A Multi-Perspective Qualitative Study Exploring the Charge Nurse Role and Safety Practices

by

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CHARGE NURSE ROLE AND SAFETY PRACTICES

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ABSTRACT

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By Lora Bognar

Dissertation Director: Dr. Teri Lindgren, PhD, RN

Literature about the charge nurse claims that they are frontline nurse leaders who contribute to quality and patient safety; however in the United States there is a lack of research regarding how the acute care hospital charge nurse keeps patients safe. This two-phase focused ethnography study explored the charge nurse role and safety practices through the perspectives of charge nurses, nurse managers and clinical nurses. The Nurse Manager Leadership Partnership Learning Domain Framework guided this study, operationalized as the American Organization of Nurse Executives (AONE) Nurse Manager Competencies (AONE, 2015). Rutgers the State University of New Jersey Institutional Review Board approval was obtained. Participants in phases one and two signed informed consents and completed demographic forms. In phase one, charge nurses, nurse managers and clinical nurses rated competencies on the AONE Nurse Manager Competencies as relevant to the charge nurse role then participated in audio recorded individual interviews to clarify the ratings. Data from phase one informed the questions for phase two. Nurse managers and charge nurses participated in in-depth individual audio recorded interviews in phase two using an interview guide while clinical nurses participated in focus groups using a focus group guide. Audio recordings were transcribed verbatim and thematic analysis occurred.

Three charge nurses, three clinical nurses and three nurse managers, all female,
with an average age of approximately 48 participated in phase one. In phase two fifteen charge nurses, thirteen clinical nurses and eleven nurse managers, males and females, with an average age of 40 participated. Two charge nurse models emerged: Permanent and rotating. An overarching theme of shift resource and traffic director included go-to resource, manage the flow, safe patient assignment/staffing and regulatory readiness, shared responsibilities among all charge nurses. Permanent charge nurses were unit shift leaders, an extension of the nurse manager who manage information flow and human resource management. Rotating charge nurses have the role of clinical nurse plus. The two charge nurse models differ in methods to keep patients safe with permanent charge nurses being the safety officer and rotating charge nurses putting out fires.
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Chapter I

INTRODUCTION AND THEORETICAL PERSPECTIVE

The Concern to Be Addressed

Safety Practices

Safety practices are “interventions, strategies or approaches intended to prevent or mitigate unintended consequences of the delivery of healthcare and to improve the safety of healthcare for patients” (Dy, Taylor, Carr, Foy, Pronovost, Øvretveit, Wachter, Rubenstein, Hempel, McDonald, & Shekelle, 2011, p. 618). Safety practices, which are driven by the safety norms and values that comprise an organization’s safety culture, are behaviors modeled by nursing leaders and serve as a strong influencer of patient outcomes. Poor organizational safety culture contributes to adverse patient outcomes and harm (O’Connor & Carlson, 2016), including surgical site infections, falls, high mortality rates in Intensive Care Units (Huang, Clermont, Sexton, Karlo, Miller, Weissfeld, Rowan, & Angus, 2007; Ulrich & Kear, 2014) pressure ulcers, medication errors, physical restraints, and patient complaints (Squires, Tourangeau, Laschinger, & Doran, 2010; Wang, Liu, You, Xiang, Hu, Zhang, Zheng, & Zhu, 2014). The culture of safety also impacts employee outcomes such as the intent to stay, emotional exhaustion and sick hours (Squires et al., 2010). Though multiple factors mold the safety culture, the behaviors of the nursing unit’s leadership have been shown to directly affect the clinical staff’s overall perceptions of safety and their safety practices, such as reporting of errors (Ballangrud, Hedelin, & Hall-Lord, 2012; Feng, Bobay, & Weiss, 2008; Kristensen, Bartels, Jaquet, Beck, Mainz, Christensen, & Sabroe, 2016). The likelihood that a nurse
will delay a procedure because of his or her realization of an error or call an upset
physician multiple times to clarify a medication dosage is dependent on the safety culture
of the organization. Safety practices such as acknowledging errors and clarifying
information, when utilized consistently, prevent patient harm.

The safety practices of frontline nursing leaders at the unit level influence the
safety performance of the bedside staff (Thompson, Hoffman, Sereika, Lorenz, Wolf,
Burns, Minnier, & Ramanujam, 2011). Hospital staff compliance with safety practices,
along with interdisciplinary teamwork, have been associated with decreased patient
mortality and reduced failure to rescue (Brooke, Dominici, Pronovost, Makary,
Schneider, & Pawlik, 2012). However, although educating nurses about safety practices
and teamwork through simulation training has been shown to be one effective method to
improve safety practices (Reime, Johnsgaard, Kvam, Aarflot, Breivik, Engeberg, &
Brattebø, 2016), without the support of unit-based nursing leadership, staff may not
incorporate these safety practices into their daily practice.

Understanding the safety practices of unit based nursing leaders, how they
contribute to the culture of safety, and their role in the interdisciplinary unit-based team is
crucial to keeping patients and staff unharmed. Although researchers have explored the
leadership practices of the nurse manager and their impact on the nurse practice
environment at the unit level, few publications examining the safety practices of the nurse
manager exist. Even more startling is the lack of empirical evidence supporting the
clinical need for the acute care hospital charge nurse, a unit-based leadership role that
works closely alongside clinical nurses delivering patient care, to promote safety
practices among the unit.
Unit Level Nursing Leadership

In acute care hospitals within the United States (U.S.), the frontline nurse manager is the unit leader who has 24-hour accountability for the staff, the unit and the patients (Moore, Sublett, & Leahy, 2016). With oversight of at least one nursing unit, the nurse manager is responsible for leadership and management decisions related to maintaining the unit budget, staffing the unit, hiring and firing staff, and setting goals and objectives for the unit (Moore et al., 2016). This leader also acts as the interface between administration and the frontline staff, communicating organizational changes back to the unit level and sharing unit-level feedback with the administrative team. Cadmus and Wisniewska (2013) identified that a nurse manager’s work involved financial management (i.e. creating capital budget, payroll, staffing), human relations (i.e. mentoring, conflict management, holding staff meetings) and practice-based work (i.e. rounding, problem solving with staff, investigating complaints and hospital supervisory activities).

Along with the nurse manager, the acute care charge nurse is also a key member of the hospital unit-level leadership team. Historically identified as “sisters,” “charge nurses,” or “head nurses,” this highly complex hybrid role encompasses both a clinical expert and leadership component (Sherman, Schwarzkopf, & Kiger, 2011; Sorensen, Delmar, & Pedersen, 2011). Charge nurses have at least one level of nursing leadership above them, usually the nurse manager, and are the closest nursing leader during each shift, for the direct care bedside nurse (i.e. staff nurse). They oversee the patient care provided by both licensed and unlicensed personnel. According to Homer and Ryan (2013), charge nurses “manage the operations of the patient care area for a shift and, as
such, their responsibilities include staffing, admissions and discharges, coordination of activities in the patient care area, conflict resolution, and facilitating resolution to patient complaints” (p. 39).

In the absence of the nurse manager, charge nurses are the voice of leadership, working alongside the clinical nurses delivering direct patient care during their shift (Connelly, Yoder, & Miner-Williams, 2003). Additionally, in a recent listserv survey conducted through the New Jersey Hospital Association by this researcher in December 2016, many New Jersey hospitals reported that a charge nurse figure is present even when the nurse manager is working. However, there is a gap in the literature regarding the role of the acute care charge nurse in the U.S. in contrast to that of the nurse manager. To address this gap, an inductive approach will be used to explore the role through the perspectives of the charge nurses, nurse managers and clinical nurses and to provide insights into this complex unit leadership role in the U.S.

Not only are the roles of the acute care charge nurse and nurse manager poorly differentiated in the literature, their distinct relationship to patient safety has also not been fully explored. Although the presence of nurse managers has been linked to positive patient outcomes, Warshawsky, Rayens, Stefaniak, and Rahman (2013) point out the inconsistencies in this empirical literature, suggesting that they may not directly impact patient care. Similarly, with a lack of published research about the charge nurse role in safety, the practices they employ to keep patients safe are also unclear. Responding to recommendations from authors for further research about the charge nurse (Connelly et al., 2003; Eggenberger, 2012), Cathro (2016) used an inductive approach to conduct a qualitative study exploring the presence of a charge nurse in relation to patient safety.
She described the charge nurse’s actions and processes for keeping patients safe from the perspective of the charge nurses in a hospital in California. By playing multiple roles, including educator, advocate and resource, charge nurses explained how they assisted the staff with problem solving, educated patients, families and staff about patient safety, and developed the patient assignment for the shift. They also reported on how they were responsible for auditing compliance of protocols and procedures related to safety initiatives such as fall prevention, infection prevention, core measures, and pressure ulcer prevention. Cathro (2016) also uncovered themes and subthemes related to the charge nurse role in building an effective team, role modeling positive behaviors, and “promoting a collegial work environment.”

However, this work only provides a small insight into the role that charge nurses, as front-line nurse leaders, play at the unit level. Though this study provides valuable insights into uncovering the safety practices of the charge nurse in the U.S., a limitation of this study was the convenience sample of charge nurses in one hospital in California. State regulations in California require mandated staffing ratios, but charge nurses are additional resources outside of the mandated nurse to patient ratios. Additionally, the study by Cathro (2016) only examined the safety practices of charge nurses from the first person perspective. In response to this limitation, the following focused ethnography will utilize a purposive sample from New Jersey, a state without staffing ratios, which may or may not include charge nurses in their staffing. It will also explore the charge nurse role and safety practices through multiple perspectives, including charge nurses’, nurse managers’ and clinical nurses’ views to gain further insight into the inadequately
explored work of the charge nurse. Further exploration into the charge nurse role is imperative to understand how they contribute to keeping patients safe.

The Phenomena of Interest: 1. The Role of the Charge Nurse

Literature about charge nurses dates back forty years, although the role of charge nurses in the U.S. has not been fully defined. Much of the literature reports that they work in a dual role encompassing both administrative and clinical components (Drach-Zahavy & Dagan, 2002; Sherman et al., 2011; Sorensen et al., 2011). However, understanding the responsibilities of this role in the U.S. has not been fully investigated from the perspectives of those healthcare workers who work most closely with the hospital charge nurse. Furthermore, the terms first-line and frontline nurse leader have been used interchangeably in the empirical literature to refer both to nurse managers and charge nurses, leaving the role of the charge nurse muddied. The unique and differentiating characteristics of the charge nurse role from that of the hospital nurse manager have yet to be defined. In addition, the way in which their role relates to the nurse manager role has not been explored. This focused ethnography will begin to uncover the uniqueness of the charge nurse role.

Charge nurse role preparation, recruitment and leadership training have also been discussed in the literature over the past twenty years (Eggenberger, 2012; Ernst, 1995; Krugman, Heggem, Judd Kinney, & Frueh, 2013; Patrician, Oliver, Miltner, Dawson, & Ladner, 2012), highlighting role conflict of the charge nurse due to the lack of preparation and obscurity about the role responsibilities (Ernst, 1995). Inconsistencies currently exist in whether hospitals employ permanent charge nurses who function under a job description or if hospitals rotate nurses in and out of the role (Hughes & Kring,
2005). In the permanent charge nurse model, when the charge nurse is not on shift, other nurses assume the charge nurse role and are referred to as “relief charge nurses.” Another inconsistency with the role is whether or not the charge nurse is expected to take a patient assignment in addition to the responsibilities of the charge nurse role. Oftentimes, they lack job descriptions to provide clarity about the expected actions of the person in the role.

Charge nurses also lack leadership preparation for the role (Patrician et al., 2012) and, as such, spend the majority of their time performing clinical skills in which they are most comfortable (Drach-Zahavy & Dagan, 2002; Ernst, 1995). Their expert clinical skills and affable personalities are usually the characteristics which lead nurse managers to promote clinical nurses to the charge nurse leadership role. In fact, studies have focused on building leadership skills through training programs (Homer & Ryan, 2013; Krugman et al., 2013; Schwarzkopf, Sherman, & Kiger, 2012). Oftentimes, recruitment for someone who possesses both leadership and clinical experience for the role is bypassed because the most experienced nurse on the unit is usually chosen for the job.

Research about the charge nurse role thus far has also explored their competencies, actions and processes and their lived experiences (Cathro, 2016; Connelly et al., 2003; Eggenberger, 2012). However, according to Kivak (2017), the term “role” in sociology encompasses the duties and behaviors that are expected of someone, which influences how others react to that person in the role. Therefore, in addition to interviewing charge nurses, this focused ethnography will seek the perspectives of nurse managers and clinical nurses who work in hospitals with charge nurses. Through multiple
perspectives, this researcher will seek to understand the charge nurse role in the U.S. Additionally, data in the form of job descriptions for the charge nurse will be analyzed to inform the practices of this role.

**The Phenomena of Interest: 2. Charge Nurse Safety Practices**

In today’s volatile healthcare environment, the Institute of Medicine’s (IOM) *The Future of Nursing: Leading Change, Advancing Health* report (Institute of Medicine [IOM], 2010) describes the urgent need for nurses at all levels to use extraordinary leadership skills to promote the evidence-based practice changes necessary to improve the quality and safety of patient care. Nurse leaders, including charge nurses, are being challenged to articulate a clear vision, lead change, and empower their staff to engage in efforts to meet organizational goals (McSherry, Pearce, Grimwood, & McSherry, 2012; Wong, Cummings, & Ducharme, 2013). Despite having two unit-based hospital nurse leaders, serious hospital-acquired adverse events continue to occur, with hospitals struggling to reach the goal of zero patient harm. More research is needed to examine unit-level leadership with regards to patient safety.

The charge nurse role has been cited as an important one which contributes to quality, patient safety, as well as patient satisfaction (Admi & Moshe-Eilon, 2010; Bradshaw, 2010; Carlin & Duffy, 2013; Eggenberger, 2012; Hinkle & Hinkle, 1977a; Hinkle & Hinkle, 1977b; Hughes & Kring, 2005; Krugman et al., 2013; Moss & Xiao, 2002; Schwarzkopf et al., 2012). Qualitative work by Eggenberger (2012) described the themes of *creating a safety net* and *monitoring for quality* which emerged from charge nurse interviews. Although they are the most numerous, frontline nurse leaders in hospitals, few studies provide evidence of the contributions to patient outcomes made by charge
nurses’ safety practices, a gap identified by many authors (Eggenberger, 2012; Schwarzkopf et al., 2012; Stoddart, Bugge, Shepherd, & Farquharson, 2014). Most recently, Cathro (2016) conducted a grounded theory study with charge nurses from medical-surgical units in a hospital in California. An emerging theory, navigating through chaos, was identified with embedded themes of balancing multiple roles, maintaining a watchful eye, and working with and leading the healthcare team. However, an opportunity exists to build upon this study by focusing on the relationships in the unit leadership team and their impact on patient outcomes, as well as the expected actions of the charge nurse from other perspectives. Understanding multiple perspectives about the expected safety practices of the charge nurse will provide insight into their contribution towards the prevention of patient harm.

Theoretical Framework

Though not required for all qualitative studies, theory can shape studies by defining concepts, steering research questions, and directing data analysis. To guide the design and methodology for this focused ethnography, the Nurse Manager Leadership Partnership (NMLP) Learning Domain Framework, operationalized as Nurse Manager Competencies (American Organization of Nurse Executives [AONE], 2015), will be utilized. Through a partnership between AONE, the American Association of Critical-Care Nurses (AACN), and the Association of Peri-Operative Registered Nurses (AORN), the three domains forming the framework for the model were developed (AONE, 2015). The NMLP of the AONE and the AACN then continued the work in developing the Nurse Manager Skills Inventory, which includes items within each domain. In 2015, the Nurse Manager Skills Inventory was revised based on A National Practice Analysis Study
of the Nurse Manager and Leader (2014) and is known as the Nurse Manager Competencies (AONE, 2015). In this focused ethnography, the skills and behaviors listed in the Nurse Manager Competencies, which are specific to the acute care hospital nurse manager role, will provide a comparison for the charge nurse role behaviors and safety practices, allowing insight into the differences and similarities between the two roles. The AONE Manager Competencies (AONE, 2015) include multiple behaviors under the umbrella of three domains—The Science: Managing the business, The Art: Leading the people, and The Leader Within: Creating the leader within yourself. Figure 1.1 NMLP Learning Domain Framework displays the list of subcategories under each domain.

In the Nurse Manager Competencies (AONE, 2015) specific items within each subcategory display the expected behaviors and skills of nurse managers. For example, under The Science domain, behaviors such as creating a budget, interviewing candidates for open positions and developing project plans, presentations, and strategic plans are highlighted. Within this domain, the nurse managers’ involvement in patient safety is defined as monitoring sentinel events, incidence reporting, monitoring medication practices through policies and procedures, and having an understanding of regulatory safety practice requirements. Under The Art domain, the following behaviors are included: involvement in performance evaluation and staff development, facilitating effective groups, employing conflict management techniques, and implementing shared governance structures and processes at the unit level. Lastly, in The Leader Within domain, behaviors to promote the professional development of the nurse manager are employed including education advancement, certification, and managing councils.
Questions related to the skills and behaviors that are based on these three domains will be developed to better understand these skills in relation to the charge nurse, another hospital frontline nurse leader. For example, to understand the charge nurses’ role in managing *The Science*, the following probe will be used: *tell me how you are involved in the financial management of the unit*. Safety practices are within *The Science* domain of *Performance Improvement*. The following questions will be asked regarding safety practices: *what is the charge nurses’ role in patient safety; Tell me what you do when an error occurs; and tell me how you prevent errors from occurring*. To uncover the charge nurses’ role in leading the staff under *The Art* domain, interviewees will be asked, *how are you involved in the development of the staff?* To learn how charge nurses enhance their own professional development and career planning, the following question may be
asked, *what do you do to promote your own professional development?* However, the questions related to the categories and domains of the theoretical framework may be revised based on the informal interviews with clinical nurses, nurse managers, and charge nurses in phase one. By utilizing multiple perspectives, including clinical nurses, nurse managers, and charge nurses, the distinct acute care hospital charge nurse role and safety practices can be uncovered. The AONE Nurse Manager Competencies can be accessed at [http://www.aone.org/resources/nurse-manager-competencies.pdf](http://www.aone.org/resources/nurse-manager-competencies.pdf).

**The Purposes of the Research**

The purposes of this focused ethnography are three-fold: to explore the role of the hospital acute care charge nurse in the U.S. from the perspectives of the charge nurses, nurse managers, and clinical nurses; to investigate how the hospital acute care charge nurse contributes to keeping patients safe; and to explore how the charge nurse and nurse manager roles relate to each other within a unit based leadership team.

**Overarching Research Question**

The overarching research questions are 1. What are the role responsibilities of the hospital acute care charge nurse; and 2. How does the hospital acute care charge nurse contribute to patient safety?

**Foundational Assumptions**

In this focused ethnography, several foundational assumptions are believed to be true. Samples from Magnet® and non-Magnet® designated hospitals will be sought because of the focus on high-quality patient care expected from hospitals who have received Magnet® designation (Drenkard, 2011; Kutney-Lee, Sloane, Aiken, Stimpfel, Cimiotti, & Quinn, 2015; O'Connor & Carlson, 2016). Leaders in these hospitals will
direct their efforts towards providing safe, high-quality patient care. To be awarded Magnet® designation by the American Nurses Credentialing Center, hospitals must meet strict criteria encompassed in five Forces of Magnetism including Transformational Leadership, Structural Empowerment, Exemplary Professional Practice, New Knowledge, Innovations and Improvement, and Empirical Outcomes. Comparative analyses with both Magnet® and non-Magnet® designated hospital outcomes data shows better patient outcomes in Magnet® accredited hospitals including reduced hospital acquired pressure ulcers (Ma & Park, 2015), better patient satisfaction (Chen, Koren, Munroe, & Yao, 2014), lower 30 day mortality, and failure to rescue rates (Friese, Xia, Ghaferi, Birkmeyer, & Banerjee, 2015). Therefore, participants from both Magnet® and non-Magnet® designated hospitals will be sought with the understanding that the roles and safety practices of charge nurses may differ because of the emphasis on safety and quality in Magnet® designated facilities.

Another assumption is that the charge nurse role may differ depending on whether the nurse rotates in and out or is permanently designated in the role. A nurse who is in the charge nurse role during every shift may exhibit different role behaviors than a nurse who is just serving in the role occasionally. The expected charge nurse role behaviors may be exhibited by the permanent charge nurse and not by the nurse in the rotating position. Consequently, the clinical nurses and nurse manager who work closely with the charge nurse may expect the behaviors to differ based on the type of position, albeit permanent or rotating, that the charge nurse assumes. The interactions between the charge nurse, clinical nurses, and nurse manager might also differ between the two charge nurse positions because the permanent charge nurse may be viewed as a unit-based leader. By
comparison, the rotating charge nurse may just be viewed as a peer who performs a limited number of the shift-related charge nurse responsibilities expected from a permanent position. To capture the variety of expected behaviors and to better understand the differences, participants from both permanent and rotating charge nurses will be sought from multiple hospitals in New Jersey.

Furthermore, though there is a lack of literature examining the role responsibilities specific to the charge nurse and to the nurse manager, it is assumed these roles are unique and different, but that both function at the hospital unit level. Both the charge nurse and nurse manager work collaboratively and comprise the unit leadership team. This focused ethnography will begin the dialogue with nurse managers, clinical nurses, and charge nurses to better understand the charge nurse role responsibilities and glean light on the unique role they play in relation to the nurse manager and the clinical nurses.

This focused ethnography will be conducted in the U.S. using multiple perspectives to investigate the charge nurse role and their safety practices. When these safety practices are evident to both the leaders and the direct care nurses, a trusting relationship will be built. This will result in a positive safety culture and, ultimately, improved patient outcomes. Leaders must provide the support and resources for nurses to deliver the best possible evidence-based, safe care to their patients.

