safety, and leadership. This nurse researcher articulated that keeping patients safe calls for creating a culture of caring.

Compassion and competence are necessary to create optimal healing environments for a culture of safety to occur. An infrastructure of support is required for nurses to arrive at the point of care with what is needed to complete their mission of providing for safe outcomes, and charge nurses are positioned uniquely to be able to respond with support.

Swanson (2008) has suggested that all relationships that involve social support are caring; therefore, the charge nurse role can be seen as supportive and caring. Charge nurses engage in knowing, being with, doing for, enabling, and maintaining belief as they provide support for staff nurses. Swanson (1991) previously described these caring processes within her middle range theory of caring. Knowing is "striving to understand an event as it has meaning in the life of another" (p. 163). Being with is "being emotionally present to the other" (p. 163). Doing for is "doing for the other what he or she would do for the self if it were at all possible" (p. 164). Enabling means "facilitating the other's passage through life transitions and unfamiliar events" (p. 164). Finally, maintaining belief is "sustaining faith in the other's capacity to get through an event or transition and face a future with meaning" (p. 165).

Swanson (2008) has elaborated on her five caring processes of knowing, being with, doing for, enabling, and maintaining belief in terms of leadership (2008), and providing structural support. Knowing includes knowing the staff as individuals, recognizing their perspective and experience, assessing resources, identifying growth opportunities, and evaluating outcomes. Being with includes listening and being accessible, acknowledging losses and celebrating accomplishments, and being present authentically. Doing for is securing resources, advocating for staff, making decisions, using positional power for protection, developing supportive infrastructures, and

providing technology. Enabling is communicating, including crucial communications; supporting; allowing autonomy; supporting decisions and taking the blame; and correcting mistakes. Maintaining belief is recognizing those with leadership traits, investing self, finding meaning in work, encouraging hope, planning and anticipating change, staying the course, and remaining positive. This work, which is based on "categorizing experience and business literature under the five caring processes" (K. M. Swanson, personal communication, May 8, 2009), has not been published yet, but permission has been received to include this discussion of caring leadership in terms of increasing the understanding of how charge nurses provide leadership support at the unit level, as well to compare findings.

Boykin and Schoenhofer's Nursing as Caring

The charge nurse, as they represent nursing leadership, enters the world of the nurse and the patient, identifying needs and providing resources as they each "live and grow in caring" (Boykin & Schoenhofer, 2001, p. 33). As one way of supporting the nurse at the bedside, the nurse administrator can provide charge nurses, who additionally may provide time for nurses to respond directly to patients, increasing the patient satisfaction with their care. Nursing leaders can help others grow in their understanding of why they are there as nurse, which is to nurture the wholeness of person.

Everything, including quality and safety measures, must be within the context of the people for whom we care. Boykin and Schoenhofer's (2001) discussion of practice implications for leadership was directed toward nursing administration, but charge nurses may be the conduit for relating their theory at the unit level once the

nurse administrator has committed to the strategic vision of nurse as caring. *Nursing as Caring* honors the importance of budgetary decisions, but urges the monetary support of time for nurses to be with their patients. Within this context, there is a desire to "support the living of caring" (p.36). Since the bureaucratic structure of most hierarchical healthcare organizations is not flat, it is seen as not allowing for the valuing of all nurses; however, charge nurses can provide encouragement for this level of respect among the team. Nursing leaders must be able to respond in an authentic way to whatever nurses are calling for in terms of support.

Charge nurses must nurture and sustain the work of the staff nurses and seek opportunities to allow the nurses to truly nurse. Charge nurses themselves must live their caring within the context of the nursing situation by being present authentically so they can come to know the other as a caring person (Boykin & Schoenhofer, 2001). This study will provide an opportunity to discover how charge nurses live their caring while providing support.

Chapter Summary

In chapter one the research purpose was outlined for the reader, and the research questions introduced were the need to explore the experience of being a charge nurse in acute care practice and how charge nurses live caring in their support of nurses and patients. The background laid the groundwork for charge nurses needing to be able to support frontline staff in moving toward priority agendas. The significance of the study is the importance of understanding the charge nurse role since there is a lack of research from the perspective of those who are in this role. Findings may provide insight into an essential emerging role that improves patient safety, while supporting and enhancing the

retention of nurses. Furthermore, results of this study may influence redesign of the charge nurse role for greater efficiency and effectiveness. Knowledge gained from the study then can be used to strengthen recommendations for charge nurse development. The chapter concluded with the theoretical grounding for the study.

CHAPTER TWO. REVIEW OF RELATED LITERATURE

Creswell (2007) supports conducting a literature review prior to conducting a qualitative study to verify the existing gaps in the literature. A review of the existing literature on charge nurses found descriptive articles that outlined the responsibilities of the role and the preparation needed to assume the role. Researchers have evaluated applying nurse manager competencies to the charge nurse role, defined charge nurse competencies, studied charge nurse effectiveness, and measured charge nurse stress. Other discussions of the charge nurse in the literature evolve around international implementations of the role, legal implications of the role, and the leveling of leadership roles. This review validated the need both to provide a forum to hear the 'voice' of charge nurses as they describe the experience of what it means to be charge nurse in the current acute care environment and to explore how charge nurses support nurses and patients.

Charge Nurse Role Delineation and Preparation

Most of the nursing literature that has been published on the charge nurse role since the 1970s is not grounded in research and focuses on role preparation. Sherman and Eggenberger (2009) discussed the role responsibilities of the charge nurse and the need to develop skills in communication, conflict resolution, and team building. Other authors have presented recommendations for educational programs to meet the development needs of charge nurses (Arzoomanian & Keys, 2008; Cartier, 1995; Ducket & Brunette, 1988; Lifson & Cantlon, 1986; McKinney, 2008; Sherman, 2005;

Yee & Swillum, 2003). Ambrose (1995) discussed selection criteria for being able to participate in a charge nurse program on an obstetrical unit. Lifson and Cantlon (1986) reported the results of the top five items identified on their needs assessment with charge nurses: leadership theory and practice, change theory, evaluation of staff performance, problem identification and resolution, and coordination of activities with team members. One author has discussed the dual nature of the charge nurse role - having the responsibility of coordinating patient care and handling some management responsibilities while also caring for patients, which can lead to stress (Geary, 1988).

Hudson (2008) described the importance of following a systematic approach when managers begin delegating administrative or non-clinical tasks to charge nurses. The manager then is transferring the authority for the decision-making to the charge nurse, and the charge nurse is acting without gaining approval first. Static delegation to a charge nurse might be unit or patient education or a performance improvement project, which are not time sensitive. Dynamic delegation, such as facilitating fluctuations in patient flow, changing assignments, and flexing staffing up or down, is time sensitive and involves critical thinking. Other authors described the challenges of filling in and assuming the role of temporary charge nurse (Meredith, 1979; Costello-Nickitas, 1997), and the benefits of assigning a permanent charge nurse (Hughes & Kring, 2005; Lillis, 2009).

Application of Nurse Manager Competencies

Authors also have focused on the application of nurse manager competencies being transferable to the charge nurse. Osguthorpe (1997) described the nurse manager as having 24-hour accountability for the unit, for human resource functions, and for

outcomes, and so deduced that the charge nurse had the same role and leadership responsibilities for a defined shift. Westphal, Jenkins, and Miller's (1986) study aligned the functions of the charge nurses under the "four fundamental management categories of planning, organizing, directing and controlling unit activities" (p. 56). The charge nurse anticipates problems that may occur on the unit shift, puts together the people and resources to respond, disseminates orders, and assesses outcomes to ensure quality care. Interviews were done with supervisors who work with charge nurses in 21 South Carolina hospitals to validate the list of 275 managerial tasks that the researchers identified as falling under the four categories. Eighty percent (or 220 of the tasks) were expectations for charge nurses. Factor loading narrowed the list down to 42 tasks.

Mejia, Vasquez, and Sanchez (2006) described the role of the charge nurse, like the role of the nurse manager, as influencing staff productivity and effectiveness; therefore, the charge nurse must support the nurse manager's vision. Although the manager and charge nurse were seen as supporting a common vision, the staff nurses described the charge nurses as more accessible and active in patient care than the nurse managers, and as playing a vital role in overseeing the admissions, discharges, and transfers that resulted in rapid turnover for the nurses.

Charge Nurse Skills and Competencies

Other researchers have focused exclusively on attempting to define charge nurse specific competencies. Connelly, Yoder et al. (2003) conducted one of the few research studies on the charge nurse role reported in the nursing literature. In their exploratory qualitative study, they used semi-structured interview questions based on Katz's (1974) categories of management skills. A military medical center was the setting for this

study, which was completed in response to a need to have unit leaders when the head nurse was absent or on the night shift. Forty-two interviews were conducted with charge nurses (12), head nurses (10), staff nurses (11), and supervisory personnel (9), yielding four categories of competencies: clinical/technical, critical thinking, organizational, and human relations skills. A total of 54 charge nurse competencies were identified. Constant comparative analysis was done and to sustain rigor, an audit trail, memos, peer-briefing, and member checking were carried out.

Findings revealed many clinical competencies, including performing patient assessments and providing for patient safety (Connelly, Yoder et al., 2003). Among the critical thinking competencies described were assessing and evaluating clinical and operational information, managing crises, making decisions, and using good judgment. Overseeing the unit function to ensure overall quality of care/practice was one of the many organizational competencies. Finally, human relations competencies included communicating effectively with all constituents and developing and building team efforts. In addition, 15 characteristics of an effective charge nurse were described as traits that could be a precursor to charge nurse candidate selection. Based on the research findings, Connelly, Nabarrete et al. (2003) later designed and published a charge nurse workshop and a form that a head nurse could use to assess these competencies. Recommendations were made for an experiential, interactive format for charge nurse education.

Flynn, Prufeta, and Minghillo-Lipari (2010) used the Connelly, Yoder et al. (2003) competencies when attempting to clarify the charge nurse role and make their responsibilities consistent throughout the facility. The authors also prepared consistent

criteria for charge nurse selection, and developed a resource manual and charge nurse shift report. An orientation workshop was facilitated that focused primarily on "providing guidelines for decision making processes" (p. 60).

From their initial work, Connelly and Yoder (2003) also published a qualitative study of the barriers and facilitators of the charge nurse role. The categories were personal, interpersonal, and organizational for the 24 barriers and facilitators that were identified, and factors could be either a barrier or facilitator depending on the situation. Personal barriers/facilitators included a need to control situations, manage time, plan and assess the unit, understand the 'big picture', level of experience, abuse of the role, effective delegation, fairness in making assignments, self-confidence, interest in being a charge nurse, and ability to handle stress. Interpersonal barriers/facilitators reflected the importance of effective communication; support and relationships with head nurse, supervisors, and staff; respect from others; and expectations and perceptions of the charge nurse. Organizational barriers/facilitators were role definition, staffing, ancillary support, and paperwork. Recommendations were made for a charge nurse coach to meet weekly with a novice charge nurse to review their progress.

Allison (2007) utilized qualitative action research and appreciative inquiry in a master's thesis to assess the leadership abilities required in the charge nurse role from their perspective. The research question was "How can a healthcare organization facilitate/support the development of leadership in the charge nurse?" (p. 80). Six participants from a Canadian health care facility were interviewed and participated in a focus group for the desired goal of facilitating leadership development for the facilities' charge nurses. Results identified from the participants were categorized under three

leadership categories: resources, relationships, and capacity building. Findings included challenges with staffing shortages that impacted job satisfaction; charge nurse workloads, which increased stress levels; distress caused by not having enough time; and a need for role clarity, including a job description and charge nurse manual.

Relationships in the charge nurse role were described as needing to be based on trust, requiring collaboration to get team work done, and needing support from managers and peers (Allison, 2007). Themes identified to build capacity were ongoing workshops, education, and mentoring. Competencies required by a charge nurse were found to be clinical, technical, critical thinking, organizational, and human relations skills, which support those identified by Connelly and Yoder (2003). Limitations of this study were that it was conducted in one Canadian facility and that it had a small sample size.

McGilton et al. (2009) conducted a qualitative study of 16 charge nurses in eight long-term care facilities in Canada to determine how the charge nurses perceived their role, which was so important to retention in that environment. Common themes were "against all odds, getting through the day", "stepping in work", and "leading and supporting unregulated care workers" (p. 723). Discussion revolved around the need to redesign the role to allow time for charge nurses to demonstrate leadership behaviors.

A grounded theory study was conducted by Nunn (2008) to identify the skills and behaviors that would increase the effectiveness of charge nurses. Fifteen charge nurses who worked in the role of staff nurse, relief charge nurse, and charge nurse as well as former charge nurses who now were managers were interviewed. Interview questions revolved around the technical and behavioral skills needed for the role and

discussion of how those skills could be acquired. This researcher also utilized two-hour observational sessions to observe the participants' interactions in their natural setting. Results indicated that leadership skills that would enhance the effectiveness of the charge nurse included the core leadership skills (communication, team leader, leading by example, delegation, dependable, confident, and resourceful), relationship management (fairness, good listener, trustworthy, positive attitude), and emotional intelligence.

Competencies of an effective charge nurse were described as gaining the power to lead by earning trust and respect, possessing self-awareness, having the ablity to delegate, possessing a knowledge of resources, clarifying expectations, acting as a change agent, resolving conflict, becoming a service recovery expert, being a safety and error prevention specialist, acting as a mentor, and being mission focused (Leary & Allen, 2006) .Yee and Swillum (2003) focused on how experienced charge nurses effectively communicated their intuitive knowledge, and developed a reference manual for charge nurses to assist with consistency in decision-making in the emergency room. Another facility developed a support group for those in a permanent charge nurse position on the evening and night shift. This group provided a forum to support decision-making problem solving (Franks & Hayden, 1990).

Sherman (2005) addressed the skills needed by charge nurses in her workshop: communication, supervision and delegation, conflict management, and team building. This scholar also introduced the dilemma many charge nurses face when they are accountable for unit functions without being given the assigned authority to hold others accountable as well. Because of the role of charge nurses in providing for safer patient

care units, Sherman also made a business case for investing resources in preparing charge nurses. Potential benefits of charge nurse education were described as a reduction in complaints, medical errors, and employee turnover; with subsequent improvements in job satisfaction; admission, discharge, and transfer processes; and customer satisfaction.

Others have focused their inquiry on specific tasks or aspects of the tasks that are performed by the charge nurses, such as the decision-making that goes into making patient assignments (Bostrom & Suter, 1992). These researchers explored whether the charge nurses' staging on Benner's levels of novice to expert impacted how they completed this task. The questionnaire was completed by 271 nurses, about 51% of whom currently served as charge nurses. Assignments usually were made 33% of the time by the charge nurse on the current shift for their shift, while 31% made them for the following shift. Not surprisingly, findings indicated that experienced charge nurses took more factors (such as nurse expertise with the type of patient, nurse preference, orientation needs of new nurses, patient or family preferences, and patient/nurse language match) into consideration when making the assignment, rather than just the acuity information.

Admi & Moshe-Eilon (2010) developed a tool to measure the charge nurse's role stress in hospitals due to the fact that they must respond to the needs of patients and families, nursing staff, and the interdisciplinary team while maintaining control of the unit. Additionally, they have responsibilities to serve as role models, give advice, troubleshoot, respond to emergencies, resolve conflicts, advocate for families, communicate with physicians, and make decisions such as patient assignments. This

quantitative study of charge nurses and managers utilizing a questionnaire identified the following stress factors: conflicts between authority and responsibility, making decisions independent of their manager, lack of resources, role conflict, patient and nurse interactions, and being overloaded physically and emotionally. If they had attended graduate school, charge nurses felt more stress with lack of resources and conflicts between authority and responsibility, and experienced more stress with managerial decision-making. The tool was reliable with Cronbach Alpha's of 0.71-0.90.

International Discussions of Charge Nurse Role

In other parts of the world, such as the United Kingdom, charge nurses are given a different title. The role of modern matron was implemented in an acute teaching trust, composed of two sites and an 1100 bed teaching hospital, when 20 modern matrons were given the task of providing strong clinical leadership, improving quality, and increasing patient satisfaction (Dealey, Moss, Marshall, & Elcoat, 2007). Impact of the role then was studied and evaluated using a questionnaire. There was a 45.3% reduction in drug errors after the introduction of the matrons, and an 11.6% reduction in Methicillin-resistant *Staphylococcus aureus* (MRSA) infections. Of the 97 staff members who responded to the questionnaire, 90% felt they received support from these senior nurses, and 80% felt there was a positive impact on patient care.

In New Zealand (Malcolm & Stewart, 2008), a recent trend has been to change the title from clinical charge nurse to charge nurse manager to reflect an increase in managerial responsibilities and a movement away from the bedside. Given the complexity of care required of patients with ever-increasing acuity levels, these authors express concern regarding losing this level of clinical support and expertise, which they

feel will impact levels of safe quality patient care. Scotland currently has plans to make all of its senior charge nurses responsible for quality on their wards; components of their duties now are to include safe and effective clinical practice and responsibility for patient experiences, managing teams, and meeting performance targets ("Resources needed to make charge nurses guardians of quality," 2008).

Legal Implications of Role

Some publications have discussed the legal implications of functioning in a charge nurse role (Hinkle & Hinkle, 1977a; Hinkle & Hinkle, 1977b; Mahlmeister & Koniak-Griffin, 1999) and being held accountable for patient safety. The charge nurse may be named in a patient-initiated lawsuit for practices that occur on their shift, especially when it is not yet known if there are issues with their supervision of a nurse. Hinkle and Hinkle (1977a) define the charge nurse duties in terms of patient care, protection of the hospital, and interactions with the staff. Charge nurses must ensure that nurses are competent to deliver patient care and that there is early recognition of a change in patient status. Hospitals are protected by ensuring that all documentation of patient care is completed, and that patients receive informed consent. Suggestions to guide charge nurse staff interactions include remembering that nursing staff are people who exist outside of their nursing role and the organization. The importance of delivering ongoing education regarding potential legal issues also was highlighted (Hinkle & Hinkle, 2007b).

Mahlmeister and Koniak-Griffin (1999) discussed the charge nurses' responsibility for promoting safety and maintaining clinical standards by being aware of their responsibilities in terms of the Nurse Practice Act and the State Board of Nursing,

especially in terms of supervision and delegation. Accountability of "unit-based coordinators of care" (p. 300) has increased with flattened organizational structures and the increased use of unlicensed assistive personnel (UAPs). Charge nurses can have claims of negligence brought against them if they are not aware that they are accepting "ownership for the outcomes of care provided by the entire patient care team" (p. 301) and are found not to have responded appropriately. Charge nurses play a vital role in resolution of patient problems, and must be careful to fully document when called to assess a patient.

