EXPLORING THE ADMINISTRATIVE SUPERVISOR ROLE AND ITS PERCEIVED

IMPACT ON NURSE AND PATIENT SAFETY

by

SUSAN H. WEAVER

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ABSTRACT OF THE DISSERTATION

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SUSAN H. WEAVER

Dissertation Director:

Teri Lindgren, PhD, RN, FAAN

The current model of off-shift management or supervision in acute care hospitals in the United States is having an administrative supervisor, who is the nurse leader present on the evening, night, and weekend shifts. Despite the existence of the administrator supervisor role in hospitals for more than 100 years, research on this role is lacking.

The purpose of this focused ethnographic study, which was conducted in two parts, was to explore the administrative supervisors' perspective of their managerial practices and how these practices contribute to nurse and patient safety. The first part consisted of seven focus groups with off-shift staff registered nurses to identify the administrative supervisors' role in nurse and patient safety. The second part consisted of in-depth telephone interviews with 30 administrative supervisors, recruited nationally from 20 different states, to describe the managerial safety practices and role responsibilities of the supervisor.

The overall theme identified in this research study was the administrative supervisor as the shift leader who does whatever is necessary to get the patients, staff and hospital safely through the shift. The administrative supervisors viewed themselves as leaders, not

managers, and felt disconnected from the nursing leadership team. Regardless of the size, type or location of the hospital, the findings revealed the administrative supervisors achieve nurse and patient safety when performing their role responsibilities, of staffing, patient flow, crisis management, and hospital representative, and through processes of making it work. The supervisors, who function as off-shift safety officers, establish trust with the staff, do rounds, educate, and provide support by which they "make it work" and achieve the outcomes of nurse and patient safety.

This is the first time that research has identified the administrative supervisor role responsibilities and processes through which they achieve safety. The often-invisible administrative supervisor role is now being brought to the forefront, revealing the impact this shift leader has on safety. Thus, the findings from this groundbreaking research study identify emerging questions and implications for hospitals regarding the nursing leadership structure and nurse and patient safety, and are relevant for hospital nurse leaders, nurse leader organizations, nurse scientists, and administrative supervisors.

Dedication

This work is dedicated to all past, present and future administrative supervisors. Thank you for taking care of the patients, staff and hospital during the evening, night, and weekend shifts. A special recognition must be made of Ruth Mellick, RN who was the evening supervisor when I was a new charge nurse in ICU. "I am so glad you are here" were the words I would often exclaim when Ruth would come to the ICU. Thank you, Ruth, for your guidance and support in my first leadership position, and for showing me the importance of presence and caring.

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CHAPTER I

INTRODUCTION AND THEORETICAL PERSPECTIVE

The Concern to be Addressed

Off-shift Outcomes in Hospitals

> When a hospital admits a patient, the hospital is charged with the responsibility of caring for the patient no less by night than by day. But does it? (Pfefferkorn, 1932, p.1179)

More than eighty years ago, nurses began questioning the difference in patient care at night. Recent studies have now associated poor patient and nurse outcomes with the off-shift, defined as evening, night, and weekend shift, in hospitals (de Cordova, Phibbs, Bartel, & Stone, 2012; Gould, Qin, & Chavez, 2005; Peberdy et al., 2008). For example, adult inpatients who have a cardiac arrest at night experience a lower survival rate (Peberdy et al., 2008), and there is an increased neonatal mortality rate for infants born at night (Gould et al., 2005). Additionally, night shift registered nurses have a higher occupational injury rate along with more depression and poorer sleep quality (Horwitz & McCall, 2004; Ruggiero, 2003). Research has yet to determine the reason for these poor outcomes. However, the off-shift has been found to be different, with less nursing and ancillary staff, newer staff, and fewer services available (de Cordova, Phibbs, Bartel, & Stone, 2013; Hamilton, Eschiti, Hernandez, & Neill, 2007; Ruggiero & Pezzino, 2006). There is also less management and supervision on the off-shift, with typically just one administrative supervisor for all the nursing units in the hospital (Hamilton et al., 2007). Yet despite fewer resources, the off-shift staff reported higher levels of teamwork when compared to day shift staff, which may be out of necessity because of less staff (Kalisch & Lee, 2009).

Off-shift Nursing Leadership in Hospitals

In most acute care hospitals in the United States, administrative supervisors are the nurse leaders who work the off-shifts, the evening, night and weekend shifts. During these times, the unit managers, directors, and hospital administrators are not present in the hospital. Considerable research has focused on the unit-based nurse manager role, but research is lacking on the administrative supervisor role and the importance of this role on the off-shift. Researchers have studied the unit-based nurse manager role and found that nurse manager leadership and support of nurses, such as backing up the staff, being supportive and providing praise and recognition, are related to increased staff nurse satisfaction, job enjoyment, and decreased nurse burnout (Friese, 2005; Hall, 2007; Hanrahan, Aiken, McClaine, & Hanlon, 2010; Kovner, Brewer, Wu, Cheng, & Suzuki, 2006; Wade et al., 2008). Furthermore, highly effective nurse managers have been linked to supportive nurse practice environments and nurse-assessed quality of care (Friese, 2005; Zori, Nosek, & Musil, 2010). Researchers are now beginning to investigate the relationship between nurse manager practices and patient outcomes, and are finding increased patient satisfaction and decreased adverse patient events when staff nurses trusted and had a favorable perception of their nurse manager (Boev, 2012; Vogus & Sutcliffe, 2007; Wong & Giallonardo, 2013). Yet, despite the important role that unit-based nurse managers have with regard to nurse and patient outcomes, little is known regarding off-shift leadership and the managerial activities or "best practices" that administrative supervisors use to achieve positive patient and staff outcomes.

The Phenomenon of Interest

The Institute of Medicine (IOM) (2004) report entitled *Keeping Patients Safe:*

Transforming the Work Environment for Nurses recognized the important role that nurse leaders have in creating practice environments that are conducive to patient safety. In this report, the negative impact of a loss of nurse manager positions along with a concomitant increase in their span of control was highlighted as a clear and present danger to patient safety. One IOM recommendation to improve patient safety, which may be applicable to off-shift leadership, was to have nurse leaders foster mutual trust with the nursing staff, and support the clinical decision making and actions of the nursing staff. Although there was no direct focus on off-shift nursing leadership in the IOM report, another recommendation was to conduct additional qualitative research to better describe the work nurses perform in different settings.

Administrative Supervisor Managerial Practices

This qualitative research study explores the influence the administrative supervisor, as a representative of nursing leadership, has on the off-shift nurse and patient safety. Specifically the study focuses on administrative supervisor managerial practices and how these practices contribute to patient and nurse safety. In hospitals, nurses provide patient care 24 hours a day. Yet, the majority of research has focused on staff nurses and nurse managers during daytime hours, with limited focus on the specific delineation of roles and responsibilities and related outcomes of nurses who work during the off-shift hours, and thus missing the uniqueness of the off-shift. Since patients need care regardless of the time of day, it is important to identify the practices across all nursing roles and shifts. Other than a pilot study conducted by Weaver and Lindgren (2016) published empirical research is lacking on management of the off-shift. In the pilot qualitative study, the researchers interviewed ten administrative supervisors who framed their discussion of

this off-shift role within a different hospital world that has fewer resources, less staff, different management, and different workflow (Weaver & Lindgren, 2016). The administrative supervisors explained that they oversee and do "everything" and have responsibilities for staffing and patient flow, crisis management and support for the staff. These independent, autonomous administrative supervisors were challenged with appropriately staffing units, emergent problem solving, and supporting the nursing staff. However, the managerial practices these supervisors used to achieve the goal of safely getting through the shift was not explicitly addressed in the pilot study. This research study was the first to explore the managerial practices of the administrative supervisor and their impact on nurse and patient outcomes. Guided by the Nursing Organization and Outcomes Model, this research addresses the gap in empirical research on the administrative supervisor role and the practices that contribute to nurse and patient safety (Aiken, Sochalski, & Lake, 1997).

The nursing organization and outcomes model posits that structures in organizations, such as staffing and a supportive practice environment, which includes nurse manager leadership and support, lead to care processes which impact nurse and patient outcomes (Aiken, Clarke, & Sloane, 2002). In accordance with the nursing organization and outcomes model, the purpose of this study is to explore the managerial practices of the administrative supervisor, who fulfill an organizational role, and explore administrative supervisor's perceptions of their impact on nurse and patient safety.

This research on the managerial practices of administrative supervisors and how these practices contribute to nurse and patient safety is necessary along with examining the off-shift differences and the impact of the administrative supervisor role has on nurse and

patient safety. Hospital nursing leadership teams who wish to foster favorable nurse practice environments and reduce patient adverse events need to have an understanding of the off-shift differences and the role of the administrative supervisor in nurse and patient safety.

The Purpose of the Research

The purpose of this focused ethnography study is to identify and describe the managerial practices of administrative supervisors in hospitals and their perceptions on how these practices contribute to nurse and patient safety.

Overarching Question:

What are administrative supervisors' perspective of their 1) managerial practices; and 2) how do these practices contribute to nurse and patient safety.

Sub Question:

What are off-shift staff nurses' perspective of the administrative supervisor role and how does the administrative supervisor contribute to nurse and patient safety.

Foundational Assumptions

Despite the existence of the administrator supervisor role in hospitals for more than 100 years and a belief by nurse leaders that they have an understanding of this role, little attention has been paid to how this supervisor impacts nurse and patient safety ("Editor's Miscellany," 1901). A qualitative research method was selected for this study because there is a lack of research on the role of administrative supervisors. The first step in understanding the role required in-depth interviewing with those who have direct experience as administrative supervisors. According to findings from the pilot study, administrative supervisors viewed themselves as different from unit-based managers,

therefore, this research aimed to explore more closely how these supervisors view themselves and how they ensure nurse and patient safety (Weaver & Lindgren, 2016). A focused ethnography approach was used for this study because this methodology allows for exploration of a specific phenomenon, the managerial practices of administrative supervisors, through interviewing and accessing extant documents such as job descriptions (Knoblauch, 2005). Focus groups with off-shift staff registered nurses were also conducted to augment the administrative supervisor perspective in exploring the administrative supervisor world and managerial practices (Denzin & Lincoln, 2011). Focus group discussion and interaction enable participants to recall and share their experiences more readily than in private interviews (Roper & Shapira, 2000). Since focus groups with staff nurses has provided rich experiential information, off-shift staff registered nurses were recruited to discuss and explore the administrative supervisor role and what these supervisors do to keep nurses and patients safe (Johansen, 2014).

This research study was conducted in two parts: the first part with off-shift registered nurses and the second part with administrative supervisors. The first part consisted of focus groups with off-shift staff registered nurses to describe the off-shift environment and identify the administrative supervisors' role in nurse and patient safety. The second part consisted of telephone interviews with administrative supervisors to identify and describe the managerial safety practices and role responsibilities of the administrative supervisor that enhance nurse and patient safety in hospitals.

Definition of Terms

Off-shift.

Off-shift is defined as evening and night shifts, along with weekends and holidays

(de Cordova et al., 2012).

Administrative Supervisor.

Administrative supervisor is the nurse leader present on the evening, night, weekend and holiday shifts when the unit managers, directors, and hospital administrators are not in the hospital (Weaver, 2012; Weaver & Ellerbe, 2013). The administrative supervisor does not have 24-hour responsibility but rather typically has responsibility for all nursing units in the hospital during a given shift (evening or night).

Managerial practices.

Managerial practices are those practices performed by the administrative supervisor that impact nurse and patient safety, such as effective communication, team building, enforcing policies and procedures, staffing, being available, and caring about the staff (Buelow, Winburn, & Hutcherson, 1999; Grant, Christianson, & Price, 2007; McClure, Poulin, Sovie, & Wandelt, 1983; Thomas-Hawkins, Flynn, Lindgren, & Weaver, 2015).

The Significance of the Study

An administrative supervisor has the responsibility to ensure that the hospital continues to function smoothly and efficiently. This is the current model of off-shift management in hospitals. Nurse leaders may believe they have an understanding of this administrative supervisor role, however empirical data on this role are lacking. This is unfortunate because the off-shift work environment is distinctly different. Patients get sick regardless of the time of day, so it is vital to explore the managerial practices of the administrative supervisor that enhance nurse and patient safety (Weaver & Lindgren,

2016)

In the United States, there are administrative supervisors at the 5,686 American Hospital Association registered hospitals, and this research explores how these supervisors impact the nursing care that 2.8 million staff nurses provide to the 35 million patients who are admitted to these hospitals each year (American Hospital Association, 2015a; U.S. Department of Health and Human Services, 2013). Furthermore, off-shift management consists of management after 5PM on weekdays, and 24 hours on weekends and holidays, which can be calculated to about 128 hours weekly. Despite administrative supervisors being present in hospitals more hours each week than unit-based nurse managers, who tend to work the traditional 40-plus-hour workweek during the daytime hours, Monday through Friday, empirical data on their managerial practices is lacking. To further enhance nurse and patient safety, it is time to explore the invisible world of the off-shift and describe the managerial practices or best practices of the administrative supervisor.

Hence, this qualitative study provides a better understanding of the managerial practices and role responsibilities of the administrative supervisor. The often invisible administrative supervisor role will be brought to the forefront, revealing the impact this off-shift nurse leader has on nurse and patient safety. Furthermore, this qualitative research addresses the gap in research in management of the off-shift.

Since there is no valid and reliable instrument that measures the managerial practices of administrative supervisors, this research will provide the groundwork for development of such a measure to further understand and quantify the impact of administrative supervisor practices on nurse and patient safety. Such a valid and reliable measure is

sorely needed to further understand and quantify the impact of administrative supervisor best practices on nurse and patient outcomes. As the administrative supervisor role is further investigated, discussion of the best practice model of management on the off-shift may result, along with a better understanding of the off-shift practice environment.

Summary

This focused ethnography study describes the managerial practices of the administrative supervisors and how these practices contribute to nurse and patient safety. The intended audience for this study includes administrative supervisors, nurse leaders, nurse educators, and nurse researchers. Data was collected through focus groups with off-shift staff registered nurses and phone interviews with administrative supervisors.

CHAPTER II

LITERATURE REVIEW

Purpose of the Literature Review in Qualitative Inquiry

A literature review for a qualitative study involves critically examining previous research so as to provide background on the topic, establish the need for the research and guide the researcher in formulating the research study (Field & Morse, 1985; Roper & Shapira, 2000). Additionally, familiarity with the classic and current research allows for an understanding of the topic and a comparison of topics: the administrative supervisor role, the nurse manager role, enhanced researcher sensitivity, and assistance with creating interview questions (Corbin & Strauss, 2015). Thus, a literature review in advance of qualitative research supports the need for the research and provides background on why this need is important.

After working as an evening nursing supervisor for many years and reading numerous research articles about unit nurse managers, the Principal Investigator (PI) searched the literature and found minimal information on the administrative supervisor or evening/night supervisor role. This early review of the literature and apparent lack of empirical research provided direction towards qualitative inquiry.

Background of the Phenomenon

Administrative supervisors are the nurse leaders present on the evening, night and weekend shifts when the unit managers, directors, and hospital administrators are not in the hospital. To provide a foundation for understanding the need to explore the administrative supervisor's role in nurse and patient safety, the background of the phenomenon commences with the off-shift nurse and patient outcome literature. After

that, a review of the off-shift qualitative nursing research provides a view into the evening and night shift, weekend and holiday hospital world. Articles on off-shift nursing leadership are reviewed, along with the one administrative supervisor pilot research study. For this research study, it is also critical to examine the related phenomena, which includes the empirical literature on the unit-based manager role and its relationship to nurse and patient outcomes. Finally, this chapter concludes with discussion of the literature on managerial practices and the theoretical framework guiding this research study.

Off-shift outcomes in hospitals

Poor patient and nurse outcomes have been associated with the off-shift in hospitals (de Cordova, Phibbs, Bartel, & Stone, 2012; Gould, Qin, & Chavez, 2005; Peberdy et al., 2008). For patient outcomes, as shown in Table 2.1, three retrospective studies found that on weekends, as compared to weekdays, adult patients had a higher mortality rate, delay in receiving procedures such as angioplasty, and more complications such as postoperative hemorrhage (Becker, 2007; Bell & Redelmeier, 2001; Bendavid, Kaganova, Needleman, Gruenberg, & Weissman, 2007). While at night, there were lower survival rates for adult patients who sustained an in-hospital cardiac arrest and an increased neonatal mortality rate for infants born at night as compared to daytime births (Gould, Qin, & Chavez, 2005; Peberdy et al., 2008; Urato, Craigo, Chelmow, & O'Brien, 2006). These studies demonstrate that there is a significant association between day of admission (weekday versus weekend) and time of birth, (daytime versus nighttime) and poor outcomes. Although reasons have been proposed to explain these off-shift differences, such as caregiver fatigue, staffing and reduced availability of services,

research has yet to determine the factors that affect these off-shift differences in patient

outcomes (Bendavid et al., 2007; Peberdy et al., 2008; Urato et al., 2006).

Table 2.1

Summary of Studies that Examined Patient Outcomes on the Off-Shift

Authors/Year	Participants	Relevant Conclusions
Becker (2007)	Retrospective, longitudinal study for elderly (Age: 77.14 mean) acute myocardial infarction (AMI) Medicare patients from 1989-1998 examined the timing of cardiac cath, angio, or CABG. Weekday patients = 659,006 Weekend patients =263,068	On their day of admission, weekend AMI patients are less likely to receive cardiac catheterization, angioplasty, or bypass surgery (p < .001). Becker theorizes that this difference may be related to the fact that Medicare does not reimburse based on timeliness.
Bell & Redelmeier (2001)	Retrospective, longitudinal study of 3,789,917 acute care admissions for ruptured aortic aneurysm, acute epiglottis, and pulmonary embolism from emergency departments in Ontario, Canada.	Weekend admissions had a higher in-hospital mortality rate when compared with weekday admissions among patients with ruptured aortic aneurysm (42% vs. 36%, p < .001, acute epiglottis (1.7% vs. 0.3%, p = .04), and pulmonary embolism (13% vs. 11%, p = .009).
Bendavid, Kaganova, Needleman, Gruenberg, & Weissman (2007)	Retrospective, longitudinal study of 4,967,114 inpatient admission data from 1999 to 2001 examining 8 complication rates using patient safety indicators.	On weekends, complications were more frequent: postoperative hemorrhage (OR = 1.07, 95% CI = 1.01, 1.14), newborn trauma (OR = 1.06, 95% CI = 1.03, 1.10), and obstetric trauma during cesarean sections OR = 1.36, 95% CI = 1.29, 1.44).
Gould, Qin, & Chavez (2005)	Retrospective, longitudinal study of birth-death certificate data on 3,363,157 California infants from 1992-1999. Births were 56.7% daytime, 23.4% early night (7PM to 12AM), and 19.9% late night (1AM to 6AM).	Neonatal mortality rate per 1000 live births was 1.88 for daytime births, and increased to 2.37 (OR = 1.12, CI = 1.05, 1.19, p < .001) for early night births, and 2.31 (OR = 1.16, CI = 1.09, 1.23, p < 001) for late night births.

Peberdy, Ornato, Larkin, Braithwaite, Kashner, Carey, & ... Berg (2008)	Retrospective, longitudinal study from 2000 to 2007, 86,748 adult in-hospital pulseless, cardiac arrest cases from 507 hospitals with 58,593 during day/evening and 28,155 during night.	Cardiac arrest outcomes, survival to discharge, return of spontaneous circulation longer than 20 minutes, survival at 24 hours, and favorable neurological outcome, were all statistically significant ($p < .001$) lower at night compared with day/evening. Survival from cardiac arrest during the week night shift compared with weekend night shift was similar. *The ED and trauma services were the only areas that had no significant difference in survival rates.
Urato, Craigo, Chelmow, & O'Brien (2006)	Retrospective case-control study, 80 deaths from Florida birth-related Neurologic Injury Compensation Association database from 1989 to 2002, and 999 births in Florida in 1996.	Fetuses sustaining injury severe enough to result in death were more than twice as likely as controls to have been born at night (OR = 2.09, 95% CI = 1.29, 3.40).

Research on nurse outcomes has found, as shown in Table 2.2, that healthcare professionals who worked weekends had increased work-family conflict, and night shift registered nurses were at higher risk for occupational injury, had lower commitment to nursing, and had more depression and poorer sleep quality than nurses working other shifts (Barnes et al., 2008; Brooks & Swailes, 2002; Horwitz & McCall, 2004; Ruggiero, 2003). The disruption in the night shift nurses' circadian sleep-wake rhythms may contribute to these poor outcomes, however research has yet to determine the reason for these poor nurse outcomes.

Table 2.2

Summary of Studies that Examined Nurse Outcomes on the Off-Shift

Authors/Year	Participants	Relevant Conclusions
Barnes et al. (2008)	Cross-sectional, correlational study surveyed 906 healthcare professionals from Australia, Brazil, Croatia and USA regarding shift length and working on Sundays.	Working on Sundays ($\beta = .14$, $p < .001$) was associated with increased levels of work-family conflict or the frequency with which one's work interferes with family life.
Brooks & Swailes (2002)	Cross-sectional, correlational study surveyed 2,987 British nurses regarding shift pattern and commitment to nursing. The commitment to nursing was measured with questions about enthusiasm for their job and recommending nursing as a career.	The 201 permanent night shift nurses had significantly lower commitment scores than nurses working the other shifts ($t = -3.51$, $p < 0.001$).
Horwitz & McCall (2004)	Retrospective study of 7,717 Oregon hospital workers compensation claims between 1990-1997.	The injury rate for day shift registered nurses was 145 (95% CI =135, 154) per 10 000, while the injury rate for evening and night shift registered nurses was 210 (95% CI = 195, 225) and 257 (95% CI = 231, 282) respectively.
Ruggiero (2003)	Cross-sectional, correlational study of 142 female permanent day and night shift critical care nurses.	Night shift nurses ($n = 75$) had significantly more depression ($t = -2.60$, $p = < 01$) and poorer sleep quality ($t = -2.94$, $p<.01$) than day shift nurses ($n = 67$).

Qualitative research on off-shift nursing in hospitals

In the last ten years, researchers have begun to investigate why poor patient and nurse outcomes have been associated with the off-shift in hospitals. When no significant difference was found in the nursing practice environment of weekday and weekend nurses, researchers turned to qualitative research for an explanation (Hamilton, Mathur, Gemeinhardt, Eschiti, & Campbell, 2010). Through focus groups the staff nurses

described their practice environment and identified three additional unique constructs, temporal fluctuation in patient needs, individual characteristics of nurses, and legal factors affecting care processes, which may begin to explain the off-shift difference in practice environment (Hamilton, Eschiti, Hernandez, & Neill, 2007). Other studies (see Table 2.3) with night shift nurses have demonstrated differences in the off-shift work environment with less people, newer staff, certain services not available, and less direct supervision (de Cordova, Phibbs, Bartel, & Stone, 2013; Eschiti & Hamilton, 2011; Hamilton et al., 2007; Powell, 2013). Yet the night shift staff nurses identified some positive factors to working this off-shift: more team work and learning opportunities, along with autonomy and independence (Nasrabadi, Seif, Latifi, Rasoolzadeh, & Emami, 2009; Nilsson, Campbell, Andersson, 2008; Powell, 2013; Ruggiero & Pezzino, 2006).

Table 2.3

Summary of Qualitative Studies that Examined the Off-Shift

Authors/Year	Participants	Relevant Conclusions
de Cordova, Phibbs, Bartel, & Stone (2013)	Qualitative study with 23 RN interviews (14 day/night; 1 day; 8 night) Four observer-as-participant observations	Themes: ➢ Less experienced staff/newer nurses worked at night ➢ Decreased resources/nursing and ancillary staff and support service so night nurses adapt and are self-reliant ➢ Lack of appreciation for night nurses
Eschiti & Hamilton (2011)	Institutional ethnography, interviewed 38 night and weekend critical-care nurses at three US hospitals.	➢ Inadequate staffing – fewer and newer nurses ➢ Less ancillary staff
Hamilton, Eschiti, Hernandez, & Neill (2007)	Exploratory, descriptive study with three focus groups consisting of 2, 3 and 9 labor and delivery and nursery nurses in four Texas hospitals	➢ Focus group data fit into constructs of Aiken's model moderately well: staffing and skills mix, early detection of complications, organizational

	to explore the differences between weekend and weekday nurse work environments. The nurses in the focus groups worked weekdays and weekends, however it was not specified whether they worked day shift or night shift.	support for nursing (resource adequacy, nurse autonomy, nurse control, and nurse-physician relations), processes of care, patient outcomes, and nurse outcomes. With three additional constructs: temporal fluctuation in patient needs, individual characteristics of nurses, and legal factors affecting care processes.
		➢ Additional data from focus groups:
		  ❖ Identified differences of less hospital supervision and problems getting physician backup for emergencies on weekends.
		  ❖ One participant stated the importance of the night/weekend supervisor presence and checking in.
		  ❖ Participants did not distinguish between weekend and night shift work environments.