**Definitions**

**Charge nurses** are the “frontline unit leaders in absence of or conjunction with the nurse manager, managing patient flow, staffing, patient and family concerns, interdepartmental issues, and a myriad of other administrative processes” (Patrician et al., 2012, p. 461).
The **Clinical nurse** role consists of “the interaction between the nurse and a person, family or group, in view of the decision processes that conduct care experiences and the governance of the environment of interaction” (Mendes, da Cruz, & Angelo, 2015, p. 327).

**Nurse Managers** are “responsible for translating strategic goals and objectives formulated at the operational level into practice and for providing not only administrative and clinical leadership, but also holding 24-hour accountability for all patient care activities on the unit” (Gunawan & Aungsuroch, 2017, p. 1).

**Safety practices** are “interventions, strategies or approaches intended to prevent or mitigate unintended consequences of the delivery of healthcare and to improve the safety of healthcare for patients” (Dy et al., 2011, p. 618).

A **Role** is a position that a person plays within a group accompanied by a set of behaviors that impacts the expectations that other people have toward that person (Kivak, 2017).

**Significance of the study**

Study findings will add new insights to the historically sparse extant literature on the valuable relationship between charge nurses and patient safety. Implications of this study may be expanded to other important, yet under-studied, nursing leadership roles such as the administrative supervisor. Future research will be necessary to expand upon this work in order to connect charge nurse leadership to patient and workforce outcomes. Further examination of charge nurse safety practices, as perceived by direct care nurses, will provide direct insight into their relationship to quality outcomes. Furthermore, future research may explore the impact of the charge nurse relationships on patient safety outcomes.
Summary

Although authors agree that the acute care hospital charge nurse affects patient outcomes, there is a gap in the empirical literature exploring how they do so. This focused ethnography, through its concentration on this role in the acute care hospital setting will expand upon the limited literature surrounding the safety practices of the charge nurse, a phenomena in which the principal investigator has familiarity. In addition, recognizing that this position is part of a hospital unit-based leadership team in the United States, the study will investigate how the charge nurse and nurse manager roles relate to each other in this leadership team in efforts to keep patients safe.
Chapter II

LITERATURE REVIEW

Purpose of the Literature Review in Qualitative Inquiry

Although early in the history of qualitative research conducting an initial literature review was believed to be unnecessary, today it is an acceptable and expected step in the research process (Holloway & Wheeler, 2010). The purpose of the literature review in qualitative inquiry is to allow the researcher to understand what has already been published about the concept of interest and identify experts in the topic, while simultaneously identifying gaps in the literature. In qualitative inquiry, the researcher uses the extant literature as a foundation to build upon with future study, to stimulate and define subsequent research questions, and to develop his or her sensitivity to recurrent themes about the topic found in the literature (Hammersley & Atkinson, 2007; Strauss & Corbin, 1998). The literature review begins prior to the data collection and ends upon completion of the written description of the qualitative study findings, as a comparison of themes and quotes in the literature may be made by the researcher to validate the findings (Holloway & Wheeler, 2010).

For this focused ethnography, CINAHL, Pubmed and MEDLINE databases were utilized to search for research articles regarding the charge nurse role and charge nurse safety practices; the research yielded few results. The minimal number of studies published regarding the work of the acute care charge nurse role in the United States (U.S.) led the researcher to using a multi-perspective focused ethnography.

Background of the Phenomena
A lack of published evidence about the important role charge nurses play in hospitals throughout the U.S. is evident, despite their emergence in the literature 40 years ago (Hinkle & Hinkle, 1977a). Charge nurses are the frontline nurse leaders working closest to the point of care and they typically report to a nurse manager. Authors have supported the argument that charge nurses contribute to patient outcomes, including patient safety (Eggenberger, 2012; Hughes & Kring, 2005; Krugman et al., 2013); yet, strong empirical evidence has not been published to support this hypothesis.

To provide a foundation for the need for this study, chapter two will begin with a review of the literature surrounding the relationship between leadership and safety culture. As a unit-based leader, the charge nurse may play a critical role in shaping the unit culture, leading to positive unit-based outcomes through safety practices. Then, articles about the role of the acute care hospital charge nurse, as the focus of this study, will be discussed. A review of the safety practices of the charge nurse will provide insight into how they might contribute to patient outcomes. Finally, to understand the role of the nurse manager and how the nurse manager may differ from the charge nurse in hospitals, a literature review will be provided regarding the nurse manager role and safety practices.

**Leadership and Safety Culture**

Kristensen et al. (2016) defined safety culture as “an integrated pattern of individual and organizational behavior, based upon shared beliefs and values that continuously seeks to minimize patient harm, which may result from the processes of care delivery” (p. 1). The expected norms in the organization drive the safety culture, which has been described as “the way we do things around here” (Huang et al., 2007, p. 165). The literature is replete with research and non-research articles supporting the claim
that leadership influences safety culture, as demonstrated in Table 2.1. More specifically, the leader’s behaviors influence their staff’s perceptions of the tenants of safety culture. The staff recognize the support of their leader, which results in the staff’s adherence to safety practices, and ultimately, leads to improved patient safety outcomes (Ulrich & Kear, 2014). Leadership may be a barrier or stimulator for staff performance, acting as a lever. El-Jardali, Dimassi, Jamal, Jaafar, and Hemadeh (2011) conducted the only study this researcher could locate which found positive correlations between the scores related to the leadership and management in the safety survey and the perceptions of safety ($r = 0.371$), as well as to the frequency of events reported ($r = 0.206$). Specifically, management level leadership’s commitment to safety was shown to improve the likelihood of staff reporting a patient harm event. They also tested predictive models which provided evidence of differences between the staff perceptions of safety culture at the hospital unit level. This supports the statement that unit-level leadership influences safety culture. Studies in Table 2.1 also demonstrate that partnering with staff during walking rounds and leadership education and training help to increase visibility and engagement improves safety culture (Kristensen et al., 2016; Morello, Lowthian, Barker, McGinnes, Dunt, & Brand, 2012; O'Connor & Carlson, 2016).

However, there are limitations in the studies listed in Table 2.1 as well. Though the sample sizes were large in these studies, most of the studies used convenience samples from one hospital, creating a potential sampling bias. Although the study by El-Jardali et al. (2011) utilized a large variety of hospitals in Lebanon, providing a broad sample representation, one may wonder if the significant results were inevitable given the very large sample size.
Unit-level leadership influences the unit-level safety culture. Research has shown that multi-faceted interventions implemented at the unit level positively impact the unit-level safety culture (Ulrich & Kear, 2014). There is evidence to support the hypothesis that the relationship the leader has with staff influences the perception they have of their leader, translating into how they view safety culture at the unit level (Thompson et al., 2011). If there is a low-quality relationship, then the staff will perceive their leader as poorly supportive of safety practices, potentially leading to poor patient outcomes.

Evidence surrounding leadership and safety culture provides support for the association between senior leaders (chief nursing officers and other nurse executives), nursing management and immediate supervisors, and safety culture (Feng et al., 2008; O'Connor & Carlson, 2016). The charge nurse is a frontline, unit-based leader working closest to the admitted inpatients and nurses and, as such, has great potential to influence the unit-level safety culture and, in turn, the performance of the staff on the unit. As a first step, this focused ethnography will examine the work and safety practices of the acute care hospital charge nurse to understand this leader’s potential impact on the safety culture at the unit level.

Table 2.1

<table>
<thead>
<tr>
<th>Author/ Year</th>
<th>Participants</th>
<th>Relevant Conclusions</th>
</tr>
</thead>
<tbody>
<tr>
<td>El-Jardali et al. (2011)</td>
<td>Cross-sectional study conducted in Lebanon. 6,807 hospital staff from 126 different hospitals participated by taking the Hospital Survey on Patient Safety Culture.</td>
<td>• A one unit increase in the composite score for supervisor/manager expectations and actions to promote patient safety increased the odds of reporting a better patient safety grade by 1.23 (95%CI =1.03-1.47; p = 0.024). There was a weak positive correlation between the</td>
</tr>
</tbody>
</table>
perception of safety culture and the supervisor/manager expectations and actions to promote patient safety ($r = 0.371$).

- A one unit increase in the composite score for hospital management support for patient safety increased the odds of reporting a higher patient safety grade by 1.85 (95% CI = 1.53-2.28; $p < 0.001$).
- An increase of 0.050 ($p = 0.05$) in the frequency of events reported was observed for a one unit increase in the score on hospital management support for patient safety.
- Perception of patient safety improved by 0.094 ($p < 0.001$) for a one unit increase in the score on supervisor/manager expectations and actions promoting safety.

<table>
<thead>
<tr>
<th>Source</th>
<th>Methodology</th>
<th>Findings</th>
</tr>
</thead>
<tbody>
<tr>
<td>Morello et al. (2012)</td>
<td>A systematic review of publications from 1/1997 to 4/2011, yielding 22 total publications. Aim to evaluate strategies used to improve safety culture.</td>
<td>- A positive effect on patient safety culture was detected for nurses participating in leadership walking rounds compared with those in the control group ($p = 0.02$).</td>
</tr>
<tr>
<td>O'Connor and Carlson (2016)</td>
<td>Quasi-experimental study conducted in four units in an U.S. hospital. 80% of staff responded to a Safety Attitudes Questionnaire (raw number unknown) about pre- and post- behavioral changes by nursing senior leadership.</td>
<td>- Post survey showed more than 70% of respondents felt senior leaders had elevated the importance of culture of safety. - 73% of respondents recognized the importance of leader visibility for stopping the line, had active support for implementing chain of command, and take actions on staff driven safety interventions. - Risk reporting doubled between the two survey times showing increased comfort in staff reporting errors.</td>
</tr>
<tr>
<td>Thompson et al. (2011)</td>
<td>Cross-sectional study with 711 staff and 34 unit managers from one medical center in U.S.</td>
<td>- Comparing the mean for “Supervisor expectations and actions promoting safety” across groups with high LMX, middle</td>
</tr>
</tbody>
</table>
who took the Agency for Healthcare Research and Quality Hospital Survey on Patient Safety Culture and the Leader-Membership Exchange tool (LMX-7 modified) LMX and low LMX scores, there was a significant between group difference \((F = 26.65, p< 0.001)\). High LMX had highest scores in supervisor dimension \((m =4.19(SD 0.14))\). But “hospital management support for safety” was not significantly different between groups \((F =2.17, p = 0.132)\).

- Positive relationships were found between all safety culture dimensions and individual LMX scores \((p< 0.0001)\), indicating high quality relationships are associated with positive perceptions of safety behaviors.
- Varied types of nursing units presented varied high and low quality relationship scores \((Z = 2.67, p = 0.004)\) showing that the outcomes are more directly influenced by leadership behaviors than type of patient care provided.

| Kristensen et al. (2016) | Quasi-experimental study conducted in a psychiatric hospital in Denmark. Safety Attitudes Questionnaire in Danish (SAQ-DK) taken by 358 staff prior to a leadership training intervention and 325 staff took the survey post leadership educational intervention. | • An improvement of greater than or equal to 5% was observed between pre- and post-survey scores in safety culture tenants: teamwork culture, safety culture, job satisfaction, working conditions, and unit management. The greatest improvement was in safety culture \((14.8\%\text{ improvement}, p< 0.01)\). • Study showed improvement in safety culture tenants after enhancing leadership. |

**The Role of the Acute Care Hospital Charge Nurse**

Role is defined by Kivak (2017) as a position that a person plays within a group accompanied by a set of behaviors that impacts the expectations that other people have toward that person. The charge nurse role includes the skills, behaviors, competencies, and responsibilities performed while assuming this position. Using this framework, the
CINAHL, PubMed, and MEDLINE databases were extensively searched for scholarly publications related to the charge nurse role. Search terms such as “charge nurse”, “head nurse,” “sister ward,” and “nurse manager assistant” were applied to the search to correctly identify literature related to the charge nurse as defined in Chapter One.

Literature surrounding the charge nurse emerged in 1977 with the first non-research publications by Hinkle and Hinkle (1977a) in a two part series which discussed the multi-faceted role as involving patient care (life and death, promote recovery and patient comfort), hospital protection (documentation, speaking up, and confidentiality) and staff interactions (motivation, education, and criticism). The focus of the articles was on how the charge nurse may avoid litigation by knowing her responsibilities, which were only clinically based. Relatively no well-defined patient safety practices were mentioned.

In England, Lewis (1990) conducted a qualitative study of sister wards and uncovered a core category of professional gatekeepers. In this work, charge nurses were found to maintain patient safety in hospitals by adhering to standards and/or policies in patient care. Lewis (1990) highlighted the value of this leadership role by addressing the powerful status of the charge nurse, who was viewed as the go-to nurse on the unit because he/she knew what and where to access resources within the hospital. The charge nurse in the Lewis (1990) study also possesses control over access of the nursing unit by acting as the gatekeeper to outsiders. This work showed the importance of the charge nurse role in hospitals both by having control as a nursing leader and decision maker, and by playing a gatekeeper role in keeping patients safe.
Then, in the 2000s, three qualitative studies were conducted, two within the U.S. and the other in Denmark, which focused on the behaviors and duties of the charge nurse. In all of these qualitative studies, themes and subthemes emerged from the data elicited from interviews and observations with charge nurses themselves. In one of the first studies about the role of the charge nurse in the U.S. by Connelly et al. (2003), competencies necessary for someone to be successful in the charge nurse role were explored. The fifty-four charge nurse competencies which emerged from the data showed the necessity for someone in this role to require both leadership and clinical skills, as did the study findings by Eggenberger (2012) listed in Table 2.2. Themes such as creating a safety net and monitoring for quality emerged from the data, revealing the work of charge nurses in keeping patients safe (Eggenberger, 2012).

In Denmark, the charge nurse role was examined related to their clinical and leadership behaviors in a qualitative study undertaken by Sorensen et al. (2011). However, in this study, the leadership of the first-line leader (charge nurse) is compared to the departmental leader (nurse manager), revealing that both leaders work in clinician, manager and hybrid roles; hence, there may be a lack of differentiation between the nurse manager and charge nurse work. Therefore, this scarcity of research surrounding the current charge nurse role in the U.S. reveals a need to better understand the work and the expected behaviors specific to the charge nurse in today’s healthcare climate.

Table 2.2

<table>
<thead>
<tr>
<th>Author/ Year</th>
<th>Participants</th>
<th>Relevant Conclusions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Connelly et al. (2003)</td>
<td>Exploratory qualitative study</td>
<td>• Competencies were conceptualized as the expectations that professionals have for a role.</td>
</tr>
</tbody>
</table>
- 11 staff nurses, 12 charge nurses, 10 head nurses, and nine supervisory personnel assigned to one military medical center in southwest U.S. participated in interviews utilizing Katz three categories of administrative skills (human relations, technical, conceptual).

  Primarily working on medical-surgical and intensive care units.

  Definition: Charge nurses take ownership of all unit activities during their shift.

- 54 specific competencies emerged from the data-grouped into four categories:
  - Clinical/technical (15): responsibilities directly related to patient care or some technical aspect of working on a clinical unit;
  - Critical thinking (13): responsibilities that address effective decision making and problem solving involving both clinical and operational issues on the unit;
  - Organizational (Nine): responsibilities to understand and operate in the organizational environment on the unit as well as in the larger institutions;
  - Human relations skills (17): responsibilities to interact effectively with other personnel to accomplish the requirements of patient care, as well as administrative activities.

- Characteristics to expect in a charge nurse were identified: accountability, assertiveness, positive attitude, authority, confidence, need to control, fairness, flexibility, humor, image, initiative, maturity, ability to learn from mistakes, command respect, and responsibility.

<table>
<thead>
<tr>
<th>Eggenberger (2012)</th>
<th>Qualitative descriptive study</th>
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<tbody>
<tr>
<td>• 20 day-shift “charge nurses” and “assistant nurse managers” (held different titles but same role) working in medical-surgical and telemetry units in four U.S. (Florida) hospitals participated in semi-structured interviews about the experience of being a charge nurse. Nurses included held the title</td>
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- Eight themes with subthemes:
  - Creating a safety net (Subthemes: keeping patients safe, making safety a priority, creating an environment of safety, providing for staff safety),
  - Monitoring for quality (Subthemes: Checking back, vigilantly guarding patient care, maintaining a state of watchfulness)
  - Showing the way (Subthemes: Advising clinical practice, leading the team, setting an example, guiding decision making)
of either charge nurse or assistant nurse manager and had shift accountability for the performance of their unit. They had no patient assignment in addition to their charge nurse role.

- **Completing the puzzle** (Subthemes: Putting it all together, coordinating care, maintaining collaborative connections)
- **Managing the flow** (Subthemes: Balancing the staffing, fast paced environment, getting caught in the middle)
- **Making a difference** (Subthemes: Appreciating the role, close to the bedside, quantifying the value)
- **Putting out fires** (Subthemes: Frontline go-to person, responding to calls, problem solver)
- **Keeping patients happy** (Subthemes: Listening to concerns, promoting patient satisfaction, doing my rounds)

### Sorensen et al. (2011)

- **Qualitative, ethnographic study**
  - Five charge nurses and seven department level leaders from six hospitals in Denmark were observed over 11 months with each week ending in an interview.

- **Three combined overall professional roles defined:**
  - Clinician, manager and hybrid.
- **Themes for charge nurses, main finding:** Closeness vs. Distance.
- **Themes:**
  1. **Presence in the clinic.** (Subthemes: A necessity [clinician], a dilemma [manager], a prioritization [hybrid]);
  2. **The mysterious work.** (Subthemes: An unstable practice [clinician], an invisible practice [manager], a stable practice [hybrid]),
  3. **Care and nursing.** (Subthemes: A practicist practice [clinician], a theoretical, practical practice [manager]), a theoretically based practice [hybrid]).
- **Themes for departmental level nurse:**
  - Main finding: The Recognition Game. Themes:
    1. **Clinical practice.** (Subthemes: Everyday participation [clinician],
Despite the need for more research that explicitly delineates both the role of the hospital-based charge nurse and their safety practices aimed at preventing patient harm on the unit level, only one grounded theory study exploring charge nurses’ actions to keep patients safe has been published. As shown in Table 2.3, findings from this study revealed an emerging theory of navigating through chaos. Themes of balancing multiple roles, maintaining a watchful eye, and working with and leading the healthcare team to keep patients safe emerged during the interviews (Cathro, 2016), providing seminal evidence of how medical-surgical charge nurses on the day shift contribute to patient safety in hospitals. Both Eggenberger (2012) and Cathro (2016) found a similar theme/subtheme in watchfulness over patient care and care delivery, as well as the monitoring quality of patient care. Building on this early work, the proposed focused ethnography will provide multiple perspectives about the inpatient acute care hospital charge nurse role and safety practices from a purposive sample of charge nurses, as well as nurse managers and clinical nurses, who work closely with the unit-based charge nurse. This will provide insight into the expected behaviors of the role from the nurses who work most closely with this frontline nurse leader.
Table 2.3

*Summary of Studies that Examined the Safety Practices of the Hospital Acute Care Charge Nurse*

<table>
<thead>
<tr>
<th>Author/ Year</th>
<th>Participants</th>
<th>Relevant Conclusions</th>
</tr>
</thead>
</table>
| Cathro (2016) | Qualitative study-Grounded Theory  
- 11 charge nurses from one U.S. non-Magnet hospital were interviewed  
- Six charge nurses from day, evening, and night shifts agreed to observations of two hours each. | Three main categories with subcategories:  
- *Balancing multiple roles*: (Subcategories: direct interventions, resource, educator, advocate, patient assignments)  
- *Maintaining a watchful eye*: (Subcategories: fall prevention, pressure ulcer prevention, infection prevention, core measures, equipment)  
- *Working with and leading the healthcare team*: (Subcategories: collaborating, building a high-functioning team, taking care of staff).  
- Emerging theory: Navigating through Chaos. |

**Nurse Manager Role and Safety Practices**

The differentiation between the nurse manager and charge nurse roles in the literature is critical to this focused ethnography. The acute care hospital nurse manager is a leadership role with 24-hour accountability over one or more departments and all of their included staff and patients. Holding a unit-based leadership role that is similar to that of the charge nurse, the nurse manager influences a healthy work environment which contributes to patient safety (Warshawsky, Lake, & Brandford, 2013b). However, there are surprisingly few research publications which specifically address the work behaviors of the acute care hospital nurse manager as shown in Table 2.4.

Three out of the five articles which were located examined the hospital nurse manager role in the U.S. Only one study conducted by Cadmus and Wisniewska (2013)
utilized a sample of chief nursing officers in hospitals in addition to nurse managers. The other articles, which focused on working within this role, utilized nurse managers to give the first person perspective, leaving a gap in the literature related to the perspectives of others working closely with the nurse manager. The role itself seems to revolve around responsibilities regarding the professional nurse manager, the staff and the patients (Cadmus & Wisniewska, 2013; Surakka, 2008). Similar to what was published about the role ambiguity of charge nurses more than twenty years ago (Ernst, 1995), McCallin and Frankson (2010) identified both role ambiguity and role overload among nurse managers, perhaps providing support for a need for further clarification of both roles. Nevertheless, Moore et al. (2016), Shea-Messler (2007), and McCallin and Frankson (2010) agree that the nurse manager is a complex, demanding and undervalued role in hospitals. Additional research is needed to determine the complexities of the acute care hospital charge nurse role.