With team nursing, the accountability for outcomes by the entire patient care team has increased and damages have been awarded for claims of negligence (Mahlmeister & Koniak-Griffin, 1999). This accountability especially is difficult when the charge nurse also has a patient assignment, because when the charge nurse "must choose between meeting patient needs or maintaining unit operations, the patient usually receives priority," and the charge nurse simply cannot be in "two places at once" (p. 306).

Charge nurses are seen as playing a crucial role in preventing negative patient outcomes (Mahlmeister & Koniak-Griffin, 1999). Woodard (2009) studied the effect on patients of having the charge nurse make rounds every two hours. During these rounds the charge nurses were to assess the "4 P's"; "pain, potty, position, and presence" (p. 200). Charge nurses were chosen to conduct the rounds because of their level of experience, assessment skills, and ability to identify subtle changes. Results indicated a decrease in call bell usage, a decreased fall rate, and an increase in patient satisfaction scores.

Due to increased scrutiny on the charge nurse's response or lack of response to changes in patient status, as well as claims of negligence, recommendations have been made to professionalize the charge nurse role (Federwisch, 2008). In terms of legal liability, Mathias (2001) defined the accountability of the charge nurse as being a "consultant for patient problems; advisor for clinical dilemmas; arbitrator in clinical disputes; triage agent for patients, staff, and resources; and expert in unit operations" (p. 18).

Leveling of Leadership Roles

Several authors have discussed evolving and changing leadership roles in response to economic drivers and reductions in layers of management. Inconsistent job descriptions have evolved into varying levels of authority and compensation for the charge nurse role. Given the shortage of critical care nurses and the rapid turnover of critical care patients with higher acuity, Noll, Hix, and Hawley (1989) discussed strategies for evaluating the need for a charge nurse role in critical care and a change in the charge nurse function.

Krugman and Smith (2003) studied the evaluation framework of the implementation of a charge nurse role using Kouzes and Posner's Leadership Model (1995). Data were collected over a six-year period to determine if the nurse manager role could be eliminated and replaced with a model of permanent charge nurses reporting to a nursing director. Permanent charge nurses (104) assumed additional duties, such as performance evaluations, scheduling, payroll, and the chairing of committees.

After additional education was provided, the gap between the charge nurses' self appraisal and the staff's reflections of their leadership skills closed over time (Krugman & Smith, 2003). Improvements were seen in mean scores for Inspiring a Shared Vision and Challenging the Process. Yet staff perceptions of the charge nurses' ability to Model the Way, Encourage the Heart, and Enable Others to Act declined, which was felt to be due to charge nurse turnover. Some of the gaps between charge nurse and staff nurse perception were felt to be related to director development and coaching. One particular benefit noted was that gaps that existed at the point of care delivery were identified. One example was that the shift reporting tools that were developed resulted in resolution of systems issues such as pharmacy delays.

Zimmermann (2000) published a series of questions and answers about the role and compensation of the charge nurse in various emergency departments. Finally, Armstrong and Hedges (2006) described the challenges of redesigning the charge nurse role in a union environment, as they simultaneously negotiated the charge nurse role into their new union contract. As they researched and developed a job description and competencies for the charge nurse role, charge nurses endeavored to gain the support of the union and the staff nurses for this role. Competencies were based on communication/collaboration, customer service, professionalism, problem solving, and leadership behaviors.

Chapter Summary

In the 1970s -2000s, many descriptive articles were written on defining the charge nurse role and describing the results of needs assessments to implement educational development programs and workshops. The benefits of assigning a

permanent charge nurse role and the challenges of being in charge in specialty areas also were discussed. Legal implications of the role also have been a matter of concern. Leveling of leadership roles has necessitated a new look at the role and, internationally, many modifications have been made to the role to promote a focus on quality.

The majority of research published has been for competency development for the charge nurse role. Barriers to the role also have been explored, as well as ways to increase the effectiveness of the role. One aspect of charge nurse decision-making has been investigated, and researchers developed a tool to measure charge nurse stress. The gap in the literature is that the charge nurse insight into their role is notably absent in the data. This study will increase understanding of what the experience of being a charge nurse is in the acute care environment from the perspective of the charge nurse. Charge nurses will also be given an opportunity to describe how they live their caring in support of nurses and patients.

CHAPTER THREE. METHODOLOGY

Introduction

Qualitative inquiries allow researchers to study situations in their entirety and participants to share their own perceptions and experiences (Munhall, 2007). Qualitative descriptive methods draw from naturalistic inquiry. Researchers using this methodology are committed "to studying something in its natural state" (Sandelowski, 2000, p. 337) and to studying "intensely a phenomenon to discover patterns and themes about life events when the researcher has specific questions about the phenomenon" (Parse, 2001, p. 57). Relevant assumptions of the method include that the participants have social networks and can describe retrospective life events, allowing for patterns and themes of the phenomenon to emerge.

The qualitative descriptive exploratory method takes into account "the meaning of a life event for a group of people" (Parse, 2001, p. 58). A qualitative descriptive exploratory perspective specifically guides the researcher in gaining an understanding of the experience of being a charge nurse in acute care practice from the perspective of those who have experienced it. As there have only been limited studies of charge nurses and these primarily have focused on defining their competencies, skills, and abilities, this method allows for a deeper exploration of the phenomenon,

In addition to the qualitative descriptive exploratory method, the researcher also used methods of narrative inquiry. Narrative inquiry allows the researcher to gain a sense of how the participants make meaning of experiences in their lives (Munhall,

2007). The researcher is a co-participant as the charge nurses explore and reflect on their life experiences and gain new perspectives on those experiences. Narratives allow the participants to organize their experiences into "meaningful wholes," to see the consequences of those experiences (Denzin & Lincoln, 2008, p. 64), and permit the participants to "relate their importance to others" (Polit & Beck, 2010, p. 272).

During the interviews, the specific method of narrative inquiry used was explanatory narratives. Explanatory narratives describe "how and why an event occurred" (Parse, 2001, p. 44). Participants were asked to share a story about a situation where they felt they were able to provide support to a staff nurse or patient that they felt had a significant impact. Participants also were asked to share a story about a situation where they felt they were not able to provide the support needed for a staff nurse or patient.

Chapter three includes a general discussion of the methods of inquiry, researcher biases and assumptions, ethical considerations, sample and setting, data generation, data analysis, methodological rigor, and strengths and limitations of the study.

Design

An exploratory qualitative descriptive design using methods of narrative inquiry was conducted to answer the research questions. The design of the study is sound in that there is congruence between the "ontology, epistemology, and methodology" (Parse, 2001, p. 59). In this study, the researcher developed descriptions of the experience of being a charge nurse in acute care practice from semi-structured interviews with the charge nurses and the stories that they shared. These findings were combined with the researcher's understanding of charge nurses from her own experiences, blended with

data from the hospital documents on job descriptions, care delivery models, competencies, and pay practices obtained from each facility. Hospital documents provided insight into charge nurse role expectations from the perspective of nurse leaders in the organization. Finally, emerging findings were shaped by viewing them through the lens of the theories identified in chapter one: Ray's theory of Bureaucratic Caring (1989, 2006), Swanson's (2008) caring attributes and leadership, and Boykin and Schoenhofer's (2001) theory of Nursing as Caring.

Researcher Biases and Assumptions

Prior to beginning a study, researchers should engage in reflexivity to identify any biases or presuppositions regarding the phenomenon (Polit & Beck, 2010). This reflexivity allows the researcher to conduct a self assessment of how their own experiences may influence data collection and analysis. In this work, the researcher brings both academic and practice knowledge of charge nurses to the research experience. In practice, as a nursing supervisor, the researcher works directly in relationship with charge nurses at an acute care facility, and responds either to support the charge nurses when they call for assistance or to urgent events. "Nurses are task oriented, and being a leader, I create confidence that if something is missed, I'll catch it" (Charge Nurse Personal Communication, September 12, 2009) was a statement recently heard by the researcher in practice. One assumption that this qualitative researcher has formed is that the outcomes of a given day, or on a particular unit, usually can be predicted based on who is assigned to be in charge. If staffing levels are so short that no charge nurse has been designated, a whole different set of circumstances is created, leading to emergencies, conflicts, and dissatisfied physicians,

staff nurses, patients, and families. This assumption is indicative of a bias that the charge role is central and critical to successful outcomes on an acute care unit.

As an Instructor at a university who teaches leadership to RNs who have returned to school, the researcher participates in many discussions about the role of the charge nurse in making assignments, providing resources, managing unit flow, assessing for and responding to staff needs for support, fostering teamwork, problem solving, communicating, and mentoring. This type of dialogue could lead to the researcher forming preexisting notions regarding the charge nurse role. The researcher has engaged in a previous study to understand the role of managers and directors and to develop a leadership competency model for their development (Sherman, Bishop, Eggenberger, & Karden, 2007). Sherman and Eggenberger (2009) also have written a descriptive article regarding the role of the charge nurse in which role responsibilities were outlined and suggestions were made for developing the necessary skills.

In this study, the qualitative researcher attempted to set aside the previously mentioned assumptions and biases during the actual interview process to remain open to the participant's understanding of the experience of being a charge nurse. The sample did not include any charge nurses who have been supervised by the researcher; an assumption of the researcher was that charge nurses then would share their experience of being a charge nurse in acute care practice more honestly.

Ethical Considerations

The researcher obtained Institutional Review Board (IRB) approval from Florida Atlantic University (FAU). IRB consent also was obtained from two of the four hospitals whose charge nurse/assistant nurse managers participated in the study, as

required by their research committees. The remaining two facilities accepted the FAU IRB approval for conducting the study at their facilities. The results are reported in an aggregate format to ensure confidentiality and that no data can be linked to individual facilities. The identities of study participants were protected by assigning each of them a number and a pseudonym. All information in this study was kept confidential. Data are stored in a locked file cabinet in the researcher's office and on a password protected computer for a maximum of three years and then will be destroyed.

Participation in the study was voluntary and participants were told that they could withdraw from the study at any time. The researcher discussed with the participants the need for audiotaping, and permission to audiotape was part of the consent process. Audiotapes will be destroyed when the dissertation has been defended and the results of the study are published. Participants incurred no more than the minimal risk that one would experience in regular workplace activities.

Description of Method

Sample and Setting

Four acute care hospitals in Southeast Florida were selected as study sites: two for-profit and two non-profit, so that the researcher could explore the role of the charge nurse in both types of organizational structures. The researcher received permission to conduct the study from the Chief Nursing Officers in four acute care hospitals whose charge nurses/assistant nurse managers met the research criteria. Facilities selected to participate in the study had a permanent formal charge nurse or assistant nurse manager position where the charge nurse or assistant nurse manager routinely was not required to take patients in addition to their leadership responsibilities. Only day shift charge nurses

who worked on medical-surgical or telemetry units were included in the sample. Charge nurses who worked in critical care, the emergency room, or on specialty units were excluded from the study as role expectations of charge nurses typically are different in specialty settings. Units to which the charge nurses were assigned did not have any nurses in support roles such as nurse practitioners, clinical nurse specialists, clinical nurse leaders, or clinical educators. This eliminated the possibility of a different source of support, which could impact the findings regarding the support that charge nurses provide in the four settings. Letters of support and agreement to collaborate in the study were obtained from each of the facilities and included in the IRB submission.

Onsite interviews at the hospital were scheduled with charge nurses/assistant nurse managers who volunteered for the study through a designated point person or gatekeeper at each facility (Polit & Beck, 2010). The researcher obtained written consent (Appendix A) prior to the interviews being conducted. A copy of the signed consent was given to each participant. Individual in-depth interviews, lasting no more than one hour, were scheduled and conducted with the charge nurses. The taped interviews were conducted onsite at the hospitals in a quiet office, break room, or conference room either during their shift when appropriate unit coverage could be arranged, or at time that was convenient to the participant. Participants were informed that follow-up interviews may be necessary to verify the researcher's understanding of the interviews and the themes that emerged in the findings.

A purposive sample of four to six charge nurses/assistant nurse manager participants from each facility was obtained through attendance at various hospital nursing leadership meetings where the researcher explained the study, assessed their

interest, and inquired about volunteers to participate. Additional volunteers were solicited by posting flyers in the facilities (Appendix B and C). This sample size of twenty total participants was deemed reasonable for a descriptive exploratory study using a semi-structured interview guide to represent the typical cases of the charge nurse phenomenon.

Description of Participants

Twenty charge nurses who met the criteria for the study consented to participate in the interviews. Participants were asked to complete a demographic survey (Appendix D), which contained no information identifying the study participants or their employment sites. Demographic data included the following information regarding the charge nurses: age, gender, ethnicity, length of time they have been a nurse, length of time they have been a charge nurse, number of years employed by the acute care facility, to whom they report, level of education, number of shifts worked per week, qualifications for assuming the role, and any formal training received for the charge nurse role. Since pseudonyms were used, names were not included on any of the handwritten notes or transcribed reports. Pseudonyms, ages, type of facility, years as a nurse, years as a charge nurse, highest level of education, and whether they received formal training for the charge nurse role are reported in Table 1.

Table 1

Demographic Data of Participants

Participant	Pseudonym	Age	Type of Facility*	Years as a Nurse	Years as a Charge Nurse	Highest Level of Education*	Formal Training for Role*
1	Aida	38	P	12	10	B	N
2	Betty	39	P	19	12	A	N
3	Cynthia	62	P	39	20	A	Y
4	Dahlia	38	P	16	11	D	Y
5	Ellen	67	P	47	10	A	N
6	Fay	33	NP	13	3	A	Y
7	Gail	32	NP	5	3	B	N
8	Hannah	27	NP	5	2.5	A	N
9	Isabel	35	NP	9	3	A	N
10	Janet	55	NP	32	6	A	N
11	Kelsey	40	NP	15	6	B	N
12	Libby	40	P	10	4	A	N
13	Mae	39	P	18	10	A	N
14	Nita	53	P	30	25	A	N
15	Olive	47	P	4	2	A	N
16	Paula	65	NP	44	28	B	N
17	Rachel	51	NP	19	5	A	N
18	Sandy	37	NP	13	6	B	Y
19	Tina	58	NP	34	3	B	N
20	Verona	50	NP	15	10	A	N

* P=Profit NP=Non-Profit D=Diploma A=Associate B=Bachelor N=No Y=Yes

Age	Min=27	Max=67	Mean=45.3	SD=11.68
Type of Facility	Profit=9	Non-Profit=11		
Years as a Nurse	Min=4	Max=47	Mean=19.95	SD=13.11
Years as a Charge Nurse	Min=2	Max=28	Mean=9.0	SD=7.46
Highest Level of Education	Diploma=1	Associate=13	Bachelor=6	
Formal Training for Role	Y=4	N=16		

All of the participants were female and their ethnic background varied. Ten participants were categorized as White American, two participants as Eastern European, three as Asian, two as African American, and three as African Caribbean. Of the African Caribbean, two of the charge nurses were Jamaican and one was Haitian.

Thirty-five percent of the participants worked on a telemetry unit, 40% on a medical unit, and 25% on a medical-surgical telemetry unit. The number of beds on the units ranged from 18 to 56. The length of time that the participants had been employed at the facility varied from 1 to 20 years, with a mean of 8 years. Only five participants from a nonprofit facility worked a five day, eight hour work week; the remaining worked either three or four, twelve hour shifts. Twelve participants reported to a director, the remaining eight reported to a clinical manager or a manager. The layers of leadership at each facility are reported within the Organizational Artifacts section within this chapter.

Participants described the qualifications for the charge nurse role as experience, leadership and teamwork ability, bachelor's degrees, and certifications. However, only 33% of the sample had a bachelor's degree in nursing. One participant also discussed organizational and critical thinking skills as being important for her role. The type of training that the participants described receiving for the role predominately was on the job training with a preceptor or shadowing. Four participants discussed various types of educational classes.

Organizational Artifacts

Each facility was asked to provide data regarding their individual job descriptions, qualifications, professional development for the role, competencies, and

compensation for charge nurses/assistant nurse managers, as well as the care delivery model the facility utilizes and their nursing organizational chart. The identities of the hospitals were protected by assigning them a letter code of A, B, C, or D. All facilities use a team care delivery model, consisting of registered nurses, licensed practical nurses, and patient care assistants (PCAs).

Hospital A is a for-profit facility. This hospital provides some leadership education for charge nurses, which includes a charge nurse specific course as well as courses on hiring staff and maintaining physician relations. The organizational chart indicates that the charge nurses report to a clinical manager, who reports to a director, who then reports to the chief nursing officer (CNO). The specific job description for the charge nurse defines responsibilities pertaining to communication, role modelling, knowledge of current nursing practice, assistance with resource control, participation in hiring, and assistance with performance evaluations. This hospital prefers a bachelor's degree in nursing for the position of charge nurse. Competencies for the charge nurse role reflect accountabilities for prioritizing patient care, monitoring flow, staffing the unit, providing resources, and improving quality. The minimal promotional increase for nurses assuming the charge nurse position is 6%.

Hospital B is a for-profit facility where charge nurses are given no formal education. Charge nurses report to a director, who reports to the CNO. Other than the title, the job description for the charge nurse is similar to the description for a registered nurse. Three years of nursing experience are preferred for those who are assuming the charge nurse role. There is not an educational requirement for the position. Charge nurses complete the competencies for a registered nurse; there is not an additional

competency that is specific to the charge nurse role in this facility. Minimal salary increase for the charge nurse position in this organization is 5%.

Hospital C is a non-profit facility that provides a leadership program to support the development of new nurse leaders. Charge nurses report to a director, who reports to the Assistant Vice President of Patient Services. The job description for charge nurses indicates that they have shift accountability for nursing care and for facilitating interdisciplinary practice and the day-to-day operations. Responsibilities include providing an environment to promote teamwork and collaboration, coordinating care across the continuum, integrating of evidence-based practice, and implementing a patient focused nursing care delivery model. A bachelor's degree with a major in nursing is preferred for the position as well as one year of acute care experience. Competencies are not specific to the charge nurse role; they are framed around Roach's (1987) Caring Competencies. Minimal salary increase for assuming the charge nurse role is 7%.

The final hospital is D, which is a non-profit facility. There is an orientation for those who are assuming a leadership role as well as classes on hiring and coaching staff, setting performance expectations, and conducting performance reviews. Charge nurses report to a nurse manager, who reports to a director, who then reports to the CNO. The charge nurse job description includes responsibilities for overseeing customer service, developing people, providing visionary leadership, leading change, maintaining quality, creating innovation, focusing on systems thinking, having organizational savvy, and leveraging diversity. There is not an educational requirement for the position.

Competencies for charge nurses are the same as those for the staff nurses. Minimal salary increase for the charge nurse role is 7%.