Nasrabadi, Seif, Latifi, Rasoolzadeh, & Emami (2009)	Qualitative study exploring night work experiences, 18 Iranian night shift RNs working at four general hospitals were interviewed on two occasions.	The themes identified were: ➢ Socio-cultural impacts of night work ➢ Health-related impacts of night work such as fatigue ➢ Gain more clinical experience on nights, more independent
Nilsson, Campbell, Andersson (2008)	Descriptive study, interviewed 10 registered and 10 enrolled night nurses (RNs assistant) at a Swedish hospital to obtain their insight into the work of nurses at night.	Three themes were identified for the night shift nurses whose work is invisible and unknown: ➢ Conceptions of night work such as "Holding the fort" ➢ Working conditions, such as working in dim light, fatigue, and team work ➢ Duties

Powell (2013)	Qualitative case study to explore the experiences of night-shift nurses working in a regional public hospitals in Australia, interviewed 4 night nurses and the diaries from 10 nurses recording their night shift experiences and thoughts during the past 5-10 shifts. Ten of the participants worked night shift permanently.	The themes identified were: ➢ Work relationships – cooperative relationships with support for and from other workers ➢ Work environment – limited resources and suboptimal leadership and support ➢ Work practices – high order time management skills needed to deliver adequate care ➢ Personal impact
Ruggiero & Pezzino (2006)	Content analysis of responses to two survey questions regarding the advantages and disadvantages of the shift system from Ruggiero (2003) survey of 249 critical care nurses.	The content analysis of responses by the night shift nurses for the theme of work environment and team work revealed: ➢ Can spend more time with patients ➢ Great coworkers and teamwork ➢ More autonomy, less politics ➢ Coworkers are new graduates or new critical care nurses. ➢ Less staff ➢ Less support staff

Off-shift nursing leadership in hospitals

A review of the literature for off-shift nursing leadership commenced with searching the oldest nursing journal, *American Journal of Nursing*, which uncovered historical descriptive publications about the evening and night supervisor tasks and responsibilities (Boyer, 1939; Lefor, Anderson, & Craft, 1955; Tobin, Betterman, & Sevison, 1957). An early nurse researcher conducted field observations at seven hospitals during the night shift and found that the night supervisors made rounds and received report on the patients (Pfefferkorn, 1932). Additionally, a handbook for night supervisors, published more than sixty years ago, assisted supervisors with their administrative duties for which they had no prior training such as release of bodies, refusal of treatment, and suspicious persons

(Clare, 1960).

Further review of the literature was conducted searching electronic databases CINAHL, MEDLINE, and PubMed utilizing the terms "night supervisor" and "evening supervisor" and "off-shift management." MEDLINE and PubMed were searched from 1950 through 2015 and CINAHL was searched from 1981 through 2015. The role of the administrative or evening and night supervisor remains neglected, as there continues to be a paucity of articles published. In 1956, the American Hospital Association (AHA) recognized the evening and night supervisor role and identified staffing and making decisions "on the spot" as key functions of these supervisors (McWharf & Knotts, 1956). In the 1970s, an article was published regarding the elimination of evening and night supervisor positions at a neuropsychiatric facility because they performed primarily clerical and administrative tasks (Dahlsten & Flood, 1970). Although the authors reported a favorable response from a small sample of staff nurses surveyed after these supervisory positions were eliminated, no further articles were found regarding removal of the traditional evening and night supervisor positions.

During the 1980s, in the seminal, qualitative, descriptive study of magnet hospitals, staff nurses specifically identified the evening and night supervisors as being supportive and helpful (McClure, Poulin, Sovie, & Wandelt, 1983). Additionally, the staff nurses described the importance of supervisory staff, which includes the administrative supervisor, as being accessible, willing to help with care, and complimentary for a job well done (McClure, Poulin, Sovie, & Wandelt, 1983). Then, three non-empirically based articles were published, including a chronological account of a night supervisor's weekend shift, a commentary that nursing supervisors should move past the stereotypical

pre-retirement incompetents, and a case study on how a supervisor dealt with trying to keep employees awake on the night shift (Holness, Williams, Scott, Bolstad, & McCrary, 1992; Law, 1984; Sherwood, 1982).

More recently, this PI published evidence describing off-shift nursing management (Weaver, 2012; Weaver & Ellerbe, 2013). However, the only research on off-shift management was conducted by the PI, finding that the administrative supervisors oversee and do everything with responsibilities for staffing and patient flow, crisis management and manager support for the staff (Weaver & Lindgren, 2016). In the pilot study, all the interviewed administrative supervisors identified staffing and patient flow as a primary responsibility encompassing covering sick calls, calling in on-call staff, and patient bed assignment, even though the majority (60%) of the administrative supervisors had support personnel to assist with staffing. Another key role identified by the administrative supervisors was crisis management, which includes dealing with unexpected emergencies, responding to all codes, and dealing with patient and physician issues (Weaver & Lindgren, 2016). Manager support for the nursing staff was a category that emerged from the interviews and includes: being available, providing resources, being a resource, and caring about staff (Weaver & Lindgren, 2016). However, the managerial practices administrative supervisors use to achieve nurse and patient safety was not specifically addressed in the pilot study, and no other published research was found on off-shift nursing leadership. Although there have been publications describing the administrative supervisor role, this literature search revealed a significant gap, a vast chasm, with the absence of empirical studies published on management of the off-shift. This research study addresses the gap in empirical research on the role and the

managerial practices of the administrative supervisor explaining how this contributes to nurse and patient safety.

<div align="center">**Related Phenomena**</div>

Clearly research on the administrative supervisor role is lacking, however considerable research has been conducted on the unit-based nurse manager. Since administrative supervisors are the nurse leaders present on the evening, night and weekend shifts, the research on the unit-based nurse manager role is related. Thus, this portion of the literature review examines the empirical literature on the unit-based nurse manager role and nurse and patient outcomes, and concludes with the literature on managerial practices and the theoretical framework.

Unit-based nurse manager and nurse outcomes

Researchers have studied the unit-based nurse manager role and found that nurse manager leadership and support of nurses, such as backing up the staff, being supportive and providing praise and recognition, are related to increased staff nurse satisfaction, job enjoyment, retention and decreased nurse burnout (Anthony et al., 2005; Friese, 2005; Hall, 2007; Hanrahan, Aiken, McClaine, & Hanlon, 2010; Kovner, Brewer, Wu, Cheng, & Suzuki, 2006; Van Bogaert, Meulemans, Clarke, Vermeyen, & Van de Heyning, 2009; Wade et al., 2008). Furthermore, highly effective nurse managers have been linked to supportive nurse practice environments and nurse-assessed quality of care (Friese, 2005; Van Bogaert, Meulemans, Clarke, Vermeyen, & Van de Heyning, 2009; Zori, Nosek, & Musil, 2010).

Table 2.4

Summary of Studies: Unit-based Nurse Manager and Nurse Outcomes

Authors/Year	Participants	Relevant Conclusions
Anthony (2005)	Qualitative study with 32 nurse managers in four focus groups with six to nine nurse managers from seven acute care hospitals, exploring the role of the nurse manager related to nurse retention.	The roles of the nurse managers were classified as technical, professional, administrative, and fiscal. The following nursing unit characteristics, facilitated by the nurse manager, contribute to nurse retention: ➢ Team construction ➢ Good precepting and orientation ➢ Coaching and mentoring ➢ Proper staffing ➢ Recognition ➢ Availability of the nurse manager
Friese (2005)	Correlational, cross-sectional study with 1,956 RNs using the PES-NWI, Maslach Burnout Inventory, and questions on job satisfaction and quality of care.	Nurses who responded favorably to the PES-NWI subscale: Nurse manager ability, leadership and support of nurses, were less likely to have high emotional exhaustion ($\beta = -0.24$, $p < 0.01$) and job dissatisfaction ($\beta = -0.81$, $p < 0.01$) and more likely to report high quality care ($\beta = 0.31$, $p < 0.01$).
Hall (2007)	Correlational, cross-sectional study with 69 RNs from three nursing units at a large US hospital using the Inventory of Socially Supportive Behaviors and the Nurse Work Stress Scenarios.	Nurses with more perceived supervisor support had increased job satisfaction ($\beta = 0.51$, $p < 0.0001$) and less work stress ($\beta = 0.41$, $p < 0.05$).
Hanrahan, Aiken, McClaine, & Hanlon (2010)	Correlational, cross-sectional study with 353 psychiatric RNs from 67 hospitals using the PES-NWI and Maslach Burnout Inventory (MBI).	There was a significant association between the PES-NWI nurse manager ability, leadership and support of nurses' subscale and the MBI subscales of emotional exhaustion ($r = -.20$, $p < 0.001$) and depersonalization ($r = -.13$, $p < 0.05$) that was also supported in the regression models.

Kovner, Brewer, Wu, Cheng, & Suzuki (2006)	Correlational, cross-sectional study with 1538 randomly selected RNs, from metropolitan areas in the United States, and five of the survey questions were specifically about supervisor support, the degree to which supervisor supports and encourages employees	High supervisor support was significantly related to job satisfaction ($\beta = 0.81$, $p < 0.001$); 20% of the nurses who responded to the survey worked the night shift, however the researchers did not report specifics about the shift worked and the relationship with supervisor support.
Van Bogaert, Meulemans, Clarke, Vermeyen, & Van de Heyning, (2009)	Correlational, cross-sectional study with 401 RNs at two Belgium hospitals with Dutch version of the Revised Nursing Work Index (NWI-R-VL), Maslach Burnout Inventory (MBI), and questions regarding job outcomes (job satisfaction and intention to stay) and nurse-assessed quality of care.	There was a significant association between the NWI-R-VL nurse management at the unit level subscale and job outcomes ($r = 0.345$, $p < 0.01$), nurse-assessed quality of care ($r = 0.480$, $p < 0.01$), and the MBI subscales of emotional exhaustion ($r = -0.372$, $p < 0.01$), depersonalization ($r = -0.266$, $p < 0.01$), and personal accomplishment ($r = -0.352$, $p < 0.01$).
Wade et al. (2008)	Correlational, cross-sectional study with 731 RNs at one US healthcare system with Job Enjoyment Scale and PES-NWI	The PES-NWI subscales had a significant effect and explained 30.6% of the variance on the participants rating of job enjoyment, with the subscales of nurse manager ability, leadership and support of nurses ($\beta = 0.54$, $p < 0.001$) and staffing and resource adequacy ($\beta = 0.513$, $p < 0.000$) having the most influence on job enjoyment.
Zori, Nosek, & Musil (2010)	Correlational, cross-sectional study with 12 nurse managers and a random sample of their respective RNs; the nurse managers completed the California Critical Thinking Disposition Inventory and the staff nurses completed the PES-NWI.	There was a significant difference in staff nurses overall PES-NWI scores and nurse manager critical thinking disposition ($t = -4.048$, $p = 0.000$). A positive relationship was found between nurse managers critical thinking disposition, open-mindedness ($t = -3.989$, $p = 0.000$), and critical thinking confidence ($t = -6.049$, $p = 0.000$), and staff nurses' perception of the practice environment.

Unit-based nurse manager and patient outcomes

 Nurses play a key role in patient safety and act as surveillance in detection of errors and preventing adverse events (Institute of Medicine, 2004), and nurse managers also have a role in patient safety. Healthcare organizations are promoting a culture of patient safety, where errors and near misses are viewed as opportunities for improvement. When the nurse manager fosters a culture of safety at the unit level, by acting with integrity and fostering trust, staff are able to discuss errors and near misses, resulting in a reduction in errors (Vogus & Sutcliffe, 2007). Specifically, researchers uncovered that safety organizing behaviors, such as talking about and learning from mistakes, and trusting leadership (β = -0.68, p< 0.001) had a significant negative relationship with reported medication errors (Vogus & Sutcliffe, 2007).

 Along with establishing culture of patient safety, nurse managers have an important role with patient outcomes such as patient satisfaction, preventing errors and preventing adverse events (Wong, Cummings, & Ducharme, 2013). As shown on Table 2.5, effective nurse manager leadership is associated with an increase in patient satisfaction, decreased adverse events, and enhanced error interception practices (Boev, 2012; Flynn, Liang, Dickson, Xie, & Suh, 2012; Wong & Giallonardo, 2013).

Table 2.5

Summary of Studies: Unit-based Nurse Manager and Patient Outcomes

Authors/Year	Participants	Relevant Conclusions
Boev (2012)	Correlational, longitudinal study, 671 critical care nurses completed the PES-NWI and 1532 patients completed a patient satisfaction survey between 2005-2009.	The PES-NWI nurse manager subscale was significantly associated with patient satisfaction ($p = .018$). Nurses' favorable perception of their nurse manager was associated with a 0.424 increase in patient satisfaction.
Flynn, Liang, Dickson, Xie, & Suh (2012)	Correlational, cross-sectional study, 686 acute care hospital day shift RNs in New Jersey completed the PES-NWI and medication error interception practices survey	The PES-NWI nurse manager subscale was significantly associated with nurses error interception practices ($\beta = 0.64$, $p = 0.32$).
Wong & Giallonardo (2013)	Correlational, cross-sectional study, 280 acute care hospital RNs in Ontario, Canada completed the authentic leadership questionnaire and nurse-assessed adverse events of medication errors, nosocomial infections, patient/family complaints, and falls with injury.	A model of authentic leadership, which is a leader who has honesty, transparency and integrity, was significantly associated with decreased adverse outcomes through trust in the manager and areas of work life. ($x^2 = 1.30$ (df = 2, P = 0.52), $x^2/df = 0.65$, CFI = 1.00, IFI = 0.99 and RMSEA = 0.00)

Managerial practices

Nurse researchers have studied the unit-based nurse manager role and have linked

effective nurse managers with the supportive hospital nurse practice environments along

with high quality of care, increased patient satisfaction, and decreased adverse events

(Boev, 2012; Friese, 2005; Wong & Giallonardo, 2013; Zori, Nosek, & Musil, 2010).

Yet, despite the important role that nurse managers have with nurse and patient

outcomes, there is limited research on the specific managerial practices that nurse

managers utilize to achieve these positive outcomes. In management and organizational

research, managerial practices are defined as work redesign, team-building, strategic planning, career development, and clear communication (Grant, Christianson, & Price, 2007; Yoon Jik & Poister, 2014). Whereas in healthcare, there is some research identifying specific managerial activities or practices performed by nurse managers, commencing with the seminal study of magnet hospitals, which describes supervisory staff as being accessible, supportive, willing to help with care, and complimentary for a job well done (McClure et al., 1983). In home care research, the managerial practices of the nurse manager are described as effective communication, caring about the staff, and maintaining high standards (Buelow, Winburn, & Hutcherson, 1999). Currently, researchers are beginning to describe the specific managerial practices utilized by nurse managers to enhance patient safety. The managerial safety practices identified by nurse managers of outpatient hemodialysis units may be applicable to nurse managers in other settings and include: enforcing policies and procedures, monitoring and observing staff, advising staff and taking disciplinary action when needed, assessing and redesigning the environment, and staffing: making it work and filling in as staff (Thomas-Hawkins, Flynn, Lindgren, & Weaver, 2015). Thus, based on the literature, this research defines managerial practices as effective communication, team building, enforcing policies and procedures, staffing, being available, and caring about the staff. This research study explores the managerial practices of the administrative supervisor and how these practices contribute to nurse and patient safety.

Theoretical/Conceptual Framework

The theoretical framework guiding this research on management of the off-shift is the Nursing Organization and Outcomes Model, which links organizational attributes with

nurse and patient outcomes (Aiken, Sochalski, & Lake, 1997). This model, which was

developed from sociological Organizational Theory, posits that organizational factors,

such as nurse-to-patient ratio and nursing skill mix, affect the nurses' ability for early

detection of adverse patient events (Aiken, Clarke, & Sloane, 2002; Flood & Fennel,

1995; Flynn, 2007). Empirical investigation of the model established that structures in

organizations, such as staffing, and the nursing practice environment lead to care

processes which impact nurse and patient outcomes (Aiken et al., 2002). The nursing

practice environment, which includes nurse autonomy, nurse-physician relationships,

resource adequacy and nurse manager support, affects processes of care and thus has an

impact on patient outcomes (Aiken et al., 2002; Aiken et al., 1997). Furthermore, on the

unit level, staff nurses were identified as the professional around-the-clock surveillance

system in hospitals because of their presence and ability to identify patient complications

(Aiken et al., 2002). Thus, this research study proposes that the administrative supervisor

contributes to the off-shift nurse practice environment and thereby has a positive impact

on nurse and patient outcomes. Additionally, the administrative supervisor may act as

professional surveillance at a higher level, with their presence and ability to identify

problems and find solutions. The Nursing Organization and Outcomes Model guiding this

research on management of the off-shift is illustrated in Figure 2.1 and theorizes that off-

shift staffing, which is coordinated by the administrative supervisor, and the managerial

practices of the administrative supervisor impact nurse safety and patient safety.

Figure 2.1

Nursing Organization and Outcomes Model and Off-shift Management Research
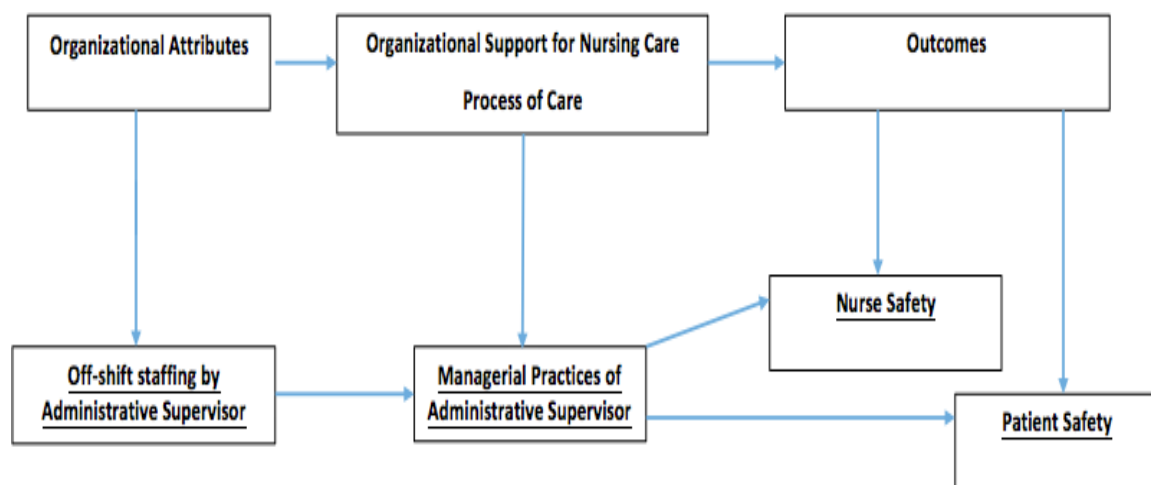
Research Questions

Researchers have found that nurse and patient outcomes are worse on off-shifts, as compared to the regular daytime shifts, with less people, newer staff, certain services not available, and less direct supervision. A glimmer of the positivity has been identified for off-shift including more teamwork, learning opportunities, autonomy and independence. Research is lacking on off-shift nursing leadership, other than one study in which the administrative supervisor responsibilities were classified as staffing and patient flow, crisis management and support for the staff (Weaver & Lindgren, 2016). Considerable research has been conducted demonstrating the important role that the unit-based nurse manager has on nurse and patient safety, however no comparable research has been conducted on the role the off-shift leader or administrative supervisor has with regard to nurse and patient safety. Therefore the overarching research question for this study informed by the Nursing Organization and Outcomes Model is: What are the administrative supervisors' descriptions of their managerial practices and how do these

practices contribute to nurse and patient safety? Additionally the sub question is: What are off-shift staff nurses' perspective of the administrative supervisor role and how does the administrative supervisor contribute to nurse and patient safety.

CHAPTER III

METHODS

In Support of Method

Despite the presence of an administrator supervisor in hospitals, there has been no published research on this role. Little attention has been paid to how this supervisor impacts nurse and patient safety. A qualitative research method was selected for this study because of a lack of empirical research. Exploring the role and impact of nurses who have direct experience as administrative supervisors, an inductive approach, provides the first step in understanding the role.

Two decades ago when there was little systematic research on the front line nurse manager role, qualitative research was utilized and nurse managers were interviewed to explore the role and responsibilities (Coulson & Cragg, 1995). Since then, qualitative research continues to be utilized when foundational research is lacking. In the exploration of the off-shift work environment, nurse researchers used a qualitative approach, with focus groups and interviews to better understand the experiences of night shift nurses and their off-shift work environment (de Cordova, Phibbs, Bartel, & Stone, 2013; Eschiti, & Hamilton, 2011; Hamilton, Eschiti, Hernandez, & Neill, 2007; Nasrabadi, Seif, Latifi, Rasoolzadeh, & Emami, 2009; and Nilsson, Campbell, & Andersson, 2008; Powell, 2013; Ruggiero & Pezzino, 2006). Only one of these qualitative studies clearly identified the methodology utilized. Specifically, institutional ethnography was used to study critical care nurses perspective of the off-shift work environment (Eschiti, & Hamilton, 2011)

Ethnography is a qualitative approach originally used in the nineteenth-century by

Western anthropologists to study non-Western cultures and societies and consisted of field-orientated activity and cultural interpretations (Hammersley & Atkinson, 2007; Lambert, Glacken, McCarron, 2011). During the twentieth century, sociologists joined anthropologists in studying Western societies with the ethnographic method. The resultant key ethnography characteristics are: research that takes place in the field, unstructured data collection through participant observation and informal conversations, small sample size and no quantification of data (Hammersley & Atkinson, 2007). While ethnographers studied whole communities or cultures, medical ethnographers recognized the importance of exploring cultural beliefs and health behaviors of sub-cultures or groups of people (Roper & Shapira, 2000). Thus, modified ethnographic methods emerged such as medical ethnography and focused ethnography.

Focused ethnography, or microethnography, is commonly used by nursing ethnographers and differs from classic ethnography because it focuses on a particular group of people exploring a specific phenomenon (Roper & Shapira, 2000). Other characteristics of focused ethnography include having background knowledge on the phenomenon, and conducting the study over a short period of time with key informants who have specific knowledge related to the study (Knoblauch, 2005; Muecke, 1994). Rather than using participant observation to become conversant with contextual factors influencing knowledge and behaviors, focused ethnography assumes that the researcher has background knowledge of the phenomenon and understands, to some extent, the world of those whom they are studying, such that they have an "insider" perspective (Knoblauch, 2005; Muecke, 1994). Therefore this method uses in-depth interviewing and focus groups with those who have specific knowledge related to the study, triangulated

with extant documents (Higginbottom, Pillay, & Boadu, 2013). Nurse researchers have used focused ethnography to explore nurses' roles on cardiac assessment teams (Smallwood, 2009) and on interdisciplinary teams (Al Sayah, Szafran, Robertson, Bell, & Williams, 2014). Additionally, nurse researchers have used focused ethnography with focus groups to explore community mental health nurses perspective in building a therapeutic alliance (Spiers & Wood, 2010).

A focused ethnography approach is well suited for this study to answer the specific question concerning the managerial practices of the administrative supervisors and how these practices contribute to nurse and patient safety. The characteristics of focused ethnography illustrate that it is a particularly appropriate methodology for this research because: 1) the Principal Investigator (PI) has background knowledge of this phenomenon with previous experience as an administrative supervisor, 2) the focus is on a specific group, administrative supervisors, and 3) there is a specific phenomenon that will be investigated, the managerial practices of administrative supervisors (Higginbottom, Pillay, & Boadu, 2013). Additional features of focused ethnography (formulation of the research question based on a specific phenomenon in advance, short-term and data intensive) will allow for exploration of the everyday/every night life and experiences of the administrative supervisors through interviewing and accessing extant documents such as job descriptions (Knoblauch, 2005).

This focused ethnography research study was conducted in two parts: focus groups with off-shift staff nurses and interviews with administrative supervisors. In part one, focus groups were held with off-shift staff registered nurses, who worked at hospitals in the pilot study conducted by the PI, to gain their perspective and to augment the

administrative supervisor perspective in exploring the administrative supervisor world

and safety practices (Denzin & Lincoln, 2011; Weaver & Lindgren, 2016). The focus

group discussion provided an opportunity for participants to explore their views and

experiences while listening to and responding to other participants' experiences and

viewpoints (Plummer-D'Amato, 2008). The focus group interaction revealed more about

how the managerial practices of administrative supervisors contributed to nurse and

patient safety than individual interviews. A focus group discussion guide (see Appendix

C), developed by the PI, consisted of a series of questions and probes (based on the pilot

study), was used to lead the focus group discussions with the staff nurses.

In part two, in-depth telephone interviews were conducted with administrative

supervisors from hospitals throughout the country, to identify and describe the

managerial safety practices and role responsibilities of the administrative supervisor that

enhance nurse and patient safety. These in-depth, semi-structured interviews provided

rich, detailed information with examples and stories about the administrative supervisors'

experiences (Rubin & Rubin, 2012). The telephone interviews were semi-structured

interviews utilizing an interview guide along with follow-up questions. The interview

guide (see Appendix D) was revised from Weaver and Lindgren's (2016) pilot study and

was created based on the AONE (2005) nurse manager competencies. This interview

guide was modified, as needed, based on the analysis of the focus group data and the

early administrative supervisor data.