Table 2.4

Summary of Studies that Examine the Role of the Acute Care Hospital Nurse Manager

<table>
<thead>
<tr>
<th>Author/Year</th>
<th>Participants</th>
<th>Relevant Conclusions</th>
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</thead>
<tbody>
<tr>
<td>Cadmus and Wisniewska (2013)</td>
<td>Quantitative pilot study utilizing 173 first line nurse managers from 73 New Jersey hospitals to pilot instrument and conduct validity and reliability testing of the First Line Nurse Manager (FLNM) Work Index.</td>
<td>FLNM Work Index contains nine categories and 87 total items (broken down by category below). Content validity testing: participants suggested adding items (listed below under category). Terminology revised based on their feedback. Added multiple options to item about managing full-time equivalents because it was concluded that hospitals differ in their management. Test-retest reliability: ranges for categories below. Twenty nine of the 87 items had at least 70% agreement in the test-retest group.</td>
</tr>
<tr>
<td></td>
<td>Ten nurse managers and five chief nursing officers from acute care hospitals</td>
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</table>
in New Jersey completed the instrument and participated in focus groups to test the new instrument for content validity
- 13 FLNMs tested the tool for test/retest reliability.

1. **Financial management**: (17 items) (% agreement 29 to 86%): allocating merit increases for employees, negotiating prices with vendors, producing reports
2. **Human resource management** (13 items) (% agreement 21 to 86%): collecting data for union negotiations
3. **Performance improvement** (17 items) (% agreement 31 to 83%): producing reports for performance improvement activities, educating frontline staff about performance improvement process
4. **Technology** (7 items) (% agreement 39 to 100%): overseeing downtime procedures, participating in informational system selection
5. **Strategic/tactical management** (14 items) (% agreement 29 to 100%): Participate in system-level meetings outside the hospital
6. **Practice** (7 items) (% agreement 64 to 93%): investigate complaints, work within a shared governance structure
7. **Personal and professional accountability** (6 items) (% agreement 50 to 85%)
8. **Relationship activities** (5 items) (% agreement 31 to 93%)
9. **Other** (1 item) (% agreement 100%)

<table>
<thead>
<tr>
<th>Study Authors</th>
<th>Study Type</th>
<th>Themes</th>
</tr>
</thead>
</table>
| McCallin and Frankson (2010) | Qualitative exploratory descriptive study | 1) **Role ambiguity**—lack of clarity associated with the role
                                                            2) **Business management deficit**—lack of needed skills in information technology, finances, human resources, business strategies, and organizational operations
                                                            3) **Role overload**—high expectations and multiple demands of the role led to role overload |
<p>| Moore et al. (2016)    | Qualitative descriptive study     | The data was analyzed with a focus on three separate areas and        |</p>
<table>
<thead>
<tr>
<th>Study</th>
<th>Methodology</th>
<th>Participants</th>
<th>Categories and Subcategories</th>
</tr>
</thead>
<tbody>
<tr>
<td>Surakka (2008)</td>
<td>Longitudinal, mixed methods study</td>
<td>13 nurse managers from five different acute care hospitals in Midwestern U.S. were interviewed.</td>
<td>Path to becoming nurse manager. Categories: Paid dues, actively seeking-passively accepting, climbing the leadership ladder, trial by fire; Growth in the role. Categories: Someone to walk alongside, a stronger foundational knowledge from which to draw; Personal attributes essential for the role. Categories: Valuing, seeking and seizing opportunities, intentional self-growth; Lessons learned. Categories: The art of managing role demands, comfort in the role comes with time.</td>
</tr>
<tr>
<td>Shea-Messler (2007)</td>
<td>Qualitative, phenomenological study</td>
<td>Eight nurse managers from acute care hospitals in southeastern U.S. were interviewed.</td>
<td>Responsibility activities (Subcategories: communicating, organizing, cooperating); Accountability activities (Subcategories: supporting staff, ensuring staff competencies, developing); Understanding nursing practice (Subcategories: direct and indirect nursing care, expertise in nursing, handyman tasks); Emerging theory: Recognition of underlying premises of one's work.</td>
</tr>
</tbody>
</table>
Nursing staff: The part I like the least: Counseling, bent over backwards: staffing & scheduling and Clock in, clock out: A lack of professionalism.

5. Patients: I never forget what it's like to be a nurse.

Some research surrounding the leadership of acute care hospital nurse managers has been shown to impact patient and staff outcomes within positive work environments (Wong et al., 2013). And yet, other studies have shown little support for this hypothesis (Larrabee, Ostrow, Withrow, Janney, Hobbs, & Burant, 2004; Warshawsky et al., 2013a), leaving a question about whether the context in which the other studies were conducted was conducive for quality outcomes to occur. In addition to the mixed evidence supporting the impact of the nurse manager on patient outcomes, there is a lack of published research regarding the nurse manager’s safety practices. These are the practices and processes that are performed by nurse managers and, as such, may play a critical role in patient and staff outcomes.

When investigating the role they play as a unit leader in the hospital environment, Cadmus and Wisniewska (2013) found possible evidence of safety practices within the “practice” category including: rounding on the unit, huddling with staff, providing direction to staff on clinical matters, assuming house supervision, investigating complaints, and working within a shared governance structure. However, the mechanisms through which nurse managers keep hospitalized patients safe were not explicitly explored. Similar to findings in the study by Cadmus and Wisniewska (2013), providing clinical guidance to staff was a practice also found among hemodialysis nurse managers where nurse manager safety practices were investigated (Thomas-Hawkins, Flynn,
Lindgren, & Weaver, 2015). Risk reduction was the overarching theme and goal of the hemodialysis nurse managers’ safety practices. As displayed in Table 2.5, the identified sources of risk included the patient, the staff, the hemodialysis environment, and the dialysis organization, all of which are very specific to an outpatient hemodialysis center nurse manager. Because the researcher was only able to locate one study specifically about nurse manager safety practices in the literature, it is evident that a gap in knowledge exists.

Table 2.5

<table>
<thead>
<tr>
<th>Author/ Year</th>
<th>Participants</th>
<th>Relevant Conclusions</th>
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</thead>
</table>
| Thomas-Hawkins et al., 2015 | Qualitative descriptive study 17 unit-level nurse managers with oversight of outpatient hemodialysis (HD) center from Northeast, Western, Southern and Eastern regions of the U.S. | • Overarching theme: Risk reduction was goal for safety practices  
• Four categories as sources of risk identified: the patient, the staff, the HD environment, the dialysis organization  
• Safety practices identified for each source of risk:  
  The patient: Monitor risky behaviors; Enforce unit safety policies/procedures; Formal and informal patient education; Manage patient turnover flow; Encourage patient engagement in care  
  The staff: Monitor and observe staff; Conduct formal audits; Address safety lapses in staff care practices  
  o Informal, real-time clinical guidance and advising  
  o Policy review and enforcement  
  o Informal and formal staff education/retraining  
  o Advise, coach, and discipline staff |
## The HD Environment:
Environmental assessments and redesign
- Clear hazards and obstructions
- Create an environment of safety

Ensure infection control
- Monitor and observe staff
- Routine audits

Ensure water safety
- Routine audit of staff adherence to water safety regulatory procedures

## The Dialysis Organization:
Make staffing work
- Augment staffing by “filling in”
- Juggle staff to balance staff per-treatment ratios

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In summary, this chapter provides a literature review of leadership and safety culture, the charge nurse role and safety practices, the role of the nurse manager, and their safety practices in acute care hospitals. Through their behaviors, leaders such as nurse managers and charge nurses influence safety culture which, ultimately, impacts patient outcomes. As a frontline nurse leader, the charge nurse is positioned to exert great influence over the culture of safety at the unit level. The charge nurses’ behaviors and relationships with other staff on the unit will influence the safety culture that develops.

When comparing the literature from the role and safety practices of the charge nurse to that of the literature regarding the nurse manager, similarities are evident. For example, both nurse managers and charge nurses are a resource for the clinical nurses in advising them about clinical care (Cadmus & Wisniewska, 2013; Cathro, 2016; Eggenberger, 2012; Thomas-Hawkins et al., 2015). The charge nurse and nurse manager
also both play a role in safety by being educators (Cathro, 2016; Thomas-Hawkins et al., 2015). By monitoring, being watchful, and running reports, both nurse managers and charge nurses ensure the safety of the patients on their units (Cadmus & Wisniewska, 2013; Eggenberger, 2012; Thomas-Hawkins et al., 2015). One concept which was threaded through the charge nurse literature, but missing from the nurse manager literature, is the practice of leading the team (Cathro, 2016). This requires further exploration because safety practices influence team culture, which is a component of safety culture (Kristensen et al., 2016). Perhaps because the charge nurse works closer to the point of care than the nurse manager during the shift, the charge nurse may play a more apparent role in leading the unit-based healthcare team in patient care. Nevertheless, both unit-based nurse leaders seem to play a role in keeping patients safe, but the context in which safety occurs at the unit level needs further investigation.

Despite the existence of both the charge nurse and nurse manager role internationally for more than forty years, there is a lack of research describing the tenets of each of these roles and the value that they have in keeping patients safe. This focused ethnography will utilize a multi-perspective approach to further examine the acute care hospital charge nurse role and how they maintain patient safety within a unit-based healthcare team.
CHAPTER III

METHOD

In Support of Method

Though they work closer to the point of patient care than any other nursing leader, little attention has been paid to the role of the acute care hospital charge nurse in the United States (U.S.) and how this role impacts patient safety. Because there is a scarcity of research on this topic, an inductive research approach was used to explore the charge nurse’s role in keeping patients safe, while acknowledging that each individual brings a different perspective to the study. To investigate this specific nursing leadership role in the hospital setting through multiple perspectives, this study used a focused ethnography methodology, which is appropriate to seek understanding of shared experiences in particular “complex societies” (Knoblauch, 2005, p. 2; Venzon Cruz & Higginbottom, 2013).

Dating ethnography’s beginnings back to the Greek and Roman times in the fifth century BC, Holloway and Wheeler (2010) define ethnography as “the direct description of a group, culture or community” (p. 153). To discover commonalities among a group of individuals who share experiences in a specific context, ethnography involves direct observation, interviews and analysis of documents as the primary methods of data collection (Hammersley & Atkinson, 2007). This qualitative method evolved in social anthropology in the 19th century as a process to compare different cultures as in ethnology (Hammersley & Atkinson, 2007). It was in the 20th century when the term ethnography developed to describe the investigation into a case study of a culture. In its early stages, researchers immersed themselves in an unknown, non-Western culture by
spending lengthy amounts of time observing and interacting with the people of that culture in the field. Written accounts of the events and memorandum were analyzed to interpret the meanings behind the words and observed behaviors. At that time, this form of qualitative inquiry was not highly regarded because often researchers would conduct their fieldwork uninvited into the culture of interest and lacked an appropriate cultural informant (Hammersley & Atkinson, 2007). However, it gained momentum in disciplines outside of sociology and anthropology, including psychology and nursing (Hammersley & Atkinson, 2007). Later in the 1900s, ethnonursing emerged as a form of ethnography used to enhance nursing practice and knowledge (Holloway & Wheeler, 2010). In the 21st century, micro-ethnography, or focused ethnography was introduced (Venzon Cruz & Higginbottom, 2013), which investigates a very specific issue or phenomenon in a particular context and within a somewhat narrowly defined group.

Focused ethnography is suitable for this research study because it presumes that the principal investigator has familiarity with the subject of study, unlike conventional ethnography in which the researcher has no knowledge of the group under study (Holloway & Wheeler, 2010). Indeed, the researcher has worked in the hospital setting for more than 20 years, as well as in the charge nurse role, bringing an intimate, emic view to the research. And yet, this personal knowledge demands reflexivity prior to, during, and after data analysis, specifically to validate the interpretations of the findings (Higginbottom, Pillay, & Boadu, 2013; Venzon Cruz & Higginbottom, 2013).

The findings of focused ethnographies should be applicable in meaningful and useful ways to nursing practice (Higginbottom et al., 2013; Knoblauch, 2005). The knowledge gained through this study will assist nursing hospital administrators and
clinical nurses in understanding the role of the charge nurse and the value they add to the unit nursing leadership team. It also provides clarity to the question about how the charge nurse contributes to patient safety. Thus, these findings may assist hospital leaders in meeting the Institute of Medicine’s (IOM) recommendations by supporting the leadership efforts of the charge nurse to keep hospitalized patients safe during their shift (Institute of Medicine [IOM], 2010).

This particular focused ethnography was conducted in two phases. Phase one consisted of informal interviews with three groups of nurses, namely those in nurse manager, clinical nurse, and charge nurse roles. Prior to the individual interviews, participants rated items on the American Organization of Nurse Executives (AONE) Nurse Manager Competencies based on relevance to the charge nurse role using a one to five Likert scale (AONE, 2015). The informal individual interview was then conducted to clarify the ratings on the tool and modify the pre-determined questions based on the Nurse Manager Leadership Partnership Learning Domain Framework for the in-depth interviews and focus groups in phase two. This data also provided a foundational understanding of the role responsibilities of the charge nurse through not only a first person perspective, but also through the expectations of the clinical nurses and nurse managers.

Phase two of this focused ethnography was also conducted using three groups of nurses employed in three different hospital roles: in-depth semi-structured interviews with hospital inpatient nurse managers, focus groups with clinical nurses from acute care hospital inpatient units, and in-depth semi-structured interviews with charge nurses from acute care hospital inpatient units. To supplement the interviews and focus groups and to
further inform the role and safety practices of charge nurses, attempts were made to
obtain documentation in the form of charge nurse job descriptions from participants.
However, only one job description from one acute care hospital with permanent charge
nurses was obtained. Most participants with permanent charge nurses or assistant nurse
managers in their facility assumed there was a job description in place for these unit-
based leaders, but they did not produce a copy upon request. In contrast, participants
from hospitals with rotating charge nurses felt strongly that they had never seen a job
description for this role.

Individual interviews were conducted with the first group, nurse managers, to
gain their perspectives surrounding the role responsibilities and the safety practices of
hospital charge nurses. Homogeneous focus groups were conducted with the second
group of nurses, clinical nurses, who worked in acute care hospital inpatient units. This
provided a perspective from nurses who typically work alongside the charge nurses
during the shift and take direction for patient care from the person in this role. Finally,
semi-structured interviews were conducted with the third group of nurses, inpatient acute
care hospital charge nurses. Permanent charge nurses, or those who are in this role every
shift they work, as well as those who are rotated between clinical nurse and charge nurse
roles, were included in the charge nurse sample to gain perspective of the differences in
the charge nurse role between these variations in the position. Nurses who work in
unionized and those who work in non-unionized hospitals were included in the study to
explore whether union membership might have an impact on nursing leadership structure
at the unit level and the charge nurse role. All three perspectives from charge nurses,
nurse managers, and clinical nurses provided authentic insight into the work of this complex hospital role both in Magnet® designated and non-designated institutions.

**Description of the Settings**

Charge nurses, nurse managers and clinical nurses working in hospitals across New Jersey participated in this two phase focused ethnography study to gain better perspective in the charge nurse role and safety practices. In phase one, individual interviews and completion of the AONE Nurse Manager Competencies (AONE, 2015) occurred at mutually agreeable locations, such as coffee shops, participants’ homes, and in hospital meeting rooms.

In phase two, charge nurses and nurse managers participated in in-depth individual interviews conducted in coffee shops, restaurants, participants’ homes, hospital offices and meeting rooms. Clinical nurses participated in focus groups which were held in the hospital where the nurses worked. Coordinating schedules for agreeable times to meet with clinical nurses from completely different hospitals was difficult. As such, the four focus groups were held with acute care hospital clinical nurses who worked in the same hospital. Sharts-Hopko (2001) points out that it may be more comfortable for participants to express their views if they are alongside others in the group with whom they do not work daily. Therefore, focus groups were arranged to include clinical nurses who worked in the same hospital, but in different units, providing a more comfortable forum in which to openly share their thoughts. Only one focus group was conducted in each hospital to allow for maximum variation of the sample. In most focus groups, participants sat around a table in a circle so participants were able to see each other.
For phases one and two, attempts were made to attain a representative sample in New Jersey by recruiting participants from three hospitals within the northern, the central and the southern areas of the state. Gaining access to hospitals proved to be more challenging than expected with some having a lengthy wait for Institutional Review Board (IRB) approval or simply not allowing external researchers to conduct research at their organizations. The researcher referred to the New Jersey Hospital Association’s website (http://www.njha.com/membership/list-of-nj-providers/hospitals/) to find a map of New Jersey hospitals to identify acute care hospitals and their respective locations and regions. The American Nurses’ Credentialing Center (ANCC) website (https://www.nursingworld.org/organizational-programs/magnet/find-a-magnet-facility/) was also utilized to identify whether a hospital was Magnet® designated, not designated, or on the journey to designation. Hospitals that have made a commitment to apply for the ANCC’s Magnet Recognition Program and submit narrative examples demonstrating excellence in nursing are recognized to be “on the journey” to designation (ANCC, 2019).

Characteristics of the Participants

Phase 1. Sample - Nurse Managers

The nurse manager sample consisted of nurse managers who met the following inclusion criteria: 1) at least one year of hospital inpatient nurse manager experience working in New Jersey acute care hospital; 2) willing to rate the AONE Nurse Manager Competencies (AONE, 2015) for charge nurses; 3) supervision over at least one charge nurse for one of their departments; 4) able to read and speak in English; 5) willing to sign consent for participation; and 6) share thoughts and experiences during one informal
interview while being digitally recorded. Exclusion criteria was: 1) nurse managers who did not work in New Jersey acute care hospitals; 2) were unable to read or speak in English; 3) did not have a year or more nurse manager experience; and 4) did not have supervision over at least one charge nurse.

**Phase 1. Sample – Clinical Nurses**

The clinical nurses met the following inclusion criteria to participate: 1) could read and speak in English; 2) had a minimum of one year of experience as an acute care hospital nurse; 3) had never worked in a charge nurse or relief charge nurse role; 4) worked full time or part time in an acute care New Jersey hospital inpatient unit where there was a charge nurse present; and 5) were willing to rate the AONE Nurse Manager Competencies (AONE, 2015) for charge nurses. Exclusion criteria were clinical nurses who: 1) did not work in an acute care New Jersey hospital inpatient unit or worked per diem; 2) did not have a charge nurse working currently in the hospital unit during the shift the clinical nurse works; 3) were unable to speak or read in English; 4) had experience themselves of being a charge nurse; and 5) had less than one year acute care hospital nursing experience.

**Phase 1. Sample – Charge Nurses**

The charge nurses met the following inclusion criteria to participate: 1) currently employed at the hospital in either part-time or full-time status; 2) had either permanent or rotating experience in this role over the past 6 months, with the last shift worked as a charge nurse within the last week of the researcher’s contact with them; 3) willing to sign consent for participation; 4) able to speak and read in English and share thoughts and experiences during an informal interview; 5) willing to rate the AONE Nurse Manager
Competencies (AONE, 2015) and be digitally recorded during the interview; and 6) working part-time or full-time in an acute care New Jersey hospital. Exclusion criteria included charge nurses who: 1) did not work part-time or full-time in an acute care New Jersey hospital; 2) did not have at least 6 months experience in the charge nurse role either permanently or rotating; 3) did not work in the charge nurse role at least once in the last week since recruitment; and 4) unable to speak or read in English.

**Phase 2. Sample – Nurse Managers**

Inclusion criteria for nurse managers to participate included: 1) had at least one year of hospital inpatient nurse manager experience and was working in New Jersey acute care hospital; 2) supervision over at least one charge nurse for one of their departments; 3) able to read and speak English; 4) willing to sign consent for participation; and 5) share thoughts and experiences during one in-depth, semi-structured interview while being digitally recorded. Exclusion criteria was nurse managers who: 1) did not work in New Jersey acute care hospitals; 2) did not read or speak English; 3) did not have a year or more of nurse manager experience; and 4) did not have supervision over at least one charge nurse.

**Phase 2. Sample - Clinical Nurses**

To be a participant in this study, the clinical nurses must have met the following inclusion criteria: 1) able to read and speak in English; 2) had a minimum of one year of experience as an acute care hospital nurse; 3) must never have worked in a charge nurse role; 4) presently work in an acute care New Jersey hospital inpatient unit where there is a charge nurse present during the shift in which the clinical nurse primarily works; 5) willing to sign consent for participation; 6) willing to share thoughts and experiences in
one focus group with other clinical nurses and be digitally recorded during the focus group discussions; and 7) working part-time or full-time in an acute care New Jersey hospital. Exclusion criteria included clinical nurses who: 1) did not work in an acute care New Jersey hospital inpatient unit or work per diem; 2) did not have a charge nurse working currently in the hospital unit during the shift the clinical nurse works; 3) unable to speak or read in English; 4) had experience themselves of being a charge nurse or relief charge nurse; and 5) had less than one year acute care hospital nursing experience.

**Phase 2. Sample - Charge Nurses**

Charge nurse participants must have met the following inclusion criteria: 1) employed at the hospital in either part-time or full-time status; 2) had either permanent or rotating experience in this role over the past 6 months, with the last shift worked as a charge nurse within the last week; 3) willing to sign consent for participation; 4) able to speak and read in English; 5) willing to share thoughts and experiences during an in-depth semi-structured interview and be digitally recorded during the interview; and 6) working part-time or full-time in an acute care New Jersey hospital. Exclusion criteria included charge nurses who: 1) did not work part-time or full-time in an acute care New Jersey hospital; 2) did not have at least 6 months experience in the charge nurse role; 3) had not worked in the charge nurse role at least once in the last week since recruitment; 4) unable to speak or read in English.

**Protection of Human Subjects**

This focused ethnography was submitted and approved on October 12, 2017, via an expedited review by the IRB for Rutgers the state University of New Jersey, Newark, New Jersey, to ensure human subjects were being protected based on federal regulations.
With Rutgers, the State University of New Jersey IRB approval, four hospitals required approval of the hospital specific IRB. Because of the design of this qualitative study, there was no more than minimal risk to research participants. No participants expressed any uncomfortable thoughts or feelings during the interviews or focus groups. Though participants could freely cease participation in this research study at any time during the focus groups and individual interviews, no participants withdrew from the study. No participant refused to answer any questions.