Data Generation

The primary method of data generation was interviews. The researcher used a semi-structured interview guide (Appendix E) during these interviews with 14 questions to guide the dialogue. The questions on the interview guide were developed using the caring leadership theoretical lens and feedback from content experts. The first goal was to determine what the experience of being a charge nurse in acute care practice was like. Participants were asked to describe the charge nurse experience, their activities on a typical shift, their priorities and challenges, how they function as a team leader, what kind of decisions they make, how their role impacts patient safety, and what their needs were in terms of professional development. Questions regarding activities, priorities, challenges, team leader functions, decision-making, and safety elicited details of how the charge nurses served the organization (Ray, 2006) and created a culture of safety and caring where leadership was present (Swanson, 2008).

The second goal was to develop an understanding of how charge nurses live caring in their support of staff nurses and patients. Participants were asked specifically how they provide support for other staff, patients, and families. These questions brought forth aspects of how the charge nurses lived their human caring with the staff and patients while interconnected with their organizational caring (Ray, 2006). Then the researcher asked the participants to tell a story about a situation where they truly were able to provide support to a staff nurse or patient that had a significant impact. These stories gave the researcher a glimpse into how the charge nurses were able to “support

the living of caring" (Boykin & Schoenhofer, 2001, p. 36). They also were asked to tell a story about a time when they were not able to provide the support that a staff nurse or patient needed. As the dialogue unfolded, additional questions for clarification were asked and the participants were encouraged to share thoughts about the role, which were not directed by the interview questions.

Conducting the interviews onsite at the facilities may have made participants wary of sharing institutional information that could be considered confidential. To overcome this limitation, the researcher utilized skills for engaging in an empathic, trusting relationship with the informants, including truly listening and using silence. The individual interviews were recorded and transcribed verbatim by a professional transcriptionist. The researcher listened to each tape and verified the accuracy of the transcription prior to beginning data analysis.

The researcher also kept a journal throughout the study. This personal journal contained the researcher's ongoing field notes, ideas, assumptions, reactions, and feelings about the study. The journal provided a reference for the researcher to make the link between the relationship of these findings to the caring leadership theory as well as to the review of the literature.

Data Analysis

Data analysis began after each interview session. Parse (2001) describes the following steps as being part of the process for data analysis of qualitative descriptive exploratory studies:

a. Identifying major themes according to the objectives in the language of the participant(s).

b. Reading the transcribed text of the interview while listening to the audiotape.
c. Identifying and separating major ideas contained in the data about the phenomenon of concern.
d. Identifying and separating major ideas common to all participants.
e. Naming representative themes of the major ideas common to all participants.
f. Stating major themes according to the objectives in the language of the researcher.
g. Constructing a description of the phenomenon from a synthesis of the themes in the language of the researcher.
h. Moving the description to the level of science in the discipline—for example, nursing (p. 58-59).

This method focused the researcher on immersing herself in the data transcriptions, reading and rereading the interviews, and coding the data until themes emerged. This was an inductive process. Initial codes for theme development evolved while reading the transcripts that were in the language of the participants. Similar codes then were grouped together. As the researcher continued reading the transcripts, major ideas or subthemes about the phenomenon of being a charge nurse emerged from the codes. Subthemes that were common to all participants then were grouped. From the subthemes, themes that described the charge nurse experience were identified. Objectives of the study were supported by the themes being named in the language of the researcher from a caring nursing leadership lens. In interpreting the language of the participants, the perspective of the researcher comes through as intended in the Parse (2001) method of analysis. The meaning of each theme then was summarized. Themes

then were strengthened with exemplars from direct quotations from the interviews in the discussion.

Data generation and data analysis converged and informed one another. Interviews were coded as the interview process continued so that each enlightened the other (Sandelowski, 2000). The researcher selected MAXQDA software to assist with data management and analysis. This software permitted the researcher to make memos while reading the transcripts. This process allowed for further reflection on codes, emerging subthemes, and themes at a later time.

Using narrative analysis, the researcher additionally looked for patterns in the stories from the interviews, "identifying common themes and core plots in the stories" (Parse, 2001, p. 44). The core plots were used to describe and interpret situations where charge nurses were able to provide support, or were not able to provide support, which would make a difference for a staff nurse or patient. Exemplar stories were selected for each of the contrasting queries of support or no support being provided by the charge nurses. These stories then were each reconstructed to shape them and make them more readable, while staying true to the participant's intent. Reconstructed stories, however, do allow the researcher to weave in their perspective of the phenomenon being discussed (Smith & Liehr, 2005). The meaning of the story from the researcher's perspective then was identified in the title of the story. The researcher next wrote a reflective synopsis (M. C. Smith, personal communication, February 8, 2011) to capture the whole of each story of support or no support from the lens of caring nursing leadership. Common narrative threads from within all the stories then were shared.

Methodological Rigor

In qualitative descriptive exploratory research, it is important that the researcher strives to enter the world of the participants by identifying and setting aside frank preconceptions from experiences, the literature review, and personal biases during the actual interviews. Guba and Lincoln (1981) discussed four factors related to rigor in qualitative research: credibility, applicability, auditability, and confirmability. Truth in qualitative research is based on credibility. This study was credible because the descriptions of the phenomenon resonated with the study participants (Sandelowski, 1986). Member checking when the study findings were presented to the participants contributed to this credibility. Participants reviewed and confirmed that the study findings reflected the experience of being a charge nurse in acute care practice. The researcher reviewed the process for data analysis with one participant from each of the four facilities. Each participant was shown their transcribed coded interview in MAXQDA along with the subthemes and themes that emerged from the findings. All four participants agreed that from the data they were able to recognize the experience of being a charge nurse in acute care. Guba and Lincoln (1981) link applicability to fittingness. Fittingness, which in later work was termed transferability (Lincoln and Guba, 1985), is present since the findings can be used in context outside of the study. Providing rich descriptions of the phenomena being studied contributes to applicability. Direct quotations from the charge nurse interviews are included in the discussion. Auditability, which was termed dependability (Lincoln and Guba, 1985), is the criterion for consistency or reliability. This study is auditable as the members of the dissertation committee can follow the researcher's decision trail in data analysis. The study

demonstrates confirmability as credibility, applicability, and auditability have been established. Confirmability is present as the findings "reflect the participants' voices" (Polit & Beck, 2010). Additionally, the researcher's reflective journals provide affirmation and contribute to confirmability regarding the findings.

Space and method triangulation (using multiple sites, interviews, and documents), an audit trail, and member checking contributed to the quality of the data collection in this study. Space triangulation was present as data were collected on the experience of being charge nurse at multiple sites (Polit & Beck, 2010). Method triangulation is evident as data were collected from documents at each facility and from participants at each facility. MAXQDA software permitted the researcher to memo and develop a comprehensive audit trail of all decisions made as the data were analyzed.

Strengths of the Study

The findings from this study provided insight into what it means to be a charge nurse in acute care practice from the perspective of those in the role. A rich description of the participants and the practice settings was given within the study to facilitate the ability to transfer the findings to charge nurses in other acute care settings. Strengths of the study include the large sample size, the diversity of ethnicity and education within the participants, and the diversity of the hospitals. The credibility of the researcher, in terms of qualifications and experience with the study phenomenon, contributed to the confidence in the data that were generated (Polit & Beck, 2010).

Limitations of the Study

Trustworthiness of the study can be impacted by the participants' biases, or their endeavors to tell the researcher what they think they want to hear. The conduct of the

study at the participants' work sites may have made participants less likely to share sensitive data. The charge nurses in this study were markedly positive in their responses. This may have been due to the nature of responses that can be expected from people who would volunteer. Self-reporting may be a factor in these positive upbeat replies. The researcher could have asked specifically how support was provided for the charge nurses, which might have caused the participants to elaborate on one of their biggest challenges, which is their ability to accomplish all of the expectations of the role.

Perceived issues with power in the researcher's role may have existed if the researcher was known to the participants. Participants may have felt obligated to engage in the study because it took place in their work setting. An additional limitation of the study is that the study sample was composed of an all female subgroup of charge nurses working only on medical-surgical or telemetry units in four acute care hospitals in one geographic area. The sample also only included charge nurses assigned to the day tour of duty.

Chapter Summary

This chapter presented qualitative descriptive exploratory research with methods of explanatory narrative inquiry as the approach for describing the experience of being a charge nurse in acute care practice, and for growing in understanding of how charge nurses live caring in their support of nurses and patients. The design of the study was addressed, as were the procedures for methodological rigor and protection of human subjects. Processes for analyzing the data that were congruent with the methods were introduced. In the next chapter the findings will be presented.

CHAPTER 4. PRESENTATION OF FINDINGS

The purpose of this chapter is to present the findings of this study, which answered the research questions: What is the experience of being a charge nurse in acute care practice? How do charge nurses live caring in their support of nurses and patients? To understand the role of the charge nurse and how charge nurses live caring in their support of nurses and patients, 20 charge nurse participants were interviewed and data were analyzed using processes consistent with a descriptive exploratory method and explanatory narrative inquiry.

In response to these questions, the major themes will be shared and grouped under the two objectives of the study: 1) To describe the experience of being a charge nurse in acute care practice and 2) To discover how charge nurses live caring in their support of staff nurses and patients. Each of the themes will be described. Then exemplar quotations from which the themes emerged will be provided. Representative samples of the participants' stories of how they gave support or were unable to give support to nurses and patients will be presented.

Development of Themes

The descriptive exploratory method as described by Parse (2001) was utilized as a guide for analyzing the data. To organize the transcribed data from the interviews, first the researcher coded the interviews using MAXQDA while reading and rereading the transcripts. These codes are shown in Table 2.

Table 2

MAXQDA Codes

Code	# of Times	#of Participants
Safety	55	20
Follow-up	39	14
Quality	43	17
Monitoring	88	17
Educate	18	9
Advising	46	17
Thinking	25	11
Possessive	11	7
Team	42	18
Leader	12	7
Delegation	21	11
Communication	41	16
Putting it all Together	35	17
Coordination/Collaboration	70	20
Discharge	34	13
Professional Development	28	20
Patient Assignments	75	20
Providing Resources	10	6
Fast Pace	23	13
Flexibility	14	8
Being Fair	12	6
Acuity	24	15
Flow	40	15
Human Resource Functions	34	13
Pleasure in Role	18	12
Make Difference	27	11
Go to Person	20	11
Putting Out Fires	18	11
Customer Svc/Satisfaction	60	16
Providing Help	83	18
Mentoring	55	18
Patient Advocacy	51	17
Family	20	10
Nurse Support	66	16

After extensive review of the transcripts, the codes were clustered into subthemes, which are presented in Table 3.The subthemes were clustered into the major themes that reflect the meaning of being a charge nurse in acute care. Moving from codes to subthemes to themes was an inductive process. A second researcher with expertise in qualitative coding reviewed five of the transcripts in the language of the participants and confirmed the findings for theme development. The naming of themes and subthemes were informed by the lens of caring nursing leadership.

Objective 1

The first objective of the researcher was to describe the experience of being a charge nurse in acute care practice. There were eight themes that described the experience of the charge nurse: *Creating a Safety Net, Monitoring for Quality, Showing the Way, Completing the Puzzle, Managing the Flow, Making a Difference, Putting out Fires,* and *Keeping Patients Happy*. Each theme will be discussed separately.

Creating a Safety Net

The subthemes that contributed to this theme were *Keeping Patients Safe*, *Setting Safety as a Priority*, *Creating an Environment of Safety*, and *Providing for Staff Safety*. Safety was introduced into the discussion by 12 participants, including all of the charge nurses from hospital A, before they were asked, “How does the charge nurse role impact patient safety?” On six occasions, safety was described as being a priority and, for some, as the goal of patient care. The remaining six participants mentioned safety when explaining their activities as a charge nurse on a typical shift.

Table 3

Themes and Subthemes

Themes	Subthemes
Creating a Safety Net	Keeping Patients Safe
	Setting Safety as a Priority
	Creating an Environment of Safety
	Providing for Staff Safety
Monitoring for Quality	Checking Back
	Vigilantly Guarding Patient Care
	Maintaining a State of Watchfulness
Showing the Way	Advising Clinical Practice
	Leading the Team
	Setting an Example
	Guiding Decision-making
Completing the Puzzle	Putting It All Together
	Coordinating Care
	Maintaining Collaborative Connections
Managing the Flow	Balancing the Staffing
	Fast-paced Environment
	Getting Caught in the Middle
Making a Difference	Appreciating the Role
	Close to the Bedside
	Quantifying Value
Putting out Fires	Frontline Go-to-Person
	Responding to Calls
	Problem Solver
Keeping Patients Happy	Listening to Concerns
	Promoting Patient Satisfaction
	Doing My Rounds
Jumping in the Trenches	Second Set of Hands
	Keeping Them from Drowning
	Advocating for Staff
Nurturing Staff Growth	Setting an Example
	Giving Encouragement
	Building Confidence
Offering Authentic Presence	Advocating for Patients
	Providing Information
	Supporting Decision-making
Looking after Nurses	Keeping Staff Happy
	Promoting Caring for Self
	Honoring Scheduling Requests

Charge nurses in this study wanted to create an environment that fosters safety for both patients and nurses. Being the “eyes,” “different eyes,” or “another set of eyes” was a descriptor put forward five times in relation to providing another perspective that leads to safety. According to these participants, the charge nurse frequently picks up on something that has been missed by more than one primary nurse. Participants saw charge nurses as buffers who catch things that are not as obvious and have potential for falling through the cracks, which may result in errors. Frequently, it was the charge nurse who stepped forward and spoke up if there was a break in policy or a risk that could jeopardize safety. Because they have no preconceptions from the specific patient handoff or report, the charge nurse perspective was described as fresh and untainted by any bias.

Participants stated that charge nurses protect nurses and patients from outside stressors that could impact safety. To be effective in this aspect of the role, participants identified that it was necessary to come to know patients and staff through caring. Promoting safety includes ensuring that nurses are not feeling overwhelmed and that they are practicing with a clear mind as well, free from distractions. On busy days, one participant’s primary goal was just to keep everyone safe and thriving.

Adequate preparation and planning by the participants was seen as contributing to providing a safe environment for everyone. These charge nurses initiated safety rounds, including checking equipment, maintaining a physical environment that was free of hazards, and making sure supplies were in reach.

According to the participants, patient assignments were related to safety. Charge nurses in this study assessed a team of patients from a comprehensive perspective. They

anticipated variables that created unsafe circumstances, acknowledging that experienced nurses must care for the most critical patients to keep them safe. Participants stated that they assume that inexperienced nurses will check with them before engaging in any procedures, skills, or competencies with which they are unfamiliar.

Participants voiced that safe patient care includes identifying and responding efficiently to any changes in patient status. These charge nurses knew that they were able to get things done quicker because of their role authority, so it was important that they intervened early. Additionally, they often assisted with acute patient transfers.

Participants stated that they often provided the evidence for nursing interventions pertaining to pain management and nursing sensitive indicators. When safety initiatives were introduced, these charge nurses were tasked with helping the nurses realize the importance of incorporating the processes into their care practices. Participants helped staff nurses relate these initiatives to their own specific goals of keeping their patient's safe, informing them of organizational agendas, and the importance of not developing workarounds.

Fay's statement illustrated creating a safe, caring environment by remaining attentive to both patient and staff responses to situations:

> Patient safety…That's my number one goal…make sure every patient is safe and cared for properly; pain free, well not pain free…but as …comfortable as possible. Everything…is centered around the patient, and …in order for a patient to be safe, the nurse has to not be so overwhelmed. Otherwise, she's not going to be able to give the best care to the patients. I try to look out for nurses that are overstressed.

Isabel actually saw herself as the "safety net," viewing the patient from "different eyes:"

> I think it's very important…we're…the safety net. When I go in a room …I look at it from different eyes because I'm not the primary nurse who has already … been given a report and a certain picture of the patient. I…go in with a fresh view. A charge nurse can be a really good buffer…catching…some things that aren't as obvious on …first glance...I usually have accumulated knowledge because I'm here much more often…a little more insight into some of those overall things…I think having those fresh eyes to kind of look at a situation differently and then helping them connect the how's and why's we have certain safety measures in place…helps them utilize it more for the patients.

The importance of identifying risks from physical and emotional factors that can compromise safety was vividly described by Kelsey:

> I think…the biggest thing is safety. That is …my number one thing. I mean that every single body on this floor is safe. I can't even stress it enough, whatever the nurse assignment is, whoever the physician is and safety in …a broad sense …not only safety as in safety from an injury…people …with clear minds. …Safety that you can assess and see that a nurse is not herself and that she may be having issues and she may need to go home…She doesn't feel well. Whatever it is, it's becoming an unsafe environment for everybody...It helps just to let them vent…Maybe they can't vent anywhere. Maybe there's no one there and it can be ANYTHING…but it jeopardizes the nurses, everybody...You'd be surprised…the things that you can identify and kind of nip in the bud. So my big

thing is safety.

Monitoring for Quality

Checking Back, Vigilantly Guarding Patient Care, and a *State of Watchfulness* are all subthemes that contributed to the development of this theme. The participants mentioned the importance of being the "eyes" or the "second set of eyes" four times again in reference to this aspect of their role.

The vigilance that was described here is with patients, with nurses, and between patients and nurses. These charge nurses were monitoring patients and monitoring nurses. They were making their own rounds to make sure that all was well. Watching over the care process allowed them to oversee and verify that patients were getting what they needed and deserved from the nurses and the healthcare system. Participants checked to see that patient rounding was being completed every hour. They described every aspect of patient care being monitored in detail, and worked to ensure continuity of care. There was accountability for making certain that patients were prepared for the operating room or that there were no delays with diagnostic testing, and that nothing interfered with seeing that these procedures were completed.

Participants maintained a state of watchfulness to see that all went smoothly. The purpose of this surveillance was to allow for early identification of signs of patient or nurse distress so that the charge nurse could ensure that nothing was missed and desirable outcomes were promoted. Some of these charge nurses described feeling like they were "all my patients," as they looked for trends in laboratory data and notified the physician for orders in response to diagnostic information. Participants said that they tried to round with physicians because nurses often were unable to do so.

Participants described checking all of the regulatory measures to ensure completion, and to evaluate outcomes. They were the lookout persons who made sure that the nurses had all of their "ducks in a row," and that quality patient care was being given. The tasks of these charge nurses broadened to ensuring that nothing was missed in terms of patient care, that ineffective therapies were replaced or enhanced in response to patient and diagnostic indicators, and that all essential information was documented.