Description of the Settings

This research study was conducted in two parts and with two sets of populations, off-

shift staff nurses and administrative supervisors. The first part consists of focus groups

with off-shift staff registered nurses to gain their perspective on the administrative

supervisor's role in nurse and patient safety. In the recent pilot study conducted by the PI,

ten administrative supervisors were interviewed at ten hospitals in New Jersey (Weaver

& Lindgren, 2016). The PI returned to seven of these hospitals to conduct focus groups

with off-shift staff registered nurses to expand upon the administrative supervisor

perspective. These hospitals were primarily non-profit hospitals (86%), with three

hospitals having the ANCC Magnet® designation and one hospital having the ANCC

Pathway to Excellence® designation.

The second part consisted of telephone interviews with administrative supervisors to

identify and describe the managerial safety practices and role responsibilities of the

administrative supervisor that enhance nurse and patient safety in hospitals.

Administrative supervisors were interviewed from thirty different hospitals throughout

the United States. Purposive sampling to gain maximum variation was utilized to obtain

participants from different states and different types of American Hospital Association

(AHA) (2015b) registered hospitals such as teaching hospitals, non-teaching hospitals,

urban hospitals, rural hospitals, for profit ownership, not for profit ownership, ANCC

Magnet® designated hospitals, and ANCC Pathway to Excellence® designated hospitals

(Sandelowski, 1995).

Characteristics of the Participants

Sample. Part One – Focus groups. The focus group sample consisted of registered

nurses who met the following inclusion criteria: 1) currently working full-time, part-time

or per diem (as needed) in one of the ten hospitals in New Jersey that were part of the

PI's pilot study; 2) identified current position as staff registered nurse on the evening

and/or night shift; and 3) speaks and reads English. While exclusion criteria were registered nurses who: 1) do not work in one of the ten hospitals in New Jersey that were part of the PI's pilot study; and 2) are not a staff registered nurse on the evening and/or night shift.

Sample. Part Two – Administrative Supervisor Interviews. The administrative supervisor sample consisted of registered nurses who met the following inclusion criteria: 1) currently working full-time or part-time in different states and different types of AHA registered United States hospitals such as teaching hospitals, rural hospitals, and ANCC Magnet® designated hospitals; 2) identified current position as administrative supervisor, the nurse leader present on the evening, night or weekend shift representing off-shift nursing leadership; and 3) speaks and reads English. While exclusion criteria were registered nurses who: 1) do not work in an AHA registered hospital in the United States; 2) are not an administrative supervisor, the nurse leader present on the evening, night or weekend shift representing off-shift nursing leadership; 3) work per diem (as needed) as administrative supervisor; and 4) do not have time to participate in a telephone interview.

Protection of Human Subjects

Institutional review board (IRB) approval was obtained from Rutgers, the State University of New Jersey for this qualitative study, and as required, from participating hospital institutional review boards to ensure that the rights of human subjects were protected prior to data collection. The design of this study was such that there is no more than minimal risk to subjects participating in the study. The participants may have become tired or may have some unpleasant memories when answering the questions during the focus group meetings or the interviews. Precautions were taken to minimize

the risk to the participants and included emphasizing that participation is voluntary, that the participants could leave the focus group or stop the interview at any time, and that the participants could skip or refuse to answer any questions.

Data was collected for this research study through in-person focus group meetings, telephone interviews, and completion of a demographic data form. Each focus group had a scribe to assist the PI, and the scribe had documentation of successful completion of Human Subjects Certification Program. Before beginning the focus groups in part one, the PI explained the research study and had the participants sign the informed consent which included: 1) an explanation of the purpose of the study; 2) an explanation that there will be no direct benefits and minimal risks to participation; 3) an assurance of confidentiality; and 4) an assurance of the participant's right to choose not to participate or to terminate participation at any time during the focus group. At the beginning of each focus group discussion, the participants were asked identify themselves when speaking with a pseudonym, such as a flower, color, food, tree, animal, rather than their own name. The pseudonym assisted with transcription along with tracking if everyone spoke.

At the beginning of each telephone interview with the administrative supervisors and prior to recording the interview, the PI explained the research study and read the telephone consent which included: 1) an explanation of the purpose of the study; 2) an explanation that there will be no direct benefits and minimal risks to participation; 3) an assurance of confidentiality; and 4) an assurance of the participant's right to choose not to participate or to terminate participation at any time during the interview. Participation in the interview served as consent to study participation and for recording the interview.

There were no financial costs to participants for participating in this study. The focus

group meetings lasted approximately 21 to 45 minutes and the individual telephone interviews were 33 to 69 minutes. For all participants there was only one focus group meeting or one interview session. At the conclusion of the focus group sessions and administrative supervisor interviews, each participant received a Visa® gift card as a token of appreciation for their time. There were no direct benefits to the participants in this study. However, a better understanding of the administrative supervisor role assists in exploring the impact of this nursing management role on nurse and patient outcomes.

The signed consent forms were kept in a separate locked file cabinet. The demographic data forms completed by the focus group participants and the transcripts from the focus group sessions have no name or identifying information other than a pseudonym. There were no names or identifying information in the transcribed interviews. The demographic data forms were kept in a separate locked file cabinet, and the PI entered the demographic data into Microsoft Excel and Statistical Package for the Social Sciences (SPSS) statistical software onto a laptop computer that was password-protected. The focus group meetings and the interviews were audio-recorded, utilizing a digital recorder, and transcribed into Microsoft Word documents by paid transcriptionists. Once the PI checked the transcripts for accuracy, the audio-recordings were erased. All audio-recordings and interview transcripts were stored on separate computers that were password-protected. De-identified transcripts were then transferred into a computer with ATLAS.ti software. Computer files were backed up on an external drive and secured in a locked file cabinet that only the PI had access. All paper documents will be shredded three years after completion of the research study. All electronic files will be destroyed three years after completion of the study. Data collected from this study that is published

or presented will be reported only as grouped data, and no participants will be identified by name.

Data Source and Collection

The first part of this research study was focus group meetings with off-shift staff nurses which augments the administrative supervisor perspective in exploring the administrative supervisor world and safety practices (Denzin & Lincoln, 2011). The second part consisted of interviews with administrative supervisors to identify and describe the managerial safety practices and role responsibilities of the administrative supervisor that enhance nurse and patient safety in hospitals.

Part One – Focus groups. In order to obtain the off-shift nurses' perspective on the administrative supervisor role, focus groups with off-shift staff nurses were held at the New Jersey hospitals involved in the PI's pilot study, The focus groups were held at the individual pilot study hospitals which allowed for participant homogeneity, because from working at the same hospital participants were more comfortable expressing their views (Plummer-D'Amato, 2008).

In order to obtain approval to conduct the focus groups, the interviewed administrative supervisor, the nursing research staff, or the Chief Nursing Officer (CNO) were contacted at the New Jersey pilot study hospitals. With Rutgers, the State University of New Jersey institutional review board (IRB) approval, only CNO approval was needed at two hospitals. Six hospitals required approval of the hospital specific IRB in addition to Rutgers, the State University of New Jersey IRB approval, and one of these hospitals also required presentation of the proposed research study to their hospital nursing research committee. Approval was obtained to conduct the focus group at eight hospitals. The PI

decided not to conduct the focus group at one of the eight hospitals, because of upcoming union negotiations and specific requirements requested by the CNO. After receiving approval at the respective hospitals, the PI set the date, time and location of the focus group with the assistance of the nursing research staff or interviewed administrative supervisor. The PI attempted to recruit eight to ten off-shift staff registered nurses from the seven hospitals by distributing a flyer and/or sending a recruitment e-mail (Morgan, 1998). If participants responded to the e-mail or flyer, the PI informed them about the study and verified their interest in participating. The day before the focus group a reminder e-mail was sent to any participants who responded to the flyer or e-mail, and the administrative supervisor was contacted to remind the staff, during his/her rounds, about the focus group. The focus groups were held at a convenient location in the participants' hospital and at a time that was convenient for the participants: either 6 p.m., before the 7 p.m. to 7 a.m. shift, or 8 a.m., after the 7 p.m. to 7 a.m. shift. The seven focus groups sessions lasted approximately 21 to 45 minutes and had a total of 39 staff nurse participants, ranging from two to nine participants. Beverages and snacks were served to provide a comfortable atmosphere for the participants (Krueger & Casey, 2015).

For each focus group the PI had a scribe (who did not work at that particular focus group hospital), to take notes and ensure the tape recorder was functioning. The scribes had documentation of successful completion of Human Subjects Certification Program and were instructed by the PI on their role in the focus group. The seating arrangement for the focus group was in a circular formation, with the PI and scribe sitting opposite one another (Plummer-D'Amato, 2008). The PI began the focus group sessions with introductions and an explanation of the research study and of focus groups. After signing

the informed consent, the participants were asked complete the demographic data form (see Appendix A) and to identify themselves during the focus groups with a pseudonym. Ground rules were established, at the beginning of each focus group discussion, and included that there were no right or wrong answers, it is important to hear all participant's experiences and opinions, only one person should speak at a time, and participants should not talk about what they hear in the focus group outside of the group (Krueger & Casey, 2015). The focus group discussion guide (see Appendix C) was utilized to facilitate discussion, and all proceedings were digitally recorded. At the conclusion of the focus group, the PI thanked the participants and gave $20 Visa® gift cards to each participant as a token of appreciation for their time. The demographic data form and transcribed focus group discussion were not linked with the consent form. Due to the lengthy and arduous process in obtaining individual hospital approval, the first focus group was held on June 1, 2015 and the final focus group was held on October 21, 2015. The PI conducted seven focus groups over a 20-week period; saturation was reached and no new information was emerging (Plummer-D'Amato, 2008).

Part Two – Administrative Supervisor Interviews. To reach administrative supervisors throughout the United States, telephone interviews were the most cost effective method and convenient for the participants (Chapple, 1999; Sturges & Hanrahan, 2004). The PI recruited potential administrative supervisor participants from hospitals throughout the United States with the assistance of the American Organization of Nurse Executives (AONE) and nursing colleagues. A recruitment flyer was distributed at the April 2015 AONE annual meeting. An advertisement was placed in the AONE electronic newsletter requesting Chief Nursing Officers (CNOs) to invite administrative supervisors at their

institution to participate in this research study. This paid advertisement was e-mailed to AONE members every Tuesday in the *AONE Working for You* e-mail and every Friday in the *AONE eNews Update* e-mail from June 16, 2015 through September 15, 2015, when the advertisement was stopped because enough participants had been obtained. Additionally, nursing colleagues in hospitals throughout the United States were asked to forward a recruitment e-mail to administrative supervisors inviting them to participate in this research study. When responses were received from the recruitment flyer, advertisement, or e-mail, the PI informed them about the study, asked them the name of the hospital where they work, and verified their interest in participating. Purposive sampling to obtain variation was used to select participants from hospitals in different states and different types of hospitals such as teaching hospitals, rural hospitals, and ANCC Magnet® designated hospitals (Sandelowski, 1995). The PI then confirmed that the participant's hospital was an AHA registered hospital and that no other participants had been interviewed from that hospital prior to scheduling the phone interview. The one-time interviews were conducted at a date and time that was convenient for the participants and the interviews lasted between 33 minutes and 69 minutes. The interviews occurred over a 12-week period from June 19, 2015 until the final interview on September 14, 2015. Despite having the same themes after the 20th interview, the PI decided to continue to interview supervisors to explore multiple perspectives and variation by states (Guest, Bunce, & Johnson, 2006; Sandelowski, 1995). All interviews were digitally recorded.

At the beginning of the phone call and prior to recording the interview, the PI explained the research study, read the telephone consent and asked if the participant had

any questions. Participation in the interview served as consent to study participation and for recording the interview. The participant was asked to e-mail or fax the PI the current administrative supervisor job description at their institution and 18 job descriptions were received. The recording of the interview commenced with asking the demographic data questions (see Appendix B) followed by the interview, which was a series of questions and probes as outlined on the interview guide (see Appendix D). At the conclusion of the interview, a $25 Visa® gift card was mailed to the participant as a token of appreciation for their time. The transcribed demographic data information and interviews were not linked with the consent form.

Demographic Data Form. For both parts demographic data forms (see Appendices A and B) were used to collect data that describes the characteristics of the sample, such as age, gender, position title, education, and certification along with description of the hospital.

First Part. The PI used a focus group discussion guide (see Appendix C) consisting of a series of questions and probes, based on the pilot study conducted by the PI, to guide the focus groups with the staff nurses. This guide included asking for examples or stories about what the administrative supervisor does to support the staff nurse, to keep nurses safe, and to keep patients safe.

Second Part. The PI used an interview guide (see Appendix D) consisting of a series of questions and probes, based on the AONE (2005) nurse manager competencies, to guide the interviews with the administrative supervisors.

Documents. The participants were asked to e-mail or fax the PI the current administrative supervisor job description at their institution.

Field notes. There were four types of field notes in this research study: scribe field notes, descriptive field notes, analytical field notes, and a reflexive journal. During the focus groups, the scribe took field notes about the impression the scribe received from the group along with the nonverbal behaviors, and these field notes supplemented the digital recordings (Field & Morse, 1985). The PI wrote descriptive field notes after each focus group and interview. Throughout this research study, analytical field notes were written by the PI and functioned as an audit trail on analytic ideas, perceptions of patterns and concepts, and emerging themes and codes (Roper & Shapira, 2000). Additionally, the PI kept a reflexive journal recording personal reactions, feelings and emotions (Roper & Shapira, 2000).

Data Analysis

An inductive, systematic approach was used for analyzing this focused ethnographic research study (Roper & Shapira, 2000). The focus group transcripts were analyzed for the staff nurses' perspective of the administrative supervisor practices and how these practices contribute to nurse and patient safety. The interview transcripts with the administrative supervisors were analyzed in similar fashion and compared with the job description data. The PI was immersed in the data. The transcripts and field notes were read, re-read and coded by the PI beginning with the first focus group and continuing throughout the study. In conducting thematic analysis, the PI used an iterative, cyclic, comparative method to identify codes and sort for patterns (Fetterman, 2009; Hammersley & Atkinson, 2007). Frequent meetings were held with the faculty mentor to reach consensus. After the focus group transcripts and interview transcripts were analyzed separately, these transcripts were then compared for common patterns and

themes. When analyzing the data, diagrams and contrast tables were drawn, mapping was done to systematically display common patterns and themes (LeCompte & Schensul, 1999). Additionally, the scribe field notes, descriptive field notes, analytical field notes, and reflexive journal, were used in the analysis and provided a better understanding of the data. To enhance the validity of this ethnographic research, triangulation was done with the data from the interviews, focus groups, and job descriptions (LeCompte & Schensul, 1999). The demographic data was analyzed using standard descriptive statistics.

Trustworthiness

Considering that intimate knowledge of the area to be investigated is a key aspect of focused ethnography, trustworthiness must be established (Knoblauch, 2005). For this research study trustworthiness was established with respondent validation (member check), reflexivity, thick description and triangulation (Hammersley & Atkinson, 2007).

Respondent validation (member check) was employed to confirm the accuracy of the analysis. After some of the administrative supervisor interviews, the PI asked these supervisor participants if they would be willing to review a synopsis of the findings to determine if it corresponds with their practices as an administrative supervisor. Then after the data analysis was completed, an overview of the findings was sent to five administrative supervisors for confirmation of themes.

As a former administrative supervisor, the PI found it was important to be reflexive and remain explicit and transparent, to minimize the effect of the PI's experience might have on data collection and analysis (Cruz & Higginbottom, 2013; Roper & Shapira, 2000). This was important for the PI to identify potential influences and possible biases

on the research process. The PI adopted a self-critical stance during the focus group meetings and interviews by clarifying statements, not assuming understanding of statements, and monitoring reactions to statements. The PI was identified as a researcher and only disclosed previous experience as administrative supervisor if asked by participants. A reflexive journal was written after each focus group and interview and maintained throughout the research process to document feelings and interactions with participants, along with personal reactions and emotions that emerge with analysis. In this reflexive journal, the PI contemplated if she was imposing her perspective and feelings or is this what the off-shift nurse or supervisors were really saying. The reflexive journal was also used in the data analysis.

Thick description of thinking, reading and reflecting, was utilized to thoroughly analyze the data from the focus groups, interviews, job descriptions, reflexive journal and scribe, descriptive and analytic field notes (Gertz, 1973). This data was read, re-read, contemplated, and analyzed to uncover and draw conclusions based on the deeper, not the superficial, meaning. This research study included direct quotes from the participants, which allows the readers of the research report to follow the process and draw similar conclusions.

Triangulation was utilized with data-source, investigator and methodological triangulation (Hammersley & Atkinson, 2007). Data was obtained from not only the interviews with the administrative supervisors, but also from the focus group meetings with off-shift staff registered nurses. The data from these different groups augmented understanding of the managerial practices of the administrative supervisor. An expert qualitative researcher, the faculty mentor, also reviewed the data and analytical notes

throughout the study. The researchers used an iterative, comparative method to identify codes and themes, and held frequent meetings with the faculty mentor to reach consensus. Methodological triangulation occurred through comparing the interview transcripts with the job description data and the focus group data.

Summary

Focused ethnography was the research methodology utilized to answer the specific question about the managerial practices of the administrative supervisors and how these practices contribute to nurse and patient safety. The characteristics of focused ethnography illustrate that it is an appropriate approach for this research because the focus is on a specific group and specific phenomenon of which the PI has background knowledge, and it is short-term and data intensive. This focused ethnographic study was conducted in two parts: the first part with off-shift staff nurses and the second part with administrative supervisors. The first part consisted of focus groups with off-shift staff registered nurses to describe the off-shift environment and identify the administrative supervisors' role in nurse and patient safety. The second part consisted of interviews with administrative supervisors to identify and describe the managerial safety practices and role responsibilities of the administrative supervisor that enhance nurse and patient safety in hospitals. The focus group and interview transcripts were thematically analyzed. For this research study trustworthiness was established with respondent validation, reflexivity, thick description and triangulation. This methodology provided insight into the managerial practices of the administrative supervisors in hospitals and how these practices contribute to nurse and patient safety.

CHAPTER IV

CONTEXT AND INFORMANTS

Historical and Sociocultural Context of the Research

The administrative supervisor role has existed in hospitals for more than 100 years, as revealed in a recent review of the oldest nursing journal, *American Journal of Nursing* ("Editor's Miscellany," 1901). And now in the 21st century, empirical research is beginning on the administrative supervisor role. This focused ethnography study explored the managerial practices of the administrative supervisors and how these practices contribute to nurse and patient safety. For this research, data was collected in two parts and with two sets of related populations and two data collection methods: 39 off-shift staff nurses participated in seven focus groups and individual interviews were held with 30 administrative supervisors from hospitals throughout the United States. In addition to describing the participants, it is important to describe the seven hospitals where the staff nurses work and the 30 hospitals were the administrative supervisors work.

Introduction to the Hospital Participants

Based on hospital profile information from the American Hospital Association (AHA), the hospitals where the focus group staff nurses and administrative supervisors worked are described according to hospital bed size, teaching status, location and ownership (AHA, 2015b). The AHA has pre-defined bed size ranges and classifications of teaching hospitals as major teaching, minor teaching, and non-teaching. Major teaching hospitals are those with Council of Teaching Hospitals designation (COTH); minor teaching hospitals are those approved to participate in residency and/or internship training by the Accreditation Council for Graduate Medical Education (ACGME), or

American Osteopathic Association (AOA), or those with medical school affiliation reported to the American Medical Association; non-teaching hospitals are those without COTH, ACGME, AOA, or medical school affiliation. The AHA classifies hospitals as urban or rural, according to the size of the local populations. An urban hospital is a hospital located inside a Metropolitan Statistical Area (MSA), in an urban area with a large population base (AHA, 2014). A rural hospital is described as a hospital located outside a MSA (AHA, 2014).

Part One – Focus Groups. The first part of this research study consisted of focus group sessions with off-shift staff registered nurses. In the pilot study completed by the Principal Investigator (PI), administrative supervisors were interviewed at ten hospitals in New Jersey (Weaver & Lindgren, 2016). The PI returned to seven of these New Jersey hospitals to conduct focus groups with off-shift staff registered nurses to expand upon the administrative supervisor perspective. According to the AHA, these seven hospitals were all considered urban hospitals, with no distinction of suburban, just urban and rural. Additionally, the seven hospitals were primarily non-profit (86%), teaching hospitals (71.5%), and three hospitals had the ANCC Magnet® designation, and one hospital had the ANCC Pathway to Excellence® designation. Based on hospital profile information from the AHA, additional descriptors regarding the seven New Jersey hospitals are listed in Table 4.1.

Part Two – Administrative Supervisor Interviews. The second part of this research study consisted of telephone interviews with administrative supervisors. Purposive sampling to obtain maximum variation was utilized to recruit participants from different states and different types of AHA registered hospitals: teaching hospitals, non-teaching

hospitals, urban hospitals, rural hospitals, for profit ownership, not for profit ownership, ANCC Magnet® designated hospitals, and ANCC Pathway to Excellence® designated hospitals (Sandelowski, 1995).

Table 4.1   Table 4.3

Focus Group Hospital Descriptors   *Administrative Supervisor Hospital Descriptors*

n = 7 Hospital Bed Size	n	%
100 - 199	1	14
200 - 299	2	29
300 - 399	0	0
400 - 499	1	14
500 +	3	43
Teaching Status	n	%
Major Teaching	3	43
Minor Teaching	2	28.5
Non-Teaching	2	28.5
Location	n	%
Urban	7	100
Rural	0	0
Ownership	n	%
Non-profit	6	86
For-profit	1	14
ANCC Designation	n	%
ANCC Magnet®	3	43
ANCC Pathway®	1	14

n = 30 Hospital Bed Size	n	%
25-99	2	7
100-199	5	16
200-299	8	27
300-399	1	3
400-499	3	10
500+	11	37
Teaching Status	n	%
Major Teaching	11	37
Minor Teaching	12	40
Non-Teaching	7	23
Location	n	%
Urban	27	90
Rural	3	10
Ownership	n	%
Non-profit	25	83
For-profit	3	10
Government (Federal/ NonFederal)	2	7
ANCC Designation		
ANCC Magnet® designation	11	37
ANCC Pathway to Excellence® designation	3	10

The 30 interviewed administrative supervisors worked in 20 different states as listed in Table 4.2 and shown in Figure 4.1. These 30 different hospitals were primarily non-profit (83%), teaching (77%) hospitals, with eleven hospitals (37%) having the ANCC

Magnet® designation and three hospitals (10%) having the ANCC Pathway to

Excellence® designation. According to the AHA classification, 90% of the hospitals

were considered urban hospitals, with no distinction of suburban, just urban and rural.

Based on hospital profile information from the AHA, additional descriptors regarding the

hospitals are listed in Table 4.3.

Table 4.2

Administrative Supervisor Location in the United States

State	Number of Administrative Supervisors Interviewed	State	Number of Administrative Supervisors Interviewed
1. Arkansas	1	11. Nebraska	2
2. California	2	12. New York	3
3. Colorado	2	13. North Carolina	1
4. Florida	1	14. Oklahoma	1
5. Idaho	1	15. Pennsylvania	4
6. Iowa	1	16. Rhode Island	1
7. Kansas	1	17. Texas	1
8. Kentucky	1	18. Virginia	1
9. Massachusetts	2	19. Washington	1
10. Missouri	2	20. Wisconsin	1

As shown in Table 4.4, some hospitals had more than one administrative supervisor

working during the shift. Fisher's Exact test showed that there was a statistically

significant association ($p = 0.03832$, $n = 30$) between the size of the hospital and the

number of supervisors, such that hospitals with more than 500 beds were more likely to

have more than one administrative supervisor. As will be discussed in Chapter V, staffing

is a key role responsibility for administrative supervisors. At some hospitals,

administrative supervisors reported having assistance with staffing, either with a regional

staffing office or staffing personnel. Eight hospitals (27%) have staffing assistance 24

hours a day, seven days a week, while nine hospitals (30%) did not have staffing

assistance for a period of time during the night shift such as from midnight until 4AM,

shown in Table 4.4. Fisher's Exact test demonstrated that there was no statistically

significant relationship ($p = 0.0937$, $n = 30$) between the size of the hospital and staffing

assistance.