During both phases of this focused ethnography study, the perspectives of nurse managers, clinical nurses, and charge nurses were elicited. Prior to the start of each of the individual interviews (phases one and two) and each focus group (phase two), the researcher explained the study and asked the charge nurses, clinical nurses, and nurse managers to sign an informed consent (see Appendices H, I and J) which included: 1) assurance of anonymity and confidentiality; 2) a statement about the purpose of the study; 3) a statement that their participation would be voluntary in a research study; 4) an explanation that there would be no direct benefits and minimal risk of harm to them for taking part in the study; 5) the right of the participants to refuse to answer any questions or cease their participation in the research study at any time; and 6) an explanation about digitally recording the interviews. The consent also included a check box to indicate whether they would permit the researcher to contact them after the study to review the identified codes and themes and provide feedback. Two of the hospital’s IRBs required modifications to the Rutgers IRB approved consent form. Participants from these hospitals were consented using each of their IRB approved consents. All other
participants were consented using the consent forms approved for each phase of the study by the Rutgers the state University of New Jersey IRB (see Appendices H, I and J).

At the start of the individual interviews and focus groups and after they signed consent forms, all participants were asked to complete a demographic data form (Appendices A, B and C) which was specific to their role. To link the demographic information to each participant interview, a unique number was assigned to each participant. This number was not linked to the consent form or to personal identifying information. In addition, both charge nurses and nurse managers were asked via phone or email, prior to meeting in person, to bring the charge nurse’s job description to the interview if available and if they were comfortable doing so.

There was no financial cost for participants to be part of the study. Charge nurses, clinical nurses, and nurse managers were informed that their time commitment would involve participation in only one focus group or individual interview, with focus groups lasting 21 to 36 minutes and individual interviews lasting 19 to 35 minutes. At the conclusion of every interview and focus group, in both phases one and two, each nurse manager, clinical nurse, and charge nurse received a $10 VISA® gift card to show appreciation for their time. Snacks and beverages were provided during the focus groups as well.

The researcher guided each interview and focus group in phases one and two, transcribed the digital recordings verbatim, entered the demographic data into Excel, and analyzed the data. The recordings on the digital recorder were deleted after all data was verified to be accurately transcribed. The transcribed interviews and focus group discussions were uploaded to NVivo (QSR International Pty Ltd., Version 12), which
assisted with the initial coding and segregation of data into thematic categories. De-identified electronic records of the data in Microsoft Excel and Word were maintained on a password-protected laptop computer. Backup copies of the computer files were saved on a thumb drive and secured in a locked file cabinet to which only the researcher and her dissertation chairperson had access. Signed consent forms were maintained in another locked file cabinet that was separate from the demographic forms and job descriptions. The electronic files and paper documents, including consents and job descriptions, will be destroyed after five years. If data collected during this study is published or presented, it will be done in aggregate form only. No individual participant will be identified.

Data Source and Collection

Digitally recorded focus groups and individual interviews were the primary methods of data collection used in this focused ethnography. In phase one, charge nurses, nurse managers, and clinical nurses were asked to rate the items on the AONE Nurse Manager Competencies tool in relation to the charge nurse role (AONE, 2015). Then, the participants were interviewed to glean a basic understanding of their expectations of the charge nurse, as well as to modify the interview guide questions developed for phase two. In-depth individual interviews were also conducted with charge nurses and nurse managers in phase two using interview guided questions (See Appendices D, E and F). Focus groups with clinical nurses were also held during phase two to hear the perspectives of those who work under the supervision of the charge nurse. Additional sources of data, documents in the form of job descriptions, as well as demographic data forms completed by the participants. All of these documents were analyzed for the purpose of this study.
Recruitment

Recruitment for clinical nurses, charge nurses, and nurse managers for phases one and two was completed via purposive solicitation and snowball sampling methods. These are common sampling methods for focused ethnography because individuals with specific knowledge are sought for the study (Higginbottom et al., 2013). The researcher planned to obtain permission to recruit nurses from the 71 acute care New Jersey hospitals from their respective chief nursing officers (CNOs) during the quarterly New Jersey Hospital Association meetings. However, using the snowball sampling method and speaking with informants at New Jersey hospitals proved to be a more effective way to learn about the methods for obtaining approval to recruit participants from different sites. Clinical nurses, nurse managers, and charge nurses who met inclusion criteria were recruited to participate because of their intimate knowledge of this topic. The researcher worked with a different informant, who was either the CNO, the Research Council Chairperson or the Director of Nursing Research, at each hospital. The methods to gain access to nurses at each hospital varied. For two hospitals, the researcher presented a summary of the study at their Research Council meeting, which led to some members agreeing to participate. Other hospital informants assisted the researcher with navigating the organization’s IRB process and then subsequently emailing a recruitment flier to nurses at the organization. Specifically for the focus groups in phase two, the researcher worked with informants who assisted in reserving a room at the hospital and coordinating emails and schedules with participants. In addition, through word of mouth, colleagues and participants informed other nurses of the opportunity to participate and they contacted the researcher directly. When the nurse managers, clinical nurses, and charge
nurses contacted the researcher, they were informed about the study and their interest in participating was confirmed. The researcher also confirmed that they met inclusion criteria based on their identified nursing position by asking them questions specific to their roles.

For phase one, participants from a total of four hospitals were recruited. A maximum of three subjects inclusive of one nurse manager, one clinical nurse, and one charge nurse were recruited from one of the hospitals. Participants from 11 different hospitals were recruited for phase two. For phase two, a maximum of one focus group was recruited from each hospital and a maximum of five charge nurses and four nurse managers were recruited from one of the hospitals.

**Phase One. Individual Interviews with Nurse Managers, Clinical Nurses and Charge Nurses**

During phase one, individual interviews were conducted with nurse managers, clinical nurses and charge nurses. Prior to the interviews, the participants provided insight into the role of the acute care hospital charge nurse by rating charge nurse behaviors according to the AONE Nurse Manager Competencies (AONE, 2015). The ratings on the tool and the interview data helped to inform the interview guidelines for phase two and provide a foundation of knowledge about charge nurses based on higher and lower rated items. For example, most participants in phase one rated the financial management competencies as least applicable to the role of the charge nurse. Therefore, questions in the informal interviews during phase one focused on financial management confirmed and clarified the ratings.
The interviews began with an introduction about the purpose of the study and assurance of confidentiality. Participants read and signed the informed consent and completed a demographic data form (See Appendices A, B and C), which was collected by the researcher. Then, participants were given a blank paper copy of the AONE Nurse Manager Competencies and asked to rate each item on a scale of 1 to 5 (1=not applicable, 2= slightly applicable, 3= applicable, 4=very applicable, 5= extremely applicable) (AONE, 2015). Participants related the rating of the items to the importance of the skill to the charge nurse role specifically. While digitally recording software was running, the participants were interviewed using focused questions, probes, and clarifying questions related to the items rated extremely important and not applicable. Participants also discussed items that they felt were important to the charge nurse, but missing from the tool. For example, one of the participants mentioned that the charge nurses really “create the weather” for the unit. This was explored further in subsequent interviews.

**Phase Two. Individual Interviews with Charge Nurses and Nurse Managers**

In phase two, audio recorded, individual, in-depth interviews were conducted with nurse managers and with acute care hospital inpatient charge nurses using guided interview questions (See Appendices D and F). Individual interviews with nurse managers provided an interesting perspective from the supervisors who oversee the work of the charge nurses. To ensure that the data was accurate and comprehensive, charge nurses provided a first-person perspective of the job they do. This was critical to the effectiveness of this study. One on one interviews allowed the researcher to hear the individual’s own perspective without the influences that may occur in a focus group approach (Sharts-Hopko, 2001).
A mutually agreed upon location was selected with each participant after they were screened for inclusion criteria. Each of the individual interviews began with an introduction about the purpose of the study and assurance of confidentiality. Participants read and signed the informed consent and completed a demographic data form (See Appendices A and C), which was then collected by the researcher. A nurse manager interview guide and an acute care hospital charge nurse interview guide (See Appendices D and F) containing pre-study created, open-ended questions based on the Nurse Manager Leadership Partnership Learning Domain Framework directed the semi-structured interviews to target the role of the charge nurse in keeping patients safe (AONE, 2015). Utilizing guiding questions in the semi-structured interview, the researcher was able to ensure that the purposes of the study were met during the interviews by interjecting probes and clarifying questions when necessary (Holloway & Wheeler, 2010).

**Phase Two. Focus Groups with Clinical Nurses**

Recruiting clinical nurses for focus groups was far more difficult than recruiting for the interviews in phase two, particularly in recruiting charge nurses with experience. Therefore, four homogeneous focus groups, instead of the intended five, were held with a total of 13 clinical nurses. The focus groups had between two and eight clinical nurses participating, which is smaller than generally acceptable (Jayasekara, 2012).

To elicit candid responses from the focus group participants, attempts were made to recruit nurses from different hospitals. However, with assistance from hospital informants, homogeneous groups comprising clinical nurses from the same hospital were formed for the focus groups which occurred at hospital sites. Nurses in the focus groups
worked in different units and/or different shifts in the same hospital, providing a comfortable environment for them to be as candid as possible (Sharts-Hopko, 2001).

The focus groups began with an introduction about the purposes of the study and participants were assured of confidentiality. Light refreshments and beverages were provided at each focus group. Participants read and signed the informed consent form and completed a demographic data form, which was collected by the researcher (see Appendix I). Ground rules were provided at the start of each focus group and each participant was assigned a number for transcription purposes. All clinical nurses in the focus groups were encouraged to share their perspectives to allow everyone to be heard. If someone had not voiced their view during the focus group, they were asked about their perspective to encourage full participation. The clinical nurse focus group discussion guide, which was based on the Nurse Manager Leadership Partnership Learning Domain Framework, was utilized to focus the dialogue in all focus groups (see Appendix E).

**Demographic Data Form. (See Appendices A, B and C)**

For each of the three different nurse groups, different demographic data forms (See Appendices A, B and C) were utilized because of the variety of samples. Demographic data collection included age, years of experience as a nurse, title, shift, years of experience in nurse manager/charge nurse role, and highest nursing educational level. Demographics about the hospital in which they are currently employed, such as where the hospital had Magnet designation, were also collected in the demographic data forms. At the start of every interview and focus group in both phase one and two, each participant completed a paper copy of the demographic form after consent was obtained.

**Documents: Job descriptions for acute care hospital inpatient charge nurses**
During the phone call or via the email to confirm interest in participating in the study, acute care hospital inpatient charge nurses and nurse managers who met inclusion criteria were asked to email a copy of the charge nurse job description, if one existed, to the researcher or bring a copy to the interview meeting. Because documents can provide another layer of data to analyze in a focused ethnography, the researcher proposed using job descriptions during the data analysis phase to provide a comparison to the transcripts through triangulation (Hammersley & Atkinson, 2007).

**Field Notes**

Several types of field notes were captured during this focused ethnography. The researcher wrote descriptive notes about the participants, their nonverbal reactions, the environment, and organization during and immediately after each individual interview and focus group. Process and analytical field notes were compiled after each focus group and each individual interview to document specific details easily about each session. Hammersley and Atkinson (2007) point out that analytical field notes assist the researcher in thinking about emergent themes, planning the research strategy, and jotting down questions that arise as the data is being collected. During, between, and after completion of data collection, including coding analysis and mapping, process field notes were written to reflect on the progress of the data collection. This allowed for educated decisions to be made regarding continued sampling. For example, participants from one hospital suggested that a union environment could impact the roles and titles of charge nurses. As such, recruitment efforts for the study shifted to include additional unionized hospitals in the sample.

**Reflective journal**
A reflective journal was maintained prior to, during, and post data collection for this study. This provided an avenue to acknowledge and express feelings and personal thoughts about the information extrapolated from the focus groups and interviews. In the journal, the researcher compared her own thoughts and personal knowledge of the role with the data being obtained. She utilized the journal to acknowledge her own feelings prior to, during, and after data collection, recognizing that they could influence what she considered important and unimportant during the research (Hammersley & Atkinson, 2007).

**Data Analysis**

The analysis began when the researcher started to read, re-read, and analyze the transcripts after the first interview was completed in phase one. Subsequently, multiple detailed readings of each transcript and set of field notes (descriptive and analytic) allowed for immersion into the data and for the emergence of themes. The readings continued as additional transcripts, field notes, and the charge nurse job description were added to the data, with the goal of better understanding the role responsibilities of the charge nurse in acute care U.S. hospitals, as well as how they keep patients safe during their shift.

Extant literature about the role of the charge nurse (Eggenberger, 2012) and about the safety practices of the charge nurse (Cathro, 2016) were reflected upon during the analysis. The three domains of the Nurse Manager Leadership Partnership Learning Domain Framework were also reflected upon to better understand the differences and similarities between the role and safety practices of the charge nurse in comparison to those of the nurse manager.
The data was carefully reviewed in order to identify possible patterns such as noting anything surprising or unusual, common topics among participants or discrepancies between groups known as “sensitizing concepts” (Hammersley & Atkinson, 2007, p. 164). These concepts started to give the data shape and meaning, but changed over time as new transcripts were added and analyzed. The similar sensitizing concepts found in the transcripts and job descriptions were coded. There was a constant reviewing back and forth between the codes and the data both within interviews and across interviews. The Nurse Manager Interview Guide, the Clinical Nurse Focus Group Discussion Guide, and the Charge Nurse Interview Guide were revised as needed based on the discussions in phase one and the ongoing analysis during data collection (See Appendices D, E and F). For example, to understand whether shift influenced the role of the charge nurse, questions were added to the interviews and focus groups for clinical nurses, charge nurses, and nurse managers.

After utilizing Nvivo software (QSR International Pty Ltd., Version 12) to begin to code the transcripts and after the first interview, relationships began to emerge from the data. As interviews continued, the researcher turned to the method of mapping on large sheets of paper for diagramming relationships (Hammersley & Atkinson, 2007). More narrowly focused codes and their relationship to the charge nurse role and to their safety practices were analyzed. Then, higher level concept mapping began to occur as it became more apparent that the charge nurse role differed among permanent and rotating charge nurses. Next, more situational and positional maps were created to explain the difference between the two roles and the context in which the difference occurs (Hammersley & Atkinson, 2007). Phase one and phase two data were separately analyzed.
and then compared using maps. Responses from all three participant nurse groups were also compared to understand the expectations of the charge nurse. Hospital data was organized into maps to further explain the charge nurse role within the hospital structure. The maps were shared and discussed with the Dissertation Chairperson to clarify and verify the relationships that began to form. During frequent meetings, codes and themes were reviewed for agreement. As requested, other members of the Dissertation Committee also assisted the researcher by troubleshooting barriers during data collection. As needed, the Dissertation Committee members were consulted about the codes and themes emerging throughout the study. The AONE Nurse Manager Competencies were used in triangulation of the data and incorporated into the maps as well (AONE, 2015). To confirm the codes and themes, competencies from the tool, which derived from the Nurse Manager Leadership Partnership Learning Domain Framework, were matched with the findings. Finally, the relationship between hospital leadership structure, unit leadership structure, permanent charge nurse, rotating charge nurse, and nurse manager roles all emerged through mapping.

**Trustworthiness**

Having an intimate knowledge of the acute care U.S. hospital environment and familiarity with charge nurses, it was crucial for the researcher to ensure trustworthiness of the data collected and analyzed. Techniques, such as member validation (member check), data triangulation, thick description, and reflexivity were used during and after data collection, transcription, and analysis to confirm the authenticity of the data (Holloway & Wheeler, 2010).
A member check was used to confirm credibility of the data. Two members from the nurse manager group, two members from the clinical nurse group, and two charge nurses were asked to read the summary of findings after data was analyzed to ensure that the data was reflective of the roles and safety practices of the charge nurse. The six chosen participants who agreed to be contacted via the informed consent displayed an eagerness to share their perspectives and contributed the most interesting information during the conversations in the focus groups and interviews. All six participants agreed with the findings, one of whom stating that the themes referring to the rotating charge nurse were reflective of her role and “very accurate.” Another participant who works with permanent charge nurses highlighted how much the relief position was “unwanted” by the clinical nurses, sometimes even causing “bickering”. Using the member check technique in this focused ethnography helped to validate that the findings reflected what was shared during data collection and not the researcher’s pre-conceived thoughts based on her familiarity with the charge nurse role. The member check allowed the participants to confirm and clarify themes and their meaning.

Data source, respondent, and method triangulation were used to ensure authenticity of the data. Codes and themes discovered within transcripts from nurse manager interviews, clinical nurse focus groups, and charge nurse interviews were compared. Through comparing the perspectives of nurse managers, clinical nurses, and charge nurses, the inferences made could be empirically supported. This support was lacking in some of the studies published to date specifically exploring the role and safety practices of charge nurses (Cathro, 2016; Eggenberger, 2012). Analysis of data also included the comparison of multiple methods of data collection, specifically the multiple
samples of nursing positions involved in the interviews and focus groups and the documentation of one charge nurse job description, to ensure saturation.

A diverse sample and multiple sources of data collection, including interviews (individual and focus groups), field notes, and job descriptions, provided rich data and ensured its trustworthiness. Utilizing the focused group methodology allowed for discussion and interaction between the homogeneous groups of individuals in the same nursing position, which generated a thick description of events (Jayasekara, 2012). By sharing the experiences of being in the same role, the clinical nurses’ thoughts and feelings were supported in the focus groups by their peers.

Due to the researcher’s familiarity with the context of the study, an especially important aspect in focused ethnography (Knoblauch, 2005) is reflexivity because it calls for the researcher to analyze his or her own pre-conceived notions about the topic. During the data collection of all three groups, specific discussion guides with pre-selected questions were used to guide the discussions and maintain focus on the purposes of the study. Notes were made in a reflective journal after each focus group and interview to identify and clarify the researcher’s own thoughts and feelings based on the discussion. The researcher also used reflexivity during the interviews and focus groups with familiar subjects to maintain a neutral stance during discussions.

**Summary**

Using an inductive approach, this research study explored the role responsibilities and safety practices of the charge nurse in acute care New Jersey hospitals. A focused ethnography study was conducted because the researcher was knowledgeable about charge nurses and hospital environments, which allowed access to subjects because the
focus was on a specialized population in a specific setting. Data collection was conducted using a multiple perspective approach in two phases. Phase one consisted of a sample of nurse managers, clinical nurses, and charge nurses who rated items on the AONE Nurse Managers Competency tool based on their pertinence to the charge nurse role (AONE, 2015). Then, the researcher had informal discussions with each of the participants to clarify the ratings, which informed the questions for phase two. Phase two consisted of in-depth individual interviews with charge nurses and nurse managers, as well as focus groups with clinical nurses. Data analysis involved reading and re-reading the transcripts of the digitally recorded focus groups and interviews, then coding the data to discover emergent themes related to the role of the charge nurse and charge nurse safety practices. To ensure trustworthiness of the data, reflexivity, thick description, member check, and data triangulation techniques were used.
Chapter IV

CONTEXT AND INFORMANTS

To understand the role of the acute care hospital charge nurse in the United States, a focused ethnography study was conducted utilizing a multi-perspective approach. This research was conducted in two phases. Phase one involved individual interviews with three nurse managers, three charge nurses, and three clinical nurses which shaped the questions during phase two. In phase two, in-depth interviews with eleven nurse managers and fifteen charge nurses, as well as four focus groups with a total of thirteen clinical nurses, occurred. Including a variety of nurses at all levels in the sample provided a unique approach to truly understanding the role as perceived by not only the nurses in the role, but also by those who work alongside them and supervise them. It is important to also describe the twelve diverse acute care hospitals in which these nurses worked to provide the context in which this study occurred. The purpose of this chapter is to provide the historical socio-cultural context of this study, describe the state of hospitals currently in New Jersey at the organizational and unit levels, and describe the participants in this study.

Historical Socio-Cultural Context of Research

Participants who worked in acute care hospitals located in New Jersey were included in phases one and two of the study. The hospitals in New Jersey have undergone tremendous changes, with many hospitals having been forced to close, merge or find fiscally responsible ways of remaining independent. According to the State of New Jersey Department of Health (2018), in 2016 there were 78 acute care hospitals in New Jersey and according to the New Jersey Hospital Association (2018), only 71 hospitals
remained in 2018. Mergers have occurred among many New Jersey hospitals, the most recent of which was Hackensack University Medical Center and Meridian Health joining together within the last three years. This merger created one of the largest healthcare systems in New Jersey, comprising 16 acute care hospitals, psychiatric hospitals, and subacute facilities across the state. However, mergers such as this one have brought together facilities with very different cultures and different organizational structures.

For example, mergers have combined Magnet® designated and non-designated hospitals together. Magnet® designation, granted to hospitals which meet a set of strict criteria by the American Nurses Credentialing Center (ANCC), signifies excellence in nursing care (Drenkard, 2011). The focus of the program is on high-quality patient care, highly satisfied nursing staff, and highly satisfied patients. Nurses are empowered to make innovative patient care decisions, working collaboratively with the interprofessional healthcare team to deliver the highest quality patient care. They also have opportunities for professional advancement afforded to them by the organization, with a focus on career development, including attaining certification and higher nursing degrees. With 36% of the hospitals in the state holding Magnet® designation, healthcare systems are challenged to ensure that all of their hospitals are on the Magnet® journey (American Nurses Credentialing Center [ANCC], 2018). Hospitals are said to be “on the Magnet® journey” when they are in the process of applying for this designation. In addition, healthcare consumers have a choice of 71 hospitals throughout the state in which they can seek care. Magnet® status might be one factor they consider when choosing which hospital to visit for services, which pressures hospitals to seek Magnet® status. In this qualitative study, six New Jersey hospitals were Magnet® designated, three
hospitals were on the Magnet® journey, and nurses in three hospitals reported they did not have Magnet® designation.