Aida defined her oversight responsibilities as extending to all members of the healthcare team:

> If you are charge nurse, you are monitoring their care, make sure everybody follows policy, procedures… everybody follows the patient safety rules and that there is quality of care. Even the doctor…you make sure the doctor sees the patient every day…In the documentation…making sure they address the patient's main concern. Making sure the nurses…do their rounding…taking care of patient needs from assistance to the bathroom, medications, food and everything. Make sure patient care assistants clean up …patients …round on their patients, and respiratory therapy gives nebulizer treatments. Make sure they do what they're supposed to do. Even case managers, social workers, make sure they coordinate care and discharge the patient safely, everything from admission to discharge. Charge nurses...need to do monitoring, and make sure everything is done.

Isabel shared her thoughts about needing to be accountable and oversee care for all of the patients on the floor. Her attentiveness extended to striving to know all of the patients and all of the nurses on her unit:

I feel that when I step on the floor…I have 24 patients; they are all my patients. I feel responsible for all the patients on the unit so that's why I feel like I'm overseeing. I can't be…there for all the direct care of those patients,…but I try to have that overview of knowing their care plan, where they're at and any new things that happen throughout the day…so I feel …that I really know each and every patient, and then I also…have to really know each and every primary nurse that's taking care of those patients.

The need for monitoring core measures was espoused by Tina:

Making sure our population is up to date on their immunizations…it's been a teaching process with staff. I…check them, help them…when they're not doing them and also teach them that they need to make sure that they check those on patients before they are discharged. A pneumonia…or flu shot must be offered if it's season. It's to the point now that I don't have to …check that much because now they're doing it. It was the same way with the strokes. They know exactly what the criteria are for discharge...What they need to have…if it's a core measure with CHF…making sure they have their teaching packet…checking to find out what their…EF is. Find out if their on an ACE inhibitor, or not, and…that those things are…documented…we try and make sure that when the patient leaves, they're on the right medications. If they had a stroke, they need to be on Zocor or Lipitor…make sure they're on the right diets and that we do…teaching.

Showing the Way

The theme of *Showing the Way* emerged out of the subthemes of *Advising Clinical Practice*, *Leading the Team*, *Setting an Example*, and *Guiding Decision-Making*. These charge nurses frequently referred to the staff nurses on their unit or team as "my" nurses, one even extending that to "they're like my family." Within this distinction there was an implied obligation to those nurses. Participants described the importance of leadership; team and delegation competencies were described only minimally in relation to their role.

Participants wanted to feel confident that their nurses would come to them if they needed to. They felt it was critical that they were able to do themselves what they were asking of the staff nurses. They brought clarity to the nurses by looking at the big picture, which provided for balance in patient care. They liked to be in the center of activities, making suggestions, informing or influencing courses of action to bring about desirable patient outcomes. These charge nurses frequently guided staff nurses through communicating with physicians to obtain desired orders.

Participants described being with, listening, and remaining accessible as important concepts for leading the team. They "lead by example," role model, and earn trust by meaning what they say. Participants needed to know their nurses at a personal level, including what sustained them, so that the perception would be that "we're all in this together." Sometimes they stated that it was best if they stayed at the center of the team and facilitated the process, while letting others lead. Their role was to "do the other part" for the team, describing themselves as serving by leading, while working alongside the staff nurses.

The participants frequently used expert intuition to answer questions and engage in problem solving. Descriptions were given of their learning, taking place from repetitive decision-making. Participants helped the staff to "think outside the box," providing another perspective. Sometimes they made referrals to other available services to assist the staff nurses and patients. Providing safe quality care guided their decision-making processes. To the participants it seemed that everyone looked to them for answers.

Kelsey described the importance of being able to think on your feet and feel confident in your answers as the charge nurse:

> You learn to…make decisions and trust your judgment. In charge…everyone looks to you for answers for…their issues and concerns. Patients, respiratory, the doctor, the nurses, the nursing assistant, the visitors, so you have to learn to trust yourself…whatever decisions you make,…learn from them. Nurses, you…try to make them…think. They'll come in and say, "Should I call the doctor?" I'll…tell them "What are the concerns you have?" Because…they want to hear that "Yes, I should call the doctor." But I want them to tell me…what they saw…I… tell them, "Show me the patient." "Give me the story about the patient….What does the progress note say?" Basically you're making decisions about patient's lives. It could be something simple that you're answering…but…when they go to that room…It's time for code rescue…Those are the decisions that you're making. I…tell the nurse, "Here, this is what we're going to do." Then you'll have a code team walk in and say, "Why did they call us?…I…let that nurse know, "I am behind you 150%...I don't care what anyone

else says, you're judgment is what I want you to trust and believe in." You're making those types of decisions…when to call a doctor, when to address the supervisor.

Hannah took pleasure in being the resource person with the knowledge necessary to advise the team about patient care:

> It's…a lot of hard work, a lot of stress at times but…it's rewarding to be able to see the patients every single day, see the progress that we're making…as a resource person for the nurses. That's rewarding and…it's helped me learn…more than I would have just being a staff nurse because being that resource person, I have to…make sure that I stay up to date to what's going on in the unit…as far as changes happening…knowing the resource people that I…wind up knowing. It's…given me a…really broad view of nursing that I didn't have before as a staff nurse.

Olive described the importance of leading by example:

> If I'm going to preach it, I'd better be able to do it. I don't believe that you should preach something that you're not going to do because it doesn't set an example. A charge nurse is supposed to set an example for the rest of the staff and I find that some of the newer nurses…follow that lead and I find some of the older ones that are set in their ways,…have a little more difficult time in doing it. Unless someone says, "Well, that's how we need to do it." And over time, they eventually wind up doing it. It's just that it's a little harder.

Completing the Puzzle

Subthemes that led to this theme were *Putting It All Together*, *Coordinating Care*, and *Maintaining Collaborative Connections*. In response to the question related to their needs for professional development, charge nurses in this study identified the need to be assertive, while not being confrontational, when engaging in interprofessional relationships. Developing confidence in communicating and relating to people at all levels was important. These charge nurses desired to develop conflict resolution skills in response to some of the challenges they faced with fostering these connections.

Participants used terms like “hub of the wheel,” “facilitator of knowledge,” “all knowing,” and “we’re the glue” in reference to their role in weaving together interprofessional exchanges. These charge nurses described looking at the big picture, while remaining cognizant of everyone’s concerns. One charge nurse expressed this as “pulling everybody together.” They saw themselves as facilitating collaborative exchanges between physicians and other disciplines, which were necessary to transition patients to the next level of care. In many cases they were information sources for consultants. Participants sometimes rounded with physicians and then communicated necessary information to the nurses.

Participants described working “hand in hand with” case managers. Discharge planning and controlling length of stay required collaboration. Many times the charge nurses proactively intervened, anticipating discharge, and facilitating the patients needs being met from pharmacy, respiratory, social work and other professionals in a timely manner.

Their goal was to ensure that everyone was on "the same page," coordinating care to promote effective patient outcomes. The participants were liaisons between the nurse and physician for a variety of reasons: to provide for efficiency and time management and to intervene when staff nurses were fearful of having dialogues with physicians. Participants stated that charge nurses must be advocates for getting the physicians to communicate together on the patient's behalf and to ensure that they then communicate with the patient.

Aida explained this process of *Completing the Puzzle*:

> I put every piece of it together…we have so many consultants, and everything on one patient case. I go back there, sit down with the family…with the patient and explain…what's going on…what the diagnosis is…what…interventions…we are doing, what Dr. A, B, C, D, are doing. What the plan is, if they need discharge…if they're waiting for the INR to come up to be therapeutic to send them home…Sometimes I call the doctor back and say, "Listen, I need you to explain a little bit more in detail because they still didn't get it." Or sometimes you find stuff that the doctor is missing…the piece of assessment that the doctor missed, and you point it out to the doctor.

Hannah stated:

> I'll tell this to the family members…when they ask me, "Well what is a charge nurse?" We're the persons who help everybody stay on the same page. We want everybody to be informed…We want the doctors, the nurses and the patients, all to be…communicatin …and knowing what's going on.

Perhaps Kelsey said it best when she described how the "puzzle comes together:"

> "You're like the umbrella and everybody's underneath it. You know? So you kind of just …You're all over, but you're all over in the sense that…it makes sense. The puzzle comes together".

Managing the Flow

Subthemes that contributed to the theme of *Managing the Flow* were *Balancing the Staffing*, *Fast Paced Environment*, and *Getting Caught in the Middle*. The importance of being fair, flexible, and providing adequate resources oddly were not coded for a large number of the participants. However, resources were discussed in terms of material resources and people resources. A few charge nurses did discuss fairness in terms of patient assignments. Participants had difficulty describing the care delivery models utilized on their units when asked, although most described team nursing. Statements were made about the need for understanding financial implications to be flexible in decision-making regarding patient flow. Several participants discussed that they were required to attend meetings, which, at times, interfered with *Managing the Flow*.

Participants wanted to do what they could to provide staff nurses with time needed to care for their patients. The goal for managing flow was to create a balance in the fast paced stressful unit environment. Patient assignments were made to promote continuity of care, while factoring in acuity and staff competencies. They also attempted to balance the assignments of the patient care assistants in terms of acuity and those requiring total patient care.

The turnover in patient volumes was frequently acknowledged. Participants did not want to keep the patients waiting too long. Yet, they felt obligated to try and control the pace for the nurses so that it appeared manageable and not overwhelming. One of the challenges was that, at times, the staff nurses would push back if they felt that they were being given more than they could handle. Participants described receiving up to 8 to 10 admissions on their unit in a day, while having 10 to 15 discharges. Periodically, the charge nurse had to take report, do an admission, or facilitate a discharge to keep the flow going.

These charge nurses saw their responsibilities for patient flow as impacting the hospital on a larger scale. There was an inner struggle in being caught between the nurses and the organization, while attempting to foster an environment that supported human caring. When participants were trying to prevent delays in patient care and provide for patient safety, they were caught in the predicament of being pulled in two directions at once. This made them feel that management was out of touch with what was occurring at the unit level.

Betty described her challenges with *Managing the* Flow:

> My challenge is when I have ER calling me, wanting beds and my nurses have so many patients. They're busy; we're getting patients from direct admit; we're getting patients from the OR, and…it's difficult…to keep the pace. You have to keep them running. You have to get them in; you have to get them out. There are times where I have to take report. I have to take the patient. I have to make sure….they're taken care of.

Fay also spoke about the chaos and the need to maintain balance:

I've got people sitting in PACU…so it's my job to provide those beds. Immediately…I start formulating a plan of how I'm going to provide those people with beds…This nurse has four people receiving blood products and four fresh post-ops and this one has four 'walkie talkies.' That's not conducive to the best patient outcomes, so I mix up the mix so everyone has a balance…staffing assignments, what patients, who's going to float…I try to make sure the assignments are balanced so that every patient gets the right amount of care…and I know my staff skill levels…this one's strong in orthopedics, this one's stronger in neurosurgery, this one's stronger in gynecology, and I try to balance that…We all have our preferences and…strengths.

Kelsey stated:

But I think it makes a difference…when someone comes and looks at the assignment, they'll say…"Hey, you know, she thought about this when she made this assignment. She knew that I would…be real busy here…she's thinking about us and she cares that…if we can't get into a room on time…it would affect…the patient and it will affect the nurse and it will affect the care." That's the kind of thing that you want. Having to deal with the supervisor and…administration…when the nurses are…overwhelmed and they've gotten patient after patient…they want to send five more patients. The nurses haven't even assessed the first set…but they're looking at the number. Well the grid says if you have five nurses, you must have this many patients. So that means you can take the patients. But they don't see what's going on, on the floor. They don't see the safety aspect of it…You learn that you have to take care of the

> floor, the patients and the nurses on the floor. Because the bottom line is that everybody just wants the job done, period. Nurses know they have to get patients. Administration knows that this is the floor that has the rooms…that they staffed up. You're just expected to get it done. PERIOD. Every day it changes,…the way you run the floor when there's 50 is different from when there 40…As a team leader,…you…look…at financials. You have to. You have to say, "You know what, at 3:00 o'clock, I got to send a nurse home."

Making a Difference

Appreciating the Role, *Close to the Bedside*, and *Quantifying Value* all converged into *Making a Difference*. Charge nurses in this study lamented about not being appreciated by both administration and staff for their contributions; however, they described taking personal pride in their impact on unit function. Descriptions were given about finding excitement and joy in their work as leaders, while remaining competent at delivering patient care.

One of the benefits of being a charge nurse was described as being able to still participate in patient care, maintaining skills, while making a difference on a bigger level. Participants expressed they were able to impact more people in the course of the day in their role. One charge nurse said that she would turn down the opportunity to become a manager because she would lose that aspect of being able to get out onto the floor.

Participants communicated about the need to quantify the impact of their role. They wanted everyone to understand and appreciate what it is like to walk in the charge nurse shoes. These charge nurses thought their colleagues often failed to recognize their

value. One participant wanted the staff nurses to realize that she had an entire unit of patients, instead of five. Another charge nurse described a previous place of employment briefly getting rid of the charge nurses and then needing to bring them back to manage the volume of orders and phone calls.

A charge nurse declared that she was "the glue." One said that if you "have a good charge nurse, you have everything." Another described having a seasoned nurse who holds the unit mission close as being invaluable. Participants stated that they enjoyed being in "control" of the unit and embracing challenges. One participant relished the "broad view of nursing" that being in charge gave them. Charge nurse work was described as being wonderful, fulfilling, rewarding, and exciting. Participants discussed having the ability to make a difference for both patients and staff nurses, while remaining close to the bedside.

Ellen expressed the importance of the charge role:

> The way staffing is now…with the acuity of the patients that we have…I don't think it's as effective when you do not have a person in charge...To make all those phone calls,…check all those labs…answer all those questions for the doctors,…help all the new nurses…to just keep track of what's going on…on the floor.

Hannah stated:

> I would like everybody to…see what we do because a lot of times I think they get the impression that we're just that person floating out there, like not really having any kind of responsibility…I'd like staff nurses to be able to see…more of what our role is…Before I did it, I didn't understand what it entailed.

Olive wanted management to experience the charge nurse role:

> I…think that unless you're in that position, you…don't have a good grasp on it…that's why we're always saying "I think all management should spend one day shadowing the charge nurse." I understand it's a business, but still you have to understand there are human beings behind that business that make it happen and make it work.

Libby extols the rewards of being in a charge nurse:

> I just like being a charge nurse. And I think what I like…it keeps you grounded in the sense…it still keeps …your skill. I like to…stay on the floor…I like to interact and go and help the nurses…doing everything possible for the patient no matter who they are…and make sure the nurse is also supported. So the nurse, in return can take care of the patient.

Putting Out Fires

Being the *Frontline Go-to-Person, Responding to Calls,* and *Problem Solver* are subthemes for *Putting out Fires*. Charge nurses in this study saw themselves as the front line go-to-persons who smoothed out problems and put out fires before they started. They responded to a variety of calls in an expedient manner. Three participants described themselves as the "go-to-person." Three different people also referenced their role in "Putting out Fires." At least one participant said she "wears a fireman's hat" in her day-to-day duties.

Participants stated that they fixed and resolved problems. It was their role to make sure that everything on the unit ran smoothly and to intervene when anything threatened to disrupt the flow. Participants knew that they must respond rapidly to

resolve conflicts to reinforce the staff confidence that they would be intolerant of anything that disrupted the staff's ability to work together.

As a charge nurse, participants shared they had the ability to "get it done." Everything was on their shoulders. They were the "front-line person" of the "command unit." They also described themselves as "captain of the ship." Staff looked to them for guidance and they interceded when necessary.

Betty felt she was expected to remain available for questions. "I'm available for the doctors, for the patients…I basically run the unit and it's a big job." Cynthia stated, "There are some…nurses…they will run out of the room and try to leave…because they're not sure so I have to calm them down and to try to fix the problem if there is one." Fay described "being the resource person; for nurses as well as patients, as well as physicians…basically you know, you are the go-to person...My job is putting out fires most days." Hannah enjoyed "Being the go-to person, helping them out when they…are stressed…helping them resolve any issues clinically…or with each other that need to be handled and…just being back-up for them, and being there for the patients.

Keeping Patients Happy

Listening to Concerns, Promoting Patient Satisfaction and *Doing my Rounds* were the subthemes of *Keeping Patients Happy*. Participants kept patients and families happy by making themselves available to them. They were open to hearing concerns and worked to elicit them. Participants described doing a great deal of listening when rounding on patients.

Charge nurse participants had to come to know what patients valued. This required the commitment of time and participants made frequent rounds and visited

patients. They left their contact information and offered their services on the patients' behalf. They wanted to make sure that the patients knew them and their role.

The participants saw their role as integral to patient satisfaction scores; as charge nurses they took the time to sit with a patient when they sensed that a situation might be escalating. They were sensitive to the need to act and responded right away.

Betty discussed her activities on a typical day:

> I round on my patients. I go to each room. I make sure that they know I'm there for them. I'm available and if there's anything they need…they can call me directly…if there's any issue that the patients have or concerns, I make sure the nurses are aware of it…I go in there and I…can spend a good five to ten minutes with a patient. Sometimes longer if they just want to talk.

Cynthia detailed the charge nurse role in keeping patients satisfied:

> I try to keep the patients satisfied. We want to get our patient satisfaction scores up…that's why when I do rounds, I try to…walk in with a smile and…talk to them. Some reactions are, "Oh! It's nice to see you…they act as if it's the first time you see them… I know the night charge nurse goes around and greets the patients...you need to get the patient satisfaction scores up and…doing our rounds and making sure the nurses are doing what they're supposed to be doing is…how we're going to get it done.

Service recovery is described by Isabel:

> I do…service recovery. I like to think with the rounds it doesn't happen as often but there's usually…some kind of issue. And the nurses know that…at the first glimpse that there might be a remote possibility of…something being wrong,

they know I want a heads up because I'd rather go in that room and start early, because then it's likely not to be an issue.

Objective 2

The second objective was to discover how charge nurses lived caring in their support of staff nurses and patients. There were four themes identified to describe how charge nurses lived their caring. These themes were: *Jumping in the Trenches*, *Nurturing Staff Growth*, *Offering Authentic Presence*, and *Looking after Nurses*. Each theme will be discussed separately.

Jumping in the Trenches

Jumping in the Trenches is the first theme to reflect how charge nurse lived their caring in support of patients and families. The subthemes were *Second Set of Hands*, *Keeping Them from Drowning*, and *Advocating for Staff*.

These charge nurse participants reported that they frequently offered an extra pair of seasoned hands to colleagues who may or may not have realized they needed support. Some stated that they first must recognize the perspective and experience of the staff nurse to know when they should offer themselves to assist colleagues. Some participants emphasized that they must come to know their nurses on a personal level to recognize their strengths and opportunities. At least one charge nurse felt she was "always at the right place at the right time" to do what she could to alleviate any pressure that the nurses felt.