Figure 4.1

Administrative Supervisor from Different States in the United States
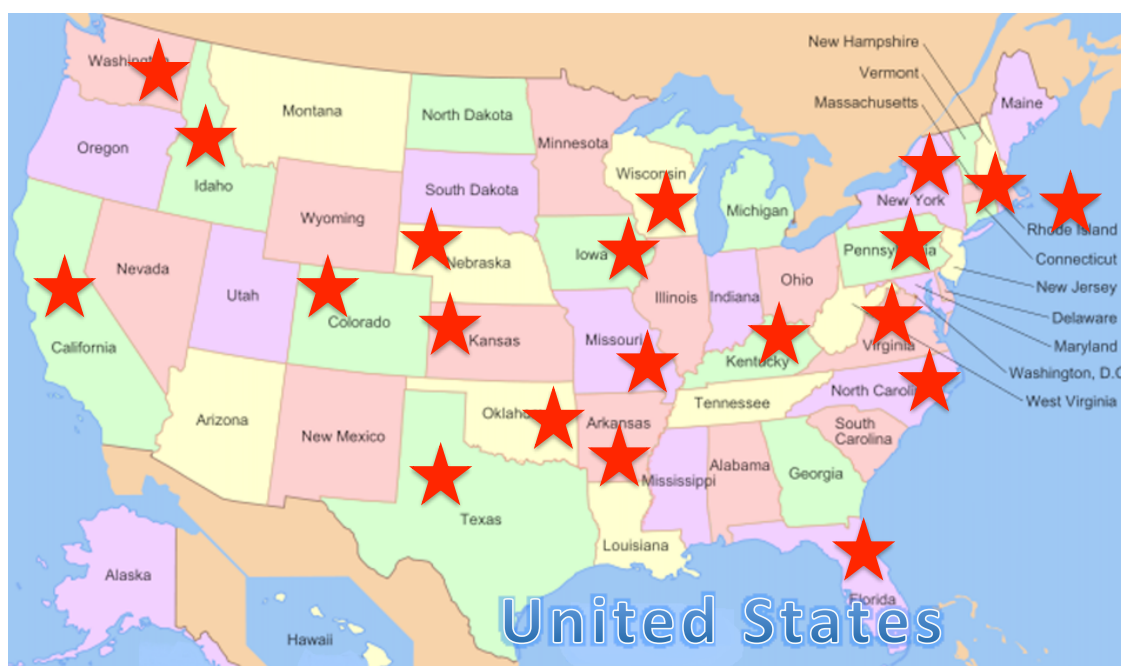
Table 4.4

Hospital Size, Number of Administrative Supervisors Working, and Staffing Assistance during the Shift

Size of Hospital	n (%)	
Small ($\leq$ 149 beds)	7 (23)	
Medium (150 - 499 beds)	12(40)	
Large ($\geq$ 500 beds)	11 (37)	
Number of Administrative Supervisors	**n (%)**	**p-value***
One	20 (68)	
Two	8 (26)	**0.03832**, n = 30
Three	2 (6)	
Staffing Assistance	**n (%)**	**p-value***
Yes	8 (27)	
Partial	9 (30)	0.0937, n = 30
No	12 (40)	
N/A	1 (3)	

*Determined with Fisher's Exact test due to small sample size.
Bold value is significant at p < 0.05.

Introduction to the Participants

First Part – Focus Groups. The focus groups with 39 off-shift staff nurses provided information about the administrative supervisors' role in nurse and patient safety along with basic staff nurses demographics (See Table 4.5). The number of participants in the seven focus groups ranged from two to nine staff nurses. The staff nurses had an average age of 41.9 years and an average of 13.97 years of nursing experience. Four of the staff nurses (10%) were male, 29 staff nurses (76%) had a BSN, 12 staff nurses (31%) had national nursing certification, and 34 staff nurses (87%) worked the night shift, 7 p.m. to 7:30 a.m.

Second Part – Administrative Supervisor Interviews. Thirty administrative supervisors provided information about their managerial practices and how these practices contribute to nurse and patient safety, along with basic administrative

supervisor demographics (See Table 4.6). The administrative supervisors were older, with the average age of 49.6 years, and had more years of nursing experience (an average of 23 years) than the staff nurses. Three of the supervisors (10%) were male. The highest nursing degree was only a diploma or associate degree for 30% of the supervisors, however eight supervisors (27%) had advanced nursing degrees. Additionally only 11 supervisors (37%) had national nursing certification. All the interviewed administrative supervisors worked evening, night or weekend shifts, which included a variety of different hours and were not the typical staff nurse shifts, such as 3 p.m. – 7:30 a.m., 6 p.m. – 6:30 a.m., 6:45 p.m. – 7:15 a.m., or 8 p.m.- 8:30 a.m. When analyzing the many different shifts and hours the supervisors reported working, the most common number of hours worked was 12 hours.

Table 4.5   Table 4.6

Staff Nurse Demographics   *Administrative Supervisor Demographics*

Staff Nurse n = 38	Mean (SD)	Range
Age (years)	41.9 (11.4)	23 – 64 years
Years as RN	13.97 (11.3)	1 – 37 years
Years in Current Role	10.14 (9.7)	0.5 – 30 years
Gender n = 39	n	%
Male	4	10
Female	35	90
Highest Nursing Degree n = 38	n	%
RN Diploma	2	5
Associate Degree	5	14
Baccalaureate Degree	29	76
Masters Degree	2	5
National Nursing Certification n = 39	n	%
Yes	12	31
Hours worked n = 39	n	%
Day shift 7AM – 7:30PM	4	10
Night shift 7PM – 7:30AM	34	87
Day and Night shift 7AM – 7:30PM and 7PM – 7:30AM	1	3

Administrative Supervisor n = 30	Mean (SD)	Range
Age (years)	49.6 (11)	33 – 70 years
Years as RN	23 (13)	3 – 47 years
Years experience as Administrative Supervisor	7.12 (6.5)	3 months – 26 years
Gender	n	%
Male	3	10
Female	27	90
Highest Nursing Degree	n	%
RN Diploma	3	10
Associate Degree	6	20
Baccalaureate Degree	13	43
Masters Degree	5	17
Doctoral Degree	3	10
National Nursing Certification	n	%
Yes	11	37
Number of hours worked during shift	n	%
8 hour shift	3	10
11 hour shift	1	3.3
12 hour shift	18	60
Varied shifts, 8 and 12 hour shifts	6	20
Varied shifts, 8 and 14 hour shifts	1	3.3
Varied shifts, 8 and 16 hour shifts	1	3.3

The majority of administrative supervisors (60%) reported to a director (see Table 4.7), and the supervisors stated they had the phone call support of their boss and/or an administrator on call. As shown in Table 4.8, the interviewed administrative supervisors identified 18 different job titles for the role, with House Supervisor and Administrative Supervisor as the most common job titles.

Table 4.7

Administrative Supervisor Report to

Administrative Supervisors report to n = 30	**n**	**%**
Chief Nursing Officer	4	13
Director	18	60
Manager	5	17
Other	3	10

Table 4.8

Identified Job Titles of the Interviewed Administrative Supervisors

Job Titles of Administrative Supervisors   **(Number of Administrative Supervisors with the Job Title)**
Administrative Coordinator (2)
Administrative Nursing Supervisor
Administrative Supervisor (3)
Clinical Nursing Supervisor
Clinical Supervisor
House Administrator
House Manager (2)
House Supervisor (7)
Night Shift House Supervisor
Nurse Administrator (2)
Nursing Administrative Coordinator
Nursing Assistant Manager
Nursing Administrative Supervisor
Nursing Supervisor (2)
Patient Care Coordinator
Off-Tour Nursing Supervisor
RN House Senior Manager
Supervisor

Description of the Audit Trail

The PI checked the focus group and interview transcripts for accuracy, transferred the transcripts into a computer with ATLAS.ti software, and coded the transcripts. The PI read and re-read the transcripts along with the scribe field notes and descriptive field notes. The PI wrote analytical field notes regarding emerging themes and codes. Biweekly meetings were held with the faculty mentor to review selected transcripts and analytical field notes, discuss codes, diagrams and emerging themes. Additionally, meetings were held with other committee members and faculty, who had leadership and research expertise, to review diagrams and discuss codes and themes. When analyzing the data, maps and conceptual schema were drawn to provide a clear picture of the common patterns and themes.

For the respondent validation (member check), a four-page overview of the findings was sent to five administrative supervisors who worked at medium and large size hospitals, teaching and non-teaching hospitals, and one supervisor who worked at an ANCC Magnet® designated hospital. These supervisors indicated that the PI captured the comprehensive nature of the role, the variety of tasks and responsibilities, and the challenges associated with this role.

Methodological triangulation occurred through comparing the data from the interviews with the administrative supervisors to the staff nurse focus group data. Both sets of data were analyzed separately. As analysis of the administrative supervisor interviews was coalescing around particular themes, the PI returned to the focus group data to explore how the staff nurse perspective of the supervisor role supported or contradicted the administrative supervisors' perspective. Additionally, job descriptions received from 18

administrative supervisors, were examined and compared with the focus group and interview data.

Summary

For this focused ethnography research study, the data was collected through focus groups with staff nurses and individual interviews with supervisors. Seven focus groups were held with 39 off-shift staff nurses who worked at seven different New Jersey hospitals. Individual telephone interviews were held with 30 administrative supervisors who worked at 30 different hospitals throughout the United States. In addition to describing the participants, the seven hospitals where the staff nurses worked and the 30 hospitals were the administrative supervisors worked were described.

CHAPTER V

DESCRIPTION AND DISCUSSION OF THEMES

This focused ethnographic research addressed the gap in empirical research on the administrative supervisor role. The overarching research question was answered regarding the administrative supervisors' perspectives of their managerial practices and how these practices contribute to nurse and patient safety. Data was collected for this research study through focus groups with off-shift staff nurses and individual interviews with 30 administrative supervisors from hospitals throughout the United States. The data analysis of the interviews and focus groups revealed an overall theme of the administrative supervisors as the shift leader who does "everything" with the goal to get the patients, staff, and hospital safely through the shift. With thorough analysis of the data, the subthemes of role responsibilities, "make it work" and outcomes along with corresponding categories emerged. Thus, the administrative supervisors achieve nurse and patient safety by fulfilling their role responsibilities of staffing, patient flow, crisis management, and hospital representative, and "make it work" by doing rounds, educating, providing support, and establishing trust with the staff.

Overall Theme

In seeking to answer the overarching research question, it became evident that the administrative supervisors and the staff nurses in the focus group view the administrative supervisor as the shift leader. An administrative supervisor explains, "You are the leader during the evening and off-shift. You represent the hospital" (Adm4). The staff nurses in the focus groups also viewed the supervisor as the shift leader and as the authority figure in the "white coat":

> She is higher up in the hierarchy. So people have more respect for her. You may tell somebody something with a patient or a co-worker and they don't take it seriously. But when it comes from the supervisor it has different impact (StaffA).

As the nurse leader present on the evening, night, and weekend shifts, these supervisors function and view themselves as a leader, not a manager, and do not view themselves as part of the nursing leadership team. This became apparent when the administrative supervisors described the managerial or human resources tasks that they performed, the different world on the evening and night shift, and the skills needed for this role. An administrative supervisor at a large ANCC Magnet® designation hospital stated, "Technically we are not managerial. We don't do evaluations and we don't do hiring or discipline other than to diffuse a situation at the moment" (Adm17).

Furthermore, the administrative supervisors do not see themselves as responsible for the hospital 24 hours a day, seven days a week, but only responsible for their particular shift. Indeed, the primary goal of the administrative supervisors was to get the patients, staff, and hospital safely through the shift by doing whatever was necessary. An administrative supervisor explained:

> We're here to help the patients and to get through this night, and make sure that everybody's safe and if it means that I need to — here's an example of something I would do—I would go to labor and delivery and answer phones and take new patients that might happen to walk through the door, back into a room and get them on a monitor while the nurses are doing an emergency C-section (Adm15).

These administrative leaders deal with not just nursing issues, but all issues that occur on the evening and night shift, as stated by one supervisor, "You make sure that everything is within order and if it's not, then you address it" (Adm18). Being the only administrative person present in the hospital, the supervisors sometimes feel like a "one man circus" or a "juggler spinning plates in the air." Surviving the shift was the indicator of success, as

described by a supervisor:

> Our census was six hundred and we were staffed for like four hundred and sixty. And I survived the night! Managed to get to each of the codes. I found someone who could accompany the helicopter coming in and still managed to get the staffing done on time and avert whatever other crisis were going on (Adm17).

The goal of the shift leader to get patients, staff and the hospital safely through the shift is clarified by the subthemes of role responsibilities, make it work and outcomes. The role responsibilities identified by the administrative supervisors were staffing, patient flow, crisis management, and hospital representative. The administrative supervisors "make it work" and achieve nurse and patient safety by establishing trust, doing rounds, educating, and providing support for the staff, as illustrated in Figure 5.1.

Figure 5.1

Visual Representative of Thematic Analysis
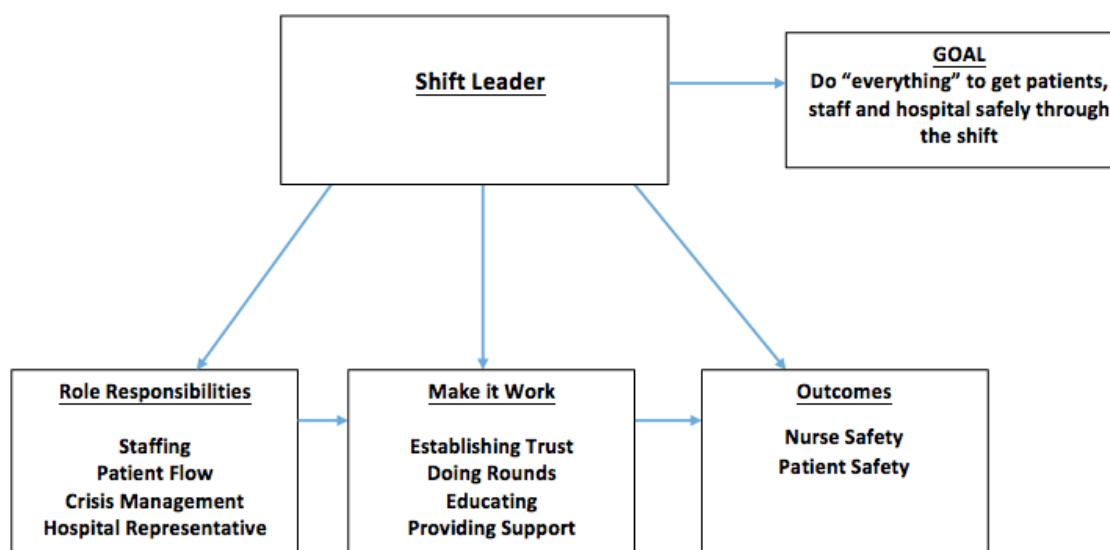
Shift Leader

The administrative supervisors did not view themselves as managers nor as part of the nursing leadership team. The supervisors identified their role more as a shift leader than

manager because of the different hospital off-shift world, along with the tasks performed and the skills needed for this role. The majority of the administrative supervisors are the only leader present during the shift they are working, while during the daytime there are multiple leaders present such as directors, managers, and the chief nursing officer (CNO). The administrative supervisors consider themselves in the background and typically work alone with responsibility for the entire hospital during the shift they work.

These shift leaders on the evening, night and weekend night shifts also articulated a disconnect with the daytime nursing leadership team, which commonly consists of the unit-based managers, directors and chief nursing officer. The administrative supervisors explained that they try to handle issues on the nursing unit without bothering the unit-based managers during the off-shift. Thus, the primary means of communication with the daytime unit-based managers was by e-mail. The administrative supervisors also talked about the frustration with the Monday morning quarterbacking and questioning of their decisions, as explained by a supervisor, "Quarterbacking: directors maybe calling you and asking you why didn't we have an extra nurse on the unit? Or because this patient fell on their unit and what was the circumstances" (Adm19). One supervisor explains her strategy for handling this Monday morning quarterbacking:

> I do try to communicate frequently with the directors if there's an event or conflict or whatever it may be, just because I'm gonna go home and go to bed and so my perspective on the incident may not be out there and available for people who come in in the morning. In fact, all of us on night shift are gone and in bed so they may only be hearing about this scenario from people who were not there and that's where that Monday morning quarterbacking can come in (Adm23).

The administrative supervisors are disconnected from the nursing leadership team due to the hours they work, and their inability to attend the management meetings because these meetings are typically held in the middle of the day. Furthermore, at some hospitals

the administrative supervisors are not even invited to the leadership meetings, and one

supervisor explained that this is due to being hourly employees:

> We will have to get paid for coming in at 11:30. So they don't want us to do that.
> So, we don't come to it. So we are kind of like the red headed stepchild of
> management. So we miss out on everything that happens during the day but we
> are expected to know about it (Adm12).

Another supervisor at a large teaching hospital, who mentioned during the interview

about being salaried and not hourly, does not attend meetings with the nursing leadership

team because "we sort of are the behind the scenes crew."

   The following example provided by a supervisor who works at a large hospital facility

that just implemented open visitation further illustrates this disconnect with the

leadership team:

> So just recently, an e-mail came out saying that there has been a lot of discussion
> about open visiting. And we were like "Wow." We have no clue that in all of
> these meetings they have been discussing open visiting, 24-7. And we were like,
> would have been nice to be able to give our input, for after 5:30 when you all
> punch out. And there is only me (Adm12).

Even though not involved in the planning of new processes, a supervisor explained how

she acted as a cheerleader with the staff during the implementation of "awesome

arrivals":

> The staff nurses have to go down and get their patients from the emergency
> department, get beside report down there and then bring them up. They're not
> very happy about that situation" (Adm21).

So this supervisor chose to tell the staff to be positive and think about how good this new

process is for the patients, instead of "being negative about it, and saying I don't know

what they're thinking" (Adm21). An administrative supervisor succinctly summarizes

this disconnect with the nursing leadership team and suggests that others do not even

understand the work that is done by the supervisor:

> Our management team does more than its share of "Monday morning quarterbacking" and does not take kindly to our input. We are simply the "behind the scenes crew" who shows up, does our work (whatever that may be), and try to leave the hospital a little better than we found it (Adm24).

These shift leaders explained they do not perform the typical managerial tasks of unit-based managers and identified unique skills needed for this role, because they are part of a different structure on the evening and night shift. When the supervisors were asked about managerial or human resource responsibilities, the administrative supervisors explained they are the administrative representative on the off-shift and perform on the spot counseling or discipline, with a few supervisors completing performance reviews and having direct reports (refer to Table 5.1 for the supporting quotes from the supervisors). Administrative supervisors reported sending employees home pending investigation for inappropriate behavior, sleeping, or refusing an assignment. If a staff member is suspected of being impaired or diverting narcotics, the administrative supervisor addresses:

> If you suspect a nurse who is under the influence, or I had a nurse who was taking narcotics, we have to go get the nurse bring her in, contact the outside company to come in and do a drug test. Stay with her the whole time until the company gets there. Lucky for me the nurse came forward and gave me the drugs. She handed me the drugs that she has stolen from the PYXIS (Adm29).

Additionally, some administrative supervisors completed annual performance reviews on charge nurses or nursing float staff, while other supervisors provided input for employee evaluations when requested by the managers. A supervisor at a rural hospital was able to complete evaluations on all the night shift nurses. Four supervisors, who work at medium and large hospitals, have direct reports; the nursing float staff reports to these administrative supervisors.

Table 5.1

Administrative Supervisor: Managerial Responsibilities

Administrative supervisor Leadership Responsibilities	Quotes
On the spot counseling or discipline	If we have a staff member that appears to be impaired, it would be my responsibility to meet with them and initiate what we call for just for cause testing. If there is any concern about their ability to work then we will remove them from the clinical area until the investigation can be completed. I usually notify their manager and notify Human Resources in the middle of the night but that would be followed up in the morning and I'd get the staff member a cab ride home (Adm9).
Performance Reviews or evaluations	All the evaluations of the charge nurses on the night shift are done by the house supervisor (Adm26).
Direct reports	I currently have thirty-five float members who report directly to me if you will. So, I am responsible to monitor their attendance; to issue any discipline for their attendance. And I also do their probationary and annual evaluations (Adm3).

As shift leaders, the administrative supervisors delineated the skills needed for this role. Clinical skills or expertise was identified as essential according to the supervisors and staff nurses. Although a few supervisors (23%) have previous management experience, managerial skills were not identified as needed skills for this role. Other important skills identified for this role include conflict management, time management, organizational, and critical thinking (refer to Table 5.2 for the supporting quotes from the supervisors). The administrative supervisors explained that courses in crucial conversations, crisis intervention and disaster preparedness training would be beneficial to current and future administrative supervisors. "I think more education on a larger scale, like what our hospital would have to be doing in our community if there was a mass casualty, if there were Ebola patients" (Adm8). Many administrative supervisors enter this role with

charge nurse experience and as stated by a supervisor, "The unfortunate thing is that as nursing supervisor they also do not get a lot of leadership courses" (Adm29).

Some administrative supervisors spoke about the importance of knowing the hospital, knowing your resources, knowing the policies and the "way things work," and having common sense. Interestingly 73% of the administrative supervisors worked at their hospital as staff nurses, most commonly as ICU charge nurses, prior to being recruited or moving into the supervisor position. Two supervisors explained the value of this longevity:

> All of the nursing coordinators that work right now, have all come from different units. So they're very familiar with the culture of the hospital. They're very familiar with the physical layout of the hospital and how the hospital operates on a daily basis. We've had people come from the outside but they seem very qualified to do the job; however, because they're not part of the culture, they're so busy trying to tell us how they do it someplace else and trying to change some way that we do it that they become very dissatisfied with their job and they don't stay (Adm28).

> I had been at the hospital for quite some time and my background was Critical Care. So I had at that point worked every critical care area, ER, ICU, Cath Lab, and I was asked if I would be interested in orienting to supervision because of my clinical expertise. And they felt like I would…I had been in charge and felt like I was a good leader (Adm29).

An administrative supervisor explained that having life experiences and commons sense helps in this role:

> You have to have common sense and the ability to not panic when a crisis comes on. You have to be able to step back from the situation to be able to observe what is going on and then make a decision upon your observations rather than to jump in and just start directing (Adm7).

Additionally, this role is physically demanding "A lot of activity, walking. You have to be physically capable to walk all of the units" (Adm4).

Thus the administrative supervisors work as the solo shift leader striving to get the patients, staff and hospital safely through the shift. These behind the scenes leaders do not

see themselves as managers and believe clinical expertise is more important for this role than

managerial skills. So despite being disconnected from the nursing leadership team, the

administrative supervisors achieve nurse and patient safety by fulfilling their role

responsibilities of staffing, patient flow, crisis management, and hospital representative,

which is the first subtheme discussed.

Table 5.2

Administrative Supervisor Skills

Administrative supervisor skills	Quotes
Clinical expertise	I think all of our House Supervisors have ICU background. I think it helps with the job. Especially with a code blue or a code white. You are able to really assess a change pretty quick and have an idea of what needs to be done. What kind of labs need to be ordered (Adm30).
People skills	You have to have the personality but you can be calm even when your environment is stressful. And you have to be able to make quick decisions… So you need to have social skills and good IPR with the staff (Adm4).
Conflict Management skills	Learning how to deal with patient complaints and how to manage those effectively is also a skill…when you're first doing it you kind of have to have in mind what you're going to say and how you're going to approach the patient who has a complaint, so that you don't escalate them, so you can help resolve their complaint more effectively (Adm9).

Role Responsibilities

The first subtheme in this research study, the role responsibilities of the administrative

supervisors consist of three categories: staffing, patient flow, crisis management and

hospital representative. The staff nurses in the focus groups also identified these categories

as essential responsibilities of this position. Additionally, in the job descriptions received

from the majority of administrative supervisors, staffing, patient flow and crisis management

were listed as principal duties and responsibilities.

Staffing

Staffing involves ensuring the appropriate nursing staff matches the patient census and

acuity on each unit for the current shift, as well as the next shift. An administrative

supervisor summarized what staffing involves:

> I'm also responsible for helping with unit staffing and making sure that we adhere
> to the staffing guidelines as well taking into account the acuity of the patients. If
> staffing needs arise throughout the shift I'm responsible for helping problem solve
> and helping to assist with any appropriate staff to that unit as needed… making
> sure we have safe staffing and that the acuity of the patients and the staffing, the
> skill mix of the nurses is appropriate on any given unit and if it is not then we
> make adjustments and try to remedy that (Adm9).

The key aspects of staffing identified by the administrative supervisors were: calling

in on-call staff, adjusting staffing during the shift, and staffing for the next shift which

includes obtaining staff to replace scheduled team members who are absent (covering

"sick calls"), following union rules, and assigning the float staff (refer to Table 5.3 for the

supporting quotes from the supervisors). Regardless the size of the hospital, the

administrative supervisors call in the on-call staff for areas such as the Operating Room

(OR), Endoscopy, or the Cath Lab. Staffing is a collaborative process that involves

talking with the resource or charge nurses and observing the activity on the units during

rounds, along with ensuring the staffing guidelines are followed. A supervisor explained:

> So it's really trying to… again, being up on the floors and saying to the nurses
> who are saying we want more staff, "Okay run the board for me, tell me what's
> going on." Helping them really get comfortable with articulating that so that I can
> make a decision and I can, in terms of the facts, when I'm asked about it later
> (Adm10).

At eight hospitals (27%), the administrative supervisors have staffing assistance 24

hours a day, seven days a week. While at nine hospitals (30%), the supervisors have some

or partial assistance with staffing such as until midnight and after 4AM. At twelve

hospitals (40%), the supervisors have no assistance with staffing during their shift, as

shown in Table 4.4. Only one administrative supervisor stated that staffing was not part of

the role, but rather the responsibility of the individual units. Even though the

administrative supervisors may have assistance with staffing, the overall responsibility for

staffing resides with the supervisor:

> The staffing department would be responsible for calling people in. We are responsible for making sure they are in their appropriate place, the appropriate number is there for the census of the day, and if there are any fluctuations or call-offs, we will be in touch with them throughout the entire 8 to 12 hour shift (Adm7).