Another factor consumers may consider when choosing a hospital in which to seek care is publically reported data. New Jersey hospitals continue to seek and attain awards and accolades for their impressive quality and patient safety data regarding hospital-acquired conditions, such as infections. Most recently, in a November 2018 Leap Frog report rating hospitals for safe patient care, 57% of New Jersey hospitals earned an “A” rating, the most of any state in the nation (Livio, 2018). It is no wonder that New Jersey hospitals are focused on quality and safety when so many are Magnet® designated, which raises the bar for those hospitals and facilities that have not attained Magnet® status.

High-quality care in New Jersey is also driven by the high reliability organization initiative. With a strong focus on error prevention, all New Jersey hospitals have joined together through the New Jersey Hospital Association to form the New Jersey High Reliability Organization (HRO) Collaborative (Matthau & Hochron, 2018). As described by Weick & Sutcliffe (2007), HROs strive to have highly reliable processes by following five principles. First, employees at HROs have are committed to addressing, minimizing and preventing failures by examining every small problem to determine whether a system issue exists. Second, HROs are careful not to oversimplify situations, potentially causing them to miss an underlying issue. HROs are also sensitive to operations, meaning that employees are taught to be mindful and present in their work. Frontline employees are empowered to voice any safety concerns and make decisions supporting safe patient care. They also have a commitment to resilience. They are able to handle crises well and
bounce back from adversity. Lastly, HROs have a deference to expertise. When a problem arises, they ask their experts, involving all disciplines necessary to solve the issue. Healthcare HROs focus on having a zero harm tolerance, transparency in their errors to prevent recurrence, and a detailed, structured approach to dealing with errors when they occur. Within a trusting environment and a culture of safety, employees are empowered to communicate errors, both before and when they occur in a non-punitive environment (Gaw, Rosinia & Diller 2018). This culture of safety and high reliability status that all New Jersey hospitals are striving for originates from the hospital organizational level leadership and permeates down through the hospital unit level leadership as well. It is the responsibility of the leaders at the unit level, through both their words and actions, to develop and nurture the culture of safety at the unit level, which impacts patient safety outcomes.

Hospital Organizational Structure

The role of the charge nurse is complicated by both the organization’s and the unit’s nursing leadership structure. Organizationally, hospitals are identified according to the American Hospital Association’s (AHA) 2018 Fast Facts as community (acute care), federal government, long term care or psychiatric. AHA also describes them by ownership type as being non-government not-for-profit, investor owned for profit, or state and local government owned (AHA, 2018). AHA (2018) also identifies another type of hospital, academic medical centers and teaching hospitals, which are defined as those that educate and train future medical professionals. In addition, hospitals can be unionized, wherein the nursing staff belong to a union, or they can adhere to a non-union structure. To understand the type of hospitals which were represented in this study and
whether they had any impact on the charge nurse role, participants were asked about these hospital descriptions. A variety of types of acute care hospitals, as described above by the AHA (2018), was sought to understand the complexity of the role within the confines of these structures. Magnet® designated and non-designated hospitals were also included to define if and how Magnet® status impacts the charge nurse role.

**Phase One**

Nurses from four different hospitals located in northern New Jersey participated. Per AHA (2018) criteria, three of the acute care facilities are not-for-profit ownership type and one is for profit investor owned. Only one of the hospitals was a teaching facility and one of the facilities was unionized. Additionally, three hospitals were Magnet® designated and one was on the journey.

**Phase Two**

As displayed in Table 4.1, 11 different hospitals from the northern, central, and southern regions of the state were represented in phase two of the study, with three of the same hospitals from phase one providing additional participants for this second phase. Of this acute care hospital sample and according to AHA (2018) criteria for ownership type, three hospitals are for profit and the remaining eight are not for profit. Five out of the 11 hospitals in phase two were teaching hospitals. Hospital size, which is based on the number of staffed beds, ranged from small hospitals with 175 beds to large hospitals with 711 beds. In addition, participants revealed that in two of the facilities, nurses were unionized. In phase two three facilities did not have Magnet® designation, three facilities were on the journey, and five facilities were Magnet® designated.

Table 4.1
### Hospital Sample Characteristics from Phases One and Two

<table>
<thead>
<tr>
<th>Hospital</th>
<th>Number of Staffed Beds (#)</th>
<th>For/Non Profit (F/N)</th>
<th>Teaching/Non Teaching (T/N)</th>
<th>Magnet (Y/N/on Journey)</th>
<th>Union (Y/N)</th>
</tr>
</thead>
<tbody>
<tr>
<td>A**</td>
<td>451</td>
<td>N</td>
<td>N</td>
<td>Y</td>
<td>N</td>
</tr>
<tr>
<td>B</td>
<td>184</td>
<td>N</td>
<td>N</td>
<td>Y</td>
<td>N</td>
</tr>
<tr>
<td>C</td>
<td>700</td>
<td>N</td>
<td>T</td>
<td>Y</td>
<td>N</td>
</tr>
<tr>
<td>D</td>
<td>587</td>
<td>N</td>
<td>N</td>
<td>On journey</td>
<td>Y</td>
</tr>
<tr>
<td>E</td>
<td>339</td>
<td>N</td>
<td>N</td>
<td>On journey</td>
<td>Y</td>
</tr>
<tr>
<td>F</td>
<td>307</td>
<td>N</td>
<td>N</td>
<td>Y</td>
<td>N</td>
</tr>
<tr>
<td>G*</td>
<td>298</td>
<td>N</td>
<td>N</td>
<td>Y</td>
<td>Y</td>
</tr>
<tr>
<td>H</td>
<td>222</td>
<td>F</td>
<td>T</td>
<td>N</td>
<td>N</td>
</tr>
<tr>
<td>I**</td>
<td>711</td>
<td>F</td>
<td>T</td>
<td>Y</td>
<td>N</td>
</tr>
<tr>
<td>J</td>
<td>463</td>
<td>N</td>
<td>T</td>
<td>N</td>
<td>N</td>
</tr>
<tr>
<td>K</td>
<td>367</td>
<td>F</td>
<td>T</td>
<td>N</td>
<td>N</td>
</tr>
<tr>
<td>L**</td>
<td>175</td>
<td>N</td>
<td>N</td>
<td>On journey</td>
<td>N</td>
</tr>
</tbody>
</table>

Note. *Included in phase one only; No asterisk: Included in phase two only; **Included in both phases one and two.

### Unit-Level Hospital Structure

The minimum requirements for a hospital’s administrative personnel at the unit level is governed by the state department of health regulations. Per the New Jersey Administrative Code 8:43G-17.1, the unit nursing leadership structure in each hospital consists of, at minimum, a nurse manager and a nurse in charge (State of New Jersey Office of Administrative Law, 2019). How these regulations are enacted within each hospital is decided at the hospital administrative level. As such, the hospital organizational leadership structure plays an important role in the nursing leadership structure on the unit level. The amount and type of positions at the unit level is determined by the executive staff at the hospital or system level. However, the responsibilities of unit-level personnel are decided by the unit leader, who is typically the manager or director. The roles and responsibilities of staff allocated to each unit,
including the charge nurse, may differ based on manager’s decision, the type of unit, and patient population.

All 12 hospitals represented in this focused ethnography have a charge nurse on every shift on every unit in compliance with the NJ Administrative Code mentioned above (State of New Jersey Office of Administrative Law, 2019). However, major differences were found between hospitals not only in the charge nurse titles, but also in their role responsibilities. Some hospitals seem to have differences in charge nurse role responsibilities between units within the same hospital. Hospitals have one of two types of charge nurses, permanent or rotating. Permanent charge nurses are those who typically apply, interview, and are hired into this position and work in this role during every shift they are on the schedule. Permanent charge nurses have administrative and clinical components to their role and usually do not have a full patient assignment. When the permanent charge nurse is off, a relief charge nurse provides coverage in his or her absence. Rotating charge nurses, in contrast, are clinical nurses who are assigned to be in the charge nurse role for a shift in addition to their typical clinical nurse role. This is a shared role on a unit wherein the clinical nurses take turns filling the charge nurse role. While in this role, nurses typically have a patient assignment to care for as well, making this an additional responsibility for them to fill.

All 12 hospitals represented in this study also have a nurse manager who oversees at least one unit. Though their title varied in the hospitals represented from nurse manager to patient care coordinator to nurse director, all reported that they had 24-hour responsibility for their unit, the patients, and staff. In addition, some units which had rotating charge nurses also had an assistant nurse manager position. The assistant nurse
manager is a nurse leader figure on the unit who has both clinical and administrative responsibilities similar to those of the permanent charge nurse role. They either work into the evening shift maintaining a leadership presence even after the manager has left or they work during the day shift alongside the nurse manager and charge nurse. For the 12 hospitals in the study, it seemed that the unit leadership structure was determined, in part, by the span of control of the nurse manager. If the nurse manager had oversight over more than one department, then he or she either had a permanent charge nurse or a rotating charge nurse with an assistant nurse manager. A charge figure without a patient assignment was present when the manager could not always be on the unit. If the nurse manager covered only one unit, typically a rotating charge nurse was present without an assistant nurse manager.

**Phase One**

Table 4.2 shows the descriptive data for the hospital unit-level nursing leadership represented in phases one and two of this study. All four hospitals represented in phase one had a nurse manager responsible for each unit, but their span of control differed greatly. Only one nurse manager, known as a nurse director, supervised more than one unit, and her charge nurse on the unit, called a patient care coordinator, was a permanent charge nurse. Two of the hospitals had nurse managers, one of which was known as a coordinator. The coordinator was responsible only for one unit, but their charge nurses rotated in and out of the role, with a different person in the role each shift, each day. Of note, one of these hospitals also had an assistant nurse manager figure on the nursing units. The nurse manager in the fourth hospital covered one nursing unit only and, in addition, had a charge nurse on each shift who was permanently in that role.
Phase Two

In phase two, all 11 hospitals also had a nurse manager figure that six hospitals referred to as nurse directors. In four of the hospitals, they were known as nurse managers and one held the title of coordinator. The span of control for the nurse manager varied in this group of hospitals as well. Five of the hospitals’ nurse managers supervised only one unit; the remaining six hospitals had nurse managers covering more than one unit. Five of the hospitals represented had a charge nurse on the unit for each shift, but they rotated a different nurse into the position each day. The other six hospitals had a permanent charge nurse in this role each day on each shift. Four of the hospitals in this phase that had a rotating charge nurse also had an assistant nurse manager figure included in their nursing unit leadership team.

Table 4.2

Hospital Unit-Level Nursing Leadership Descriptions for Phases One and Two

<table>
<thead>
<tr>
<th>Hospital</th>
<th>Charge Nurse-Permanent or Rotating</th>
<th>Assistant Nurse Manager (Y/N)</th>
<th>Nurse Manager Span of Control (1 or more than 1 unit)</th>
</tr>
</thead>
<tbody>
<tr>
<td>A**</td>
<td>Permanent</td>
<td>N</td>
<td>1 unit</td>
</tr>
<tr>
<td>B</td>
<td>Permanent</td>
<td>N</td>
<td>more than 1 unit</td>
</tr>
<tr>
<td>C</td>
<td>Rotating</td>
<td>Y</td>
<td>more than 1 unit</td>
</tr>
<tr>
<td>D</td>
<td>Rotating</td>
<td>Y</td>
<td>more than 1 unit</td>
</tr>
<tr>
<td>E</td>
<td>Rotating</td>
<td>N</td>
<td>more than 1 unit</td>
</tr>
<tr>
<td>F</td>
<td>Permanent</td>
<td>N</td>
<td>1 unit</td>
</tr>
<tr>
<td>G*</td>
<td>Permanent</td>
<td>N</td>
<td>more than 1 unit</td>
</tr>
<tr>
<td>H</td>
<td>Rotating</td>
<td>N</td>
<td>1 unit</td>
</tr>
<tr>
<td>I**</td>
<td>Rotating</td>
<td>Y</td>
<td>1 unit</td>
</tr>
<tr>
<td>J</td>
<td>Permanent</td>
<td>N</td>
<td>more than 1 unit</td>
</tr>
<tr>
<td>K</td>
<td>Permanent</td>
<td>N</td>
<td>more than 1 unit</td>
</tr>
<tr>
<td>L**</td>
<td>Rotating</td>
<td>N</td>
<td>more than 1 unit</td>
</tr>
</tbody>
</table>

Note. *Included in phase one only; No asterisk: Included in phase two only; **Included in both phases one and two.

Introduction to the Participants
In phases one and two of this focused ethnography, participants included nurse managers, charge nurses, and clinical nurses who were, at the time of the study, working in acute care New Jersey hospitals.

**Phase One**

In phase one, three nurse managers, three charge nurses, and three clinical nurses were interviewed. Table 4.3 displays the data describing this population. Participants in all of the three nursing groups in phase one were female. The average age of the nurse manager participants was 53.7 years old (SD 4.2), the oldest of all three groups in phase one. Clinical nurses’ mean age was 40.3 years old (SD 4.7), while the mean age of the charge nurses was 50.3 years old (SD 7.5). The highest level of nursing education varied among the three groups ranging from diploma nurses to masters prepared in the clinical nurse group. However, all three charge nurse participants had a baccalaureate nursing degree. The average total number of years as a nurse for both the clinical nurse and charge nurse groups was similar at 14.6 (SD 10) and 14 (SD 4.3) respectively. The nurse managers’ years of experience in this role ranged from one to 10 years with an average of 6.7 (SD 4.9). Although all participants in phase one reported that they had a charge nurse, the role varied between either the permanent or rotating type. One hundred percent of the clinical nurses had permanent charge nurses who almost never took an assignment. However, one of the clinical nurses reported that their permanent charge nurse worked Monday through Friday and that they had rotating charge nurses on the weekend shifts who always took a patient assignment. Sixty-six percent of the charge nurses had a rotating schedule for the role and always took a patient assignment, while 34% had a permanent role and almost never held an assignment. The nurse managers also had a 66%
and 34% split of rotating and permanent charge nurses with those rotating always taking
an assignment and the permanent sometimes taking patients.

Table 4.3

*Phase One Participant Demographics*

<table>
<thead>
<tr>
<th>Participants</th>
<th>Gender (%)</th>
<th>Age (Mean (SD))</th>
<th>Years Nursing Experience (Mean (SD))</th>
<th>Highest Nursing Degree (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clinical Nurses</td>
<td>Female 100%</td>
<td>40.3 (SD 4.7)</td>
<td>14.6 (SD 10)</td>
<td>Diploma 33%</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>BSN 34%</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>MSN 33%</td>
</tr>
<tr>
<td>Charge Nurses</td>
<td>Female 100%</td>
<td>50.3 (SD 7.5)</td>
<td>14 (SD 5.1)</td>
<td>BSN 100%</td>
</tr>
<tr>
<td>Nurse Managers</td>
<td>Female 100%</td>
<td>53.7 (SD 4.2)</td>
<td>*6.7 (SD 4.9)</td>
<td>BSN 66%</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>MSN 34%</td>
</tr>
</tbody>
</table>

Note:* Shows Years Nurse Manager Experience (Mean[SD]).

*Phase Two*

In phase two, 13 clinical nurses participated in focus groups (two to six people per
group), while 15 charge nurses and 11 nurse managers participated in individual
interviews. Though the majority of participants were female, there were male participants
in both the charge nurse and nurse manager samples. Recognizing that there were no
male nurses recruited for phase one, during phase two male participants were actively
sought. Table 4.4 demonstrates the demographic data for these participants. Although the
nurse manager group was still the oldest of the three groups, there were much younger
participants in all three groups in phase two. However, the nursing experience level for
charge nurses was similar in phase one and two. The nurse manager experience in this
role was also similar between phases one and two.
In phase two, nurses with higher nursing degrees also participated across all three groups. In contrast to phase one, phase two charge nurse participants with Masters and Doctorate degrees all held assistant nurse manager or permanent charge nurse positions. Although participants with more rotating charge nurses were recruited in this phase, the nurse manager group revealed that 45% of those with rotating charge nurses also had an assistant nurse manager position on their units. Similar to phase one data, most participants revealed that their rotating charge nurses were more likely to have a patient assignment and those in permanent charge nurse roles were less likely to do so the majority of the time.

Table 4.4

Phase Two Participant Demographics

<table>
<thead>
<tr>
<th>Participants</th>
<th>Gender (%)</th>
<th>Age (Mean (SD))</th>
<th>Years Nursing Experience (Mean(SD))</th>
<th>Highest Nsg Degree (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clinical Nurses n=3</td>
<td>Female 100%</td>
<td>31.7 (SD 10.5)</td>
<td>7.5 (SD 9.7)</td>
<td>Diploma 7.6% Associate 7.7% BSN 77% MSN 7.7%</td>
</tr>
<tr>
<td>Charge Nurses n=15</td>
<td>Female 87% Male 13%</td>
<td>40 (SD 11.8)</td>
<td>15.1 (SD 11.4)</td>
<td>Diploma 6.7% BSN 67% MSN 20% DNP 6.7%</td>
</tr>
<tr>
<td>Nurse Managers n=11</td>
<td>Female 73% Male 27%</td>
<td>43 (SD 9.4)</td>
<td>*6.3 (SD4.4)</td>
<td>BSN 45% MSN 55%</td>
</tr>
</tbody>
</table>
Notes. *Shows Years Nurse Manager Experience (Mean[SD]).* Four out of the nine participants with rotating charge nurse also had an assistant nurse manager.

**Description of the Audit Trail**

Data collection, analysis, and maintenance during this study utilized both paper forms of memos, notes, one charge nurse job description, interview and focus group guides, signed consents, demographic forms, mind maps, lists and diagrams, as well as electronically maintained data in the forms of Nvivo software, Microsoft Excel spreadsheets, EndNote X8 references, and Microsoft Word documents. Both methods combined provided an organized, effective method to both navigate and analyze the data. However, they also provided direction during the data collection phases of the study.

Decisions about the need for a variety of different participants and types of hospitals, as well as possible influences of the charge nurse role, were made during the ongoing data collection/data analysis phase. Dated analytical memos and notes were made immediately after each interview and focus group to reflect on the emerging data. For example, early in the data collection phase on January 10th, 2018, and immediately following the third interview with a permanent charge nurse, it became apparent that “fill-in” charge nurse and regular/permanent charge nurse roles differ. The different types of charge nurses added complexity to the role early on in this research study, leading to modifications to the interview guidelines so the charge nurse role differences could be uncovered. Those in the assistant nurse manager role were also interviewed to understand how this role was similar or different to the charge nurse role. In addition, the unit-level leadership structure’s impact on the charge nurse role became important to the research after several interviews during phase one; as was noted by the researcher, “I’m hearing that the role differs between units within the same hospital—Is this dependent on nurse
manager or the culture of the unit or what?” Shift or time of day worked were also mentioned, so questions related to the possible impact of the unit and shift worked on the charge nurse role were included in the interview guidelines. Through the progression of this focused ethnography study, copious memos and notes provided an avenue for reflective thought and guided subsequent interviews and focus groups.

**Demographic Data Forms and Consent Forms**

During the phase one and phase two interviews and focus groups with charge nurses, nurse managers, and clinical nurses, paper demographic forms were completed, one available charge nurse job description was collected, and consent forms were signed. As interviews were completed, the researcher collected these documents and entered the demographic data into an electronic Microsoft Excel spreadsheet. The consent forms, demographic data forms, and job description were stored in separate locked file cabinets in the researcher’s home during data transcription.

**Transcripts**

Each interview and focus group was recorded by audio recorder. Within a day or two after each of the interviews, the recordings were transcribed verbatim by the researcher into Microsoft Word documents on her personal password protected laptop. After verifying that the recordings were accurately transcribed, each recording was deleted from the recorder. During and immediately after each interview and focus group, analytical memos, reflective journals, and field notes were also documented in a notebook.

Analysis of the data began after the initial interview in phase one via reading and re-reading the transcripts. The transcribed interviews were uploaded into Nvivo software.
Codes were created for words, phrases, and sentences with similar meanings. As the interviews and focus groups continued, some of the codes began changing and collapsing, narrowing the focus. The researcher then began to turn back to paper and pencil, using large sheets of paper to create mind maps, diagram relationships, and analyze codes and ideas. Between and across the three participant groups of charge nurses, nurse managers, and clinical nurses, codes and ideas were analyzed for similarities and differences. Transcripts in Nvivo were cross-referenced during this process.

It became apparent during the analysis that the hospital organizational structure helped to determine the charge nurse’s role. Permanent and rotating charge nurses emerged as separate roles as well. Lists of hospital data, including whether or not they were unionized, Magnet® designated, had a permanent or rotating charge nurse, and the number of units that the nurse manager was responsible for, were written for a visual quick comparison. Diagrams were drawn to note the relationship of the hospital structure to the type of charge nurse, albeit permanent or rotating. Further paper-based analysis was completed to separate the roles and responsibilities of the permanent and the rotating charge nurse roles. To triangulate the data, attention was turned to the AONE Nurse Manager Competencies, which were utilized in phase one (AONE, 2015). Comparisons were made between the codes and ideas in the data for permanent and rotating charge nurse roles and responsibilities and the competencies listed in the tool. Similarities were found between the nurse manager role and the permanent and rotating charge nurse roles. These similar competencies were added to the models drawn for permanent and rotating charge nurses until themes emerged. Triangulation was also completed utilizing the one job description to match the role of the charge nurse outlined in the job description to the
transcript materials and the AONE Nurse Manager Competencies (AONE, 2015). In addition, multiple nurse perspectives provided a method for triangulation of the data by comparing each group’s expectations of the charge nurse.