One literal description of this help was "I'm putting on my boots." Every effort was made to be aware that a nurse was "drowning" and may need assistance. Sometimes it meant zeroing in on an issue with one specific patient. At other times it

involved passing medications or starting an intravenous access. The participants acknowledged that often they were able to get the catheter in because they had the luxury of not being stressed and so they had mental clarity and time to complete the task. They recognized that assistance with these small tasks might be what got the staff nurse "over the hump." They offered to do whatever was the most time-consuming. Sometimes they helped by finding the appropriate staff person to assist.

Aida talked about knowing her nurses on a personal level:

> In terms of working with your nurses, you know…each individual…their strengths and their weaknesses, and sometimes they don't need to ask me because I know my nurse at personal level so I know what their weakness is. I am there all the time to help them. Let's say some nurse has a weakness in dealing with…difficult family members. I don't wait until the family member...attacks my nurse. I usually intervene before that point…by being the role model and the nurse will learn…from you and the next time they will intervene better with the family member.

Fay expressed that she didn't want her nurses to feel like they were overwhelmed. She was concerned that a staff nurse might get caught up with the care of one patient and not be able to get free to continue providing care for the rest of the team:

> You watch to see that the nurse is not so encumbered by one person's care that they can't see their way out; that they're not swimming in the weeds…It's hard for nurses to ask for help sometimes…I try to pick up on it. Like right now, I was just doing the schedule, and I went up to all the nurses and I said, "You

know, I may not see you drowning, because I'm concentrating on the schedule. If you need help, please don't hesitate to come get me". Normally I would see them drowning and just step in.

Gail described some of the many ways she is quick to step in and lend a hand:

What can I do to…help your day? I can't document for you so if you want to sit down and document, I can give meds, change dressings, give baths, change diapers…whatever needs to happen. Also when we have to do drugs like Adenosine…I'm actively there…most of my nurses are very qualified for that, but it's always a second set of hands. Because everybody gets nervous…when you're going to stop a heart rate. It's just…a second set of eyes, to help.

Kelsey felt that some of the long time nurses may not be so quick to let the charge nurses know that they could use some support:

For a nurse who's been here, you have to kind of like jump in the trenches. You can tell when someone's running around…questioning something, that's where you supply support. You got to go and say, "What's going on? What do you need?"…Because no one's saying anything. That's how you do it…with those nurses. I think it's a role that you have to do. You…identify that there are issues…Even though they're not saying…because they're not going to… they've been nurses a long time…it could be something simple and…they don't come to you…you just have to go in.

Finally, Tina described how she assists the staff:

I kind of do what everybody else can't do…because I don't have an assignment…l'll do whatever I can to help them…because it's that pair of

hands…you can…take that burden from them. I can stay with the patient. I can call the doctor…get the orders…so she can do what she needs to do…I think they appreciate that I'm here…Sometimes it's just helping them with a few little things and knowing that you're there kind of gets them over the hump...Being that extra pair of hands helps…you can pick up that the nurse is having a difficult time…there are some nurses that won't ask for help. You just have to know that they need it. I'll go to the secretary and say, you know, if you see anybody that looks like they're having a hard time, just call me…Some of them feel like they can do it all. And then that's when they get burnt out…because they don't feel like they're getting the support.

Nurturing Staff Growth

Charge nurses in this study demonstrated *Nurturing Staff Growth* by *Setting an Example*, *Giving Encouragement*, and *Building Confidence*. They nurtured the growth in staff by mentoring.

The participants described nurturing novice nurses as they learned how to engage with more experienced colleagues. They provided encouragement so that the novice nurses could move out of the "nest" and build confidence. New nurses often do not understand situational urgency, so the charge nurses assisted them with prioritizing. Some described being physically present with novice nurses as they increased their knowing of nursing. Sometimes this support came in the form of assigning a more experienced nurse as a mentor. Participants developed processes for checking in to see how the novice nurse or new nurse to the unit was progressing. They looked for specific learning opportunities and kept an "extra eye" on novice nurses; they also made sure

that they communicated in a variety of ways that they were there to be resources for the novice nurses.

Participants described themselves as “natural born teachers.” They “served” the staff nurses by setting an example and guiding them through unfamiliar processes and procedures. Staff nurses were taught what they need to know to take care of the patients. They described mentoring staff nurses in how to engage with physicians. Participants motivated novice nurses to do the things they do not want to do, like caring for specific patient populations or talking to doctors. There was an understanding that those experiences may generate fear and that support was needed to walk successfully through the processes.

Aida stated:

> You know that some new nurses…may not be assertive enough to communicate with the doctor. I sit next to my nurse, I go over all the information first and say “You’re going to call the doctor for this ABC, you want him to order D”…Guide them through the process and then I listen with them talking with the doctor on the phone. We have some difficult doctors and I know who they are…So, with the difficult doctors, I’m…on the phone with them and as soon as that doctor finishes, I say, “doctor A, this is…the charge nurse. I’m on the phone with this nurse. She is new. She is learning, so please be patient.” And I’ll get them through one or two times and then after that they take off.

Isabel described the process for checking in routinely with novice nurses:

> I always encourage them out the nest. I think that they need ongoing assessment of where they’re at…every two weeks throughout the process, supporting them.

Then…a good sit down…every other week…for a good 15-20…minutes. Going over…things…making sure…if I need to send them somewhere for extra documentation or if I need to add on another day…just constantly supporting their progress. I think that really helps instead of just putting them with their preceptor. When…they're off orientation, I never…start it on a weekend because I'm not here. I like to give them that support of making sure that I'm there. I'm there encouraging them and making sure they're not...getting swamped. Then you feel that you're back at square one. So I just kind of keep a little extra eye on them and I'm their resource. I'm always positive. There's no dumb question. I turn everything into a learning opportunity. I feel that…knowing that they can come to me and I'm going to respond positively and help…supports them to move forward, which is always my goal. I don't like to coddle people too much…because I feel that they get…used to somebody doing things for them so…I help them without doing it for them.

Tina discussed making herself available for new staff nurses:

I introduce myself and…talk to them…see how they're doing and everything so as they get out on their own and away from their preceptor; they know they can feel comfortable calling me. I don't want them to feel intimidated or anything by me. I want them to feel…if the patient's going downhill…and they're not sure what's going on…that they can call me right away. We can go over the patient, the chart, the meds…if the blood pressure looks like it's going down…or the heart rate's up…what do you need to do next and…teach them. You need to have…your ducks in a row when you call the doctor…that's a big thing and I

> feel that's something I try and work on with new staff. Teaching them how to call the doctor and not feel intimidated and…knowing what you need to have in front of you because they're always going to ask you something you don't know.

Offering Authentic Presence

Offering Authentic Presence was drawn from the subthemes of *Advocating for Patients, Providing Information,* and *Supporting Decision-making.* Often it was the charge nurse participant who relayed critical information from the patient chart. Participants spent time explaining, talking with, and answering the questions of patients and families. They felt they had the time to perform this vital function because they didn't have a patient assignment. Additionally, they helped to translate medical jargon, to make it real and meaningful for the patient. They also facilitated communication from other disciplines to the patients and families in response to their requests.

Participants often supported patients and families by providing spiritual support as they navigated through end of life issues. Sometimes this support was in the form of lending an ear or providing a personal perspective. The charge nurses advocated with physicians on behalf of the patients to see that their wishes were honored and respected. Participants saw support as being physical too, as in the holding of a hand. They remained physically present with a patient who was dying, or with their loved one.

Aida responded to patient and family expectations for receiving information regarding their care:

> You are the patient advocate…Sometimes you have a patient come to you…and they say to you, "I don't know what's going on, nobody communicates with me.

> Doctors just come in and out for five minutes. They explain things so fast, I don't get it." As a charge nurse, I go over the patient record…I put every piece of it together because…we have so many consultants, and everything on one patient case and then I go…sit down with the family,…with the patient and explain…what's going on…what's her diagnosis…what are the interventions…what we are doing, what Dr. A, B, C, D is doing…and what the plan is. If you're waiting for the INR to come up to be therapeutic to send her home…or they're being discharged and you…need to call the social worker…or the case manager. Sometime I call doctor back and say, "Listen, I need you to explain a little bit more in detail because they still didn't get it." Sometime you find…the piece of assessment that the doctor missed. You point it out to the doctor.

Fay spoke about providing spiritual support and remaining present with a grieving daughter who was mourning the man her father used to be:

> I round on all my patients every day…and their families are a big part of that because they're going to be caring for them when they go home. The other day we had a daughter that was having a really hard time dealing with…her father who had severe dementia. She just was not prepared to see that. It was not her father and…it was almost like a death to her. I found the chaplain. I sat with her…and really tried to help her…she was literally grieving…Because this was not her dad, that wasn't the guy that she knew.

Cynthia supported a family after a death, working through the issues of arranging to transport their dad back home:

> In a situation…where a family member died…I was in the room with them for a…good length of time…just talking…they had lots of questions and…there was this family member who was…taking their dad's body to New York and they had all these questions as to how to go about it…and how they would get…the death certificate. I just called the funeral home and liaisoned with them. I was able to have them talk with him and…explain…I try to calm them down.

Looking after Nurses

The subthemes of *Keeping Staff Happy, Promoting Caring for Self,* and *Honoring Scheduling Requests* led to the theme of *Looking after Nurses*. Three participants expressed a desire to keep the staff from neglecting caring for self because they were "drowning" or "swimming in the weeds."

One way that participants attempted to give nurses emotional support was by making sure that they felt cared for. This support was in the form of moral support, with a "let's get it done" attitude. Participants acknowledged the link between happy nurses and happy patients, stating that staff nurses cannot provide good care if they do not take care of themselves.

Participants gave nurses physical support by making sure that their physical needs were met. They enabled staff nurses to care for themselves. Staff nurses were encouraged to eat and take breaks and to walk away for 30 minutes to recharge. Some even went so far as to take the staff nurse's phone away and gave it to someone else to answer during the lunch break.

Participants also discussed fairness in terms of scheduling. Participants stated their desire to provide staff nurses with time to care for themselves. They strove to

honor and accommodate scheduling requests and recognized the need for staff to have time off. The charge nurses wanted to keep their staff happy by complying with scheduling requests as long as the unit's needs were balanced. Attempts were made to balance the caring for both the individual and the whole.

Fay demonstrated the importance of seeing that nurses take their breaks:

> …not being able to eat...not being able to use the bathroom…if…it's 1:00 o'clock and I know a nurse hasn't taken a lunch break, I'll come up to her and say, "Can I relieve you so that you can go eat?" That's very important. You start to…not be able to think as clearly and…not be as nice a person if you don't get to eat. It's very important for nurses…We…don't like to take care of ourselves. We're always taking care of others and we put ourselves last but in order for us to care for others, we have to take care of ourselves. And that's…one of my biggest headaches. I have three or four staff members that will never go to lunch and I'm constantly…"Just come get something, sit down, take a drink, eat, and take a break. You've got to step away for a few minutes."

Gail mandated that everyone goes to lunch:

> I'm there for the staff. As the surgical's start to roll in…I make sure that these nurses are…happy and that their needs are met. They get lunch. That's a big rule on my floor…everybody walks away for 30 minutes.That's an absolute…there's no reason why you can't…That's the bottom line. Because if you let the floor eat you, it will eat you alive. You'll always be consumed by something. So everybody's got to walk away…and we take the phone away.

Libby pointed out the link between the nurse being supported and the patients being satisfied:

> We're doing everything possible for the patient no matter who they are…and making sure the nurse is also supported…so the nurse in return can take care of the patient. You want to keep a balancing act between the patient being satisfied and the nurse…feeling supported.

Ellen talked about her goals for the scheduling process:

> I personally…do the scheduling. I try to keep the staff happy by trying to accommodate everybody's requests…to work things out between the staff so that everybody has the time that they want because the time off is very important to them.

Credibility of Findings

One participant from each of the four facilities reviewed the researcher's initial coding of their interview in MAXQDA. Then the participants were shown each of the subthemes and themes that emerged from the data. These descriptions of the findings were immediately recognized by the charge nurses in the study, which demonstrated credibility (Sandelowski, 1986). This recognition was reflected in their comments of "the words are perfect," "you have hit everything," "the themes are so intricate that it shows the effort that it takes," "that's right on target," and "I think that is a really good representation."

Participants made individual comments that reflected their agreement with many of the individual themes as well, such as "I put out fires every day, all day," so I tell them to "tell me about the fire before it gets too big." With respect to getting *Caught in*

the Middle, one participant said "sometimes you just can't move at one speed, you have to adjust, minute by minute it changes." Of note was that each of the four participants expressed instant recognition of what this subtheme of getting *Caught in the Middle* represented in *Managing the Flow*. In discussing *Showing the* Way, a participant said "I've been a nurse six years and everybody else here has been a nurse less than that, they come to me constantly." *Jumping in the Trenches* "kind of seals the relationship between the charge nurse and the staff when you're elbow to elbow with them, I have to jump in everyday." *Completing the Puzzle* was described as being "a good analogy." Another comment was "you can make or break a nurse" when *Nurturing Staff Growth*. A participant said "Glad you're doing the study, because it is putting us in the spotlight and you can see our value." Another stated "Charge nurses make a huge difference on how the nurses, nursing assistants, and physicians see the floor." Finally, one participant concluded with "I think you did a wonderful job. It sounds perfect. That is what I do!"

Stories

One of the primary ways that the researcher came to understand how charge nurses lived their caring in their support of staff nurses and patients was by asking them to provide a story of a situation where they truly were able to provide support to a staff nurse or patient that had a significant impact. Participants also were asked to share stories about situations where they were not able to provide the support needed for a staff nurse or patient, which enabled the researcher to grow in understanding of how these charge nurses were not able to live their caring.

The method of explanatory narrative inquiry was used to detect patterns across stories and to identify common themes and core plots. These data were explored in

order to describe the process or events that occurred when support was provided, as told by the charge nurse participants. The process or events when the charge nurses were unable to provide support also were examined. Exemplar stories then were selected that reflected this growing understanding of the process of providing support or not providing support for these participants.

The exemplar stories that were chosen to be presented were first reconstructed to facilitate understanding and aesthetic expression (Smith & Liehr, 2005). Titles were given to the stories that reflected their meaning. A reflective synopsis from a caring lens was written following each exemplar story. Common threads from the stories are shared in a meta-story of how the participants were able to live or not live their caring in common themes, core plots, and patterns across stories.

Exemplar stories of charge nurses providing support to a staff nurse or patient that had a significant impact.

Cynthia's reconstructed story. A story of nurturing staff growth.

The night nurse had made the assignment and given a nurse two patients that had PEG tubes, one of which also had a tracheotomy. The nurse had previously been an LPN and was new to the RN role. She had a total of five patients for the day. She came to me and asked for her assignment to be changed to one that did not have as many complex patients. She specifically wanted to give up the patient with the tracheotomy. After talking with her further, she admitted to not feeling comfortable taking care of that patient. I told her that it was a good opportunity for her get some experience in caring for a patient with a tracheotomy, with the respiratory therapist and I there for support. I encouraged

her to not run away from taking care of those types of patients, so that she could confront her fears. She was able to learn how to suction from the respiratory therapist. At the end of the day I asked her about her experience. She shared that she felt she had truly been able to accomplish something that day, because she had an opportunity to learn to care for the patient with the tracheotomy.

Reflective synopsis. This story clearly reflects how charge nurses nurture the growth of staff nurses through mentoring. This nurse was supported through educational and technological/physiological caring (Ray, 1989) in assuming care for a patient that required integration of concepts, procedures, and equipment with which she was unfamiliar. The charge nurse provided the environment in which the staff nurse felt supported to live and grow in her caring for this patient (Boykin & Schoenhofer, 2001). Through knowing the nurse's capabilities and doing for by providing the respiratory therapist as a resource, the charge nurse used enabling (Swanson, 2008) so that at the end of the day the staff nurse felt confident that she would be able to care for patients with similar needs in the future.

Dahlia's reconstructed story. A story of advocating for staff.

I asked one of the staff nurses to follow up on an echocardiogram (Echo) result for core measures. The physician had already been asked once to read the Echo, because the patient was ready to go home. When the nurse spoke with the physician, he became angry and began yelling at her. He said she was telling him how to do his job. The nurse was almost in tears, and she asked me to do something. I approached the physician and privately asked him not to speak that way to the nurses. I reminded him that they are just trying to do their job, and

that it was his role to read Echos that day. He continued making remarks about the nurse. I called the nurse manager and director, and they responded with a show of force. They came to the unit and we took the physician aside and talked to him. He expressed his opinion. We spoke to him about the hospital's expectations for both the nurses and the physicians. The hospital wants to be the best in core measures. In order to get there, we have to keep checking on each other. We were able to get the physician to recognize his behavior. He apologized to the nurse and the nurse felt redeemed. She also felt important, because we took the time to defend her and addressed the issue with the physician.

Reflective synopsis. This story illustrates how a charge nurse advocated for a nurse using political and legal caring within the bureaucratic structure and role definitions (Ray, 1989; 2006). The conflict was resolved, and the patient was provided with the standard of care that was expected. Here, the caring for the patient and the organization were intertwined. Ray's social caring permitted the charge nurse to communicate effectively to encourage professional behavior from the physician. Nursing leadership used their positional power, doing for, and acting on the staff nurses behalf (Swanson, 2008). The physician apologized and the nurse felt supported in her role. The charge nurse reinforced the valuing of the nurse and team respect (Boykin & Schoenhofer, 2001).

Ellen's reconstructed story. A story of supporting family decision making.

I remember that there was an elderly woman who was dying, and the daughter was feeling guilty. She didn't know what to do, and she didn't understand everything that was going on. I spoke with her about going through the same experience with my own mother. I shared how it was the most difficult decision that I ever had to make in my life. But you have to realize that you have to do what's good for the patient, and not what's good for you. After talking to her for a long time, she started to feel that way too, and as difficult as the decision was for her, she made her mother a DNR. She did what her mother wanted. Nobody wants to let their mother go. Sometimes having had an experience, and having a certain maturity helps you to relate to somebody.

Reflective synopsis. Spiritual//religious caring allowed the charge nurse to engage in relationship with the daughter and support her decision-making (Ray, 2006). The charge nurse used her ethical caring to help the daughter to view the situation from the perspective of the patient's desired outcomes. Legal and social caring was present as the mother's patient rights and wishes were honored. Swanson (2008) calls a relationship caring when it involves social support. The charge nurse's caring was evident in being with the daughter, knowing and enabling her, and taking the time to allow her to share and work through her feelings within this unfamiliar experience.