For all administrative supervisors, the overall goal of staffing is to provide safe patient

care on all the nursing units in the hospital. However getting staffing right can be

rewarding and challenging. The administrative supervisors explained that staffing can be

rewarding when there is enough staff and "you can just concentrate on other things such

as patient satisfaction" or when a miracle happens and you can give a nursing unit the

staff they need because "you are able to pull a nurse out of thin air or a nurse drops in

your lap." Most of the time staffing is challenging for the administrative supervisors,

such as when there are "no shows," trying to meet the union deadline for cancelling staff,

or when there is not enough staff and the nurses, charge nurses, and even the unit-based

managers expect the administrative supervisor to find the needed staff. The

administrative supervisors must staff for all the nursing units in the hospital and try

"evening out" or "right-sizing" the staffing, but this can be controversial as explained by

an administrative supervisor:

> Probably one of the most challenging experiences are when we are short staffed. And the different units don't want to send a staff member to help cover another unit…The Chief Nursing Officer got involved and said, "No. That is staffing's job and everyone has to respect the decision." I look over the sheets. The staffing coordinators, they send out reports to all of the administrators about how staffing is. So, they understand that staffing has to be as fair as possible. And so with that

process, for the most part, it works. But the challenging part is when someone only sees their unit. They don't see past their unit. And we don't get the support that we need. It makes it rough for everybody that's involved in staffing (Adm30).

Staffing and patient flow, the next subtheme, are intertwined and many supervisors talked about holding admissions to a unit because there was not enough staff. One supervisor provided an example of a challenging time with staffing that was affected by multiple patients in the emergency department and not enough open beds in the hospital:

> It was just like a perfect storm, because our ER had a lot of critical patients and our ICU and most of our units were nearing capacity and we just didn't have the beds. We did not have the staff but the patients just kept coming. So it was just a situation where every patient we had to look at and decide what unit could handle it and make multiple phone calls, work with the ER staff, they actually held a couple patients until we could get staff there to take them, so they were real good with that even though they were getting pretty overwhelmed. And it was just a situation where I was helping out in emergency room, up on the units, just trying to do whatever I could. We got some of the directors to come in. They were passing meds. They were rounding on patients. They were helping out any way they could, transporting, doing everything. So, that was a situation that we made it through but like I said it was very difficult (Adm14).

The staff nurses in the focus groups also identified staffing as a key responsibility of the administrative supervisor role, and explained how staffing and the next subtheme, patient flow, are linked or connected:

> They are the one person who has an overview of what is going on in the units. So far as staffing and acuity, they really are the expert on the off-shift on where we can move people. If a step down unit has a patient and we are putting them on a Cardizem drip and we need extra help, they know where they can pull because they have the overview. They are the only one on the off-shift that has that overview, that has the knowledge and ability to take staff from one unit to the other to help if there is a crisis or a change (StaffD).

Table 5.3

Role Responsibilities: Staffing

Administrative supervisor Role responsibilities: Staffing	Quotes
Calling in on-call staff	We call in the on call team, be it the cath lab, the OR, or the ortho (Adm18).
Adjusting staffing during the shift	We make sure all the units are staffed with the appropriate nurses, nurses' aides, and the targets that we follow are based on acuity and patient care hours. So we look at that and we adjust as the shift goes on… sometimes they will come and say the unit is a bit busy. Do you have an extra nurse or do you have an aide to help? And in my rounds, I will re-evaluate what the staffing was. And I will pull someone to help them whether it be a nurse or an aide based on the acuity of what is going on, on the floor as the shift changes. So we will look at that for their safety (Adm6).
Staffing for next shift	Sometimes folks will be like, "Oh, I can't stay; yeah okay I will stay." That will be the second phase and it will literally be in the moment you are rounding. Or as you round, you find out from the charge nurse, "Well, that patient was on a one to one for safety but he is actually calming down." He is alert and we don't need another aide on the day shift so you have to take someone off observation and then you won't have to cover it. And if we prescheduled someone there we can move them to a different location (Adm3).
Obtaining staff	We actually have a target grid and we look at acuity above or below target …We are able to, of course, call and get additional staff. We can offer bonus pay which is $10 an hour extra for nurses and $5 an hour for ancillary staff. And we can offer that to bring extra people in if we are in a situation and need additional staff. We can pull or float between units. We usually try to float from ICU and ER and then our Med-Surg, Ortho/Telemetry units (Adm16).
Following union rules	Staffing and meeting the union guidelines, the union deadline of calling off the different people and doing it in the right order, that's the most stressful because you want to do what's best for the organization. You don't want to have a whole bunch of nurses there or staff there if you don't need them. But if you don't call in time, you will be responsible…And so you have like two hours to maybe call off, depending on how full the house is, to call off 30 people and you have to go in order. And then if this person says no,

	you have to go to the next person and so it gets very overwhelming and you may not have the support staff to even help you. **It's just you. Alone** (Adm13).
Assigning float staff	We are responsible for staffing, in that there is a Float Team for the hospital and we utilize those nurses and PCTs to fill the vacancies that we have per shift… we look at the needs, sick calls, leave of absence, whatever shortages are on the floor for whatever reason. And then we utilize our Float Team to fill those needs, you know. And balance out throughout the house. Of course, addressing the most critical shortages first (Adm17).

Patient Flow

Connected with staffing, the administrative supervisors are also responsible for patient

flow or ensuring that patients move efficiently through the hospital and are placed in the

appropriate beds (refer to Table 5.4 for the supporting quotes from the supervisors). The

administrative supervisors achieve efficient and effective patient flow with their

knowledge of the activity and patient acuity on all the nursing units in the hospital along

with good communication to the staff. A staff nurse in the focus groups explains,

> I think a lot of it is just communication. We are moving a patient from here to
> here, then you can move your patient and then you can take that patient from the
> ER. So long as we all know that. Whether it takes fifteen minutes or an hour and
> fifteen minutes. Things are working but as long as everyone is on the same page.
> The supervisor is the person in the middle. So long as they tell everyone the same
> story, it all works out. Then you are not placing twenty phone calls back and forth
> to a unit that won't take report and you just wasted more time, got more people
> aggravated (StaffE).

Whether patients are being admitted from the emergency department, direct

admissions (patients admitted without going to the emergency department), or are

transfers due to a code emergency or from another hospital, the administrative

supervisors make sure the patients are admitted to the appropriate unit. The staff nurses in

the focus groups value the administrative supervisors role with patient flow and explained

how important it is to receive appropriate patients for their nursing units. A staff nurse

stated,

> We are the only other floor that take ventilated patients that are trached. So,
> sometimes they are very sick still when they get to us. So, they (Administrative
> Supervisor) usually go down to the ICU and are really looking at the patients
> before they send them up to us for the most part. And knowing who we are as a
> unit, knowing what the ICU looks like, and kind of getting a whole idea of what
> the hospital looks like after that time (StaffE).

Even though many administrative supervisors have personnel to assist with patient

placement, they have the overall responsibility and are called upon for advice. An

administrative supervisor talked about his role in patient placement,

> Admitting will call and ask me to look at a patient and make sure the bed
> placement's right, whether they might need, instead of just a medical bed, they
> might need full telemetry or ICU. And we do catch those more frequently than I
> would like because the ER's just trying to get them out so they can get the next
> one and it's just one of those things where, they need to be in the right bed
> ...otherwise dangerous things can happen (Adm24).

Additionally, at some hospitals, the administrative supervisor will make the decision with

the administrator-on-call regarding diverting patients to another hospital when the

hospital is at capacity.

Table 5.4

Role Responsibilities: Patient Flow

Administrative supervisor Role responsibilities: Patient flow	Quotes
Admissions from emergency department	I am bed control so I work with the ED to bed patients in the appropriate beds and I deal with the hospitalists, trying to make sure that we're putting them in the right place at the right time so that we're not transferring them to a higher location if they should be there to start with (Adm2).

Direct admissions	Making sure that the patients that are being admitted through the emergency department are being placed in the proper department. As well as taking the direct admissions, taking the information from physicians and placing those patients into the proper departments (Adm15).
Code emergencies	If some patient codes on the floor they need an ICU bed. I have three ICUs with available beds then it's my decision, which unit should that patient go to based on acuity and the activity of each of the units, which is most appropriate (Adm23).
Transfers	The other night I worked, speaking and dealing with transfers, patients transferring in to our facility, we have to find rooms and coordinate that with, we have a transfer center (a call center) but we have to be the ones to find the beds and kind of coordinate where to put the patients (Adm14).

Crisis Management

Another key role of the administrative supervisors is crisis management that includes

dealing with unexpected hospital issues such as building and weather emergencies, and

patient emergencies (refer to Table 5.5 for the supporting quotes from the supervisors).

The administrative supervisors described utilizing problem solving approaches when

dealing with unique building and weather situations. Building issues included dealing

with increasing humidity in the ORs because the air handlers were down, power outage,

no phone service, chemical spill, no air conditioning, or an unscheduled computer

downtime. One supervisor illustrated the complexity of a building issue, "There was

flooding in the OR and we had to get the AOC (Administrator on Call) involved because

we had to obviously get it stopped, cleaned up, and start cancelling surgeries for the next

day" (Adm8).

The weather also poses problems and the administrative supervisors talked about the

importance of keeping the hospital functioning during snowstorms, ice storms or tornado

warnings. An administrative supervisor explained the impact of an ice storm, "There was a forty car pileup because of an ice storm and our ER was inundated with traumas" (Adm29). In addition to managing the multiple hospital admissions, this supervisor had to rearrange staffing because the ice storm was preventing nurses from getting into the hospital. A few supervisors mentioned setting up the incident command center for any type of disaster situation. "If a patient comes in identified as possibly having Ebola, then we are the site manager (the incident command person) for about a half hour until the whole team arrives," explained an administrative supervisor at a teaching hospital with greater than 500 beds (Adm23).

All administrative supervisors respond to patient emergencies, which include RRT (rapid response team), Code Blue (cardiopulmonary arrest), Code Grey/Orange (aggressive or violent patient), Code Pink (possible infant/child abduction), Code Purple (emergency cesarean section), trauma, STEMI (ST-segment elevation myocardial infarction), Stroke Alert, postpartum hemorrhage, and Code Red/Yellow (fire). The role of the administrative supervisor in patient emergencies is essentially, "Making sure they (the staff) have what they need," and may consist of getting more help, running the code until the physician arrives, ensuring that everyone is performing their role, acting as the recorder, talking to family, making sure that everyone is safe, or facilitating transfer of the patient to another unit. An administrative supervisor at a teaching hospital with greater than 500 beds explained that when a RRT is called for an unstable patient on a medical-surgical nursing unit, "we are trained to start and titrate the drips and monitor the patient until they actually arrive in the ICU" (Adm23). When responding to fire emergencies, the administrative supervisors investigate and address the cause. One smoke

emergency was caused when a nursing assistant (NA) put a towel in the microwave for a

patient, so the administrative supervisor educated the NA, "We never heat up anything

for a patient in the microwave" (Adm27).

Table 5.5

Role Responsibilities: Crisis Management

Administrative supervisor responsibilities Crisis Management	Quotes
Hospital issues: building emergencies	The air conditioning…One day it shut down and the units were getting very warm, I am calling the Administrator - Emergency Management came in and we had to deal with the situation (Adm19).
	If there are issues with the phones or the phones go down, we're in charge of getting the pagers out and setting up the incident command center (Adm11).
Hospital issues: weather emergencies	For tornadoes just make sure the doors to the patient rooms or the windows are closed. Make sure staff are aware that we are in a bad weather type situation so everyone just pitch in (Adm30).
	Last winter was a truly challenge. We had a lot of the snowstorms… For nurses who want to come in early, we will also have to set that up to get the accommodations for them. So that was the thing that was very challenging winter as the evening administrator, working to get that set up to ensure that the nurses worked. And the nurses and the nurses' aides that were coming off-shift had somewhere to stay comfortable. Working with nutrition getting meals set up for them, getting them meal vouchers (Adm6).
Patient Emergencies	I run the code with the physician because I'm the one that tells them when it's been three minutes since epis been given and now it's time to shock again. I'm the one that watches to make sure the compressions are fast enough (Adm27).
	I respond to traumas. And they utilize me however, depending on the clinical level of the nurses that's in there. I am usually the documenter. But there are times that I have assisted the physician if we have young staff or there is not enough staff (Adm29).

Hospital Representative

On the evening and night shift, the administrative supervisor is the in-house hospital representative for all issues that are typically dealt with by other hospital personnel or departments during the daytime (refer to Table 5.6 for the supporting quotes from the supervisors). Patient and family concerns, are addressed by a patient representative, physician issues, are dealt with by the medical staff office, legal issues, are addressed by the legal or risk department, media questions, are addressed by the marketing department, and employee work- related injuries, are addressed by employee health, are handled on the evening and night shift by the administrative supervisor with the support of an administrator on call.

The administrative supervisor handles any patient, family or physician complaints or concerns as described by a supervisor:

> We're the contact for any complaints in the hospital at night as we're the kind of administrative representative that's always there in the house and we contact the administrator on call if need be for any problems (Adm21).

The administrative supervisors described utilizing effective communication along with problem solving and conflict resolution approaches when dealing with these circumstances, and occasionally will have to enlist the assistance of the administrator on call to help resolve an issue. An administrative supervisor provided an example of a time when she used her conflict resolution skills:

> I mean, we had a really frustrated patient and the charge nurse was sort of amplifying it and they were kind of arguing back and forth and really having to use those skills to deescalate both the patient and the charge nurse and try to just take this situation down so we can figure out what the patient really needs at this moment (Adm8).

The staff nurses in the focus group stated that they seek assistance from the supervisor

with patient and family complaints and recognize the value of their presence, particularly

how patients and families respond to differently to "someone in a white coat." The staff

nurses confirmed that the supervisors use a problem solving approach and good

communication to "smooth out the situation" and one staff nurse provided the following

example:

> A patient came in that had a GI bleed and they needed transfusion, but it took a long time for the transfusion because they had to check the blood and take a type and screen. And the husband was really impatient. He was like, "Ok, why is that not happening." He wanted to speak with the supervisor. I told him that it takes time and that they have to check the type and screen. And basically the supervisor just came and talked to them and basically told him the same thing, but he was calmed down after hearing it from the supervisor (StaffA).

The administrative supervisors also assist the staff with physician issues, such as when

physicians are not responding to their phone calls during the night, the supervisors will

"call the doctor, or go to the next in line, and get somebody to see the patient" (StaffD).

Table 5.6

Role Responsibilities: Hospital Representative

Administrative supervisor Role responsibilities: Hospital representative	Quotes
Patient and family complaints	I have to go up and speak with the family members. It is usually that they are unhappy with the discharge plan. The patient is being discharged and the family member is not happy with the discharge. I have to go up and speak to them. Typically what happens is that the patient ends up staying overnight until tomorrow morning until they can get the things that they want (Adm12).
	The patient is that irate. Usually they're irate because our hospital stays very, very full and they've been very frustrated by having to wait in the ER for extended periods of time, for having to wait overnight in our PACU; waiting for a bed, they're usually angry about our process. Sometimes we get physician complaints, that's mostly about patient flow (Adm28).

Physician issues	There is a chain of command if you have physician that doesn't answer their pages promptly. They are to notify me. I make the call. If the physician refuses to come in while I am there then I follow the chain of command. My next step is, I call the Medical Director of the physicians. Talk to him, let him know what is going on, and I call Administration (Adm29).
Legal issues	I have been called by the ED regarding a custody issue between mom and dad, and the mother didn't want the father to be there. But the child needed to be admitted. I think they had a warrant out for their arrest. So we were trying to deal with that and connect our ED doctor with the attorney on-call (Adm8).
Media	We actually did have somebody talk their way into our building and this guy he had a Super 8 … It was the biggest camera I have seen in a while. But my staff, because I have done some 'what if' kind of conversations with them, they were polite, they said, "Oh, have a seat please. We'll call our supervisor." I said, "This is not usually how we do things. Let me get the officers and we'll register you etc. and when you want to come and talk to folks you'll have to make an official appointment through our media representative. That's just not how things are done here. The middle of the night is not appropriate" (Adm5).
Employee Health	Also employee injuries, some routine things, dirty needle sticks, make sure that the employee's seen. Employee health is closed but our ER sees employees during the off tour (Adm5).
	We do a lot of immunizations, we do blood borne package if there is a needle stick on the weekend or night. The Nursing Supervisor takes over the Employee Health role (Adm29).

Make it Work

Administrative supervisors "make it work," and through these actions achieve nurse

and patient safety, which is the second subtheme in this research study. These supervisors are

a "walking resource" who "help out whenever I need to, to make it work" and through their

rounds, the supervisors ensure that the staff have the information, resources and tools to do

their job. This second subtheme consists of four categories or processes through which the

administrative supervisors "make it work": establishing trust with the staff, doing rounds, educating and answering policy and procedure questions, and providing support. The staff nurses in the focus groups confirmed the importance of having an approachable supervisor who achieves nurse and patient safety and "makes it work" through rounds and answering their questions "without feeling like you are bothering them."

Establishing trust

Establishing trust and building relationships with the staff was an underlying theme of "make it work" that emerged from the interviews. The administrative supervisors explained that "building trust" with staff was critical to making it work and fostering nurse and patient safety in the unique off-shift hospital world with less and newer staff. One supervisor explains how building trust and having a relationship with all staff helps with patient safety by facilitating a patient transfer to the appropriate bed,

> I spend a lot of time building trust. Not only just with the nurses, with all the ancillary staff too because they're very important asset to you and a lot of times your relationships with people like housekeeping become critical. If I can walk up to a housekeeper and tell her I need you to stat clean this room because I got a kid coming in five minutes and know that they're gonna bust bones to get in there and do that, that's very rewarding to have the reputation that you're truly a team player (Adm28).

Strategies used by the supervisors to establish trust and build relationships included demonstrating they had clinical expertise, talking with the staff, and showing that they care.

Clinical expertise. Clinical expertise helps with building trust as explained by an administrative supervisor:

> I think you need to have a really strong clinical background so that the staff have confidence in your clinically expertise. That you know what you are doing. You know what you are talking about. So they trust you so they will tell you stuff (Adm3).

Talking. The administrative supervisors took time to be friendly, to talk and "chitchat" with the staff about not only professional topics but personal things such as about their family and children. A supervisor explained that when she socializes or chitchats with the staff it allows them to feel comfortable talking to you and then they will be at ease and comfortable asking patient related questions.

> You're approachable when you're out there and sometimes it means that you're gonna talk to them about their kids or their dog or whatever it is in their personal life to get them to open up (Adm15).

The supervisors stated that being responsive and helpful to staff's questions, following up on issues, being honest and trustworthy were also important in building these relationships.

Caring. During the interviews, it became apparent that the administrative supervisors were caring nurses, which was illustrated by their description of rewarding times in this role: when they mentored novice nurses, helped nurses who were completely overwhelmed with their assignment, simply made a difference in a nurse's shift or "watched a nurse grow in their position from a fresh, novice nurse to now, they're an expert in their field" (Adm18). The administrative supervisors explained how helping staff through a difficult shift is an opportune time to build trust such as helping a nurse with her first patient death by doing postmortem care with her or debriefing with a nurse after her first cardiac arrest. Showing that they care and providing emotional support also helps to build trust and relationships, such as crying with a nurse when she tells you about her recent miscarriage or "just giving that nurse a hug." The following story is just one example of how it seems natural for these administrative supervisors to be helpful and caring to staff, patients and visitors:

> This is kind of sad story. We had a new security guard working and I noticed that

third night I worked with him, I could tell he hadn't had a shower. So, of course, I had to be the one to go over and tell him that he needed to get a shower. So **I went to sit down and talk to him and get to know him** and tell him that he had to have a shower and wash his uniform and all that stuff. And he started crying when I was talking to him and I learned that he, his wife and a new baby and a two year old were living in a car. They had been without showers for a long time. So he got the job and they were living in their car in the parking lot. They didn't have food, they didn't have gas money and they didn't have anything. So, I got off work that morning and I went over to Walmart and got him deodorant and all the things he needed, toiletries and got formula for the baby, food for the little kid, snack cakes and things that wouldn't spoil. I brought that back to him and I told him before you come to work I will show you a shower downstairs that is actually like a hazmat area, that we use to train hazmat. It's away from everybody and nobody will see you coming and going. You all come in here and get a shower when I am here. Here are your toiletries. I am going to ask for another uniform for you and you can put yours in a bag and I will wash it for you and bring it back until you are able to get your own place. So, I did that for probably a week. And then somebody came to me and said if anybody is looking for a cheap apartment, we have this place. So I gave the guy money to get the apartment and he paid me back $50.00 per paycheck until he paid me back. Now he has moved up the ladder and he is one of our really good employees. He always comes and tells me, "I never would have made it if hadn't been for you" (Adm16).

It is easily understood why the evening and night shift staff often say to the administrative supervisors, "I am so glad you are here" (Adm23).

Although the administrative supervisors worked purposefully to build trust and to "make relationships" with all of the staff, it seemed natural to those supervisors who identified themselves as friendly, personable and "a people person." A supervisor explained the value of developing a relationship with staff: "I make that extra effort to get to know everybody coming in. If you do that and if there is an issue, they will come to me and say this is going on or whatever" (Adm16). Another supervisor explained that staff will call about safety issues or concerns, "I become their resource of who to call and then I follow up with them." Two supervisors further explained the benefits of establishing trust and these relationships:

If you do what you say you're going to do, and tell them like it is, be honest with

them, you gain their trust. So when we have to deliver hard news or take resources that they were counting on, it's not -- they're more likely to go along with it or understand (Adm13).

Trust, to be able to talk to openly, and I think if they feel that with me then they're willing to ask me questions and then they're able to provide better and safer care if they're willing to ask questions (Adm15).

When administrative supervisors work to build trust and develop relationships, the staff is not only comfortable asking them questions, but also willing to talk to them and help them. One supervisor shared the following example of how she uncovered a problem because the staff was comfortable talking to her,

I don't want to just be this supervisor that is wandering through checking up on people. I consider myself as part of the hospital team and I'm a resource. I want them to also come to me and ask me questions. One night through rounding, one of the nurses told me…Oh, we have this patient and she is going through a manic episode and she thinks she is being sexually assaulted by so and so. I said…Well, that is an issue. Even though she has a mental health concern, she is reporting an assault and for your protection we need to refer that to Risk Management, and really get all the information, and make sure that staff member isn't in her room (Adm9).

Another administrative supervisor provided an example of how "knowing people" helped find a much needed breast pump for a mom admitted to a medical unit:

They were calling the labor & delivery floors and trying to get a breast pump and were not reaching with much success and apparently our central supply people didn't have any extras. So I stepped in, made some direct contact with the people I know in those L& D units and, low and behold, a resource nurse was able to go find one in a closet somewhere. So sometimes just that kind of piece, like knowing the staff who have the right equipment (Adm23).

The staff nurses in the focus groups confirmed the importance of having supervisors who are approachable, friendly and honest along with having clinical expertise. One staff nurse explains how a supervisor builds relationships by taking time to sit down and talk to staff,

When she makes her rounds, not only will she say, "Hi, how are you?" She will

actually sit down, she will take a seat there will be like three or four of us in a circle. Not every night of course there are busier nights than others. But she will take the time to actually sit down and talk to you about your life, about her life. And of course what is going on in the unit as well. But that alone helps build relationships between the nurse and supervisor. You are not just a staff nurse. You are not just an employee. You are a person and she makes you feel that way (StaffH).

The staff nurses respect the honest supervisors who explain, "I don't know but I will get back to you" and then come back with the answer. A staff nurse explains the ramifications of this transparency, "I think if you have that level of honesty you kind of work through everything together" (StaffE).

Unfortunately, not all Administrative Supervisors are viewed approachable by the staff, some supervisors "get the census and leave" or during a rapid response "stand out in the hallway on the phone." A staff nurse explains that work arounds result when a supervisor is viewed as unapproachable,

She is very smart, but she is just not approachable. And it just doesn't seem like when I am in an emergency situation she is not the first person I would call. I would probably reach out to somebody else before her (StaffE).

Trustworthy, approachable administrative supervisors enhance patient safety, because staff, especially the newer staff who typically work the night shift, know if any problems come up the supervisor is willing to help them. The benefits of building trust with the staff are that "patients receive the right care" and nurses and patients get safely through the shift.

Doing Rounds

All the administrative supervisors and the staff nurses in the focus groups discussed the importance of having a supervisor who is available and visible to the staff by doing rounds during their shift or physically going to all the nursing units in the hospital (refer

to Table 5.7 for the supporting quotes from the supervisors). While doing rounds, the

supervisors took time to talk with the charge nurse and the other staff and ask, "How is

your night going?" Regardless of the size of the hospital, the administrative supervisors

made rounds to the nursing units as frequently as possible, as explained by one

supervisor:

> I do my rounds and go everywhere in the building. Go to the nursing units. I make
> sure that the staffing that I received from the previous shift is accurate, and that I
> know there are no gaps. I speak with the charge nurse mainly and often other
> nurses, and ask about any clinical issues, or any type of issues that they are having
> or encountering since they started the shift. I make sure I let them know that I am
> working and that they can reach me. If they're any problems while I am rounding,
> like for example like a patient complaint, I immediately go to the patient and
> speak with them, and try to resolve how I can improve their hospital stay (Adm4).