After the data themes were identified from the data, a summary with final themes were sent to two nurse managers, two charge nurses and two clinical nurses who agreed to being contacted at the end of the study as indicated on their consent form. They reviewed the summary report and themes and provided feedback to confirm the validity of these findings.

Summary

In summary, this focused ethnography was conducted in two phases. To obtain a multi-perspective viewpoint, charge nurses, nurse managers, and clinical nurses were interviewed. In phase one, three charge nurses, three nurse managers, and three clinical nurses were interviewed one on one with the researcher after they provided ratings on AONE’s Nurse Manager Competency tool as pertinent to the charge nurse role (AONE, 2015). Then, focusing on the information received in the ratings and interviews in phase one, phase two began. In phase two, 15 charge nurses and 11 nurse managers participated in individual, semi-structured interviews with the principal investigator (PI). Also in phase two, 13 clinical nurses with no charge nurse experience participated in four focus groups. All 48 subjects were currently working in 12 acute care New Jersey hospitals at the time of the study. The hospital nursing leadership structure and characteristics may have some association with the role of the charge nurse in each hospital, providing a level of complexity to this role.
Chapter V

DESCRIPTION AND DISCUSSION OF THEMES

Major Themes: Role of Charge Nurse

The role and safety practices of the acute care hospital charge nurse were explored in this focused ethnography study. Utilizing a two phase approach, multiple perspectives, including those of nurses who work in the charge nurse role, work alongside those in the charge nurse role, and supervise those in the role, were sought to clarify their perceptions of the charge nurse. Individual interviews with charge nurses, clinical nurses, and nurse managers were conducted by the researcher in phase one after participants rated each of the items on the AONE Nurse Manager Competencies (AONE, 2015) relative to the charge nurse role. In phase two, charge nurses and nurse managers participated in individual interviews using an interview guide. Focus groups with clinical nurses without charge nurse experience were also conducted in phase two using similar pre-selected questions. The interview and focus group guided questions concentrated on areas pertinent to the charge nurse role, which were identified in the competency ratings and during the interviews in phase one.

Through data analysis, the complexity of the charge nurse role, both permanent and rotating, was found to have an overarching theme of the charge nurse serving as both a shift resource and traffic director. Within this overall theme, there are charge nurse role responsibilities demonstrating how the charge nurse is a resource by nature of the role and how he or she controls resources for the unit during the shift.
As shown in Figure 5.1, subthemes, categories, and subcategories also emerged which were specific to each of the charge nurse models. The data for the permanent charge nurse model revealed that assistant nurse managers (ANMs) filled the same role as the permanent charge nurses (PCNs) in this model; “relief” charge nurses, who filled in for the PCN when he or she was not working, had the same role responsibilities as the rotating charge nurses in the rotating model. In addition to the shift resource and traffic director responsibilities, the role responsibilities of the PCN/ANM fit that of a unit shift leader role, a subtheme for the permanent charge nurse model. A category within the unit shift leader role includes extension of the nurse manager, with subcategories of managing information flow and human resource management. These subcategories align with the AONE Nurse Manager Competencies (AONE, 2015). In contrast, the leadership
expectations for the rotating/relief charge nurses are far less complex and have fewer administrative responsibilities; they hold a clinical nurse plus (+) role, which is a subtheme found in this study, in addition to the shift resource and traffic director responsibilities.

This study also explored how the charge nurse contributes to keeping patients safe. The safety subtheme which emerged from the permanent charge nurse model data is safety officer, while the data on the rotating/relief charge nurse model revealed the subtheme of put out fires. The purpose of this chapter is to discuss the overall themes of shift resource and traffic director and explain the subthemes, categories, and subcategories which emerged from the permanent charge nurse model data and the rotating charge nurse model data.

**Overall Theme: Shift Resource and Traffic Director**

Regardless of whether the charge nurse is a PCN, an ANM, a rotating or a relief charge nurse, there are common responsibilities for all nurses in this role. These role responsibilities, which are known to nurse managers, charge nurses, and clinical nurses as “the housekeeping tasks” or “typical charge nurse responsibilities,” emerged from the data as the overall theme of shift resource and traffic director. As the shift resource and traffic director, the charge nurse is expected to have “a general idea” of the patients and unit activities during the shift.

**Shift Resource**

As the shift resource, the charge nurse is a “go-to” resource for the staff both inside and outside of the unit during the shift. Experienced and novice staff seek information, as well as hands on clinical assistance, from the charge nurse. He or she
offers an “extra pair of hands” to the staff, but this assistance may be limited when the charge nurse has his or her own patient assignment. Nevertheless, staff turn to the charge nurses when they need a “lifeline” for help.

**Go-to Resource.**

As a resource for both the staff on the unit during the shift, as well as for the clinical and administrative staff outside of their unit, the charge nurse is the “go-to” resource for information and assistance. If they are unable to provide the answer, it is expected that the charge nurse knows who to call and/or where to find the answers to clinical problems. One nurse manager said:

>I think they [clinical nurses] see them [charge nurses] as a clinical resource. I also think they know that their job is much more than that. But I think in my own area, my staff use the [charge nurse] very often…whether it’s for support or needing assistance in a patient room or they’re behind and need help with an admission. They use them very clinically…and they also use them to bounce issues, concerns, anything new, off of them. (NM11P2)

Not only do the nurse managers observe the clinical nurses requesting assistance and information from the charge nurse, but charge nurses themselves concurred with this perspective of being sought out frequently by “everyone.”

>You are the one everyone comes to with questions. Everyone expects you to help them with their problems that they cannot troubleshoot on their own…they have to be resourceful above all. Even if they don’t have the answers, they have to know who to go to to get the answer and that’s what I almost find more valuable than experience these days, just the resourcefulness. (CN6P2)
They are also the go-to for nurse managers to receive highlights about patient care problems, patient satisfaction issues or staff concerns. They keep managers updated on the events on the unit while managers are absent from the unit. As one manager shared, “that was my go-to person when I came in in the morning, she knew what I needed.” (NM8P2)

In return, the manager is responsible for providing the charge nurse with the necessary resources in order for him/her to do their job well and keep the activities of the unit running smoothly during the shift. As one nurse managers said:

I think that my role is just to make sure that the people that need to do the work and need to keep the unit running smoothly have the support and resources that they need to be able to do that…and to translate what’s happening at the system or hospital level down to the unit level and vice versa (NM3P2).

One item that was mentioned often during the interviews is that the charge nurse carries a “charge phone” and sometimes has a designated desk or computer, which gives the other staff on the unit a way to easily locate the charge nurse when needed. One rotating charge nurse said, “You get the charge phone and anything that goes on, everything comes to you.” (CN9P2) The charge nurse is sought out by both experienced and novice nurses to discuss clinical patient problems or to seek assistance with an unfamiliar skill.

We have a lot of floats and they don’t know practically how the floor works and…we have a lot of turnover and a lot of newly graduated nurses so…they ask that we know how the hospital works and you know everything that’s going on in
the hospital and practices so...they come to you for knowledge so we try to teach them. (CN1P1)

Knowing that PCNs/ANMs and rotating/relief charge nurses are expected by clinical nurses and nurse managers to assist with clinical skills and tasks when staffing is compromised or when a patient’s health is declining, charge nurses often will ask the staff if they can assist in any way before they are approached. One PCN/ANM said:

I try to be an extra hand...busy times are afternoons. A lot of our discharges are leaving at the same time as a lot of our ORs are coming out of the PACU. So it can be a little crazy for a couple hours...I try to be an extra set of hands...whatever helps. (CN13P2)

In order to be the go-to resource, the charge nurse needs to have clinical expertise. As one nurse manager stated, “it’s usually somebody who has been here quite a while and is really knowledgeable.” (NM2P1) Many clinical nurses also strongly expressed the need for charge nurses to be knowledgeable, experienced and skilled and they also talked about when charge nurses lack clinical experience. During one of the focus groups, a clinical nurse shared:

I think at least on our unit on evenings I know they had chosen someone to fill in as a charge who just got out of school last year... Last year!... And going for a big fancy degree, but doesn’t have a ton of experience, so I was amazed when they chose that person! (CLNP2)

Clinical nurses expected the charge nurse to have the experience and knowledge to be able to assist them with questions or clinical problems. One clinical nurse shared:
You will not be able to lead a path if you are blind yourself. So you have to have extensive clinical knowledge to get the respect from your peers and at the same time the trust. Because if you don’t know what you’re doing it’s in vain. You will not be able to lead them and they will not listen to you. (CLN3P1)

Trusting that the experienced charge nurse would have the solutions to any problem, the clinical nurses had respect for this charge nurse. As one nurse manager said, “They are considered a clinical resource so the staff needs to be able to trust them… they are able to assist them whenever they have clinical issues.” (NM1P1) By being accessible, able to problem solve and being hands-on, charge nurses build trust with their clinical nurses, showing them that they are working as a team towards the same patient-centered goals. Another manager said, “I think most of the charge nurses that we have are respected by the staff because they’re also seen as a resource because they’re typically the staff who have been here the longest or has the most amount of experience.” (NM3P2)

When the charge nurse was hard-working, dependable, fair and helpful, they were trusted by the clinical staff. One charge nurse shared how he built trust with his staff:

There’s a saying, …it can take years to build trust, but only one time to break the trust. And nurses by nature are not trusting people...and I wanted to build that relationship early where [clinical nurses] know [the charge nurse] is going to be fair, but you can trust him and he will always speak the truth and he will always be honest…so when it comes and I give them an admission they know its not out of malice or like hatred. It’s out of, well, this is just what has to happen on the floor…and the consistent nature of fairness I think helps build trust. (CN6P2)
Clinical nurses expect the charge nurse to behave in a way that they expect their staff to behave. During a focus group, a clinical nurse commented:

I have total respect for all of them because I don’t want to do it and I trust all of them, it’s just that some work a little bit harder than others. So I have a lot of trust for the ones that work really, really hard. Because I’m working hard, so I want everybody to. (CLNP2)

Trust diminishes when the charge nurse is seen as “desk-planted,” and not working alongside the clinical staff “in scrubs.” When charge nurses and clinical nurses work as a team and there is trust, clinical nurses are more likely to call the charge nurse when they need a second opinion in a clinical matter or to report an error.

In addition, the charge nurse is the go-to resource for both clinical and administrative staff outside of their own unit for clinical expertise or information. Ancillary staff, the emergency department, bed control, the admitting department, and the hospital supervisor all seek out the charge nurse for each unit to discuss unit shift issues such as staffing, admissions or any important patient concerns. All of the communication with the unit is funneled through the charge nurse; as one nurse manager said, “They are the ones the supervisor calls and has questions or concerns, and leadership is not here, it’s the charge nurse that they go to… Everything funnels through the charge nurses on the unit.” (NM10P2)

Sometimes, the charge nurse is considered an expert in specific skills and he or she is called to assist another unit during an off-shift. As one charge nurse explained, “The ICU will call me frequently, especially if it is not a regular charge nurse…to ask a
question or something about equipment or policies...supervision will call me to ask to go
to a unit to put an IV in.” (CN2P2)

Fulfilling this expectation, however, becomes a challenge when charge nurses
have their own patient assignment, leading to frustration. One rotating charge nurse
expressed her frustration:

When I do have patients, if I am busy, you can’t help other people. So when I am
in the role, I feel a lot more helpful to my coworkers, to the [nursing assistants], to
the nurses because I can be. Because I don’t have a personal patient to look after
and do all the charting on. (CN6P2)

Another rotating charge nurse shared how she needed to depend on the experienced
clinical nurses on the unit sometimes to assist because having a patient assignment
limited her ability to be a resource. She said, “It’s so hard having a full assignment…like
sometimes I really count on the people who are there…I know they’re senior nurses, they
got this. They’re good.” (CN9P2) When experienced and novice clinical nurses feel
supported by the charge nurse through a trusting relationship, they seek out the assistance
of the charge nurse as the go-to resource. However, the charge nurse also acts as a traffic
director, as stated by one nurse manager, “They’re out there. They’re directing traffic.”
(NMP1)

Traffic Director

To be the go-to resource, charge nurses need to have a broad view of the activity
of the unit so they know where resources are needed. As a traffic director, the charge
nurse maintains watch over the unit activities and directs the flow of patients and staff.
By having a “general idea” of the activities on the unit at all times, they can provide
updated information when requested. This includes information about the patients, as well as the staff, during the shift. As one assistant nurse manager said, “I do see [the rotating charge nurses] having a general idea of what’s going on in the unit and touching base with their peers…I should have an idea of what’s going on with the general flow with my unit, touching base, helping if there’s anything that’s escalated.” (CN14P2)

Charge nurses need to know which patients are critical and which ones are cleared for discharge. They also need to keep track of how busy each clinical nurse is during the shift. Some hospitals have systems in place which track the activity level of each nurse. Most systems use a color-coded stoplight system of green, yellow, and red to denote the range between manageable nursing activity levels to very high activity levels. One PCN/ANM explained how the charge nurse uses this system to know which nurse needs help:

We have a system where we have a huge white board with magnets that mean different things and it’s all identified. And we have big yellow, big red, and big green that would go next to the name and that lets you know how that person is doing right at that moment. So the secretary might ask every person, “Are you red? Are you yellow? Are you green?” and keep it updated. The [charge nurse] would maybe himself, herself, or ask someone else…That person is in the red and you’re in the green, please go help them out and I’ve seen them do this. (CN14P2)

As the traffic director, it is the charge nurse’s role to monitor the activity level of all the clinical nurses and offer help to the nurse “in the red.” In order to do this, they must manage the flow of work and patients.

Manage the flow. Charge nurses are “directing traffic” by managing the flow of
patients entering and exiting from their units. Charge nurses are notified of patients who need to be admitted to the unit, transferred out of the unit or discharged out of the hospital. They are the decision makers who “control the flow” of patients on their unit during their shift. They play an important role in assessing the patient’s clinical situation to determine whether the patient is appropriate for admission to the unit.

My charge nurse, when she finds out that we’re getting a patient from the emergency room, she researches the patient. Why are they here? What tests have been done? The results of the panels that were done, the bloodwork, are they an appropriate roommate to the other patient that they’ve been assigned to room with? That’s a big job, it takes time. So she will determine whether the patient is appropriate for [our unit] or not. (NM2P1)

Clinical nurses and nurse managers both see the charge nurse advocating for the patient to be placed in the correct bed and unit. They also advocate for the staff by making sure to communicate to the appropriate departments when a patient is assigned inappropriately for admission to the unit.

They advocate for their fellow nurses in a lot of situations…a patient might get assigned to my unit, but they might not be the most appropriate unit that that patient should go to. So the charge nurse will go to bat for the staff and call the supervisor or say this patient has neuro checks q4 hours, you know, it looks like they’re ruling out stroke. This isn’t the unit…we have another unit in the hospital that’s the preferred unit for patients with a stroke. So a lot of times, they’ll help in those situations. (NM6P2)

When the patient arrives on the unit, the charge nurse may also assist the clinical nurse in
assessing the patient to understand the patient’s condition and whether they are a good fit for the unit and the room assigned.

We are always involved actually with bed control. We try to make beds for the right patients. When patients come up…we’re the ones who have to go in, assess the patient, see what’s going on, give feedback also to the nurses…come up with a game plan, just to see what is going to be done, whether or not the patient can stay on our unit, whether or not we have to…put calls out and kind of just... collaborate with each other. (CN3P1)

On the other hand, if a patient is critically ill, the charge nurse facilitates a transfer to a higher level of care or, if improving, a transfer to a lower level. He or she also keeps track of the patients who are prepared for discharge, while being aware of which rooms are vacant and ready for another patient.

Another way the charge nurse controls the flow is by ensuring patients are in an appropriate room and with an appropriate roommate, if necessary. For newly admitted patients, sometimes moving patients between rooms is necessary because of the patient’s condition, roommate compatibility or patient safety. As one nurse manager explained, her expectation is that the charge nurse will assess the patient’s safety risks and admit her/him to an appropriate bed based on that risk:

They will make sure that the patient is appropriate for the unit because our unit is a weird layout. So you can have one room way at the top just at the end of the hallway with no traffic and we are a geriatric floor. And we have some rooms that have like videos so they try to put the high risk for falls patients in those rooms. (NM3P1)
The charge nurse also has to critically think about the patient’s condition, including whether the patient requires isolation precautions, and accommodate this need accordingly with an appropriate room, with or without a roommate.

Like yesterday, somebody came over and said “Oh, I need a room for this person” and like in five minutes we had to change this person from here to there and like in five minutes they wanted me to figure out which patient I could put with him, but we have a lot of respiratory isolations right now…so I’m like, this one we can’t do, this one we can’t do, they gave us literally a minute to do it because they needed to move somebody. (CN1P1)

It is the charge nurse’s role to determine the best room for each patient and delegate the move to the staff. This can be a very time consuming and difficult task for a charge nurse with a patient assignment, as well as for the staff on the unit.

The charge nurse also needs to assign the new admission fairly to the clinical nurses on the shift. To make sure that the patient can be admitted to the unit in an appropriate time and his or her patient care needs can be addressed in a timely fashion, the charge nurse must assign the patient to a nurse who can handle the additional responsibility. Considering the charge nurse’s knowledge of the activity of the unit and using activity monitoring systems previously mentioned, the charge nurse decides who is assigned the admission based on how busy each clinical nurse is at that time. One nurse manager explains how he expects the charge nurse to keep the flow of patients moving by monitoring the activity levels of the clinical nurses and making sure admissions are assigned fairly:
Sometimes…they know she can’t take another patient because she’s drowning.
We do have sort of an acuity tool where we use a red, yellow, green magnet system where if someone’s in the weeds we know to go and…ask that person if they need help…and I really rely on them to coordinate the flow of the unit, that’s really important. (NM7P2)

When matching a new admission with a clinical nurse, the charge nurse also needs to have some knowledge about the nurses on the unit. She considers how competent each nurse is in complex skills, their experience level, and comfort in caring for certain patient populations when deciding which nurse will be assigned the admission. Assigning a complicated admission to a novice nurse could potentially put the patient at risk of harm. As one charge nurse said, “I’m making sure the skill of the nurse meets the need of the patient.” (CN4P2)

Managing the flow of patients in and out of the unit during the shift is an important role of the charge nurse. Another important connected role responsibility is creating a safe patient assignment and managing staffing.

**Safe Patient Assignment/Staffing.** The second subtheme under traffic director is safe patient assignment/staffing. Creating an appropriate assignment based on patient acuity, nurse skill level, and staffing is a human resource management competency listed in the AONE Nurse Manager Competencies (AONE, 2105) which are shared by those in the permanent and rotating charge nurse models. By having not only a general idea of the unit activities, but also knowledge about the staff on their shift and the next one, assists the charge nurse in creating a safe patient assignment. The charge nurse is responsible for creating an assignment for the next shift and he or she is responsible for reviewing the
assignment for his or her own shift and making modifications if necessary. The modifications made to the assignment on the charge nurse’s own shift are based on the competency level of each clinical nurse and the complexity of the patients. One charge nurse said, “It might not be an appropriate assignment so I do change it.” (CN2P1)

Even when assigning admissions, the knowledge and experience of the nurses are considered by the charge nurse in order to match the nurse with the patient. One charge nurse explained how during one shift and decided it was safer for her to take the new admission herself:

I remember this one time we had this patient she was oncology, but she was going down for a VATS procedure and when she was coming back up I was like “Don’t those patients go to ICU first, like we never get those patients”. And they said “No, you’re getting the patient.”…I literally had a float nurse, a new nurse, and then another new nurse and I was like alright, well then I took the patient. I’d rather take the patient for the safety of the patient then give it to a new nurse and her not knowing what to look out for and me always having to be with the patient. (CN5P2)

They also try to “balance the assignment” for their own shift to make sure the “heaviness” or complexity of the patients being cared for by each nurse is equalized between the nurses. The assignment needs to be fair and equitable. If there are available beds where new patients may be admitted, the charge nurse will pre-plan which nurse will potentially care for that patient. One charge nurse explained:

I check with the outgoing charge nurse…Which one is heavy? Which one is not the heavy side? So at least we know how to balance the assignment because
sometimes there are new nurses--very, very new. Sometimes you don’t want to
overwhelm them. So that gives me those 15 minutes time for me to think about it.
(CN10P2)

Charge nurses also create an assignment based on the number of staff that they
have scheduled to work. However, without an appropriate number of clinical nurses
scheduled, a fair and safe patient assignment cannot be created. Charge nurses are
responsible for checking the schedule to ensure that they have enough staff for the next
shift based on the patient census and acuity. Many charge nurses spoke about being
required to use a staffing “grid” showing how many nurses they were supposed to have
based on patient census. They shared how they were responsible for adhering to the ratios
of clinical nurses to patients based on this grid:

[Rotating charge nurses] know our grid…It’s at the nurses’ station. So they know
we have this many patients, this is how many staff we should have. They will
come to me [ANM] if I’m here or X [Director] and say “Hey, we’re getting three
more admissions that bring us up to this number. We have one less nurse.”
(CN13P2)

If they have more nursing staff than they should based on the grid, they have to report it.
The only thing I’m required to do is not to have too much extra staff because it
destroys our whatever, if we have extra people that sometimes happens…you
know there’s a mistake with having people working on that day. I have to call the
supervisor and let them know that there is an extra person. (CN1P1)
If they have insufficient quantities of staff for the next shift based on the grid, charge nurses advocate for their units and request additional staff. Several clinical nurses recognized how charge nurses “have their backs” for the next shift staffing needs.