Hannah's reconstructed story. A story of caring for a patient and wife.

There was a patient who had been admitted to the hospital several times that year, who had a very attentive wife. They'd been married for about sixty years and were still deeply in love. I've never seen anything like the way she loved him. She was at his bedside constantly. He couldn't swallow anymore; so he kept getting aspiration pneumonia, and was always coming in for antibiotics. The doctors finally told her he was going to need a PEG tube put in. He got a little better after that discussion, and they were going to send him to an acute rehab instead, and then overnight there was a dramatic decline. I went in to talk to her. Every morning I'd go in and check up on them. She was crying because she said he looked so different. She was really worried that he wasn't going to be able to go to rehab because he was having difficulty breathing. I called the doctor and updated him and he said she was going to have to think about hospice. I knew that going from acute rehab to hospice in her mind was going to be a huge change for her. I went in the room with the doctor when he told her. She was beside herself, just like I knew she was going to be. Her husband was no longer able to speak with her. So I stayed with her that day, while all four or five doctors came to see her husband and spoke with her. She kept changing her mind. Every hour, she would say, PEG, no PEG. She wasn't sure if her husband would want a PEG tube or to go to hospice. He had previously been very active.

I was with her from the moment she got the news about not being able to go to acute rehab, and the need to consider hospice. I went with her through that

whole process. When she left, she gave me a big hug. She said she didn't think she would have been able to get through that experience without me. She needed someone to tell her that it was okay, whatever decision she made. She finally ended up going with hospice. She just needed someone to listen who wasn't trying to tell her what to do. I just was so grateful that I could be there for her. I feel like if I wasn't there, the staff nurse wouldn't have had time to do that. She wouldn't have had anybody there.

Reflective synopsis. This story strongly reflects the charge nurse being authentically present and responding to the wife's calls for nursing (Boykin & Schoenhofer, 2001). Political caring was evident as the charge nurse fostered the communication between the wife and her husband's team of physicians (Ray 1989, 2006). As a result, the wife was supported through this difficult decision-making. This situation does represent Ray's act of "brotherly love" (p. 36) between the charge nurse and the wife, as she was present with the wife and engaged in spiritual/religious caring in this end of life nursing situation (Boykin & Schoenhofer, 2001). The charge nurse's knowing and being with the wife (Swanson, 2008) allowed her to really come to know her as a caring person (Boykin & Schoenhofer, 2001). Through enabling (Swanson, 2008), the charge nurse helped ease the wife's transition towards supporting the love of her life through end of life care. It was important for the wife to be in a nonjudgmental accepting atmosphere as she worked through this process.

Libby's reconstructed story. A story of advocating for the patient.

We had a young girl who came in with headaches. She had been in our ER a few times since a motor vehicle accident on I-95. She was wearing a seat belt when

the car hit the guardrail and she was thrown around in the car. They worked her up, did a CAT scan of the brain, and everything was negative. She sustained a fracture to her right leg and the ER doctor instructed her that if she developed any neurological signs and symptoms that she should come back. She had some leakage from one of her ears and an intractable headache, so she returned. We thought it was CSF fluid. She was unable to sit up. Whenever she lay flat she didn't have a headache, but when she got up she began to get dizzy. The doctor saw her, and she asked to speak with the charge nurse afterwards. I went in, introduced myself, and asked her to tell me what her concerns were. She told me she felt that the doctor was very unprofessional. At that time she wasn't having any CSF leak, but she was still having the headache and nausea. I called the doctor and I let him know the patient's concern. She was unable to sit up so I asked the doctor if we could get a neurological consult. Neuro checks weren't ordered. The doctor said he would look over the case in meditech and call me back. Her symptoms persisted. He didn't call me back right away so I called the patient physician liaison. I said that I felt like something else needed to be done. I also called the nursing supervisor, my director, and risk management. I let everybody know. The doctor called me back and gave me orders for a neuro consult and neuro checks. I went back and told the patient. She felt better and thanked me. She didn't want to change doctors, she just felt he wasn't listening, and that something was going on. The neurosurgeon came and I spoke with him. He did an MRI of the brain and she ended up having a Chiari one malformation. The patient was very thankful. I'm glad that I intervened. The neurosurgeon

took over. The primary doctor wasn't threatened, I just let him know that I realized that he has a lot of patients, and I'm here with the patient, seeing the signs and symptoms, and what she's verbalizing to me, and I'm just trying to help. I'm not trying to tell him what to do. I'm just SUGGESTING, and telling him the data. Basically, we're on the same team. He was very receptive to that. He thanked me.

Reflective synopsis. In this story, the charge nurse used political caring to advocate on the patients' behalf so that her symptoms would not be ignored (Ray, 1989; 2006). The charge nurse's clinical expertise guided her to be persistent. Caring was present on a personal level, which ultimately led to legal caring for the physician and hospital. Swanson's (2008) "healing trinity" was present as the charge nurse guarded the patient's safety and demonstrated caring and leadership. Being with the patient allowed her to do for the patient and obtain the consult. The charge nurse engaged in enabling as she had the difficult conversations with the physician to obtain the needed orders. The charge nurse's intuition and expert knowing led to her being persistent in seeking a response to the patient's concerns. As the charge nurse identified the patient's needs and obtained the resources, she was engaged in "living caring" (Boykin & Schoenhofer, 2001, p. 2).

Narrative Threads for Providing Support

The narrative threads (M. C. Smith, personal communication, February 8, 2011) of nurturing staff growth through mentoring are one way that charge nurses in this study lived their caring in support of nurses. These charge nurses were persistent in creating circumstances and opportunities for nurses to grow in their caring (Boykin &

Schoenhofer, 2001). Participants extended this mentoring to helping others become competent to assume a leadership role in emergent situations. They provided help in the form of expert clinical assessment, which led to a more efficient economically caring response to changing clinical statuses (Ray, 1989; 2006). Participants remained present at the side of staff nurses and coordinated the care, providing educational and technical caring and guidance in an emergency. These charge nurses were doing for (Swanson, 2008) when they accompanied a patient for diagnostic testing so that the nurse could remain with their other patients (Boykin & Schoenhofer, 2001).

Charge nurse participants lived their caring for nurses by advocating on their behalf within the bureaucratic system (Ray 1989; 2006). They stood up with political and social caring for the nurses and communicated when other healthcare provided treated them poorly. Charge nurses illustrated knowing their nurses when they interceded on the staff nurses' behalf with family situations (Swanson, 2008). Participants also advocated on the patients' behalf to see that they received care or were reevaluated when symptoms persisted. Additionally, the charge nurses demonstrated political caring (Ray 1989; 2006) when they utilized the chain of command to seek answers once they felt that a patient was at risk.

Other threads in the stories that were not shared on how participants lived their caring in the support of staff nurses were that through knowing the staff nurses, the charge nurses were able to protect them when they become a safety risk due to personal circumstances or health issues (Swanson, 2008). These charge nurses helped the staff nurses to remember that with legal caring (Ray 1989, 2006) the patient must come first; when they become distracted or are not thinking clearly, nurses must not do any harm to

the patient. The participants also encouraged the staff nurses to take time to care for self as a preventive measure.

Many of the stories of charge nurses living their caring in support of patients were found in the physical and emotional support that they offered (Boykin & Schoenhofer, 2001). The threads in these stories reflected the importance of the charge nurse being with the patients (Swanson, 2008) and providing ethical caring (Ray, 1989, 2006) as they supported patients through the grieving process or guided patients and families through end of life issues. Participants provided support for patients and families as they engaged in difficult decision-making. These charge nurses took the time to listen, offering hope, and comfort. Participants also responded to patient and family needs for education and information within their stories.

Stories of where charge nurses felt they were not able to provide the support needed to a staff nurse or patient.

Dahlia's reconstructed story. A story of not providing the staff nurse with the help that was needed.

One thing that stands out was a nurse who was fired because of a judgment that she made. I walked on the floor that morning and the night shift nurse gave report that the patient was having chest pain early that morning and they didn't call the physician. I don't know if he just didn't assess the patient properly or he was worried because it was nighttime. The patient had morphine ordered so he gave the morphine and he reassessed in an hour and there was still a mild discomfort. The patient didn't have complete relief. He gave report to the morning nurse. Within an hour, the cardiologist walked in and he was very upset

that the patient had chest pain and he wasn't called. The patient was having an MI. He ordered heparin and left. When he came back, the heparin still wasn't started. We were arranging to transfer the patient out for a cath at another facility. I felt that I didn't provide the support the nurse needed because there was a whole root cause analysis after that regarding the delay in treatment. The patient survived, but had a complicated MI, and had bypass surgery. So they looked into the situation. I don't know if she was fired or left but they made a big deal out of the fact that the nurse felt that she was not getting the support or the back-up that she needed. You know, she was so busy. It was the beginning of the shift and she got a bad report, combined with it being too busy on the floor. I was there and I felt that I could have done better. I didn't tell anybody about this, but I felt I should have helped her at that time. As I walked in, that should have been my priority.

Reflective synopsis. Dahlia was not able to provide this staff nurse with the support that was needed so that she truly could nurse (Boykin & Schoenhofer, 2001). No time was provided for the nurse to respond to the patient's needs. Here the result of the charge nurse not living her caring with the nurse was that the nurse lost her job and the patient had a negative outcome. In this instance, conditions for a culture of caring (Swanson, 2008) were absent and safety was at risk.

Gail's reconstructed story. A story of not supporting a staff nurse through change.

We had one staff nurse who is no longer with us that I felt I could have given more support to. She left the floor because she was having problems with some of the changes that were being incorporated into patient care, like bedside report and hourly rounding. She thought that it was a violation of HIPAA. She felt administration was making her life more difficult. I was not able to give her the educational time she needed from me. I just wasn't able to help her understand the benefits. She had always been open to things changing with support. In relooking at what we did and how we did it, we did it wrong. Instead of mandating the change, we should have introduced the evidence behind the change first. That was a learning curve for me. I think our directors made a mistake. I stepped back a little bit. I produced all the documents. But the damage was already done. We lost one or two very good nurses.

Reflective synopsis. This charge nurse was unable to balance between human caring for the nurse and the organizational caring that was being mandated (Ray 1989; 2006). Team processes for political caring could have been instituted here to work through the conflict. Legal and educational caring could have been demonstrated by providing the evidence for the recommended standards of practice, and responding to concerns about the sharing of confidential patient information in an open forum. The charge nurse was unable to take the time to provide the infrastructure of support for the nurse during this practice change (Swanson, 2008). From the charge nurse's knowing, the staff nurse's perspective should have been anticipated. For caring to be reflected

here, the charge nurse needed to be enabling the nurse and being with her as she worked through her concerns.

Narrative Threads for Not Providing Support

Charge nurses also offered stories of when they felt they were unable to live their caring and provide adequate support for patients. Situational contexts for these stories included the charge nurse being unable to provide for psychological needs, provide desired pain medications, stop a patient from leaving against medical advice, or provide treatment for a rare medical condition. There also was frustration at not being able to meet the needs of a homeless patient on discharge presented in one story. In each of these stories, the charge nurses saw themselves as being unable to balance human caring with the organizational caring (Ray 1989; 2006) for multiple reasons. At times, what the patient was seeking was not in their best interest, or the resources were not available.

Charge nurses expressed disappointment when they were unable to prevent the loss of a nurse on their unit due to personal circumstances or competency issues. Feelings of inadequacy were expressed concerning the ability to counsel staff to change behaviors. One charge nurse described a situation where she did not intervene and a nurse left after a confrontation with a patient care assistant. In these stories, political, educational, and social caring were absent (Ray 1989; 2006).

One charge nurse participant felt that she did not provide adequate support for staff nurses when multiple patients deteriorated while waiting to be transferred because there were not enough beds in the intensive care unit. At these times, economic caring was lacking (Ray 1989; 2006). Economic caring applies to securing the necessary

resources for the interpersonal exchange to occur. One participant felt distress when she would have to leave the nurses in crisis and go home. On these occasions, it was clear from the stories that the charge nurse felt they were unable to provide the support for the staff nurses to respond to their patients (Boykin & Schoenhofer, 2001).

Chapter Summary

In this chapter, the researcher used Parse's (2001) descriptive explanatory method and narrative analysis to develop the themes. Major themes identified for objective one, which described the experience of being a charge nurse in acute care practice, were *Creating a Safety Net, Monitoring for Quality, Showing the Way, Completing the Puzzle, Managing the Flow, Making a Difference, Putting out Fires,* and *Keeping Patients Happy*. Major themes for how charge nurses lived their caring in their support of staff nurses and patients were *Jumping in the Trenches, Nurturing Staff Growth, Offering Authentic Presence,* and *Looking after Nurses*.

In chapter five, the description of the findings will move to integration with the science. The findings and implications for practice will be discussed from the perspective of nursing leadership in Ray's (1989, 2006) Bureaucratic Caring, Swanson's (1991, 2008) caring attributes and leadership, Boykin and Schoenhofer's (2001) Nursing as Caring, and from the perspective of the existing literature related to the role of the charge nurse.

CHAPTER FIVE. DISCUSSION, IMPLICATIONS AND RECOMMENDATIONS

Summary

The purpose of this study was to explore the experience of being a charge nurse in acute care practice, and to gain an understanding of how charge nurses live caring in their support of nurses and patients. The researcher used a qualitative descriptive exploratory method to describe how the participants perceived their charge nurse role. Semi-structured interviews were conducted with 20 charge nurses in acute care practice. Eight themes emerged from an inductive analysis of the data: *Creating a Safety Net, Monitoring for Quality, Showing the Way, Completing the Puzzle, Managing the Flow, Making a Difference, Putting out Fires,* and *Keeping Patients Happy*.

Participants also were asked questions about how they provide support to staff nurses and patients. Themes that reflected how charge nurses live caring in their support of staff and patients were: *Jumping in the Trenches, Nurturing Staff Growth, Offering Authentic Presence,* and *Looking after Nurses*. Additionally, the researcher used methods of narrative inquiry to get the participants to share stories of how they lived caring in their support of nurses and patients. Participants were asked to share stories about situations when they were able to provide support to a staff nurse or patient that they felt had a significant impact. They also were asked to share stories of situations where they felt they were not able to provide support. The stories shared by the charge

nurses reflected how they support the nurses who work with them as well as the patients and families on their unit. Stories included situations where the charge nurses nurtured staff growth, supported family decision-making, and advocated for staff, patients, and families. Stories of where the charge nurses were not able to provide support included situations where physical, decision-making, educational, and economic support in terms of human resources were not given.

In this chapter the researcher will move up the ladder of abstraction (Parse, 2001) and study findings will be linked to what is known from the theoretical literature related to caring-based leadership and the empirical literature related to the role of the charge nurse. Implications of the study for nursing practice, education, and research also will be explored.

Findings within the Context of a Nursing Caring Leadership Framework

Ray's (1989, 2006) theory of Bureaucratic Caring, Swanson's (2008) caring attributes and leadership, and Boykin and Schoenhofer's (2001) theory of Nursing as Caring provided the theoretical lenses through which study findings can be viewed. These scholars have described nursing leadership from a caring perspective.

Ray's Theory of Bureaucratic Caring

Ray's (1989) theory of bureaucratic caring included components of economic, political, legal, social, technological/physiological, educational/social, ethical, and spiritual/religious caring. The most vivid description of how these charge nurses reflected all of these aspects of bureaucratic caring was evident in the theme of *Managing Flow.* The participants' inner struggle of being caught between their

responsibilities to the institution and their commitment to the staff nurses was most evident within this theme. Providing high quality nursing care is challenging within the current complex healthcare environment with the fragmentation of care that exists. The charge nurses in this study described the challenges of balancing safety and efficiency in their work.

Charge nurses must balance economic caring and accountability with staff nurses' calls for support, resources, and understanding (Ray, 1989, 2006). Economic caring also includes interpersonal exchanges in that time is money. The participants had to determine how to get the job done with the available resources with the least amount of conflict. Maintaining this balance was crucial for the institutions' success from both a people and business perspective.

There are power disputes that may occur between leadership and staff as they navigate this delicate balance. Team processes of communication and conflict resolution must take place for political caring to occur (Ray, 1989, 2006). Political caring is evident when charge nurses are *Putting out Fires.* During this time, the participants used their positional power either to protect themselves, to make things happen with greater efficiency, or to resolve disagreements. Quality initiatives led by the charge nurses and monitored for compliance also represented political caring. In addition, charge nurses demonstrated political caring by attending meetings, performing quality audits, facilitating scheduling, and performing evaluations.

The charge nurses were performing a critical role by *Creating a Safety Net.* In this capacity they were protecting both the patient and the organization from harm. Legal caring factors (Ray 1989, 2006) include maintaining safety standards. Within

their role, charge nurses must know both the patients and nurses to maintain a safe environment for all.

Another way that participants were contributing to optimum outcomes for patients was by social caring (Ray, 1989, 2006). When they were *Completing the Puzzle*, social caring was necessary to coordinate through effective communication all aspects of care that existed within the multifaceted system (Ray, 1989, 2006). Ray's social caring allowed the charge nurses to come to know what patients and colleagues valued. Charge nurses were able to provide the patient with specific context for all of the various healthcare providers who were working together on the hospital and on the patient's behalf to facilitate continuity of care.

Focusing on patient outcomes and *Monitoring for Quality* reflected Ray's (2006) holographic model of bureaucratic caring (Ray, 2006), which suggests that all caring, including political, economic, technological, legal, social-cultural, physical, and educational, has spiritual-ethical elements. Ray's spiritual/religious caring was evident in terms of support being provided by charge nurses to patients and families during extreme crisis or in providing end of life care. This support was grounded in political, economic, legal, and technological processes. Since charge nurses recognized early signs of patient or nurse distress, ethical caring could occur. Charge nurses maintained their technological/physiological caring to respond with what staff nurses needed in these times of duress. Educational caring also was present as charge nurses provided clinical practice guidance for nurses and novice nurses as they grew in their understanding of nursing.

From this study's findings, charge nurses are in a position to practice, based on Ray's (2006) holographic model of bureaucratic caring, and to assist the organization in understanding how work needs to be reorganized from a patient centered perspective while supporting the institutional mission. Patient care that is focused on patient outcomes also will support the IOM's (2001) goals for improving healthcare. A supportive leader must be available at the unit level to implement these goals and decrease fragmentation.