During these rounds, the administrative supervisors essentially are conducting

surveillance, and provide support to the staff by their presence, as explained by a staff

nurse, can determine the unit activity:

> We are not going to call and say "Oh, you know it's really busy." But I think when
> they made their rounds, they could gauge for themselves and feel the vibe of the
> floor (StaffB).

When rounding, the administrative supervisors talk to the charge nurses and other staff

about staffing, patient acuity and the census, discuss and assist with any issues or patients

the nurses are worried about, and answer questions about nursing practice. The

administrative supervisors demonstrate a willingness to help during these unit rounds by

answering call lights, helping a confused patient back to bed, or jumping in to de-escalate

an agitated patient. Since the administrative supervisors are rounding to the multiple units

in the hospital, they encourage the staff to call them if they need help or there are any

issues. These rounds also demonstrate a management presence,

> They need to feel like someone cares. They need to feel like someone's there.
> Because you know their unit manager isn't there - they need to know that

somebody's watching the house. If anything goes wrong they need to know that somebody's here that can make a decision (Adm13).

For some administrative supervisors, the rounds also include eyeballing patients on observation and visiting patients.

When explaining doing rounds, the supervisors and staff nurses seemed to be describing surveillance or "scanning," paying attention to potential safety concerns. A staff nurse in the first focus group stated, "Some of them when doing their rounds really scan the units. I had one of the supervisors remind me that my cart wasn't closed properly" (StaffA). Surveillance or scanning the units during rounds was explained by the administrative supervisors as noticing an overfilled sharps contained, hearing a patient yelling and discussing with the charge nurse how to intervene, medications left unattended, or redirecting visitors or patients "hanging out in areas where they're not supposed to be" (Adm13). An administrative supervisor explained how her surveillance becomes a learning opportunity:

> I'm scanning to make sure there are no medications left unattended. So when I come on a unit, the first thing I do is I speak to everybody I see and then I scan to see what's going on. How busy the unit is and then if there's anything that is out of place, then I will address it at that time. And when I say address it, it's a matter of taking the opportunity to have a learning experience. Not punitive. It's like, "Oh were you aware, that you left a medicine on the cart unattended?" or "Are you aware that the person in this room is headed out the back, no bed alarm on" (Adm18).

Table 5.7

Make it Work: Doing Rounds

Administrative Supervisors Make it work: Doing rounds	Quotes
Presence	I think being present, actually spending the time to listen, actually making rounds on the floors, being visible and always be willing to stop what I am doing and help mostly it's the charge nurse that we are interacting with. Help that nurse find an answer to their problem. I think it supports them. I think it acknowledges their value. And I think it empowers them to get on with doing what they need to do to finish their role for that shift (Adm17).
Surveillance	I round on every unit before I call in our staffing and it gives me a good idea, just walking around on the floor **you can see** how many patients are on isolation, there's a bunch of bed alarms going off, if they're really scrambling trying to get things done and getting a lot of surgical in or getting admissions and they're having issues. You just kind of can get a feel of where I would put that extra nurse or who needs help more (Adm14).
	As we round to see if there's any issues, concerns, problems that they may have or any concerns, be it patient concerns, family concerns, or just general concerns… I scan the unit the minute I walk on. So when I come to the unit, if there is something blocking the door, I will make sure that is moved by staff and explain to them, "The reason I am asking you to move this is because it is blocking the door and that's a fire safety" (Adm18).

Educating

The administrative supervisors also provide education to the nursing staff. This education ranges from helping new nurses with procedures they have never done, demonstrating how to use a new piece of equipment, answering policy and procedure questions, coaching resource or charge nurses, to providing information about hospital changes or an upcoming Joint Commission survey (refer to Table 5.8 for the supporting quotes from the supervisors). As stated by a supervisor, "They need to know that they've

got somebody that's got their back and I'm somebody that would come or answer

questions and not be critical" (Adm14). Because there are new nurses working the

evening and night shifts who have "Never started an IV or placed an NG tube," the

administrative supervisors are often educating and take advantage of teaching moments

by "Bringing the new ones with me so they can watch" (Adm29).

The administrative supervisors indicated they get called "all the time" with policy and

procedure questions. "I have to know what the current hospital policy and procedures are

so that I can be a resource for staff," (Adm9) explained an administrative supervisor.

When asked policy and procedure questions, the administrative supervisors assume an

educator role showing staff how to access a port-a-cath or as one supervisor explained,

> Someone wants to set up a medication drip for the first time. And we will go over
> the policy. But sometimes the staff just want to have the presence of another
> person. So, I may be with them when they start it for the first time. Make sure
> they are okay. Especially if it is something they think the patient is going to have
> a reaction to. I will walk them through what could happen and what to monitor the
> patient for. Have they done it before they start the procedure? Have they checked
> the patient's vital signs? (Adm3)

According to one supervisor policies are constantly being updated. The staff receive

e-mail notification about the policy changes and sometimes want clarification about the

change and the reason or "why." When asked a policy and procedure question and it is

not an urgent situation, the administrative supervisors typically help the nurse find the

policy or procedure, "so that they'll know how to do it in the future." Some of the policy

and procedure questions include what type of isolation for meningitis, can a Cardizem

drip be titrated on a telemetry floor, what to do about bedbugs, for a fetal demise when is

it a fetus and when is it products of conception, what to do when somebody brings drugs

into the hospital, and what is the prisoner policy. A night shift nurse called the

administrative supervisor when an order was received "to start a drug on the floor." The

supervisor helped the nurse find the online policy and then explained the medication can

only be given on certain units and the patient should be transferred. The supervisors also

noted that if they don't have the answer to the policy and procedure question, "I will find

out and I do get back to them" (Adm26).

Table 5.8

Make it Work: Educating

Administrative supervisors Make it work: Educating	Quotes
New equipment	We've recently starting using, it's called MARTY, an interpreter type of a system that we have for all different languages. They did have some education on it but it was, it was pretty quick and a lot of nurses, especially at night didn't make the education. They offer it during the day. So, I did take the actual machine and give them a little in-service (Adm14).
Answering policy and procedure questions	Constantly. Again, policies are all computer based and they are kind of difficult to navigate through. Like I said, we had a lot of new grads. We had an instance when a patient wanted to leave AMA. The patient was not in his right mind. So, we pull the policy for them (Adm29).
Coaching charge nurses	A charge nurse called me and had a problem with a patient's family member who wanted to stay all night…The husband of the patient wanted to sleep in the second bed and that was no longer an option. So, he got upset and yelled at her… She got scared and called me. So I went and talked to her and did a very quick role playing scenario so that she would feel comfortable going back to him and saying what she needed to say, which was you cannot sleep in the second bed. We are not moving her into a private room. We don't have a place to go. So, I showed her or told her how I would do it, walked through it with her and I allowed her to go, and do it rather than me just going and handling the situations and not allowing her that growth opportunity (Adm17).
Provide information	So, if there is something that occurs that has changed, whether it be in policy or information that needs to get out there, we do help the managers make sure that it gets to the off-shift whether it be by Fast Fact sheets or going to each of the floors

	and saying, "Okay, this is something that has changed." We are under construction at this moment. So, our intensive care unit department has moved from being directly across from the operating room to one floor up. So, on the off-shift, it was up to us to make sure - this is what you have to do in order to get an open heart patient from the operating room to the intensive care unit. The operating room, you have to call me. I will get security to get in the elevator right there. We will meet here and have respiratory help us get the patient to the right floor. So, it is an education and follow through (Adm7).
	When Joint Commission comes, prepping the staff. These are the things that I've heard they're looking at, so let's make sure we check the expirations on our insulins (Adm5).

Providing Support

On the evening and night shift, the administrative supervisors support the nursing staff by assisting with clinical tasks and providing needed items or resources. As the quotes in Table 5.9 illustrate, the administrative supervisors provide further support to the nursing staff through effective communication, fostering teamwork, and just simply helping the staff.

Clinical skills or expertise was identified as essential to the administrative supervisor role because "On the off-shift you are the clinical resource, the seasoned nurse to answer any questions." Most administrative supervisors considered themselves "hands on" and discussed the importance of helping the nursing staff with a variety of clinical procedures, such as inserting foleys and nasogastric tubes (NGTs), drawing labs, accessing port-a-caths (an indwelling device that provides long-term intravenous access), or being the second person to verify a medication and with clinical assessment of patients. Interestingly, the majority of administrative supervisors indicated that they are called to help start difficult intravenous catheters (IVs). Administrative supervisors also assisted the nursing staff with turning patients, transporting patients, helping patients to

the bathroom and answering call lights. When the nurses ask for assistance with clinical tasks, the administrative supervisors often use this as an opportunity to educate. "Should the patient be discharged in the evening and there is only a limited number of people who are certified in removing PICC lines, I would be there to help demonstrate, help educate" (Adm7).

Considering the many years of nursing experience that these administrative supervisors have, an average of 23 years, it is understood why the evening and night shift staff nurses, who are often newer nurses, rely on the administrative supervisors for their clinical expertise and for assistance in assessing patients. The majority of interviewed supervisors (60%) have critical care background, ICU and ED, and one supervisor explained the benefits of this background,

> I can look at a patient from the door and pretty much say here's what's going on, this patient can stay here or this patient needs to get going — outta here (Adm24).

Administrative supervisors obtain equipment, supplies, and medication for the staff to use when caring for patients and get food from the kitchen for patients. Generally there are supplies on the unit and the unit refrigerators are stocked with some food, but when the patient census is high or there are multiple admissions the administrative supervisor is called because, "they have run out." The administrative supervisors obtain sandwiches, tube feedings, formula, and bereavement trays for families because the dietary department is closed. Specialty beds, instruments from the Operating Room, a certain type of catheter, an IV pump, 3000mL irrigation fluid, wound V.A.C.® (Vacuum Assisted Closure®) or whatever supplies are needed for a patient are obtained by the administrative supervisor. The supervisors explained to get a needed item they went the warehouse in a different building, called a sister hospital to borrow the item, or searched their hospital to

find what was needed for the patient, because not all equipment is in one central place

such as:

> I had a request for this specific piece of wound care equipment that wasn't in Central Supply but I was able to locate it in the Wound Care Clinic nurse's office and I went ahead, because it was an urgent need. The patient couldn't be without it all night (Adm9).

A few administrative supervisors mentioned obtaining medications for patients when the

pharmacy was not open:

> We don't have pharmacy at night...We have a closet with an Omnicell in it that has certain antibiotics and IV drugs that aren't available in the other Omnicells at night (Adm21).

Support is also provided to the nursing staff through good communication and

fostering team work, such as letting staff know about a possible admission and what is

going on in the rest of the hospital, enlisting the cooperation of other departments such as

housekeeping to clean beds, getting nurses from one unit to come help another busy unit,

and helping when one unit is getting multiple admissions.

Table 5.9

Make it Work: Providing Support

Administrative supervisor Make it work: Providing support	Quotes
Clinical Tasks - Procedures	Just any clinical if they have any…to put an IV in, a foley catheter, putting a NG tube down, whatever if they have only done it in school but haven't done it in practice. I go in with them and just show them how to do that (Adm16).
	I could be the second person to verify a medication… I might pass a pill here and there…if the ER is really swamped they will call me and say can you transport a person to x-ray… if there is a difficult start I may try and get labs on a patient… I may start an IV if there is a difficult IV start (Adm20).

Clinical Tasks - Clinical Assessments	Someone will call, what am I hearing when I'm listening to these lungs? We have a lot of brand new staff on at night. "You know this guy, he's a little short of breath, and the pulse ox isn't picking up quite right." So, I went and got an ear probe from a different floor and brought it up there, and put it on and his sats were low. "If you change the settings on this part of the monitor, you can see the waveform." I was teaching her about depressed waveform and explaining, "You're probably not getting the right number" (Adm5).
Provide needed items - Equipment	I had a patient come into the emergency room, had pulled out their G-tube and I had to go down to Endoscopy and find the G-tube that we needed to place back in there. So go rummage through Endoscopy's storeroom to find the correct tube to be placed (Adm15).
Provide needed items - Food	It is 1 a.m. and all they want is a sandwich. They are not going to get a hot meal, but I can make sure they get a sandwich (Adm3).
Effective communication	They were getting more and more stressed, and so I went up to the unit and just briefly had a huddle with them and said, "Okay, tell me what's going on. Tell me how I can help. Tell me what resources you need. What are your concerns?" … Some of it is allowing them to vent, but it's also encouraging them to really strategize, because they usually have the answers (Adm10).
Fostering teamwork	For instance, one night the ED nurses were really busy with an influx of patients all at once so it was hard for them to get the patients settled and see them and I was able to call nurses in the Labor & Delivery Department to come help start IV's for them and get labs (Adm9).

Outcomes

The administrative supervisors achieve the outcomes, the third subtheme, of nurse and patient safety by fulfilling their role responsibilities and making it work. The third subtheme consists of two categories: nurse safety and patient safety. The following example by an administrative supervisor connects how the administrative supervisors get safely through the shift, achieving nurse and patient safety,

> I round…by rounding and talking to the nurses and creating that bond (you could almost say) with the nurses and the staff, to say, "I am here what do you need? Anything I can help you with?" The other night I had an orthopedic patient that set the code button off, and of course running to that…it was a false alarm. But she was confused. It was her first post-op day, post knee surgery. She was in her

80s. She was confused, kind of delirious…up all night. So, it is trouble shooting, do we need a sitter? What are the meds? Can we stay away from narcotics? And it really…I guess that's how I find myself that I am helping with patient safety, but also whether someone does say, "Hey I need an extra pair of hands. I need to transport a patient from the bed to the bathroom can you come" (Adm20).

Nurse safety

Nurse safety, particularly protecting the staff from injury, was a priority for the administrative supervisors. Whether helping nurses with combative patients, reminding nurses to protect their backs and use the lift equipment, watching to make sure nurses are following standard precautions, or ensuring the environment is hazard free, the administrative supervisors are safety advocates for not only nurses, but all staff working during that shift.

When patients are aggressive, violent or have mental health issues, an administrative supervisor explained, "We need to be readily available to go and help, and get security up there and to make sure the nurses are safe as well" (Adm8). A supervisor described a situation in which a nurse asked her to see a patient, and after assessing the patient, she took action to keep the nurse safe,

> I could see the look in the guy's eye that he looked like he was about to lose a little of what he had left. And so I got her out of the room and talked to her about this patient and how to manage the patient. And that what she was doing in the moment she was so busy trying to reason with him that she didn't realize that he was not able to be reasoned with (Adm3).

Another supervisor stated, "We always tell our nurses, if a patient gets restless, or you feel threatened in anyway by a patient don't confront the patient call a code orange. We don't want anybody to get hurt" (Adm19). The administrative supervisors also intervene with aggressive or inappropriate family members. One supervisor described a situation in which the nurse was threatened by the family, "The family was very upset, threatened

her, told her that she was going to have her fired, do not walk out, we know where you work." This supervisor notified the police and stayed with the nurse while the police completed their report.

The strategies that administrative supervisors utilize to keep nurses safe with difficult patients or disruptive family or visitors, range from going to the unit and speaking with patient or visitors using crisis intervention techniques, obtaining the assistance of hospital security, having disruptive visitors escorted out of the building, calling the local police, to locking down the building. One supervisor explained the rationale for having security escort disruptive family out of the building: "have the family leave so our nurses can do their jobs." Sometimes, the administrative supervisors have to change the nurse's assignment, such as when a patient tried to "grope" a nurse, the supervisor intervened by talking with the patient and having a male nurse take care of the patient.

Safe patient handling is a priority of many of the interviewed supervisors. "I am all the time preaching to them about protect your backs. Do not lift," stated one administrative supervisor. The administrative supervisors remind the staff to use the lift equipment, the slide sheets, slide boards because, "I find a lot of them kind of forget that in the heat of the moment but if I'm there I'll just say, somebody go get a slide board" (Adm14).

When rounding on the nursing units, administrative supervisors watch to see if nurses were wearing gloves to start IVs and "make sure people are using the proper personal protective equipment." The administrative supervisors remind staff about needlestick safety and whenever there is a blood-borne pathogen exposure, the supervisor provides support to the staff and ensures the exposure protocol is followed. A supervisor explains, "We start the whole walk-through for getting the patient tested, getting the person who

was poked tested" (Adm19).

Environmental safety is a priority for the administrative supervisor and includes intervening to prevent injuries from such things as tripping over cords. An administrative supervisor talked about safety when leaving the hospital, "They did not feel comfortable walking to their car alone. I could ensure that security walked out with them, I will walk out with them, or staff members walk out with them" (Adm7).

A few administrative supervisors identified that taking breaks contributes to nurse safety and quality patient care, "One of the most important things we do is, when we round, "Did you take your break?" If not, how can we help you do that and we encourage all nurses to leave nursing units when they take their break. Whether they go downstairs to the cafeteria, go outside and walk, or just go sit in the back room and take some time for themselves" (Adm18). The staff nurses in the focus groups rely on the supervisor to help them get a break as explained by a staff nurse,

> Especially the ER, because we are all in the float pool and we float to the ER and
> we are taking admitted patients. So the ER nurses will not break us, they will not
> watch our patients for us. So on the off-shift time the Supervisor gets called and
> they do send someone (StaffD).

Patient safety

Patient safety is also a priority for all the administrative supervisors and summarized by an administrative supervisor:

> For me a huge point to patient safety is recognizing having a patient in a bed isn't
> always the best thing for that patient, if there's not enough staff to really safely
> meet that patient's needs…that's the most important thing to keep patients safe and
> provide adequate care. Again it's just effective resources, appropriate placement of
> patients, stepping in when clinical situations deteriorate, and help triage care
> (Adm23).

The administrative supervisor role responsibilities, staffing, patient flow, and crisis

management, are all linked with patient safety (refer to Table 5.10 for the supporting quotes from the supervisors). Additionally, the supervisors identified preventing falls as a top patient safety initiative, and that making rounds assists the supervisors in advocating for patient safety.

"Staffing always impacts patient safety," so the administrative supervisors ensure that there is enough staff and the right skill mix to provide care for the patients. Skill mix is defined as not only licensed and unlicensed staff, but the years of nursing experience, which is particularly important on the night shift, composed of many new graduate nurses. When there are changes in patient acuity, or there is an influx of patients in the middle of the night, the administrative supervisors do what they need to do to keep the patients safe. This may include moving staff to the unit in need or helping out on the unit. "I will stop and take the time to see how the shift is going and a lot of times you can tell on the unit. I can tell if I need to hang around and assist with something," (Adm30) stated an administrative supervisor. Another supervisor explained, "Make sure that our staffing is appropriate so that we reduce falls" (Adm2).

The staff nurses in the focus groups confirmed the important role the supervisors have with staffing and patient safety, and one staff nurse explained this:

> She came to the unit and we were just having a bad night with admissions and we were short and you know, it's hard sometimes when there are just no nurses. There's just nobody and she got on the phone and she pulled another nurse from… she was going to pull an aide and we said an aide is not going to help us we need a nurse…and she called and she got somebody from another floor. Took them from their assignment and they came and helped us through that situation (StaffD).

For patient flow, the administrative supervisors ensure patient safety by making sure patients are placed on the appropriate nursing unit where they can receive the necessary

care. Thus patient safety is achieved by appropriate bed assignment such as cohorting

isolation patients, staggering multiple admissions to one nursing unit, facilitating

transfers, or stopping intershift transfers. A staff nurse in the focus group explained the

supervisor's role with patient flow and patient safety,

> We had a situation where a patient came up from the Cath Lab with a transvenous pacer, which shouldn't be on the floor. They brought a patient up and the nurse who took the report was a new nurse and didn't realize that the patient should have gone to CCU. So, we did get the Supervisor involved in which they intervened and there wasn't any bed available in CCU. But she did downgrade another patient so that patient could be transferred down to CCU, to make it possible for safer care (StaffE).

Regarding crisis management and patient emergencies, the administrative supervisors

ensure patient safety by checking that all team members have responded and that

Advanced Cardiovascular Life Support (ACLS) protocols are followed. A staff nurse in a

focus group provided an example of how experienced supervisors help coach residents

through emergency situations,

> When we have a Rapid Response, some of the doctors who come are just like standing there staring at the patient. And I am like, "Okay, we have been standing here for ten minutes already we have to do something like let's try this…let's try this." And they (supervisor) will kind of…be the person to be okay, push it along. Whatever it is that we are doing just kind of make it happen a little bit more smoothly (StaffE).

Another staff nurse summarized the range of things the administrative supervisor does

when responding to patient emergencies,

> In terms of Rapid Responses, and Code Blues, I know that the off-shift supervisor will respond and facilitate any movement that needs to occur. I went to a Rapid Response in PACU the other day and the supervisor was on duty and came and she helped make the phone calls, went to the blood bank and got the blood, made the call for the OR to come in and things like that. That was very helpful. And it helped with the safety of the   patient (StaffC).

The majority of administrative supervisors indicated the importance of preventing

patient falls was a top patient safety priority. During rounds, the administrative

supervisors made sure bed alarms were on, call bells were within reach, siderails were up,

and that patients who were risk for falling had fall signs posted and non-skid socks on.

"We will walk the floor and peek our heads in the room as we go by just to see if

anybody is looking to attempt to get out of bed without calling for help" (Adm7). The

administrative supervisors explained that correct bed placement was critical in preventing

falls, and often recommend placing patients at risk for falling, "close to the nurses

station." The decision regarding whether a patient should have a one to one sitter or

patient observer resides with the administrative supervisor, "So it is my job to go in and

assess the patient and I call Administration and say, look, this patient really needs a sitter.

I mean they have tried everything, we have done everything, and the patient is a very

high risk for a fall" (Adm29).

The administrative supervisors overwhelmingly indicated that making rounds has the

greatest impact on patient safety. Rounding on each nursing unit allows the supervisor an

opportunity to talk with the charge nurse and other nurses, and to see the "hot spots" or

busy units. Another import aspect of rounding is explained by a supervisor, "by rounding

and talking to the nurses and creating that…I guess, that bond you could almost say with

the nurses and the staff to say I am here what do you need. Anything I can help you

with?" (Adm20) Building this relationship and connecting with the staff promotes

communication and a willingness to talk about concerns or challenging patients, as

explained by a supervisor:

> Maybe when I make rounds they say, "Hey, I'm a little bit worried about this
> patient," and then I will take the time to go look up the chart and investigate.
> Maybe I'll go do an assessment myself. Probably most of the time I don't do a
> full head to toe assessment on a patient. It might be more of a mini assessment

regarding a specific system maybe, pulmonary usually….I'm providing support to the nursing staff so that they can provide safe care (Adm15).

When making rounds, the administrative supervisors conduct surveillance, scanning and observing many things: if staff are wearing personal protective equipment, properly identifying patients by asking patients their name and birthdate, and following the five rights of medication administration. If an adverse event such as a patient fall, or medication error does occur, the administrative supervisor gets involved in assessing the situation, implementing measures to prevent another incident, and notifying the appropriate people in the organization.

The administrative supervisors are passionate patient advocates or "the voice," doing what is necessary in the middle of the night, such as transferring a patient to ICU or consulting another physician, so the patient receives the necessary care.

> I had a patient that a cardiologist did not want to come in. I don't have a problem trumping them and calling another cardiologist. Did I make it through the storm? Yes, I did. But this patient needed to go to the Cath Lab or he was going to die (Adm29).

The staff nurses in the focus groups concur with the important role the supervisor plays with patient safety and the supervisor is their "go-to person" for anything and everything related to patient safety. A staff nurse provides an example of how the supervisor stayed by her side until the problem was resolved and she could administer medications safely,

> I was locked out of the computer system. I was just locked out. And I could not do my job. And we scan our meds. Let alone our documentation, we scan all of our meds and I had to have another nurse log on. So I am giving meds on another nurse identification. Which right there is a big problem. And because I am a night shift worker they could not get somebody from IT to fix it. So one of the Supervisors stayed with me, and she was with me on the floor, on the phone with everybody….everybody… calling and saying, "This nurse cannot do her job. She cannot do her job, I don't think you understand the severity of this right now." I

have never seen one of the Supervisor really stand by a nurses side. I mean, she stayed with me for like an hour and a half before it was taken care of (StaffD).

An administrative supervisor reflects back to when she worked as a staff nurse, "I always felt the supervisors were there for me. They were the people I could turn to if I needed anything" (Adm23). Therefore, the administrative supervisor's role with patient safety is anticipating emergencies or potentially unsafe situations and mitigating, being proactive in preventing them from happening.