I do feel like the nurses…advocate or fight for staffing especially for the next shift coming on…and I do hear them on the phone with the [staffing office]. Mostly every charge nurse that I work with will call and if something is happening they’ll ask for a [nursing assistant] to come up to draw blood or you know like I said…we’re drowning. Please don’t send us an admission or if we’re going to be short a [nursing assistant], please give us an extra nurse. I really do feel like they fight hard for staffing. (CLN1P1)

If they are under-staffed, they will often make phone calls to ask staff to work extra shifts, sometimes offering “incentives” just to meet the staffing numbers that they are allowed based on the grid. He or she may advocate for additional staff when needed so the safest assignment can be created.

I handle all of our staffing…Making sure we are at our core, near our core, texting people, need you here, need you there…offering incentives to come in, making sure staffing’s straight. (CN11P2)

We’re constantly…looking at staffing for the next shift to see if we can basically fill in staffing holes, see where I can move nurses around…actually being creative and see how we can get staff to come in even if its only part of the shift or a little bit just to cover holes. (CN3P1)

Charge nurses maintain communication with the staffing office, the nurse manager, and the hospital supervisor about staffing for the next shift. Changes to the numbers of staff
scheduled due to sick calls or the need for someone to float to another unit are communicated to the charge nurse of the unit so he or she can make the assignment based on the staff working. Charge nurses also communicate changes in the unit census at the end of the shift to the supervisor, staffing office, and nurse manager. As a shift resource and traffic director, the charge nurse is concerned not only with creating a safe patient assignment, but also with completing regulatory requirements to promote patient safety.

**Regulatory Readiness.** The third subtheme under the overarching theme of traffic director is regulatory readiness. The charge nurse is the person who ensures that the unit is ready for any regulatory visit by either assigning or completing “housekeeping” tasks regarding equipment and the unit environment. Although this is listed as one of the AONE Nurse Manager Competencies (AONE, 2015), it is the expectation of the nurse manager that the charge nurse ensures completion. One nurse manager said that her charge nurses “make sure that our regulatory requirements are being met such as filling out the department of health forms, making sure that the crash carts are being checked every day, that the omnicells are being counted every day.” Another nurse manager created a regulatory checklist of tasks that she trained her charge nurses to do and expected the list to be completed daily:

I have a Joint Commission readiness form [charge nurses] have to fill out…so there are five different sheets so [charge nurses] do it once a day, but they all cover different things, so then by the end of the week they would be through all the sheets and then everything would be checked…And another thing with the Joint Commission rounds, checking for expired items, like that was a safety thing,
any packages that looked like they were not good would go in the garbage.

(NM4P2)

These regulatory tasks included checking the code cart, checking refrigerator logs, clearing clutter from the hallway, and checking eye wash stations, to name a few. One charge nurse explained, “I’ll be checking the eyewash stations, like making sure all the equipment is up to date and tagged correctly.” (CN6P2)

The charge nurse needs to be knowledgeable about what the regulatory requirements are and how to perform the checks. Ensuring both that equipment is in working order and that the environment is ready for any surprise regulatory agency visits is the role of the charge nurse. Regardless of whether the charge nurse is rotating or permanent or has a patient assignment or not, it is the nurse manager’s expectation that the charge nurse ensures these tasks are completed.

Even though I go around and double check every day, I do have confidence that they’re doing those checks every day, which means that if the Joint Commission comes in, all of my regulatory things have been checked. All of my ducks are in a row. (NM10P2)

In addition to checking equipment and the environment in preparation for on-site inspections by regulatory bodies, charge nurses also perform many chart audits. These audits are essentially documentation checks to ensure best practices are in place for patients on the unit. Daily, the charge nurses track how many patients have urinary catheters and how many have central lines, which are regulatory requirements entered by hospitals into the National Database for Nursing Quality Indicators. Using these counts, central line associated blood stream infections (CLABSIs) and catheter associated urinary
tract infections (CAUTIs) rates are calculated and entered into the national database providing a benchmark for hospitals. As one nurse manager said, “We also have daily mandatory audits that we do like foley catheter, central lines, you know, you name it… I feel like we audit everything.” (NM3P2) Tied to reimbursement of the hospital and concentrated on patient safety, the chart audits are another “housekeeping” task in which all charge nurses were responsible. Charge nurses described the division of the audits among the different shifts and the detail in which the audits needed to occur:

We have to check foleys and central lines… so the night shift is responsible for the foleys. Day shift is responsible for the central lines. And it’s in the computer system, it’s new, and it’s the charge nurse—they got to do it… We check for central lines, we have to check the dressings clean, it’s dated, everything is compliant to what they expect, and we got to do a checklist and that goes in the computer. (CN2P1)

Nurse managers and clinical nurses also recognized the task as one that the charge nurse was responsible for during each shift. For some, they performed these checks themselves; for other charge nurses, they delegated the task to other clinical nurses on the unit during the shift to divide the workload. Checking that equipment was properly working, that the unit environment was clean and organized, and that best practices were in place to prevent infections and patient harm, were all responsibilities of charge nurses in the permanent and rotating models. However, differences between these two models do exist.

**Charge Nurse Models**

While collecting and analyzing the data, it quickly became apparent that two charge nurse models exist among New Jersey acute care hospitals, permanent and
rotating, each with different role responsibilities and safety practices. Although all charge nurses have the role of shift resource and traffic director, other role responsibilities differed between the two models. A nurse who is in a “permanent” charge nurse role, whether a PCN or ANM, has chosen to be interviewed and hired into this hospital unit position and every shift they work is in this role. They are considered a frontline leader by clinical staff and nurse managers, and are visibly present on the unit overseeing the operations of the unit for the shift. They perform both clinical and administrative tasks with much of their time focused on administrative responsibilities, usually without a patient assignment. In the rotating charge nurse model, the charge nurse “housekeeping tasks” are allocated to the clinical nurse in the charge nurse role each shift, while he or she almost always has their own full patient assignment. In contrast to the permanent charge nurse model, the rotating charge nurse model involves a clinical nurse on a unit who is not viewed as a leader; instead he or she is a clinical nurse who is assigned the charge nurse role for the shift; oftentimes these nurses do not desire this role, but have to fulfill their rotating duties. Also following the rotating charge nurse model, another type of charge nurse called the “relief” charge nurse is one who fills in for the PCN when he or she was off. Like the rotating charge nurse, this figure was assigned this role for one shift and usually returned to their clinical nurse role the next shift they worked. However, when the relief charge nurse was in the role, he or she did not have all of the administrative responsibilities of the PCN. Relief charge nurses are “just trying to get through that day, not necessarily pushing the buck to plan for the next day.” Unlike the PCN/ANM model, the rotating/relief charge nurse is responsible for some “basic charge nurse” tasks, while just managing the flow of the unit for that shift.
While most hospitals have either permanent or rotating charge nurse models, in some hospitals this varies by unit depending on whether there is flexibility at the unit level to modify the charge nurse role to meet the unit’s needs.

I know it takes many different forms in many different departments. And I think it’s kind of like whatever works for that area. And what resources they have allocated…it has to do with patient population, the flow of the unit, the pace of the turnover. Are you a unit that gets a lot of…like our orthopedic unit, I mean they get like 20 post-ops a day. So their charge might function a little bit differently. (NM3P2)

Union status may also play a part in the charge nurse role and how it is actualized. It was suggested that the union handbooks specify the responsibilities of the role, which could not be modified at the unit level. However, despite attempts to enroll participants from multiple unionized hospitals, assistant nurse managers and nurse managers from only two unionized hospitals participated in this study; thus, the degree to which the unionized hospital environment affects the charge nurse role remains unclear.

PCNs/ANMs, as well as rotating/relief charge nurses, shared that they adjust the role responsibilities themselves, depending on the skill level and personalities of the other clinical nurses working during the shift. For example, if experienced nurses are working during the same shift, then the charge nurse would adjust his or her focus to more administrative responsibilities knowing the patient care is being completed by competent nurses. On the other hand, if the charge nurse is working alongside less experienced nurses, then the focus would be more on clinical patient care in order to assist the clinical nurses in delivering safe, competent care. One experienced charge nurse described how
she assesses the skill and experience level of the nurses she works alongside and adjusts her responsibilities for the shift based on this factor.

When I’m in charge, I have to be aware of the whole unit not just my assignment…and that includes the skill level of the people who are working…so when there’s all experienced nurses, there’s really not much I have to do other than the clerical…if I have a day where I have two or three unseasoned nurses, I have to take a look at how they are doing and keep checking on their patients; touch base with them about any issues; any problems; anything you aren’t familiar with; you want me to look at anybody? (CN4P2)

Regardless of which model they use, the charge nurse in this role makes modifications to the role responsibilities dependent upon many different uncontrollable factors at the unit and organizational level.

**Comparison of Competencies Between Two Models**

During phase one of this study, three charge nurses, three clinical nurses and three nurse managers rated items on the AONE Nurse Manager Competencies (AONE, 2015) and then discussed their relevance to the charge nurse role during interviews. It became evident during this phase that there were several types of charge nurses, many different titles for the role, and two distinct charge nurse models, permanent and rotating, in which role responsibilities differed.

Table 5.1 displays the mean for each item in the list using the five-point Likert scale provided to the participants (1=no relevance to the charge nurse role, 5=extremely relevant to the charge nurse role) (see Appendix G). Clinical nurses and charge nurses perceived that most of the competencies were relevant to the charge nurse, while nurse
managers rated few competencies as highly relevant to the charge nurse role. Perceptions among charge nurses, nurse managers, and clinical nurses were congruent for several competencies that were thought to be important to the charge nurse role which included patient safety, workplace safety, appropriate clinical practice knowledge, ethical behavior, and knowing their roles. Resolving staffing needs (CLN: 4.33; NM: 4.33), within the human resource management section and facilitating change (CLN: 4.00; NM: 4.67), within the strategic management section, were two items that the clinical nurses and nurse manager rated highly relevant to the charge nurse role. Although none of the charge nurses in phase one rated these two items highly relevant to their own role, interviews during phase one and phase two validated their importance to the charge nurse role. Two competencies that only charge nurses rated highly relevant were generational diversity (4.00), within the diversity section, and supporting a culture of innovation (3.67), within the strategic management section. However, these items did not emerge as important in the subsequent interviews. Nurse managers perceived that charge nurses play an important role in shared decision making (4.00), which involves supporting a just culture. Interviews, particularly those with PCNs/ANMs in phases one and two, substantiated this perception as they elaborated about making decisions related to staffing or patient care in collaboration with the clinical nurses, the staffing office, and the hospital supervisor.

Table 5.1

Average Scores of AONE Nurse Manager Competencies (AONE, 2015) Categories by Charge Nurse Model

<table>
<thead>
<tr>
<th>AONE Nurse Manager Competencies (AONE, 2015) Category</th>
<th>Permanent Charge Nurse Model (n=5) (Mean(SD))</th>
<th>Rotating Charge Nurse Model (n=4) (Mean(SD))</th>
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</table>

It became evident during the interviews that the competencies did not apply to all charge nurses and that they differed by charge nurse model. Table 5.1 above displays the mean ratings for the categories under each domain in the AONE Nurse Manager Competencies for each of the charge nurse models as perceived by participants in phase one who work within that particular model. Clearly, the competencies were rated higher for almost all categories for the permanent charge nurse model than they were for the rotating charge nurse model, showing that those in the permanent model have more administrative responsibilities than those in the rotating model. For those in the permanent charge nurse model, the highest rated categories include relationship management and influencing behaviors (4.48), performance improvement (4.43), career planning (4.13), technology (4.20), and appropriate clinical knowledge (4.20). The lowest rated categories for the permanent model were financial management (2.24) and human resources management (2.88). A domain that was rated highly for those in the permanent charge nurse model and lower for those in the rotating charge nurse model was The Art.
Human relationship management within The Art domain involves completing staff evaluations and engaging staff in professional development. These competencies were confirmed to be accurate during interviews for the permanent model (4.20), but not for the rotating model (2.33). Relationship management and influencing behaviors (4.48) were also very highly rated by those in the permanent charge nurse model. Managing conflict, managing situations, coaching, and influencing staff were competencies within this section that were validated during interviews as tasks pertinent to the permanent charge nurse model and not pertinent to the rotating charge nurse model. Diversity was the last competency within The Art domain, in which the mean rating for the permanent model was 4.00 (1.36) and for the rotating charge nurse model it was 2.92 (1.24), suggesting that this too was more relevant to the permanent model; yet, in the subsequent interviews, cultural competence and generational diversity did not emerge as important competencies to the charge nurse. Social justice (SJ), defined as maintaining fairness in the environment, was the last competency listed under diversity. SJ seemed to have some importance to the permanent charge nurse model as it related to creating the assignments and distributing admissions, but did not have the same importance to the rotating charge nurse model. The highest rated categories for the rotating charge nurse model were appropriate clinical practice knowledge (4.25) and career planning (3.58). Participants from both models perceived clinical knowledge to be very important to the charge nurse, which was confirmed through the interviews in phases one and two. The ratings in phase one for both models were also fairly high for career planning. Specific competencies in this category that were rated highly by charge nurses, nurse managers, and clinical nurses included knowing your role (4.67, 4.00 and 4.67, respectively) and planning a career path
Subsequent interviews revealed that clinical nurses, charge nurses, and nurse managers felt that it was important for charge nurses to know their role, but planning a career path was not supported. A leadership career path was discussed by ANMs during interviews, but this was not shared by PCNs, rotating or relief charge nurses.

Other competencies that did not apply to either model included many tasks involving the budget, hiring staff, project management, managing disaster planning, establishing a vision, and staff retention. Based on the ratings and the interviews in this study, these would only be the competencies for the nurse manager. Participants also commented on any competencies specific to the charge nurse role that were missing from the list. One rotating charge nurse suggested that patient satisfaction was a “big part of their role,” but missing from the list. She explained that “if there is a complaint on the floor, the first person they call is you so you have to stop everything and have to try to resolve the situation.” Additional interviews supported this responsibility for promoting patient satisfaction, specifically situation management.

During phase one, a clinical nurse and a nurse manager commented that a missing competency was how the charge nurse “establishes the weather.” This was described as how the charge nurse sets the tone, albeit positive or negative, for the shift. “Establishing the weather” was a recurrent topic that emerged from the data. Though it did not clearly fit within the Role Responsibilities and Safety Practices for Permanent and Rotating Charge Nurse Models, (Figure 5.1) nor as a “competency;” it nevertheless surfaced as an important aspect of the charge nurse role. Clinical nurses were very aware that the charge nurse’s personality and familiarity with the role mattered in how smoothly the day-to-day
operations of the unit would run. The attitude of the charge nurse was contagious and affected the rest of the staff for the shift. If the charge nurse had a “toxic personality,” then the staff would reflect that negativity as well.

I feel, like when the charge nurse is strong and positive, it reflects….when you have a crabby, sit at the desk, complainer then it makes everyone that way... I say well, if she’s gonna sit there like a bum, then…you know I’m just going to plog through my night, too, but if someone’s happy and positive, it’s better. (CLN1P1)

Nurse managers also echoed the opinions of the clinical nurses that the tone for their day was dependent on who was in the charge nurse role.

In terms of morale for the unit, they are one of the great influences in terms of establishing the weather for the day…it depends on how they are doing…as a manager, when I come in the morning, it depends on who’s in charge there. It really greatly affects my day because I know whether or not I can be confident that I can go to my meetings and do my thing in the office and it will be okay out there. (NM1P1)

Another nurse manager with rotating charge nurses also shared the same feeling. She said, “There’s some, of course, just as in any place, people see them in charge and think, ‘Oh God, we’re going to have one of those days today,’ but we try to work through that and mentor the charge nurses.” (NM3P2)

Even PCNs/ANMs spoke about how they are a driving “force” on the unit during the shift and an influencer of the staff, which is one of the AONE Nurse Manager Competencies (AONE, 2015). Their behavior impacts the attitude and behaviors of the staff on the unit.
You don’t realize how much of a force you are to drive the floor, the attitude of
the floor, the nature of it and how you can actually make somebody’s day go
better on a day when it would have gone horribly. (CN6P2)

Staff reported that if the charge nurse was comfortable in the role and able to juggle all of
the extra responsibilities in the role, then the activities of the shift ran smoothly, but that
it “depends on who’s in charge.” One clinical nurse shared how a particular PCN sets a
tense tone for the unit because she makes the staff feel on edge. She commented, “I think
it’s like we have one [PCN] where no one really wants her around because any time she’s
there, it doesn’t seem like she’s there to help you...she’s there to get you in trouble for
something.” (CLNP2) The clinical nurses, nurse managers, and charge nurses all agree
that the attitude of the charge nurse, regardless of the model, influences the other staff on
the unit. However, all of the charge nurse competencies identified in both phases one and
two did not apply to all charge nurses and some differed based on the model.

The Permanent Charge Nurse Model

Based on the differing competencies in the permanent and rotating charge nurse
models, different subthemes, categories, and subcategories emerged for each. A
dichotomy exists between the two models based on the attributes uncovered as being
integral to the role. Table 5.2 displays the contrasting attributes of each model as they
emerged through the subthemes, categories, and subcategories.

Table 5.2

Contrasting Attributes of Permanent and Rotating Charge Nurse Models

<table>
<thead>
<tr>
<th>Permanent Charge Nurse Model</th>
<th>Rotating Charge Nurse Model</th>
</tr>
</thead>
<tbody>
<tr>
<td>Leader with authority</td>
<td>Not viewed as a leader; no authority</td>
</tr>
<tr>
<td>• Viewed as “boss”</td>
<td>• Viewed as “peer”</td>
</tr>
</tbody>
</table>
In the permanent charge nurse model, PCNs/ANMs are perceived to be in a position of authority at the unit level. Hired into this role, PCN/ANMs are paid at a higher grade than the clinical nurses, rarely take a full patient assignment, and have a close interdependent relationship with the nurse manager. In addition to being the shift resource and traffic director, the permanent charge nurse model data revealed a subtheme of unit shift leader with a category of extension of the nurse manager and subcategories of managing information flow and human resource leadership.

**Unit Shift Leader**

Evident from the AONE Nurse Manager Competency (AONE, 2015) ratings and interviews and focus groups in phases one and two, the PCN/ANM spends much of his or her time completing administrative responsibilities, which are shared with the nurse manager. As such, the PCN/ANM is viewed as a leader by managers and clinical nurses.
Specific to the permanent charge nurse model, a sub-theme of unit shift leader emerged from the data. Unlike nurse managers who were reported to be either in meetings or their offices most of the day, a PCN/ANM was identified by clinical nurses as a professional leader who was visibly present on the unit during their shift.

Definitely a leader. We have three of them for three different shifts and, across the board, they are all like very well respected you know; and they are people again, who had come from the unit. It was acknowledged that they were going to be leaders so they were groomed for the role. (CLN3P1)

Clinical nurses also recognized the PCN/ANM to be their “boss” and on the same level as management. One clinical nurse shared:

You know I always think of [permanent charge nurses] as managers. You know honestly, more so than nurses… I never thought of them as charge nurses. But then when I work the weekends and the [relief] charge nurses are trying to do all of the things that the [permanent charge nurses] do, that’s when I’m like… [the permanent charge nurses] really are charge nurses, but so much more. (CLN3P1)

PCNs/ANMs were also recognized as being part of the “chain of command.” Because they were perceived to be the next position in the nurse hierarchy ladder on the unit, clinical nurses, rotating, and relief charge nurses reported information directly to them before reporting the information to the nurse manager. A rotating charge nurse on nights explained how she would call the supervisor and PCN in the “chain of command” before calling the nurse manager if there was a problem that needed to be escalated.

If I were in charge and something big was happening, I would call the nursing supervisor and I would call the [permanent charge nurse]... I would use the chain
of command. And I think I would start with calling the permanent charge,
utilizing the nurse supervisor who is in the hospital/easily accessible with a four-
digit extension and then I think the [permanent charge nurse] would be the one to
reach out to the manager. (CN3P2)

Because the ANM has the word “manager” in their title, it is clear that they are
considered unit nurse leaders in the “ladder of respect”. In the unit leadership hierarchy,
the ANM is hired into the role like the PCN and is situated between the clinical nurses
and the nurse manager. One ANM explained how both he and the physicians consider his
role to be one of leadership wherein the physicians take him more seriously than they do
the clinical nurses who are the rotating charge nurses. He said, “The physicians are
usually better at responding to me being management than they are the nurses.”
(CN11P2)

Although PCNs/ANMs have both an administrative and a clinical component to
their role, the perception of charge nurses, clinical nurses, and nurse managers differed on
the amount of time allocation to the different tasks as shown in table 5.3. PCNs reported
that they spent, on average, 50% of their time performing administrative tasks and 50%
on clinical duties, but they explained that the distribution of their time may differ daily.

Table 5.3

<table>
<thead>
<tr>
<th>Participant Group</th>
<th>Administrative Tasks</th>
<th>Clinical Tasks</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nurse Manager</td>
<td>75-90%</td>
<td>10-25%</td>
</tr>
<tr>
<td>PCN/ANM</td>
<td>50%</td>
<td>50%</td>
</tr>
<tr>
<td>Clinical Nurses</td>
<td>75-90%</td>
<td>10-25%</td>
</tr>
</tbody>
</table>

Some PCNs/ANMs said they had “administrative days” where they were not in the
charge role during the shift. One PCN explained, “Every month, I’ll have an administrative day when they give me off and I’ll do the schedule and then I’ll come and do as many evaluations as I can” (CN6P2). Instead of being the PCN/ANM for the day, they spend the shift completing the administrative tasks such as evaluations, schedules or payroll; however, clinical nurses and nurse managers shared a very different view of the PCN/ANM’s time allocation, perceiving that the PCNs spend 75 to 90% of their time every day in administrative work and only 10 to 25% on clinical tasks, despite their assertions that the role of the charge nurse is to be a clinical resource.