Swanson's Caring Attributes and Leadership

Much of the work of the charge nurse participants reflects what Swanson (2008) describes as caring attributes. These attributes are knowing, being with, doing for, enabling, and maintaining belief. This scholar has described leading as creating environments that enable nurses to live out their values of caring, healing, and keeping patients safe. Providing for safety requires leading and creating a "culture of caring". In addition, there is evidence of charge nurses responding with caring as they were *Offering Authentic Presence* and *Looking after Nurses.*

Participants in this study used their knowing (Swanson, 2008) of patients and staff to ensure safety, identify potential problems, and evaluate outcomes of care. They saw the patients as persons within their own unique situations, so that they could advocate for, uphold and honor their wishes and those of their families. The participants knowing of staff permitted them to identify learning opportunities, so that they then could provide the resources to meet needs. Through *Nurturing Staff Growth,* the charge nurses helped to ensure that nurses were competent to keep everyone safe. Knowing includes developing an understanding of when they need to step in and offer assistance.

Listening and taking time with patients helps the charge nurses to know them as people and to provide caring. Being present with the nurses helped the charge nurses to know them at a personal level, to know what sustains them, and to provide caring for the nurses.

There were many descriptions of the charge nurses being with patients and nurses (Swanson, 2008). Many times they provided a listening ear and remained accessible, offering their authentic presence. The participants helped families acknowledge losses and offered their own personal experiences in response to needs.

Charge nurses were doing for (Swanson, 2008) staff nurses when they were *Jumping in the Trenches,* and also when they were *Showing the Way* to arrive at an effective decision by keeping the focus on safety and quality. Charge nurses also were doing for when they responded to calls at the forefront and were *Putting out Fires.*

The concept of enabling clearly was evident in the findings (Swanson, 2008). Participants in this study enabled staff by ensuring that nurses did not miss any components of care and by supporting them in unfamiliar aspects of care so that desirable outcomes were promoted. At times these charge nurses supported staff actions and provided decision-making assistance. Participants used enabling when they imparted information to patients and families as they engaged in end of life issues. Enabling occurred as the charge nurses guided them through new experiences and difficult decisions. Swanson described this enabling as only being possible because the charge nurses as leaders applied themselves to truly knowing both their nurses and patients.

Finally, charge nurses were assisting the staff nurses with maintaining belief when they set the example by providing expert care and demonstrating their competency to others (Swanson, 2008). Staff nurses then were able to find hope in knowing that they invariably will get to this level of expertise if they chose to stay the course. This reassurance that competency is achievable and that expert support is available may help staff to find meaning in their work once again.

Boykin and Schoenhofer's Nursing as Caring

Charge nurses can provide opportunities for the staff nurse to engage in a caring relationship with their patients (Boykin & Schoenhofer, 2001). Interestingly, a finding in this study was that when charge nurses were *Jumping in the Trenches*, they were not freeing up the staff nurses so that they could respond directly to what matters most to the patient at the moment; they themselves were answering that call. The rationale was that the staff nurse then was free to continue caring for the rest of their team of patients. This may explain one of the reasons that staff nurses are reporting dissatisfaction with their roles. Nurses are spending only five years in acute care, and within the first year 60% of new graduates leave their first job (Hodges, Keeley, & Troyan, 2008). Often staff nurses are not really being given an opportunity to truly nurse.

When charge nurses were *Nurturing Staff Growth,* they certainly were promoting "living and growing in caring" (Boykin & Schoenhofer, 2001, p. 11). Charge nurse participants helped both novice nurses and staff nurses grow in their understanding of what the unit norms were, as well as the expectations for competent patient care.

Within nursing situations (Boykin & Schoenhofer, 2001), which can be between the charge nurse and the patient or between the charge nurse and the staff nurse, whenever the intent is to nurse, the charge nurse must strive to be present authentically so that they can hear the nursing calls and respond with caring. Many times the charge nurses voiced that it was important to "make sure that they know that I am here." There is evidence of charge nurse caring in the themes of *Offering Authentic Presence* and *Looking after Nurses.* Charge nurses were rounding frequently and listening to concerns of staff and patients. Charge nurses also were coming to know what matters most to patients and colleagues through authentic presence and offering of self, even at times by *Jumping in the Trenches* and providing help.

Charge nurses also were expressing caring for nurses in their attempts to be fair and maintain balance while making assignments, scheduling, and *Managing the Flow.* However, the dilemma created by the need to sustain the accepted organizational culture in terms of patient volumes while fostering an environment that supported human caring was evident. Participants described being fatigued just watching the staff nurses and thinking of what the expectations were of them, and working longer than they should have to try and provide some needed assistance.

In summary, Ray's (1989, 2006) theory of Bureaucratic Caring, Swanson's (2008) caring attributes and leadership, and Boykin and Schoenhofer's (2001) theory of Nursing as Caring provided frameworks that increased the understanding of the charge nurse role and how charge nurses live their caring in support of staff nurses and patients. Within their interviews and stories, the charge nurses shared their understanding of their role and how they provided support.

Theoretical Conceptual Model

Holland and Quinn (1987) stated that "models in nursing focus on nursing's purpose and communicate what is most influential in shaping nursing knowledge and guiding practice" (as cited in Ray, 2010, p. 20). These models can be "explanatory, representational, and operational" and guide "behavior in a given situation" (p. 20). The model *The Ship Must Sail: Navigating Troubled Waters* is explanatory in that it can be used as a guide for nursing leadership at the unit level in acute care. The metaphor of the ship emerged from the language of one of the participants as representative of the daily struggle the charge nurse encounters when trying to live caring and provide support for staff nurses and patients. The researcher's intuitive understanding and interpretation of the model grew from the analysis of the data (Parse, 2001). Operationally, the model describes the dynamic process of charge nurses at the frontline steering the ship in the right direction toward desired patient and organizational outcomes.

When charge nurses are living caring on the frontlines, they do so from a lens that recognizes the connection between human and organizational caring (Ray, 1989, 2006), the need to create a culture of caring (Swanson, 2008), and the need to support nurses in living their caring (Boykin & Scheonhofer, 2001). From within this lens, depicted in the half circle at the bottom in Diagram 1, the intuitive and metaphoric understanding of the model emerged.

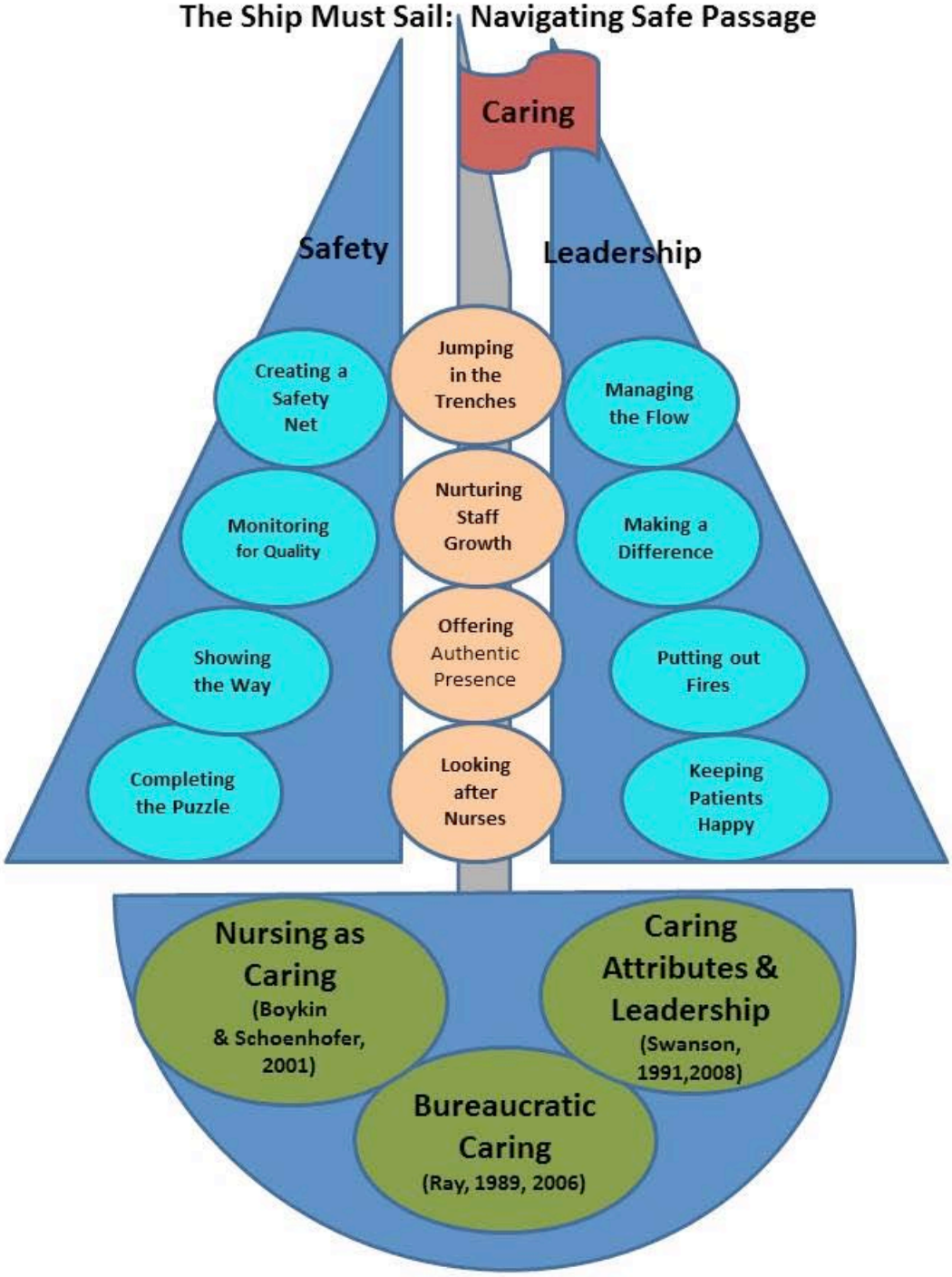
Charge nurses live caring every day in their support of staff nurses and patients by *Jumping in the Trenches, Nurturing Staff Growth, Offering Authentic Presence,* and *Looking after Nurses.* They advocate for and come to the assistance of staff nurses and

patients. Newman, Smith, Pharris, and Jones (2008) discussed the focus of the nursing discipline moving toward this relational caring. These relationships are critical to the trust on which healthcare at the unit level is balanced. These themes of support provide a foundation from which the charge nurse moves to carry out their role of steering the ship toward desired outcomes. In order to move toward safety, quality, continuity of care, patient satisfaction, mentoring, achieving balance, problem solving, and impacting outcomes these themes of support must be present. In Diagram 1 these four themes of support are located along the mast of the ship. The mast is the center or stabilizing pole that supports the sails on a ship. The mast represents the caring in Swanson's (2008) "healing trinity."

The role of the charge nurse flows from this patient and nurse centered focus of support. Descriptions of the experience of being a charge nurse in acute care practice include: *Creating a Safety Net, Monitoring for Quality, Showing the Way, Completing the Puzzle, Managing the Flow, Making a Difference, Putting out Fires,* and *Keeping Patients Happy.* These themes describing the charge nurse role are located in the sails of the ship in Diagram 1. To complete Swanson's (2008) "healing trinity, the sails independently reflect safety and leadership. These thematic descriptions are fluid in that they are in a constant state of flux as the charge nurse attempts to respond to the changing winds or tides, which represent the complexity of the acute care environment.

Diagram 1

The Ship Must Sail: Navigating Safe Passage



Findings Linked to the Literature

Information obtained from the organizational artifacts gathered from the facilities in this study was not always consistent with what was gathered from the interviews. In the interviews, the charge nurses identified that they had a clear understanding of what their job description and competencies should be. Yet charge nurses are performing without formalized role specific competencies in at least three of the hospitals, and without a job description in one hospital. There is an opportunity for the hospitals to engage the charge nurses in dialogue to increase the effectiveness of these documents by understanding what the role responsibilities of this key position are in their organization (Alison, 2007; Burns et. al, 2009; Connelly, Yoder et al., 2003; Fulks & Thompson, 2008). Development of these tools has the potential to contribute to how charge nurses are evaluated in facilities as well.

In terms of role preparation, charge nurses did recognize that they needed to develop conflict resolution skills to assist with *Completing the Puzzle* and *Putting out Fires.* Lifson and Cantlon (1986) previously had discussed the need for charge nurses to be able to provide solutions for problems and to coordinate the efforts of team members. Participants in this study frequently engaged in these activities. These charge nurses also referenced their roles in service recovery and safety and error prevention as described by Leary & Allen (2006).

Charge nurse competencies as described by Connelly, Yoder et al. (2003) were evident in this study. The participants were providing for patient safety (clinical competency), making decisions (critical thinking competency), and monitoring for quality (organizational competency). The barriers and facilitators of the charge nurse

role (Connelly & Yoder, 2003) that were categoried as personal barriers/facilitators were evident in the need for 'control,' understanding 'the big picture,' and fairness in terms of patient assignments. Participants did discuss how they are valued for *Making a Difference* in their role. A few reflected on their relationship with their manager/director as contributing to the amount of responsibility they were given. They did not elaborate on other interpersonal barriers/facilitators. Staffing was the only organization barrier/facilitator mentioned, as participants knew they were balancing adequate resources with fiscal responsibility, along with fluctuating volumes, moment by moment.

In this study, however, there was little reference to the human relations competencies described by Connelly, Yoder et al. (2003). Although themes that evolved included components of communication and team building competencies, participants did not discuss these competencies explicitly, except in identifying a need to build competencies in conflict resolution. The paucity of findings related to the charge nurse role in communication and team work may have been due to the sample being limited to day shift charge nurses only. On the day shift, there are other layers of support available, such as the manager/director. Connelly, Yoder et al. were identifying competencies from Katz's (1974) categories of management skills that would be needed on the night shift or when the head nurse was absent. Other scholars (Nunn, 2008; Sherman, 2005; Sherman & Eggenberger, 2009) have discussed the importance of nurses in the charge nurse role understanding how to lead teams. Rarely did participants in this study explicitly mention working in teams, although the five themes of *Showing the Way, Completing the Puzzle, Managing the Flow, Jumping in the Trenches,* and

Nurturing Staff Growth contain team processes. In a high risk environment, team members must learn how to help one another. If there is to be a nursing shortage, the teams likely will be composed of other roles besides nurses and patient care assistants in the future. In the interviews, the "helping hands" of the charge nurses were evident in the theme of *Providing Help*, but the help from the rest of the team was evident only when the charge nurse requested it. Although participants did discuss staffing challenges, little explicit discussion evolved around effective delegation (Connelly & Yoder, 2003).

Osguthorpe (1997) described manager competencies being transferred to the charge nurse for their assigned shift. Findings in this study concurred with this description in terms of *Managing the Flow*. Charge nurses in this study did engage in management functions of "planning, organizing, directing and controlling" in relation to this process at the unit level (Westphal, Jenkins, & Miller, 1986, p. 56). Additionally, Mejia, Vasquez, and Sanchez (2006) were correct about the level of influence that the charge nurse has on staff nurse productivity as they orchestrate the flow of admissions, discharges, and transfers and participate in patient care support as needed on their shift.

Patients are more acutely ill, and with interruptions and frequent patient turnover, less time is available for the nurse to monitor patients (Page, 2004; Vahey et. al, 2004). However, staff nurses are being held accountable for performance measures that impact reimbursement for care. In this study, charge nurse participants described assisting with this deficit as they are *Monitoring for Quality.* These charge nurses described performing a "balancing act" to maintain "continuity of care, safety, and efficiency" that supports the IOM (2001) calls for improvement to healthcare. The

charge nurses in this study also experienced role conflict as they managed patient assignments while trying to be fair, which is consistent with what has been published by Admi and Moshe-Eilon (2010). This role conflict is leading to charge nurse stress.

Keeping Patients Safe: Transforming the Work Environment of Nurses also portrays a need for support systems for the decision-making of nurses (Page, 2004). The theme *Showing the Way* relates to charge nurses modeling and supporting effective decision-making. Findings also show that charge nurses were assisting staff nurses with second order problem solving as they are *Showing the Way*. Charge nurses were helping the staff nurses with fixing the immediate problem as well as looking at the underlying causes. In this study charge nurses were providing this level of guidance and support as they acted as role models. This strong clinical leadership may help to reduce nurse burnout. Decision-making in the charge nurse role was last studied by Bostrom and Suter (1992) but only in terms of making patient assignments. Other aspects of charge nurse decision-making have gone relatively unexplored.

To reduce the potential for errors, Page (2004) also called for promoting the interprofessional communication that needs to happen on behalf of the patients. Charge nurses in this study were participating in interprofessional communication as they were *Completing the Puzzle* and making the collaborative connections to coordinate care.

Sherman (2005) previously suggested that organizations should invest development dollars in the charge nurse role because of their potential to impact safety. In this current study, opportunities for double-checking were built in by the charge nurses, which increased the likelihood of safe outcomes (Page, 2004). The charge nurse role allows for such redundancy in tasks to prevent errors. Woodard (2009) described

the value of charge nurse rounding in identifying and responding to potential risks, decreasing falls, and increasing patient satisfaction. Woodard also studied the effects of charge nurse rounds on patient satisfaction scores. Charge nurses in this current study were rounding and focused on patient satisfaction as they were *Keeping Patients Happy.*

Kalisch, Landstrom, and Williams (2009) described some of the components of care that are frequently being missed in practice. In their study, a lack of time, poor teamwork, and inadequate use of staff resources were found to be reasons for the missed care. Charge nurses in this study were performing many of the components of missed care; they were at the bedside with patients educating them, doing discharge planning, providing emotional support, and conducting surveillance. The amount of missed care certainly would be in higher percentages if these charge nurses were not present. Charge nurses also are in the unique role to be able to organize care differently to ensure that this care is not missed.

The most significant finding from linking this study to the literature from the late 1980s to early 2000s on the charge nurse is that the context of the environment in which nursing care is being given has changed dramatically (IOM, 2004; Page 2004; IOM, 2004; Vahey, Aiken, Sloane, Clarke, & Vargas, 2004; Hines & Yu, 2009; Schaffer & Tuttas, 2009). Shirey, Ebright, and McDaniel (2008) described nurse managers being pulled away from the unit, and staff nurses not feeling supported. This support is necessary for retention and to reduce burnout (Lucas et al., 2008). Charge nurses are assuming responsibilities for the education and mentoring of staff nurses and novice nurses (Kramer et al. 2007). Findings in this study suggest that these charge nurses have indeed stepped up to the role of *Nurturing Staff Growth.*

Implications for Nursing Practice

Based on this study it seems that in some settings, charge nurses are providing the day-to-day, minute-by-minute leadership at the unit level. Charge nurses clearly impact patient outcomes in terms of providing for their patients' safety and monitoring for quality. Charge nurses also may influence patient and family perceptions of their hospital experiences. In this era of pay for performance, the charge nurse's role described in the themes *Creating a Safety Net, Monitoring for Quality,* and *Keeping Patients Happy* is vital to the organization. The charge nurse may be in the unique position to be able to make recommendations for change at the unit level that can be of great benefit in terms of process and cost. Findings in this study suggest that charge nurses represent a constant source of knowledge from consistently rounding on the patients. Structured mechanisms for harnessing their insight should be sought. The charge nurse may be able to assess all of the factors that could potentially increase costs from a unit level and communicate to the disciplines to intercede as needed to prevent these additional costs.