Table 5.10

Outcomes: Patient Safety

Outcomes: Patient safety	Quotes
Staffing	One of our main things that we consider that affects patient safety is staffing. Making sure that we're evaluating staffing and making sure that a unit is not operating with less than what they need to take care of the patient, and that's where our placing of the supplemental staff and moving around nurses occurs. Just the other night, when I was working, we had a patient come in that they were taking to the OR and he was probably going to come out on ECMO [extracorporeal membrane oxygenation], which is a two to one nursing ratio for that particular patient. So I looked at the ICU and I moved two patients out to lower level of care, in order to free up a nurse to move from ICU to CV ICU to help take care of that patient when they came out of the OR (Adm28).
Skill Mix	Staffing always impacts patient safety. I would make phone calls… when I am looking at staffing for the next day. I need to make sure there is a good skill mix. You cannot run a shift when all are new nurses (Adm4).
Patient Flow	Always on the look out for what could be a risk, for example, inter shift transfers. It never fails that the ER wants to take a patient up to the ICU at shift change. We don't have a really good reason. Interdepartmental transfers are fraught with perils as it is, why do we want to add some misery to that by doing it at a risky time? (Adm5)
	If we only have semi private rooms open, we have to be careful who we put in these rooms to make sure we are

	not putting patients with infections with surgical patients (Adm19).
Crisis Management	I respond to all the codes and emergency calls, just making sure the appropriate protocols are being followed, such as in a Code Blue making sure that we follow ACLS guidelines, that everyone is fulfilling their specific roles, and that there is leadership and organization with the Code Blue response. It is not chaotic and unorganized but that we're doing things systematically so that we don't miss anything to help promote safety (Adm9).
Preventing Falls	I provide education to the nurses and such. We have some newer nurses that have started in our units, and we do have patients that are at higher risk for safety such as falls, and I go in and make sure the proper fall precautions are in the place and they are aware of the steps we can do to reduce falls, or if the patient has behavioral health issues and is a risk for leaving the facility that we work on making it safe for them as well (Adm9).
Sitters	Patient safety is also falls, so sitters. We prioritize sitters, suicides always have to be covered. Elopements always have to be covered. And then the falls risks is something we don't have to cover. But, sometimes it could be that the floor that has the suicide also has three Clin. Techs. Whereas the floor that has an elopement and six falls risk only has one Clin. Tech. So I might have to be like, I cannot cover your suicide tonight you are going to have to put your Clin. Tech into that position. Because I need to put a sitter on another floor (Adm12).
Rounds	Management by walking around, I'm walking the floors and looking at the environment. I report anything that I think that is suspicious or could be a hazard, like big rolling carts in the way and areas where I think we should be able to access if we have to move the patient quickly (Adm28).

Summary

Analysis of the data, from the focus groups with the off-shift staff nurses and the interviews with the administrative supervisors, revealed an overall theme of the administrative supervisors as the shift leader who does "everything" with the goal to get the

patients, staff, and hospital safely through the shift. The subthemes of role responsibilities,

"make it work" and outcomes, along with corresponding categories, also emerged when

analyzing the data. The administrative supervisors achieve nurse and patient safety by

fulfilling their role responsibilities of staffing, patient flow, crisis management, and hospital

representative. They "make it work" by doing rounds, educating, providing support, and

establishing trust with the staff. Thus, the findings from this focused ethnographic

research addressed the gap in empirical research on the administrative supervisor role and

answered the overarching research question.

CHAPTER VI

DISCUSSION OF FINDINGS

Through interviews with the administrative supervisors and focus groups with the staff nurses, this focused ethnography research study sought to explore administrative supervisors' managerial practices and how these practices contribute to nurse and patient safety. This research addressed the gap in empirical research on the administrative supervisor role. The data analysis revealed that the administrative supervisors see themselves, and are seen by the staff nurses, as shift leaders who work to reach the overarching goal of getting the patients, staff and hospital safely through the shift. Administrative supervisors, supported by the staff nurses' perspective, articulated their primary outcomes as nurse and patient safety. These "behind the scenes" supervisors work to achieve nurse and patient safety by enacting their role responsibilities using the processes of making it work.

This chapter discusses the findings of the study, through the lenses of the theoretical framework, and identifies emerging questions and implications for hospitals regarding the nursing leadership structure and nurse and patient safety. For nurse leaders, the findings from this groundbreaking research are valuable in providing a better understanding of the administrative supervisor role at their institutions and their role in nurse and patient safety. Nurse leader organizations can take action to support this role by providing role specific continuing education programs, and creating the administrative supervisor networking or peer support groups. Furthermore, the results indicate that additional research is needed, particularly the development of a valid and reliable instrument to measure the leadership practices of administrative supervisors. This research provides the groundwork for development of such a measure to further understand and quantify the

impact of administrative supervisor practices on nurse and patient safety.

Shift Leader

The overall theme identified in this research study was the administrative supervisor as the shift leader with the goal of getting the patients, staff and hospital safely through the shift. The administrative supervisors identified themselves as the leader during their shift. The staff nurses also viewed the supervisor as the shift leader, "higher up in the hierarchy," and the authority figure in the "white coat" who helped them get through the shift safely. When asked about the managerial tasks they perform, the administrative supervisors made it clear that they do not see themselves as managers because they do not do much in the way of managerial tasks. Truly, for these supervisors, clinical expertise is more important than managerial skills, particularly because the off-shift nursing staff consists of many new or inexperienced nurses. Working alone as the shift leader with new nursing staff, is consistent with other research studies that found differences in the off-shift work environment with less people, newer staff, and less direct supervision (de Cordova, Phibbs, Bartel, & Stone, 2013; Hamilton, Eschiti, Hernandez, & Neill, 2007).

These shift leaders are relationship-oriented leaders. The administrative supervisors discussed the importance of being friendly and supportive along with showing concern and establishing relationships with the staff, which are components of relationship-oriented leadership (Bass, 2008). Indeed, their articulation of the ways to and the value of establishing trust are reflected in relationship building. Situational leadership theory, which is relationship-oriented, may appropriately describe the leadership practices of the administrative supervisors. The premise of situational leadership is the leader adapts his or her leadership style to the situation and the follower (Hersey & Blanchard, 1982). The

interviews with the administrative supervisors revealed many examples of the supervisors adapting their leadership style to the development level of the follower, such as when directing a new, inexperienced nurse or coaching an experienced, ICU charge nurse. With a situational leadership approach, the leadership styles include delegating, supporting, coaching, or directing (Blanchard, Zigarmi, & Zigarmi, 2013). Delegating was the least frequently identified leadership style, as the supervisors, with less staff on the off-shift, really have no one to whom to delegate their tasks. However, supervisors used delegating when multiple things happened at the same time, such as when one supervisor had to finish staffing, a code occurred and a helicopter was arriving. This supervisor delegated meeting the helicopter to their staff member. There are a multitude of examples when administrative supervisors supported staff, utilizing a supporting leadership style, such as when listening to the staff or simply allowing them to vent. An administrative supervisor used coaching and role-playing when assisting a charge nurse in speaking with an upset husband. Another supervisor provided an example of when a directive leadership style was used; she pulled a nurse out of a patient's room because she knew, "…he was about to lose a little of what he had left." When supervisors adapt their leadership style to the situation and the follower, they keep nurses safe and patients safe. This is consistent with other research, which found a positive relationship between nurse leaders with a relational leadership styles and patient outcomes (Wong, Cummings, & Ducharme, 2013; Wong & Giallonardo, 2007). Thus, in the future, it would be worthwhile for nurse scientists to explore administrative supervisors' leadership style and nurse and patient outcomes.

When the administrative supervisors were asked about the managerial tasks they

perform, they made it clear that they do not do much in the way of managerial tasks. Their

discussion of their role was also not fully consistent with the unit manager role evident in the

literature. The administrative supervisors work alone with responsibility for the entire

hospital during their shift. Whereas, the unit-based managers, as shown in Table 6.1, work

during the daytime with other nurse managers and directors and have responsibility for one or

two nursing units 24 hours a day, seven days a week.

Table 6.1

Comparison of Administrative Supervisor Shift Leader and Unit-based Manager

Administrative Supervisor - Shift Leader	**Unit-based Manager**
Responsible for all units or multiple units in the hospital	Responsible for 1-2 nursing units
Responsibility for shift only	Responsibility 24 hours a day, seven days a week
Work evening, night or weekend shifts	Work daytime hours
Not involved in strategic planning/budgeting	Involved in strategic planning/budgeting
Work alone or with one other administrative supervisor	Work with other nurse managers, directors and CNO

At the onset of this research study and based on the literature, managerial practices

were defined as effective communication, team building, enforcing policies and

procedures, staffing, being available, and caring about the staff (Buelow, Winburn, &

Hutcherson, 1999; Grant, Christianson, & Price, 2007; McClure, Poulin, Sovie, &

Wandelt, 1983; Thomas-Hawkins, Flynn, Lindgren, & Weaver, 2015). The

administrative supervisor and staff nurses specified these aforementioned managerial

practices, however, new practices were identified specifically establishing trust and

educating, as shown in Table 6.2. Additionally, since the administrative supervisors do

not identify themselves as managers, these practices were renamed as leadership

practices. The leadership practices identified in this research study provide new

information specific to the administrative supervisor role.

Table 6.2

Make it Work: Leadership Practices

Managerial Practices identified in literature	Leadership Practices identified during administrative supervisor interviews and staff nurse focus groups
Caring about staff	Establishing trust and building relationships: - Demonstrate clinical expertise - Talk with staff - Show they care
Being available	Doing Rounds: - Presence - Surveillance
Enforcing policies and procedures	Educating: - Answering policy and procedure questions - New equipment - Provide information
Effective communication Team building	Providing support: - Assisting with clinical tasks - Providing needed items - Effective communication - Fostering teamwork
Staffing	(A role responsibility)

The administrative supervisors also articulated a disconnect with the nursing leadership

team. This disconnect may be due, in part, to the result of the hours the supervisors work,

not being included in the management meetings, the lack of understanding of the work

done by administrative supervisors, and may also be due to being viewed by the nurse leaders

as staff. A graphic comparison illustrating the different hospital off-shift world and the

stark difference between the daytime and off-shift management structure is shown in

Figure 6.1. The administrative supervisors typically work alone, making situationally

contingent decisions. Then the nursing leadership team often does "Monday morning quarterbacking" of the decisions made by these supervisors. This creates a further disconnect, because the supervisors are not around during the daytime, and cannot share the rationale for their actions and decisions. Furthermore, the supervisors provided examples of how they acted as cheerleaders with the staff in the implementation of new policies and processes, such as open visiting hours and awesome arrivals, despite having no input into the planning and development of such policies. Although not specifically asked during the interviews, one supervisor hinted that maybe the daytime leaders do not really understand the work of the administrative supervisor.

Figure 6.1

Graphic Comparison of the Daytime and Off-shift Management Structure
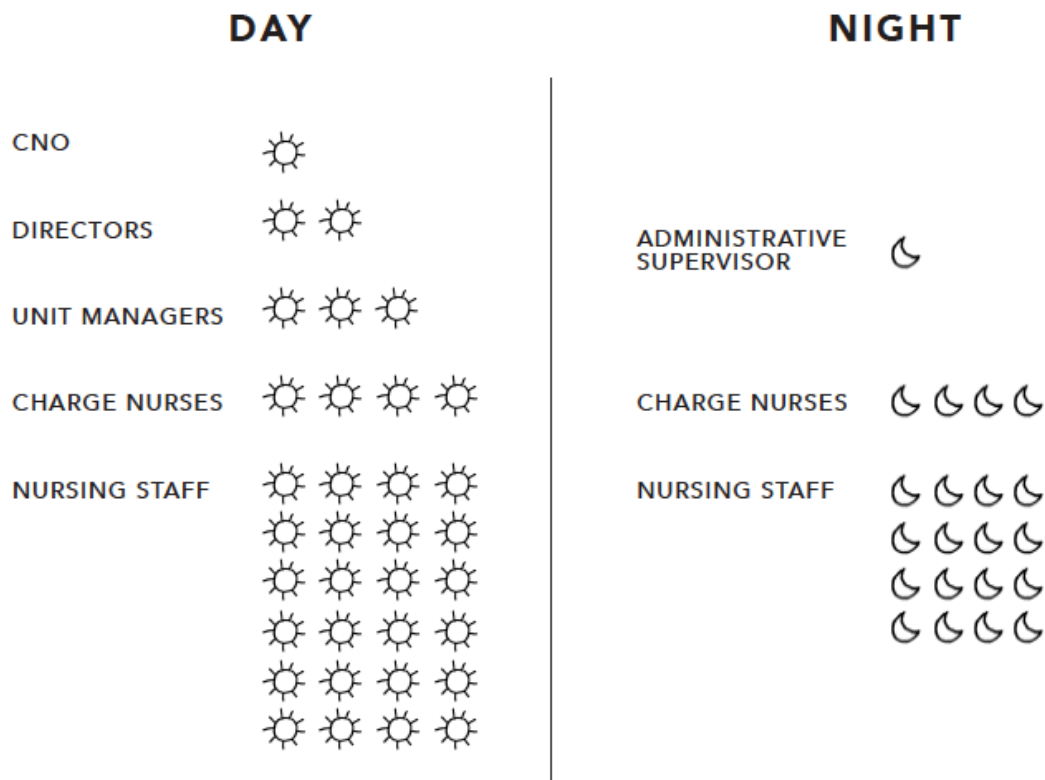
As mentioned, the administrative supervisors and staff nurses recognized the formal authority of the supervisor. However, the fact that the administrative supervisors have authority only during their shift, and otherwise no authority, may contribute to the disconnect with the daytime nursing leadership team. Additionally, the supervisor is the shift leader and authority figure but also acts as staff, jumping in and helping staff with clinical tasks such as starting intravenous catheters and transferring patients. Although this was not a question asked during the interviews, one supervisor mentioned being an hourly employee, like the staff nurses, and not salaried like the nursing leadership team. When the administrative supervisors perform clinical tasks and receive hourly salaries, these may be additional factors fostering the disconnect with the daytime nursing leadership team, who not only do not understand the role but may also view them as staff.

Thus, if hospitals are to function 24 hours a day, seven days a week with quality safe patient care, it would behoove nurse leaders to include the administrative supervisors as a valuable member of the management team and explore this disconnect between the off-shift and daytime nursing management. Nurse leaders need to consider the administrative supervisors as a key stakeholder on the nursing leadership team. Team building exercises with the nursing leadership team inclusive of the administrative supervisors would be beneficial. Nurse leaders should set the expectation that the administrative supervisors are valued members at all leadership meetings and retreats, and should even consider conducting some meetings on the off-shift.

Shared decision-making needs to be considered as a means to erase this disconnect between the administrative supervisors and the nursing leadership team. The American Organization of Nurse Executives (AONE) identifies shared decision-making as a key

nurse executive competency (AONE, 2005). Shared decision-making occurs when staff and others are engaged in decision-making (AONE, 2005). Thus, the nursing leadership team should value the administrative supervisors input and consider these supervisors as key stakeholders in the shared decision-making process.

Nurse researchers should investigate this disconnect between the nursing leadership team and the administrative supervisors and whether there are other contributing factors. Researchers could also explore the unit-based managers, directors, and chief nursing officers' perspective and understanding of the administrative supervisor role. Interventions that help build cohesive management teams inclusive of the administrative supervisors can also be studied. Additionally examining where the administrative supervisors are on the organizational chart or if supervisors are even listed on the organizational chart may assist in understanding the disconnect identified by these "behind the scenes" supervisors.

Theoretical Framework

The Nursing Organization and Outcomes Model, which links organizational attributes with nurse and patient outcomes, was the theoretical framework that guided this research on management of the off-shift and is illustrated in Figure 6.2 (Aiken, Sochalski, & Lake, 1997). The Nursing Organization and Outcomes Model posits that structures in organizations, such as staffing and skill mix, lead to processes of care, which impact nurse and patient outcomes (Aiken, Clarke, & Sloane, 2002). This research study proposed that the administrative supervisor would provide *organizational support for nursing care*, and thereby would have a positive impact on nurse and patient outcomes. The overarching theme of the administrative supervisor as the shift leader with the goal

of getting the patients, staff and hospital safely through the shift fits into the Nursing Organization and Outcomes Model. The results revealed the *organizational attributes* of off-shift leadership in hospitals consist of having an administrative supervisor role with responsibilities for staffing, patient flow, crisis management and hospital representative. New information was found in this research regarding the processes or leadership practices through which the administrative supervisor provides *organizational support for nursing care*. The support provided by the administrative supervisor is reflected in the processes or leadership practices of establishing trust, doing rounds, educating, and providing support. These shift leaders achieve the outcome of nurse and patient safety through these leadership practices and by fulfilling their role responsibilities. Additionally, according to the Nursing Organization and Outcomes Model, nurses provide clinical surveillance and intervene to prevent adverse patient outcomes (Aiken, Clarke, & Sloane, 2002). This research demonstrated that during the administrative supervisors' rounds they conduct surveillance, at a higher level of hospital wide surveillance, scanning, watching and preventing patient and staff adverse events on the off-shift. The results uncovered in this research not only add new information to the Nursing Organization and Outcomes Model but also demonstrate that this model can be used with nursing leadership research. Thus the Nursing Organization and Outcomes model guided this research in answering the research question and provided a framework to discuss the findings and the relevance along with guiding future off-shift leadership research.

Figure 6.2

Nursing Organization and Outcomes Model and Off-shift Management Research

Organizational Attributes	Organizational Support for Nursing Care / Process of Care	Outcomes

Nurse Safety
Protect staff from injury

Administrative Supervisor Role Responsibilities	Leadership Practices of Administrative Supervisor	Patient Safety
Staffing Patient Flow Crisis Management Hospital Representative	Make it Work Establishing Trust Doing Rounds Educating Providing Support	Protect patients from injury through Staffing Patient Flow Crisis Management Falls prevention Rounds

Role Responsibilities

An administrative supervisor with responsibility for ensuring that the hospital continues to function smoothly and efficiently is the current model of evening, night and weekend shift management in acute care hospitals. Regardless of the size, type or location of the hospital, the administrative supervisors and staff nurses identified staffing, patient flow, crisis management, and hospital representative as the role responsibilities. In articles written more than fifty years ago, staffing and crisis management were mentioned as key duties of the evening and night supervisor (McWharf & Knotts, 1956; Tobin, Betterman, & Sevison, 1957). Staffing (particularly getting staffing right for the next shift), patient flow and crisis management responsibilities were identified as off-shift supervisor responsibilities in the pilot study conducted in New Jersey by the PI and in articles, which merely described the role (Weaver, 2012; Weaver & Ellerbe, 2013; Weaver & Lindgren, 2016). Although nurse leaders may not be surprised by these role responsibilities, this is the first time research has documented the role responsibilities of administrative supervisors

in hospitals throughout the United States. Additionally, this research found hospital representative as a responsibility of administrative supervisors, not previously identified. On the off-shift, the administrative supervisors are the in-house hospital representatives for all issues that are typically dealt with by other hospital personnel or departments during the daytime. Delineating the administrative supervisor role responsibilities begins to provide a better understanding of management during the evening, night and weekend shifts, and this data may be beneficial to organizations when creating administrative supervisor job descriptions.

These independent, autonomous administrative supervisors are the shift leaders during most hospital hours and they are challenged to "get staffing right" and ensure patients are placed in the appropriate beds. Since the administrative supervisors are responsible for the staffing and patient flow for all nursing units, ensuring safe staffing (particularly when there is an influx of patients in the middle of the night) is their challenge. The relationship between staffing and patient flow was apparent not only when there is an influx of patients, but also when there is a change in patient acuity. Both the supervisors and staff nurses identified this link, how staffing and patient flow were intertwined, and the important role the supervisor has to ensure the patient is placed in the right bed, and the staffing and the skill mix of the nursing staff on the units is appropriate. Nurse leaders need to be supportive of the real time decisions that are made by the administrative supervisor, particularly when the unit-based managers dispute their decisions. Additionally, nurse leaders should discuss with the administrative supervisors what strategies could be done to ensure there are enough staff and the right skill mix to provide safe patient care during the off-shift.

For the crisis management responsibilities, the administrative supervisors with their years of nursing experience and critical care background assist easily with patient emergencies and only struggle when multiple patient emergencies occur simultaneously. With building and weather emergencies, the administrative supervisors utilize a problem solving approach to deal with these unique crises. The literature identifies the importance of hospital preparedness for scenarios of hurricanes, floods and tornadoes along with chemical and radiological events, and the need to conduct drills and exercises as a requirement for Joint Commission (Moore, Geller, & Clark, 2015). The American Organization of Nurse Executives (AONE) has recently published guiding principles on the role of the nurse leader in crisis management (AONE, 2016). But the gap remains, because there is no mention of preparing the off-shift staff or consideration in conducting a drill or exercise on the off-shift. So instead of administrative supervisors learning how to deal with building and weather emergencies "by the seat of their pants," nurse leaders and nurse leader organizations can assist by providing workshops or drills on the best approach when dealing with potential building and weather emergencies. Additionally, seminars or webinars at which administrative supervisors share their experience with a building or weather emergency would not only be educational but also serve as a debriefing experience for the supervisor presenting.

The administrative supervisors and staff nurses identified the supervisor as the in-house hospital representative for the patient advocate, medical staff office, legal and risk department, marketing department, and employee health. The role of hospital representative, which had not previously been identified in the literature, was added as a new administrative supervisor responsibility. With good communication skills and a

problem solving approach, the administrative supervisors described how they were able to address these issues that were typically dealt with by other hospital personnel during the daytime. Nurse leaders can assist administrative supervisors by arranging meetings with these other hospital personnel and departments in order to provide the supervisor with details on how to address issues and concerns during the off-shift.

Make it work

This research uncovered the processes within the Nursing Organization and Outcomes Model by which the administrative supervisors take action and "make it work" to reach the goal of getting the patients, staff and hospital safely through the shift. Establishing trust with the staff, doing rounds, educating and answering policy and procedure questions, and providing support are the processes by which the supervisors "make it work" and achieve the outcome or goal of nurse and patient safety. Through "making it work" the supervisors also described how they enact their role responsibilities.

Establishing trust and building relationships with the staff, by demonstrating their clinical expertise, chit chatting with the staff and simply showing that they care, appears critical to fostering nurse and patient safety in the different off-shift hospital world. The Institute of Medicine (IOM) (2004) report entitled *Keeping Patients Safe: Transforming the Work Environment for Nurses* recommended that nurse leaders should foster mutual trust with the nursing staff in order to improve patient safety. Trust in the leader and the importance of a leader establishing trust is a common theme discussed in the study of leadership (Bass, 2008). According to Kouzes and Posner (2012) trust is related to employee satisfaction and the honest sharing of information. Furthermore, leaders build trust by focusing on the needs of others, sharing knowledge and information, and showing concern

for others (Kouzes & Posner, 2012). This coincides with the administrative supervisors

reports of the importance of building trust, and as stated by a supervisor "be honest with

them, you gain their trust." The administrative supervisors establish trust with the staff by

answering clinical questions, assisting them through difficult situations, and getting to know

them, which results in the staff coming to the supervisors with issues or concerns. In research

with hospital staff nurses, a significant positive relationship was found between authentic

leadership, trust in manager, work engagement and perceived quality of care (Wong,

Laschinger, & Cummings, 2010). As nurse researchers continue to explore the relationship

between nurses' trust in their manager and patient outcomes, future research should also be

conducted on off-shift nurses' trust in the administrative supervisor and outcomes along with

strategies for administrative supervisors in the development of trust.

Although the administrative supervisors spoke about the importance of building trust

and identified themselves as personable, the staff nurses explained that not all supervisors

are approachable. The importance of being approachable, which may prevent work

arounds and enhance nurse and patient safety, should be shared with administrative

supervisors and other nurse leaders. Development of workshops on building trust with

staff should be considered by nurse leader organizations.

When the administrative supervisors make rounds they are not only visible, accessible

and available but are also conducting surveillance. Doing rounds has historically been part

of the administrative supervisor role, as an early nurse researcher observed that the night

supervisor made rounds and received report on patients (Pfefferkorn, 1932). In the seminal

study of magnet hospitals, staff nurses described the importance of supervisory staff,

which includes the administrative supervisor, as being accessible and willing to help with

care (McClure, Poulin, Sovie, & Wandelt, 1983). In another research study on the difference between weekend and weekday work environments, nurses validated the importance of having supervisors doing rounds by explaining they want the night and weekend supervisors to check in and see if they need anything (Hamilton, Eschiti, Hernandez, & Neill, 2007). Although all administrative supervisors discussed the importance of doing rounds and being visible and available to the staff, most struggled to articulate what they actually do during these rounds. In the first few interviews and focus groups, the supervisors and staff nurses explained the administrative supervisors scan the units and notice such things as a medication cart not closed properly, medications left unattended, or a patient yelling. Then in the last few interviews, when asked by the PI, the supervisors confirmed that they are really doing surveillance during these rounds. Thus administrative supervisors and nurse researchers should clearly identify what is done on these off-shift rounds, what supervisors should watch for and observe, because this information would be beneficial to current and future administrative supervisors' work in promoting nurse and patient safety.

Some nurse leaders may be surprised that the administrative supervisors provide education, but considering the unique off-shift world with newer nurses and no nurse educators, it is understandable that the staff seek out the supervisor's expertise. The administrative supervisors indicated that they get called "all the time" with policy and procedure questions, in part because the staff have difficulty navigating through the online policy system. Interestingly, the administrative supervisors did not describe enforcing policies and procedures, but rather working hard to be helpful and not critical in answering their policy and procedure questions. Nurse leaders and nurse researchers

should further investigate why the supervisors get called so frequently for policy and procedure questions and explore nurse friendly online policy systems. Additionally since the administrative supervisors are often the off-shift educator, the supervisors need to be included and attend all education programs regarding new equipment and new policies and procedures, so they can assist and answer questions on the off-shift.

The administrative supervisors provide support to the off-shift nursing staff by assisting with clinical tasks, providing needed items or resources, and fostering teamwork. Staff nurses, in the seminal qualitative descriptive study of magnet hospitals, specifically identified the evening and night supervisors as being supportive and helpful (McClure, Poulin, Sovie, & Wandelt, 1983). Considering the many years of nursing experience that the administrative supervisors have, an average of 23 years, it is understood why the off-shift nurses, who are typically newer nurses, rely on the administrative supervisors. Nurse leaders should consider the importance of clinical expertise, particularly critical care experience, when interviewing and hiring administrative supervisors. The supervisors also obtain needed items for patients such as equipment, supplies, medications and food. Since administrative supervisors are called to get items when they are busiest at times of high census or multiple admissions, nurse leaders should strategize how the staff can obtain needed items for patients without relying on the supervisors and thus better utilize this shift leader's time. The administrative supervisors also provide support to the nursing staff through effective communication and fostering teamwork. In research with critical care nurses, great coworkers and teamwork was identified as a positive factor to working the night shift (Ruggiero & Pezzino, 2006), but how teamwork was supported or encouraged and the

role of the administrative supervisor in encouraging teamwork was not explained. Since teamwork and effective communication are linked to desirable patient outcomes, administrative supervisors should receive training on improving communication and developing and optimizing teamwork on the off-shift.

Outcomes

Nurses and nurse managers have key roles in patient safety and act as surveillance in detection of errors and preventing adverse events (Institute of Medicine, 2004). And now, this pivotal research study describes the administrative supervisors' key role in nurse and patient safety, functioning as the off-shift safety officer who fosters the off-shift culture of safety. The administrative supervisors achieve nurse and patient safety when performing their role responsibilities and through processes of making it work. The specific safety priorities of these independent administrative supervisors were safe staffing, appropriate placement of patients, clinically supporting nurses with challenging patients, preventing patient falls and protecting the staff from injury. Interestingly these administrative supervisors, who assume the role as off-shift safety officers, did not articulate receiving any special safety training. Since the administrative supervisors are the solo shift leader, it would be worthwhile to invest in safety training, such as through the Institute for Healthcare Improvement, for these off-shift safety leaders.

For nurses or other staff, the administrative supervisors are safety advocates helping with combative patients, reminding staff about safe patient handling, ensuring the environment is hazard free, and encouraging nurses to take breaks. Since research has found that night shift registered nurses were at higher risk for occupational injury than nurses working other shifts (Horwitz & McCall, 2004), future research should be conducted exploring the work

related injuries on the off-shift and the administrative supervisor's role in preventing these injuries. Additionally nurse leaders should ensure the administrative supervisors have crisis intervention training and attend a safe patient handling program in order to assist staff utilizing appropriate techniques and procedures.

Patient safety is also a priority, and the administrative supervisors' actions when fulfilling their role responsibilities of staffing, patient flow and crisis management are based on patient safety and preventing adverse events. When unit-based nurse managers act with integrity and foster trust, the staff is willing to discuss errors and near misses and this fosters a culture of safety (Vogus & Sutcliffe, 2007). Similarly, the administrative supervisors are truly fostering a culture of safety through their actions of building trust, establishing relationship, and doing rounds. Building relationships and connecting with the staff promotes communication and a willingness to talk about concerns or challenging patients. A supervisor explained that because she has established relationships with the staff they are willing to talk about their concerns, "Hey, I'm a little bit worried about this patient," and this is "just good for patients and everybody that we can trust each other." Since researchers have found that relational leadership practices such as trust in their manager are significantly associated with decreased adverse events (Wong, Cummings, & Ducharme, 2013; Wong & Giallonardo, 2013), similar research should be conducted with the off-shift staff. For instance nurse researchers should investigate the relationship between off-shift medications errors and off-shift nurses' safety organizing behaviors and trust in administrative supervisors.

Summary

The overall theme identified in this research study was the administrative supervisor

as the shift leader with the goal of getting the patients, staff and hospital safely through the shift. As shift leaders, the administrative supervisors are situational, relationship-oriented leaders, who adapt their leadership style to the situation and the follower, to keep nurses and patients safe. The administrative supervisors articulated a disconnect with the nursing leadership team, as a result of the hours the supervisors work, not being included in the management meetings, the lack of understanding of the work done by administrative supervisors, and may also be due to being viewed by the nurse leaders as staff. The findings from this research study were discussed through the lenses of the theoretical framework.

Regardless of the size, type or location of the hospital, the administrative supervisors and staff nurses identified staffing, patient flow, crisis management, and hospital representative as the role responsibilities of the role. This is the first time research has documented the role responsibilities of administrative supervisors in hospitals throughout the United States. This research uncovered the processes within the Nursing Organization and Outcomes Model, by which the administrative supervisors take action and "make it work" to reach the goal of getting the patients, staff and hospital safely through the shift. Establishing trust with the staff, doing rounds, educating and answering policy and procedure questions, and providing support are the processes by which the supervisors "make it work" and achieve the outcome or goal of nurse and patient safety.

The administrative supervisors achieve nurse and patient safety when performing their role responsibilities and through processes of making it work. The specific patient safety priorities of these independent administrative supervisors were safe staffing, appropriate placement of patients, clinically supporting nurses with challenging patients, preventing patient falls and protecting the staff from injury. These administrative supervisors

actually function as off-shift safety officers. Thus, the findings from this groundbreaking

research study identify emerging questions and implications for hospitals regarding the

nursing leadership structure and nurse and patient safety, and are relevant for hospital nurse

leaders, nurse leader organizations, nurse scientists, and administrative supervisors.

CHAPTER VII

CONCLUSION

Summary

Researchers have found that nurse and patient outcomes are worse on off-shifts, as compared to the regular daytime shifts, with less people, newer staff, certain services not available, and less direct supervision. The current model of off-shift management or supervision in acute care hospitals in the United States is having an administrative supervisor, who is the nurse leader present on the evening, night, and weekend shifts. Despite the existence of the administrator supervisor role in hospitals for more than 100 years, research on this role is lacking. There is only one published research study in which the administrative supervisor responsibilities were classified as staffing and patient flow, crisis management and support for the staff (Weaver & Lindgren, 2016). Considerable research has been conducted demonstrating the important role that the unit-based nurse manager has on nurse and patient safety, however no comparable research has been conducted on the role the administrative supervisor has with regard to nurse and patient safety.

Guided by the Nursing Organization and Outcomes Model, this research addressed the gap in empirical research on the administrative supervisor role and the practices that contribute to nurse and patient safety (Aiken, Sochalski, & Lake, 1997). The research questions for this study were: 1) What are administrative supervisors' perspective of their managerial practices; and how do these practices contribute to nurse and patient safety. 2) What are off-shift staff nurses' perspective of the administrative supervisor role and how does the administrative supervisor contribute to nurse and patient safety.

A qualitative research method was selected for this study because of the lack of empirical research. Exploring the role and impact of nurses who have direct experience as administrative supervisors, using an inductive approach, provides the first step in understanding the role. Focused ethnography was the research methodology utilized to answer the specific question about the managerial practices of the administrative supervisors and how these practices contribute to nurse and patient safety. The characteristics of focused ethnography illustrate that it is an appropriate approach for this research because the focus is on a specific group and specific phenomenon of which the Principal Investigator (PI) has background knowledge, and it is short-term and data intensive.

This focused ethnographic study was conducted in two parts: the first part with off-shift staff nurses and the second part with administrative supervisors. The first part consisted of focus groups with off-shift staff registered nurses to describe the off-shift environment and identify the administrative supervisors' role in nurse and patient safety. Seven focus groups were held with 39 off-shift staff nurses who worked at seven New Jersey hospitals. The second part consisted of individual, in-depth telephone interviews with 30 administrative supervisors, recruited from 20 different states throughout the United States, to identify and describe the managerial safety practices and role responsibilities of the supervisor that enhance nurse and patient safety. The focus group and interview transcripts were thematically analyzed. Trustworthiness was established with respondent validation, reflexivity, thick description and triangulation.

In addition to describing the participants, the hospitals where the staff nurses and the administrative supervisors worked were also described. The staff nurses worked at seven

New Jersey hospitals, which were primarily non-profit (86%), teaching hospitals (71.5%), with three hospitals having the ANCC Magnet® designation and one hospital having the ANCC Pathway to Excellence® designation. The average age of the staff nurse participant was 42 years, with an age range of 23-64 years, and four staff nurses were male. Purposive sampling was utilized to obtain administrative supervisor participants from different regions in the United States, Northeast, Midwest, South and West, and different types of hospitals. These administrative supervisors worked in hospitals that were primarily non-profit (83%), teaching (77%) hospitals, with eleven hospitals (37%) having the ANCC Magnet® designation and three hospitals (10%) having the ANCC Pathway to Excellence® designation. The average age of the administrative supervisor participant was 50 years, with an age range of 33-70 years, and three administrative supervisors were male.

Analysis of the data, from the focus groups with the off-shift staff nurses and the interviews with the administrative supervisors, revealed an overall theme of the administrative supervisors as the shift leader who does whatever is necessary to get the patients, staff, and hospital safely through the shift. This focused ethnographic study uncovered new information particularly that the administrative supervisors view themselves as leaders, not managers, and feel disconnected from the nursing leadership team. Triangulation was done with the data from the interviews, focus groups, and job descriptions. The subthemes of role responsibilities, "make it work," and outcomes emerged when analyzing the data and fit into the Nursing Organization and Outcomes Model. The administrative supervisors achieve nurse and patient safety by fulfilling their role responsibilities of staffing, patient flow, crisis management, and hospital representative, and

"make it work" by doing rounds, educating, providing support, and establishing trust with the staff. This is the first time processes have been identified through which the supervisors achieve nurse and patient safety. The often-invisible administrative supervisor role is now being brought to the forefront, revealing the impact this shift leader has on nurse and patient safety.

Conclusions

The administrative supervisors in this research study demonstrated that they are relationship-oriented, situational shift leaders as evidenced by adapting their leadership style, to the situation and the follower, to keep nurses and patients safe. Despite being the leader and authority figure during their shift, the administrative supervisors made it clear that they do not see themselves as managers, as they do not do much in the way of managerial tasks. Furthermore, the administrative supervisors articulated a disconnect with the nursing leadership team. This disconnect may be the result of the hours the supervisors work, not being included in the management meetings, the lack of understanding of the work done by administrative supervisors, and may also be due to being viewed by the nurse leaders as staff.

In accordance with the Nursing Organization and Outcomes Model, the results revealed the *organizational attributes* of having an administrative supervisor, with role responsibilities, who through their leadership practices provide *organizational support for nursing* and achieve the outcomes of nurse and patient safety (Aiken, Sochalski, & Lake, 1997). This research study adds new information to the Nursing Organization and Outcomes Model and also demonstrates that this model can be used with nursing leadership research.

Regardless of the size, type or location of the hospital, the administrative supervisors and staff nurses identified staffing, patient flow, crisis management, and hospital representative as the role responsibilities of the role. This is the first time research has documented the role responsibilities of administrative supervisors in hospitals throughout the United States. The administrative supervisors are responsible for staffing and patient flow for all nursing units, and both the supervisors and staff nurses identified how staffing and patient flow were intertwined. For the crisis management responsibilities, the administrative supervisors were confident when responding to patient emergencies, but were challenged when dealing with the unique building and weather crises. The administrative supervisors and staff nurses identified a new responsibility of the supervisor: the in-house hospital representative for the patient advocate, medical staff office, legal and risk department, marketing department, and employee health.

This research uncovered the processes, within the Nursing Organization and Outcomes Model, by which the administrative supervisors take action and "make it work" to reach the goal of getting the patients, staff and hospital safely through the shift. Establishing trust with the staff, doing rounds, educating and answering policy and procedure questions, and providing support are the processes by which the supervisors "make it work." Establishing trust and building relationships with the staff, through demonstrating their clinical expertise, paying attention to staff and showing concern, appears critical to fostering nurse and patient safety in the different off-shift hospital world. Doing rounds has historically been part of the administrative supervisor role. When the administrative supervisors make rounds they are not only visible, accessible and available but are also conducting surveillance. Additionally, the administrative supervisors take the time to

educate when staff seeks out their help. The administrative supervisors provide support to the off-shift nursing staff by assisting with clinical tasks, providing needed items or resources, and fostering teamwork. It is clear from staff nurses' perspective that they rely on the administrative supervisors extensive nursing experience to assist them as needed.

The administrative supervisors achieve nurse and patient safety when performing their role responsibilities and through processes of making it work. For nurse or staff safety, the administrative supervisors are safety advocates helping with combative patients, reminding staff about safe patient handling, ensuring the environment is hazard free, and encouraging nurses to take breaks. The specific patient safety priorities of these independent administrative supervisors were safe staffing, appropriate placement of patients, clinically supporting nurses with challenging patients, preventing patient falls and protecting the staff from injury. These administrative supervisors actually function as off-shift safety officers who foster the off-shift culture of safety. Thus, the findings of the study identify emerging questions and implications for nurse leaders, nurse leader organizations, administrative supervisors, and nurse scientists.

Strengths and Limitations

The findings of this qualitative study were based on sound focused ethnographic methodology, when conducting and analyzing the data from the staff nurse focus groups and the administrative supervisor interviews. The PI obtained a representative sample of administrative supervisors from hospitals throughout the United States with varied bed size, teaching status, location, ownership, and with and without ANCC Pathway to Excellence® designation and ANCC Magnet® designations. Additionally, the

administrative supervisors and staff nurses varied in age, gender, years of experience, education, and national nursing certification.

One limitation of this qualitative study was the focus groups were conducted in New Jersey and may not reflect the experiences of staff nurses with administrative supervisors in other parts of the country. Another limitation concerns the convenience sample of administrative supervisors, as those who responded to the interview request, with one exception, held a very positive view of the role and stated they enjoyed their position as administrative supervisor. Thus, these supervisors may reflect highly skilled and motivated supervisors and not be representative of those who are less engaged in their role.

Implications for Practice and Knowledge Generation and Practice

The recommendations and implications from the knowledge generated by this research study are significant for nurse leaders, nurse leader organizations, administrative supervisors, and nurse scientists.

Nurse Leaders. The results of this research study are valuable to nurse leaders as they provide a better understanding of the administrative supervisor role at their institution and the supervisor's role in nurse and patient safety. Nurse leaders can utilize the findings from this research to update the administrative supervisor job description, and educate nursing staff, nursing leaders, hospital leaders and future administrative supervisors about this role. The nurse leaders could facilitate the administrative supervisor's attendance at a variety of workshops and continuing education programs on: leadership styles, building trust, teamwork and effective communication, potential building and weather emergencies, safety training such as through the Institute for Healthcare Improvement, crisis intervention training, and a safe patient handling program. Additionally since the

administrative supervisors are often the off-shift educator, the supervisors need to be

included and attend the education programs regarding new equipment and new policies

and procedures, so they can assist and answer questions on the off-shift. And most

importantly, nurse leaders should consider building a nursing leadership team inclusive of

the administrative supervisors. Nurse leaders could work on eliminating barriers that

preclude supervisors from being viewed as key stakeholders on the nursing leadership

team. Shared decision-making could also be considered as a means to erase this

disconnect between the administrative supervisors and the nursing leadership team.

Furthermore, nurse leaders should be supportive of the real time decisions that are made

by the administrative supervisor, particularly when the unit-based managers dispute their

decisions.

Nurse Leader Organizations. Nurse leader organizations can establish administrative

supervisor networking or peer support groups to facilitate the exchange of information

and best practice ideas. Since administrative supervisors often work alone, developing

peer groups across institutions would support these nurses in their very challenging role.

As nurse manager and nurse executive competencies have been developed, it would also

be valuable to develop administrative supervisor competencies. Nurse leader

organizations can also take action to support this role by providing a variety of role

specific continuing education programs from programs on leadership styles, to

workshops on dealing with potential building and weather emergencies.

Administrative Supervisors. The administrative supervisors may applaud this empirical

study, which begins to identify their leadership practices related to nurse and patient

safety and brings their behind the scenes role to the forefront. These supervisors should

consider joining a nurse leader organization, participate in their hospital nursing leadership meetings, and attend continuing education programs. Additionally, administrative supervisors could educate other hospital staff about their complex role as shift leader. And lastly, as nurse scientists continue to investigate the off-shift and off-shift leadership, administrative should consider participating in these future research studies.

Nurse Scientists. Clearly, since this is the first empirical investigation of the administrative supervisor role, the recommendations for future research and new knowledge development are plentiful. Nurse scientists can use the results from this research study as the foundation to further examine the administrative supervisor role and the impact of this position on nurse and patient outcomes. As the administrative supervisor role is further investigated, discussion of the best practice model for leadership/management on the off-shift, along with a better understanding of the off-shift practice environment, may result. Additionally off-shift quantitative research would be beneficial, however the measurement tools used with unit-based managers may not be applicable to the administrative supervisor role. And since there is no valid and reliable instrument that measures the leadership practices of administrative supervisors, this research could provide the groundwork for development of such a measure to further understand and quantify the impact of administrative supervisor practices on nurse and patient safety.

   The disconnect between the nursing leadership team and the administrative supervisors needs further investigation to identify other contributing factors. Although not asked in this research study, could the administrative supervisors different pay

structure, whether hourly or salaried, contribute to the disconnect with the nursing leadership team. Examining where the administrative supervisors are on the organizational chart or if supervisors are even listed on the organizational chart may assist in understanding the disconnect identified by these "behind the scenes" supervisors. Researchers could also explore the unit-based managers, directors, and chief nursing officers' perspective and understanding of the administrative supervisor role. Interventions that help build cohesive management teams inclusive of the administrative supervisors can also be studied. Furthermore, researchers should explore the engagement of the administrative supervisor with the rest of the nursing management team, with regard to planning and implementing the goals and objectives of the nursing department and hospital.

Quantitative and qualitative research needs to be conducted to explore the actions of the administrative supervisor, such as assisting off-shift nurses with assessing a patient or reviewing the placement of a patient from the emergency department, and the impact these actions have on patient outcomes. Additionally, the influence of having an administrative supervisor, who is trusted, available and supportive, on off-shift nurse satisfaction and the off-shift nurse practice environment needs investigation.

As nurse researchers continue to explore the relationship between nurses' trust in their manager and patient outcomes, future research should also be conducted on off-shift nurses' trust in the administrative supervisor and outcomes. For instance nurse researchers should investigate the relationship between off-shift medications errors and off-shift nurses' safety organizing behaviors and trust in administrative supervisors. Future research should be conducted exploring the work related injuries on the off-shift and the

administrative supervisor's role in preventing these injuries. Administrative supervisors and nurse researchers could clearly identify what is done on these off-shift rounds, what supervisors should watch for and observe, because this information would be beneficial to current and future administrative supervisors' work in promoting nurse and patient safety.

Additionally further investigation of the off-shift hospital world would be beneficial. It would be worthwhile to investigate the difference in the work of the staff nurse and the work of the administrative supervisors during peak shifts and off-peak shifts through interviews or focus groups with staff nurses and administrative supervisors who have worked both peak and off-peak shifts.

Ultimately, it's important that organizations and nursing leaders gain a better understanding of how the administrative supervisor makes a difference in the hospital's quality and safety. As we move into the next era, we will need more complete information to improve all of our practices. We will be better situated to add value for our patients when we have a more complete picture of the value provided by "off-shift" administrative supervisors. Administrative supervision is exciting, rewarding and challenging position for nurses, particularly as researchers embark on a better understanding of how this nurse leader makes a difference.

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Appendix A

Demographic Data Form for Focus Groups

Pseudonym_____

1. What is your gender? _____Male _____Female

2. What is your age? _____

3. What is your current job title? _____

4. What shift or hours do you work? _____

5. What year did you start in this staff nurse position? _____

6. What year did you receive your RN? _____

7. What is the highest degree you hold in nursing?
   ____RN Diploma
   ____Associate Degree
   ____Baccalaureate Degree
   ____Masters Degree
   ____Doctoral Degree

8. What is the highest degree you hold in a field other than nursing?
   ____Associate Degree
   ____Baccalaureate Degree
   ____Masters Degree
   ____Doctoral Degree
   ____Not Applicable

9. What best describes your acute care hospital? (Check all that apply)
   ____Teaching
   ____Non-teaching
   ____Community hospital
   ____Rural hospital
   ____For profit ownership
   ____Not for profit ownership
   ____Magnet® designation
   ____Pathway to Excellence®designation

10. Are you currently certified in specialty practice by the American Nurses
    Credentialing Center or a national nursing specialty organization?
        ____Yes, please identify
         certification_____
        ____No

Appendix B
Demographic Data Form for Administrative Supervisors

1. What is your gender? _____Male _____Female

2. What is your age? _____

3. What is your current job title? _____

4. What shift or hours do you work? _____

5. What year did you start in this position? _____

6. What year did you receive your RN? _____

7. What is the highest degree you hold in nursing?
    ____RN Diploma
    ____Associate Degree
    ____Baccalaureate Degree
    ____Masters Degree
    ____Doctoral Degree

8. What is the highest degree you hold in a field other than nursing?
    ____Associate Degree
    ____Baccalaureate Degree
    ____Masters Degree
    ____Doctoral Degree
    ____Not Applicable

9. What best describes your acute care hospital? (Check all that apply)
    ____Teaching
    ____Non-teaching
    ____Community hospital
    ____Rural hospital
    ____For profit ownership
    ____Not for profit ownership
    ____Magnet® designation
    ____Pathway to Excellence®designation

10. Are you currently certified in specialty practice by the American Nurses
    Credentialing Center or a national nursing specialty organization?
    ____Yes, please identify
    certification_____
    ____No

Appendix C

Focus Group Discussion Guide Part One

1. Describe how the evening and night shifts are different from the day shifts.

2. Administrative supervisor

    ➢ Tell me about when you interact with the administrative supervisor.

    ➢ How does the administrative supervisor provide you support? Tell me a story about how the administrative supervisor helps you.

    ➢ Can you give me an example of a time when the administrative supervisor provided you with information/assistance?

    ➢ Can you give me an example of a time when the administrative supervisor provided you with resources?

3. Patient Safety on off-shifts

    ➢ Staff nurses are important for patient safety and so are supervisors. How do administrative supervisors on the off-shift ensure patient safety?

    ➢ Describe what administrative supervisors do to keep patients safe.

    ➢ Think about a time when administrative supervisor did something that kept a patient safe.

4. Nurse Safety on off-shifts

    ➢ Describe what administrative supervisors do to keep nurses safe.

    ➢ Think about a time when administrative supervisor did something that kept a nurse safe.

5. Conclusion

    ➢ Is there anything else you would like to talk about?

Appendix D

Interview Guide Part Two

For this research on the role of the administrative supervisor, I will be talking to you about your role as an administrative supervisor.

1. Tell me about how you became or started in the administrative supervisor role.

2. Role Responsibilities:

   ➢ Tell me about the size of the hospital, the number of beds or units you are responsible for during your shift. When you are working are you the only nursing supervisor in the hospital?

   ➢ Tell me what you do in your role as administrative supervisor. What did you do
   during the last shift that you worked as an administrative supervisor?

   ➢ Tell me what clinical tasks you perform as an administrative supervisor.

   ➢ Tell me what management or HR tasks you perform as an administrative supervisor.

   a. Staffing and Patient Flow

   ➢ Tell me about any staffing/scheduling you do as an administrative supervisor, such as covering sick calls and calling in on-call staff.

   ➢ Do you have support personnel to assist with staffing?

   ➢ Tell me about your role with patient flow or patient bed assignment.

   ➢ How much time or what percentage of your time during your shift do you spend on staffing and patient flow?

   b. Crisis Management

   ➢ Tell me about your role or your response to Codes.

   ➢ Tell me about your role in dealing with patient and physician issues.

   ➢ Tell me about your role with unexpected emergencies.

   ➢ How much time or what percentage of your time during your shift do you spend on crisis management?

    c. Manager Support

       ➢ Can you give me an example of a time when you provided information for the staff?

       ➢ Can you give me an example of a time when you provided resources for the staff?

       ➢ Can you give me an example of how else you support the staff?

       ➢ How much time or what percentage of your time during your shift do you spend   providing information or resources for the staff?

3. Skills and education

       ➢ In your ___ years of experience as an administrative supervisor, what background / skills are important for this role?

       ➢ As you look back, how has your education prepared you for this role?

       ➢ What additional education may be needed for this role?

4. Management Team

       ➢ Who do you report to?

       ➢ Who does the hiring and scheduling of the administrative supervisors?

       ➢ What support do you have in the role or what do you do if you need assistance or help?

       ➢ How do you interact with the 'regular' nursing management or unit-based managers?

       ➢ Tell me about the support you have from nursing leadership or administrator.

5. Patient Safety

       ➢ Staff nurses are important for patient safety and so are supervisors. Describe what you do in your role as administrative supervisor to keep patients safe.

       ➢ How do nurses on the off-shift ensure patient safety?

> ➤ Think about a time when you did something as an administrative supervisor that kept a patient safe.

6. Nurse Safety

> ➤ Describe what administrative supervisors do to keep nurses safe.

> ➤ Think about a time when administrative supervisor did something that kept a nurse safe.

7. Conclusion

> ➤ Can you give me an example of an especially challenging time as an administrative supervisor?

> ➤ Can you give me an example of an especially satisfying or rewarding time as an administrative supervisor?

> ➤ Is there anything else you do in this role that we have not discussed?

> ➤ Is there anything else you would like to tell me?