Someone on the healthcare team must handle aspects of the charge role that promote patient safety. If any changes are made to the unit structure in terms of the charge nurse or assistant manager role, careful consideration must be given to who will perform these vital functions. Findings in this study suggest that it is necessary to have a nurse in the unit leadership role in a permanent capacity so that they can have this level of engagement with a vision for providing safety and quality. Charge nurses in this study consistently were modeling their goal of providing a safe environment for everyone and in *Showing the Way,* they were *Advising Clinical Practice* and

contributing their expertise on the patient's behalf. It is important to patient outcomes to understand how charge nurses support the judgment of the staff nurse. Unit leaders who were not nurses would not be capable of *Jumping in the Trenches* to support staff nurses in managing their work.

Charge nurses, who in many areas are assuming the unit specific functions of the nurse manager on their shift, can be key proponents of staff nurse retention. This study suggests that in some settings charge nurses provide essential support to the staff nurses. This support may be physical in terms of providing a "second set of hands," mental in terms of helping staff nurses think through situations and make decisions, and emotional in that the charge nurses may tune into what is occurring with the staff nurses. Novice nurses in particular need charge nurses to help them develop competency and confidence in their clinical reasoning. When novice nurses have this level of support it has been shown to increase their commitment to the organization, increase their job satisfaction, and increase retention (Buerhaus, Donelan et al., 2009; Kovner et al., 2009; Spence Laschinger et al., 2009). To perform these critical functions, charge nurses must be prepared adequately to assume their roles.

This study may offer some understanding about where charge nurses are filling in the gaps, which may be crucial to future health care redesign. Within the organizational hierarchy there are ever changing patterns of structural support. In these difficult economic times, administrators are working tirelessly on implementing changes in health care so services can be delivered more effectively and efficiently for less money. Support roles frequently are analyzed to determine if they are essential to the care model. Efforts will need concentrate on justifying the ongoing need for the

charge nurse role and the number of leadership roles necessary to get the job done and bring about the desired outcomes.

As other new roles, such as the Clinical Nurse Leader (CNL), are introduced and administrators consider adding this role in their facilities, questions arise about how to educate the physicians and the staff about the CNL role because many of the competencies in this role contain components of various other roles. Attempts are being made to distinguish between the different functions each support role provides in caring for the unit, staff, and patients. What is the ideal ratio of staff and patients to support the roles of charge nurse and CNL? Additionally, does the ratio vary depending on to whom the charge nurse reports and what their span of control is? In order to make informed decisions on how to organize patient care and patient care teams, it is essential to understand the roles of the various members of the team. Based on this study, there is potential overlap in the role between CNLs and charge nurses in the CNL role functions of advocate, team manager, systems analyst/risk anticipator, and educator. These findings may provide a foundation for understanding the role of the charge nurse from the perspective of the charge nurse. Charge nurses in this study already have expressed that they cannot spend even one to two hours away from managing the flow of the unit with the case managers for discharge planning and care coordination without there being a negative impact. Perhaps greater clarity can be brought between responsibility for unit function and patient outcomes with the two roles of CNL and charge nurse when they both exist within a facility. An interesting finding in this study was that few of the participants had formalized position descriptions that were specific to their role functions.

If charge nurses were better supported in growing in their roles as team leader, they might be able to be used in a greater capacity to help move their unit team to the organization's priority agendas. Charge nurses in this study were the team leaders who were the coordinators of patient care who spend a great deal of their time *Completing the Puzzle.* Indeed all 12 of the study themes suggest that charge nurses are having an impact on all of the IOM's (2001) enhancements to improve healthcare: safety, timeliness, efficiency, effectiveness, equity, and patient-centeredness. A key finding from the study is that the role of the charge nurse has become more complex over time, and the need to bridge the gaps between the disciplines has become more challenging in today's healthcare system. Development of charge nurses in terms of leading teams will be critical for the future of organizing acute care.

Implications for Nursing Education

The IOM (2010) report on *The Future of Nursing: Leading Change, Advancing Health* has made recommendations that all nurses should have opportunities to develop leadership skills. This report suggests that all schools of nursing need to integrate leadership theory across the curriculum, and include business practices as well. The inclusion of business practices will support the need for charge nurses to develop further understanding of economic and legal caring (Ray 1989; 2006). Leadership continuing education then should move to clinical practice. Facilities are challenged with the task of developing leadership programs and providing mentors.

In the practice setting, charge nurses were provided with little continuing education for their leadership role. This fact is supported by the demographic data. Initially, 35% of the participants identified that they had received formal training for the

role. However, upon closer review, participants included “precepting,” “shadowing.” and “orientation” in their definition of formal training. The number of participants who actually received formal training was only 20%. Three of those participants had this training within the last three months, and the remaining participant previously had the training at a hospital up north.

Requirements for the charge role from the organizational artifacts indicate that a bachelor’s degree in nursing is preferred for the position. Yet only 33% of the sample had this degree. This is an important finding in relationship to the IOM (2010) report, which addressed the educational needs of nurses in the current practice environment and called for increasing the proportion of nurses with a baccalaureate degree to 80% by 2020; this would apply to all nurses, not just those in formal leadership roles. Nurses who pursue their bachelor’s degree typically develop competencies in nursing leadership. Curriculum includes leadership theory, communication, team building, and conflict resolution, which all nurses who have the potential for assuming a leadership role need. Although not specifically asked how they communicate with the team during their shift, charge nurses were asked how they function as team leaders. In reply, these participants did not include any discussion of the recommended communication strategies for teams, such as briefings, huddles, and debriefings (AHRQ).

Staff development educators can use the themes developed within this study to support the objectives for current charge nurse educational programs, or to develop new programs to better meet the educational needs of charge nurses. Charge nurses must be prepared adequately for this pivotal role. Educators must address the need for charge nurses to look for opportunities to allow the individual staff nurses to nurse, providing

support and living caring with their own patients, while someone else assumes responsibilities for their other duties, in an effort to decrease burnout and increase retention. Findings in this study suggest there is a dire need for more structured orientation programs for charge nurses given the level of leadership they provide at the unit level and the scope of their responsibilities. Themes developed in this study also could support the development of high fidelity and role play simulation scenarios, for use in both academic and practice settings, designed specifically to support charge nurses in their development in managing flow, conflict resolution, and leading teams. Actual experiences of charge nurses could be used as nursing situations that new charge nurses can work through in a classroom or workshop setting to develop confidence in responding to new or typical challenges that a charge nurse encounters.

The insight of the charge nurses may be of value in addressing some of the transition pains experienced as students move from academia to practice. Participants in this study addressed knowing when novices needed encouragement to learn and grow. The fast pace of the acute care environment requires such support.

Implications for Nursing Research

Most of the current studies on charge nurses have explored the competencies for the charge nurse role in relationship to nurse manager competencies or management skills. Allison (2007) looked at leadership abilities from the charge nurse perspective with six participants from Canada. This study has explored the role itself from the perspective of the charge nurse. Further research on the charge nurse role also should be done from the perspective of the patients, staff nurses, patient care assistants, physicians, nurse managers/directors and administrators. Another area of interest for

study would be the relationship of the charge nurse to their managers/directors, and the level of support they themselves receive in the role. Additionally, researchers could explore if there are differences between being in charge at for-profit and non-profit facilities, at hospitals with Clinical Nurse Specialists (CNSs) and CNLs, or at magnet and non-magnet facilities. This could be done by using a larger number of facilities that meet these characteristics and more charge nurse participants.

Research involving work sampling and time and motion studies may provide a clearer understanding regarding how much time is spent by the charge nurses engaging in each of the themes in the course of a typical day. Analyzing a breakdown of the charge nurse activities may lead to further understanding whether the charge nurse position needs to be a nurse, or if it could be filled by someone who is not a licensed nurse. In redesigning healthcare at the unit level, care must be taken to see if the work of nurses could be organized in such a way as to allow them time to actually nurse and be *Offering Authentic Presence*.

It would be interesting to study how many times a charge nurse is able to intercede and prevent a near miss or an error from almost impacting a patient. In what kinds of events or circumstances are charge nurses called on to intervene to improve patient care and promote safety? What advice are they typically asked to give? This information could be beneficial in terms of knowing how to better support charge nurses. In this study, charge nurses *Showed the Way* by the subthemes of *Advising Clinical Practice* and *Guiding Decision-making*. Nurses wanted help clarifying when to call the physician and distinguishing what they should report.

Other areas that could be studied include the charge nurse role in communication. To promote positive patient outcomes, with whom do the charge nurses initiate communication on any given day? Who initiates communication with the charge nurse to move their agenda forward? Charge nurses also are the middle layer of communication in that they are sending communication up and down. What communication are they sending? Are they using and teaching the recommended communication tools?

Another possibility for study would be the charge nurse role in decision-making. What kinds of decisions do they make, and in what types of events do they intervene? It also would be interesting to know how they arrive at the decisions they make. That work could be extended to determining if those specific decisions and interventions have an appreciable impact on patient care, error reduction, and patient safety. Further research could be done to examine the relationship between formal preparation in the charge nurses role and success in the role as determined by patient outcomes.

Functions of the charge nurse role that contribute to patient safety would be beneficial to study and evaluate. A key finding in this study is that with the focus on patient safety and the prevention of never events, the charge nurse has a major new role function. Safety was seen as the priority and the focus of their role was on keeping the environment, the patients, and the staff safe. The next step could be to look at the major issues that occur with patient safety and study which of those issues the charge nurse role has the potential to impact. For example, how many times does the charge nurse recognize an early change in patient status, which results in preventing a rapid response or code, or in moving the patient to a different level of care early? Documentation forms

for these events and patient care notes could be evaluated to increase understanding of the charge nurse role in these situations. Charge nurses could be interviewed to determine their perceptions of the barriers that keep the charge nurses and staff nurses from promoting the safety recommendations. In this study it was evident that the charge nurses did follow-up on diagnostic studies, which resulted in changes in the treatment plan. Charge nurses also facilitated procedures being completed and interprofessional communication occurring in a timely manner. Without those interventions, there could have been a potential for a negative impact on the patient.

Recommendations

Within the current context of the healthcare environment, the charge nurse role has become very important for safety and positive outcomes. Yet, the role still remains invisible to the executive management team in that there has been little focus on the development of charge nurses. Nursing executives need to elevate the visibility of the charge nurse role and its importance to the organization, so that other executives can understand and support leadership development at the charge nurse level.

Additionally, charge nurses need role specific job descriptions and associated competencies to foster their performance and growth, which also can be used for succession planning. An orientation workshop to support the effective decision-making of charge nurses has been suggested (Flynn, Prufeta, & Minghillo-Lipari, 2010). Another recommendation might be a national certification examination at the charge nurse level, with a recognized preparatory curriculum.

Charge nurse participants did not dialogue explicitly about their functions in terms of communication and intraprofessional team building. Given the current

environment, their responsibilities in these areas may need to be made more explicit to the charge nurses so that they can focus on increasing these abilities. Also, in this study, the charge nurses were all "doers." Only one participant mentioned the challenge of knowing when to step in or when to step back. Due to their increasing involvement with mentoring novice nurses and new staff, charge nurses might benefit from education to develop coaching skills.

Despite the IOM's (2010) view on the complexity that exists in acute care today, and the need for a bachelor's level of education to be minimal for practice, only 33% of the charge nurses in this study had a bachelor's degree. Nursing administrators, directors, and managers need to recognize this deficit and focus on encouraging and supporting these unit-based leaders to continue their education.

Chapter Summary

Charge nurses were described as being the "eyes of the unit" in the introduction of this study (V.D. Noval, personal communication). Within this study, charge nurses frequently referred to "eyes" in relation to their role in monitoring and providing for safety. The results of this study do indeed indicate that charge nurses spend a great deal of time watching and observing unit activities, processes and behaviors, and responding as needed to promote quality safe patient care, while at the same time caring for staff nurses, patients, and families. Charge nurses are filling in the gaps for staff nurses because they are consumed with the tasks of providing patient care. These narratives describe barriers that staff nurses are facing in terms of time and competencies.

The charge nurse stories have shed light on what it is like to practice in today's complex healthcare environment. The results from this research provide implications

for nursing practice, education, and research on the charge nurse role. Findings from the research have provided new information on how the charge nurses view their role as essential for optimal patient outcomes and safety. Additionally, the researcher has gained understanding of how charge nurses live their caring in support of charge nurses and patients. As Ellen articulated, “it is important to have a seasoned nurse who just puts her arms around the whole floor.”

APPENDIXES

APPENDIX A

CONSENT FORM

1) Title of Research Study: Holding the Frontline: The Experience of being a Charge Nurse in an Acute Care Setting

2) Investigators: Rose O. Sherman, EdD, RN, & Terry L. Eggenberger, MSN, RN

3) Purpose: The purpose of this research study is to explore what the experience of being a charge nurse is in the current acute care environment, and to be able to describe how charge nurses live caring in their support of staff nurses and patients.

4) Procedures: Participation in this study requires an audio-taped interview with the researcher, which will last about one hour. The interview will be scheduled during a shift at the facility when prior coverage can be arranged, after a shift, or at a time that is most convenient for you. Interviews will be conducted in a quiet office or conference room at the facility. You will be asked to respond to a number of open-ended questions about the experience of being a charge nurse. Follow-up interviews may be necessary to verify the researcher's understanding of the interviews, and the meaning of the findings. You will also be asked to complete a demographic survey during the interview session.

5) Risks: The risks involved with participation in this study are no more than you would experience in regular daily activities when engaging in discussion with another professional about your viewpoints.

6) Benefits: Potential benefits that you may attain from participation in this research study include facilitating increased understanding of what it means to be a charge nurse in acute care settings. Information about how the role is being used in acute care settings may be helpful in determining what type of support charge nurses need to perform the role, and what the impact of the charge nurse is on staff retention and patient outcomes.

7) Data Collection & Storage: All of the results will be kept confidential and secure and only the people working with the study will see your data, unless required by law. The data and consent forms will be kept in a locked cabinet [or password protected computer] in the investigator's office and then destroyed after a maximum of three years. Audiotapes will be destroyed after being transcribed.

8) Contact Information: For related problems or questions regarding your rights as a research subject, contact the Florida Atlantic University Division of Research at (561) 297-0777. For other questions about the study, you should call the principal investigators, ***Dr. Rose Sherman*** at ***(561) 297-0055 or Terry Eggenberger*** *at* ***(561) 297-1087.***

9) Consent Statement: *I have read or had read to me the preceding information describing this study. All my questions have been answered to my satisfaction. I am 18 years of age or older and freely consent to participate. I understand that I am free to withdraw from the study at any time without penalty. I have received a copy of this consent form.

Signature of Subject: _____ Date: _____

Signature of Investigator: _____ Date: _____

APPENDIX B

CHARGE NURSE RECRUITMENT FLYER

WANTED!
CHARGE NURSES!

Terry Eggenberger MSN, RN, Doctoral Student is conducting a study ON the "EXPERIENCE OF BEING A CHARGE NURSE IN ACUTE CARE PRACTICE"

- **Participation is voluntary**
- **Participants will sign a consent, complete a demographic form, and engage in an interview of approximately 1 hour (which will be audio taped)**
- **Anonymity of the study participants will be protected**
- **Follow-up interviews may be necessary to verify the researcher's understanding**

TO SCHEDULE AN APPOINTMENT OR TO ASK QUESTIONS

PLEASE CONTACT:

TERRY EGGENBERGER
(OFFICE) 561-297-1087
(MOBILE) 561-596-9561
(EMAIL) teggenbe@fau.edu

REWARD

Opportunity to increase the understanding of what it means to be a Charge Nurse in acute care practice from the prospective of those in the role.

APPENDIX C

ASSISTANT NURSE MANAGER RECRUITMENT FLYER

WANTED!
ASSISTANT NURSE MANAGERS!

Terry Eggenberger MSN, RN, Doctoral Student is conducting a study ON the "EXPERIENCE OF BEING AN ASSISTANT NURSE MANAGER IN ACUTE CARE PRACTICE"

- **Participation is voluntary**
- **Participants will sign a consent, complete a demographic form, and engage in an interview of approximately 1 hour (which will be audio taped)**
- **Anonymity of the study participants will be protected**
- **Follow-up interviews may be necessary to verify the researcher's understanding**

TO SCHEDULE AN APPOINTMENT OR TO ASK QUESTIONS

PLEASE CONTACT:

TERRY EGGENBERGER
(OFFICE) 561-297-1087
(MOBILE) 561-596-9561
(EMAIL) teggenbe@fau.edu

REWARD

Opportunity to increase the understanding of what it means to be an Assistant Nurse Manager in acute care practice from the prospective of those in the role.

APPENDIX D

CHARGE NURSE DEMOGRAPHIC SURVEY

Participant Code _____

Age _____ Gender _____ Ethnicity_____

How many years have you been a nurse? _____

How many years have you been a charge nurse? _____

How long at this facility? _____ Who do you report to? _____

Type of Facility? _____Not for Profit _____ For Profit

Unit Type? ___Medical-Surgical ___Telemetry Number of beds on unit? _____

Number of shifts you work per week? _____

What qualifications did you have to meet to assume the charge nurse role?

_____

_____

What is your highest level of education as a nurse? (Associates, Bachelor's, Master's, or Doctorate) _____

Did you receive formal training for the charge nurse role? _____

If so, what did that training consist of? _____

_____

APPENDIX E

INTERVIEW GUIDE

Tell me what the experience of being a charge nurse in acute care practice is like.

Describe your activities as a charge nurse on a typical shift.

What is the care delivery model used on your unit? (How is patient care assigned?)

What are your priorities when you are in charge?

What are some of the challenges you face?

How do you function as a team leader?

What kinds of decisions are you called upon to make on a daily basis?

How do you provide support for other staff (your manager, novice nurses, and staff nurses on your team)?

How do you provide support for patients and families?

How does the charge nurse role impact patient safety?

What do you think charge nurses need in terms of professional development?

Tell me a story about a situation where you felt you were really able to provide support to a staff nurse or patient that you feel had a significant impact.

Tell me a story about a situation where you felt you were not able to provide the support that you felt was needed for a staff nurse or patient.

Is there anything else you would like to add?

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