Meetings that are held on the unit, which are called huddles, safety huddles, and circle-ups, often included all staff. However, only the PCN/ANM led these meetings. For departments that had rotating/relief charge nurses, they were not usually given the responsibility to lead the meetings. This difference points out how the PCN/ANM is recognized as someone who leads the staff on the unit and the rotating/relief is not. Other leadership meetings were held between managers, educators, and PCNs/ANMs with the purpose of discussing staff performance, setting educational goals for staff, and goals for the unit. For those units with ANMs and PCNs, they were present at the meetings. For those with rotating charge nurses, they were not included in these meetings, showing how managers did not consider them part of the unit leadership team.

As a unit shift leader who participated in “leadership meetings,” the PCN/ANM was also expected to see the big picture. They were expected to be vested in the interest of the unit and “have a pulse of the unit.” To really understand the culture and how the unit functions, you need to find the pulse.

One of the things that I first learned when I came into this role, the first thing you
do is observe. Do not act. Build relationships and really get a pulse for the unit and people will tell you get a pulse for the unit, and you’re like get a pulse for the unit? And then one day you suddenly understand what get a pulse for the unit means. It’s not just get a daily pulse for the unit. It’s understanding what is going on in that unit. Once you’ve got that, then you can support them by knowing whether it’s an acute situation and something they need or a chronic issue.

(CN14P2)

Seeing the big picture helps the charge nurse plan ahead for staffing, patient assignments or patient procedures. As one PCN stated, “I’m more of a long-term planner making sure that we’re having processes that will last not just get you through the day and then stop.” (CN6P2) PCN/ANMs are thinking ahead and seeing the big picture by getting a “pulse” for the unit to avoid potential staff issues or patient harm. They are unit shift leaders who consider the best interest of the unit when making decisions and critically think to solve unit shift situations as they occur. Because of their desire to be in this role, PCN/ANMs voiced an interest and commitment to the role. They took full responsibility for what was happening on the unit during their shift and planned ahead for staffing and patient care. Clinical nurses also noticed a commitment in the PCNs/ANMs that they worked alongside. They reported feeling more supported and comfortable when a “regular” charge nurse was there who was familiar with the responsibilities of the role.

I kind of think of it like, so our [permanent charge nurses], they do it. That is their main task that they do day in and day out. So they know what the flow is. They know what work they need to get done. They’re comfortable with it. So when its
really getting crazy, they have no problem, you know, coming in and helping you out. (CLNP2)

One nurse manager shared her experience with permanent charge nurses in another hospital where she recognized how dedicated those charge nurses were, compared to the rotating charge nurse model she worked with currently. Interest in the role led the permanent charge nurses to want to perform well in the role. She shared, “They were vested. That was their role. That was their bread and butter. That’s what they did. So they grew in that role. They were vested in that role and they took it very, very seriously.” (NM8P2)

The PCN/ANM model is one where the charge nurse is a dedicated leader who has chosen the role and its responsibilities, both clinical and administrative. He or she is an extension of the nurse manager, sharing administrative tasks and supporting the unit staff during the shift.

**Extension of the Nurse Manager.**

Because the PCN/ANM was recognized as a respected nurse leader on the unit who was included in the chain of command structure, they were considered by the clinical nurses and the nurse manager to be an extension of the nurse manager, which is an important role to fill, and a category under unit shift leader. One nurse manager explained how similar their role responsibilities are saying, “There’s not a big difference, at least for me, in the sense that they kind of are dipping their fingers in almost everything that I do.” (NM1P1) One clinical nurse shared her view of the relationship, echoing the nurse manager’s perspective. She said, “They’re like bosom buddies most of the time that I’ve seen. Frick and frack…one hand washes the other. That’s how it is. They’re like married
to each other. They have to be.” (CN1P2) Charge nurses recognize that they are expected to be the “manager’s right hand,” completing the tasks that they are asked of by the nurse manager and filling in for him or her when necessary. When a person in charge is requested to speak with a patient or physician about an issue, the PCN/ANM responds to the problem, acting on the nurse manager’s behalf. The nurse manager delegates this task to the PCN/ANM, expecting her/him to behave in a professional manner while handling these situations as if he or she were handling the problems.

I always tried to pick people who could handle it and be my left hand because I always considered it a very important role...it’s an extension of you, so I even spoke with them if they didn’t speak to people right because it’s just you’re an extension of me; Is that how I would have said it? I let them know that they were that extension as well. (NM4P2)

As an extension of the nurse manager, the PCNs/ANMs were the “eyes of the floor”. They were the manager’s “eyes and ears” when they were not physically on the floor. The manager expected the PCN/ANM to manage the operations at the clinical level on the unit for him or her. As one nurse manager said, “It’s essential for them to be here because they are my eyes and ears out there…to give me the reality of what’s going on.” (NM1P1) Through the trusting, close relationship between the PCN/ANM and the nurse manager, decisions are made and problems are solved without the nurse manager present on the unit. Clinical nurses also appreciate the trusting relationship they have with the PCN/ANM as the extension of the nurse manager in his or her absence when a leader is needed.
Managers are not always there 24/7…like we always say nursing is a 24-hour job. In the absence of the nurse manager the charge nurse is there…they are the ones that play the role of the manager while the manager is not there…like I work three to 11. I don’t see the manager all the time. I feel that I am linked to my charge nurse even though my manager’s not there. I feel safe. I feel secure and I have someone to run to without my manager. (CLN2P1)

This relationship seems to differ between the shifts. Because the PCN/ANM and nurse manager usually work together during the day shift, they are perceived as working more closely than during the other shifts. During the day shift, the nurse manager is more accessible to the PCN/ANM so they communicate and interact “often and frequently.” On the evening and night shifts, PCNs/ANMs do not have face-to-face interactions with the nurse managers as often and turn to the hospital supervisor for any issues. The nurse manager delegates less tasks to the PCN/ANM during the off-shifts, causing their role to differ slightly on these shifts.

I think there still is that stipulation, unfortunately, a view from the outside being… that each shift still has that feeling of the day shift and the manager are always together so you feel like that connection is a little bit different than evenings and nights. (CN1P2)

The interdependent relationship that they share allows the nurse manager to stay informed of clinical operations on the unit, while he or she is supportive and trusting of the decisions made by the PCN/ANM in his or her absence; He or she will manage the information at the unit level, while keeping the nurse manager informed.

**Manage Information Flow.** As an extension of the nurse manager, the
PCN/ANM is responsible for managing information flow. As shown in figure 5.2, information flows from the executive level to the nurse manager to the PCN/ANM and to the unit staff and vice versa.

**Figure 5.2**

*Two-way Communication Between Nursing Leaders in the Acute Care Hospital with the Permanent Charge Nurse Model*

As a “gatekeeper,” the PCN/ANM keeps the nurse manager informed about the unit activities related to staff and patients, but he or she decides what information should be shared with the nurse manager, when it is shared, and how it is shared.

You decide if you need to bombard the nurse manager about that…so kind of a gatekeeper for the nurse manager because I could send her stuff all day, but then she shuts me out so I have to know when that’s an issue and has to be addressed. (CN4P2)

Sometimes the PCN/ANM is a “liaison” between the nurse manager and the staff using two-way communication. PCNs/ANMs decided which issues needed to be escalated to the level of the nurse manager and which issues they should handle on their own. As one
PCN/ANM said, “If there’s any issues, usually the staff nurses come to me. Then I go to the director, so I’m definitely a liaison for the issues that need to be brought up with our director.” (CN7P2) Nurse managers also expected the PCN/ANM to handle issues effectively on their own, but reach out to the nurse managers when the issue needed to be escalated. The trusting relationship with the PCN/ANM allowed the manager to believe that the PCN/ANM would run the unit and filter information, sharing only what was necessary with him or her.

He knew when to bring something to my attention and knew when to take it on.

When he had done enough and couldn’t do any further…this is what’s going on. I just want you to know and this is what I did about it. (NM2P2)

As an extension of the nurse manager, the PCN/ANM helps to initiate and enforce any practice changes that are “trickled down” from the system to the unit level by “translating what’s happening at the system or hospital level down to the unit level and vice versa.” As shown in figure 5.2, in the chain of command, the nurse manager receives directives from the executive hospital level leadership or system level and his or her role is to communicate the information to the PCN/ANM, who is then expected to push this information down to their staff on each shift. Additionally, unit-level concerns or issues may need to be shared upwards to the executive level. Although influencing others and communicating change is part of the nurse manager’s role, as reflected in the AONE Nurse Manager Competencies (AONE, 2015), they expected the PCN/ANMs not only to present the information to the frontline staff, but also to enforce the new behaviors on the unit. Therefore, this is a shared competency between the PCNs/ANMs and the nurse manager, wherein the nurse manager ensures that the behavior changes occur on all shifts.
for his or her unit and the PCN/ANM’s responsibility is for their own shift. One nurse manager shared that the “[PCN/ANMs] are responsible to communicate information like a trickle down…the information I give them. They have to read their emails…if we change a process…that’s their job to inform the staff of everything.” (NM1P2) The nurse manager delegates to the PCN/ANM the task of informing the clinical staff about a policy or practice change and monitoring the change to make sure staff are compliant. PCN/ANMs understand that, regardless of whether they feel the change is necessary or not, their role is to be the messenger for the nurse manager by sharing the information and being the champion for the change at the frontline.

She [the nurse manager] takes care of all the big hospital stuff and she has to go to the meetings…and she comes back and says we have to do this…We pass on the changes that have occurred. For instance…for a newly delivered mother, three of the medications we would give them is hydrocortisone cream, Tucks, and Dermaplast spray for any of the vaginal deliveries. So they decided that the Tucks and the hydrocortisone cream, not appropriate anymore, unless they have hemorrhoids…so now part of my job was to come and say “Okay! We’re no longer going to be using Tucks and creams.” (CN15P2)

Clinical nurses also saw the PCN/ANMs as a “go-between,” relaying new information to them from the nurse manager. They too recognize that the changes, positive or negative, come from the manager or executive level and the charge nurse only acts as the “messenger.”

I feel like the manager sometimes makes the changes, but the [PCN] has to actually follow through and they end up being the bad cop…because it’s like well
why are we doing this? And the [PCN] wants to be like well because the manager said so, but they don’t because they’re professionals and they carry on and say well we’re doing it because of this…but you know it really wasn’t their change to make. (CLNP1)

PCN/ANMs are involved in managing the two-way flow of information by sharing facts that he or she has filtered with the nurse manager and pushing information from the nurse manager to the staff. The close, professional relationship between the PCN/ANM and nurse manager promotes this open communication and trust.

**Human Resource Leadership.**

Human resource leadership skills and relationship management are two sections within The Art domain of the AONE Nurse Manager Competencies (AONE, 2015) in which the PCN/ANMs were fully engaged. With a mix of participants from hospitals with permanent and rotating charge nurse models in phase one of this study, ratings as to this domain’s relevance to the charge nurse were mixed. However, it was apparent in phase two interviews and focus groups that these leader competencies apply to the PCN/ANM who shares some of the same staff and relationship management responsibilities as the nurse manager.

As an extension of the nurse manager, the PCN/ANM is expected to assist him or her in dealing with issues regarding the staff on the unit such as interviewing new staff, recommending professional development opportunities for staff, counseling/coaching, and conducting performance evaluations for staff on their shift. The PCN/ANM also “manages” the staff as resources by developing the schedule and assignment, while monitoring staffing levels. To perform these tasks, however, it was essential for the
The charge nurse role is crucial in ensuring the well-being of staff and patients. Regular interaction with the staff helps the charge nurse gain a deep understanding of how clinical nurses prioritize their work, communicate, and organize their time. This knowledge is essential for completing evaluations fairly and counseling staff when necessary. A nurse manager described this understanding as a “sense of knowing,” which involves recognizing how staff members work together and can identify when something is amiss, even if they are not explicitly communicating about it. (NM2P2)

This knowledge is particularly valuable when clinical nurses are needed for committees or projects. Staff development is a competency for nurse managers, with ultimate responsibility falling on them. However, the charge nurse, with knowledge of staff competency levels, assists the nurse manager in professional growth. One PCN/ANM noted, “We make recommendations actually when courses come up. I know our manager here will actually ask us…Who do you think would be the best candidate to go to this? Who has this weakness versus who has this strength?” (CN3P1) The nurse manager would then seek the PCN/ANM’s opinion to assist in the selection process, recognizing that the PCN/ANM knows the staff best.

They assist me, for example, when we need representatives for a certain council.
They are the ones who give me an idea of…who wants to be involved in certain things or who do they think has…potential, especially on the off-shifts because I don’t see them as much. So who do they think has the potential to be involved in a certain projects or certain committees or certain councils. (NM1P1)

During regularly scheduled “leadership meetings,” PCNs/ANMs were invited, as the unit shift leaders, to meet with the nurse manager and unit educator to discuss performance of staff and recommend professional development opportunities.

Every quarter, we do our unit leadership meeting. We discuss every single staff. How are they placing in terms of: Are they high performers? Are they middle? Are they low? If they are high, what opportunities do we have to keep them there? Do they have any educational needs? They coordinate directly with my administrative assistant to register them with certain classes if they need to.

Conversely, if we have low performers, the same thing. What tools can we give them in terms of classes to send them to? (NM1P1)

Another nurse manager commented on the membership of the leadership meetings and the purpose of those meetings. She explained, “When we have our monthly leadership team meetings, myself, educators, [ANMs], CNS…those are the main players in that meeting. We run through the list and identify people that we think are ready to take that next step.” (NM3P2) During the meetings, the ANM is included in the discussions about staff development as they discuss clinical nurse readiness to be included in the charge nurse rotation as a professional development opportunity.

Conflict management was a skill on the AONE Nurse Manager Competencies list (AONE, 2015) that the PCNs/ANMs assisted the nurse manager with, while
rotating/relief charge nurses did not manage conflict because they see this as a nurse manager responsibility. Conflict management referred to any conflict between patients and staff or between two staff members. PCN/ANMs felt they had the authority to try to handle the conflict behind closed doors privately before bringing it to the nurse manager.

I can tell you it’s no one’s favorite…if it’s between two employees, I find its best to pull them both in and see how it can be best worked out amongst them…because when you start throwing in another person’s opinion you know….it’s good to be… a mediator in a way to listen to both sides. So we do it a lot. Especially when we work the weekends and the manager is not here…Sometimes, we have to bring it to the manager, or I should say all the time, because she needs to know as well, but we do try our best to manage it at our level. (CN3P1)

As one manager explained, she expected PCN/ANMs to handle the conflict if it was minor, giving them the authority to do so in her absence.

A lot of times, they are the ones to give me a heads up to say, “Okay we’re having problems with these two employees,” for example…depending on the severity or the issue they will sometimes involve me. But there are times that they will just resolve it themselves. To just bring the people who are involved in the office, have a discussion with them and hopefully resolve it that way…if it doesn’t get resolved that way, then it gets escalated to me. (NM1P1)

Besides counseling and conflict management, interviewing and completing performance evaluations for employees were also noted to be tasks that the PCN/ANMs shared with their nurse manager. Having knowledge about day-to-day performance of the
staff, they completed the evaluations of staff on their shifts. Some PCN/ANMs scored the employees on the evaluation tool and provided it to the manager who would then sit with the staff member face-to-face to discuss the evaluation. Other PCN/ANMs said they completed the entire evaluation process from scoring to discussion themselves. One nurse manager shared, “For annual performance, for example, they do it first and I sit with them and go over with them every single evaluation myself before they go and you know do the evaluation with the staff.” (NM1P1) A PCN/ANM also shared a slightly different experience with evaluations wherein the manager is required to have the discussion with the employee.

I do evaluations. They can be a challenge when you have someone who’s a little off, let’s say…The manager actually has to [sit with the staff]. They mandated that the manager actually has to do the evaluations person to person. If I’m available, then we do them together. (CN15P2)

In collaboration with the nurse manager, the PCN/ANM is involved in human relations tasks on the unit. Using his or her knowledge about the staff, the PCN/ANM is expected to supervise the staff on the unit during the shift, evaluate their performance, and control any conflicts that arise. As the unit shift leader, the PCN/ANM works alongside the nurse manager, assisting in administrative tasks that the rotating charge nurse would not.

**Rotating Charge Nurse Model**

Significantly different from the permanent charge nurse model, the rotating charge nurse model included those charge nurses who were in rotating or relief positions. The rotating/relief charge nurse was a role that did not fit the administrative leader figure. Instead, they were clinical nurses doing extra work; thus, a subtheme of clinical nurse
plus (+) emerged from the data regarding both the rotating and relief charge nurse roles.

**Clinical Nurse +**

Because they often had a patient assignment to manage in addition to being the shift resource and traffic director, the rotating/relief charge nurse was a clinical nurse +. Rotating in and out of the charge nurse role, clinical nurses were expected to perform their usual clinical nurse role of caring for patients, while also being responsible for the completion of necessary tasks on the unit during the shift. Each shift a clinical nurse is “volunteered” to be the rotating charge nurse because “it’s almost like it’s expected.” A revolving schedule indicating the name of the charge nurse each shift was oftentimes created. However, the frequency in which a nurse was in charge each month varied. Despite many having no desire for the additional responsibility, by the end of their first year of employment nurses were usually included in the rotation. A few shared the tension that occurred at the start of the shift when a last minute decision needed to be made about who was going to be the charge nurse for the shift. One rotating charge nurse who disliked the role shared that, due to being scheduled too often, she decided to remove her name from the assignment. She said:

> It’s not that often, like once or twice a week, but this week for example because it was a holiday and a lot of people you know they either take the day or something and it already ends up that I have to be in charge three times. Actually, I’m supposed to be in charge tomorrow and I actually crossed off my name. (laughing)…I don’t care, you know there’s other nurses who can do it. Sometimes in the morning there’s a little tension because it’s like, you do it, no you do it, no you do it. (CN1P1)
In addition, most nurses did not receive any additional compensation for taking on the rotating/relief charge nurse responsibilities, a point of contention for many participants in this role. As one rotating charge nurse said, “I think I get a $1 more an hour because I’m clinical level three, so I don’t get paid for being the charge nurse…I think that’s a travesty. More responsibility should have equal…compensation” (CN4P2). It was recognized as being a difficult role with additional responsibilities but without proper compensation, which is something that no one being interviewed was able to explain.

We are not paid for it. That’s why on my floor we really try not to do it. I mean we are just annoyed then because you have your own full assignment and then you need to deal with other peoples’ assignments and it gets heavy. But you don’t get extra pay. (CN1P1)

Not only was the rotating/relief charge nurse not compensated for the time spent in the role, but they also received little training for these added responsibilities. Some were trained during their clinical nurse orientation period. Their preceptor was also rotating/relief charge nurse so they could simultaneously learn what the rotating/relief charge nurse responsibilities were as well. Others said they received no formal training or class, but instead emulated what they saw the other clinical nurses doing when they were in the role.

There is no education for charge. They even have education for preceptors, but not for charge. For charge there is no classes or whatever…like the first time they were just like yeah, you’re in charge. So I did what the other charge nurses were doing and that’s the way I’ve been doing it. (CN1P1)
They were labeled as the charge nurse over the unit during the shift, but were viewed by clinical nurses as “peers,” not as leaders. Because they held no authority to “manage” the staff, they were viewed by the clinical nurses as a go-to resource and as an equal peer. When the relief charge nurse filled in for the PCN, one clinical nurse shared a view that it seemed like staff behaved differently, thinking they could “get away with” something.

I also feel like sometimes it’s a different attitude on the unit when it’s not your normal permanent charge nurse...it’s like, well it’s one of us in charge so maybe I can get away with…I do feel like some of the staff members take advantage of those relief charge nurses…and like push their buttons or maybe not do things they normally do because it’s like well, my boss isn’t here today, so maybe I can kind of get away with this. (CLNP2)

Nurse managers also shared the perspective that the rotating charge nurse were not treated as leaders by other staff because staff does not see them as next in command for the clinical nurses on the unit. One nurse manager shared how she notices that clinical nurses come to her for questions and problems instead of turning to the rotating charge nurse for assistance, which she assumes is because they view him or her as a peer.

So even when there are questions and there’s a designated charge nurse on the unit, the staff will come to the manager or director for a question as opposed to go to the charge nurse because I think perhaps maybe they’re still seen as a peer, even when they wear the charge nurse hat...even though you try to say “Let’s think about that. What are your thoughts on that? Perhaps have you spoken to X about that? What does she think?” Oftentimes, they don’t go to that person.
Considering that they were viewed as their peers, rotating charge nurses who were sometimes practicing for only a year were often assisted by other, more experienced clinical nurses in completing the charge nurse role responsibilities. Ultimately, the responsibility to ensure that the housekeeping tasks are completed lies with the charge nurse, but sometimes they are shared among the clinical nurses. Clinical nurses working with rotating charge nurses saw this as a collaborative effort. They said, “It’s not just like the charge nurse’s responsibility, we all help each other” (CLNP2). Oftentimes, experienced rotating charge nurses assisted the novice clinical nurses in this role providing on the job training.

We do try to support each other. So she was in charge last night and she’d be going through, “I’ve done this, I’ve done this, I’ve done this” and so we were trying to tell her about staffing and the things to look at. So she was staffing for the next morning and there’s many things you need to think about…But it’s really important and it makes for a much better assignment if you think about those things. (CN3P2)

In contrast to the PCN/ANM, rotating/relief charge nurses are not unit leaders as they do not complete as many of the administrative competencies on the AONE Nurse Manager Competencies list (AONE, 2015) as the PCN/ANM. Nurse managers do not have the same expectations of the relief charge nurses who fill in for the PCN when he or she is not there. If counseling an employee is needed, the relief charge nurse brings this to the nurse manager’s attention. As one nurse manager said:

The relief charge nurses don’t have the expectation of counseling employees or
holding staff accountable. They still make sure the tasks get done, but if something really wasn’t getting done and it needed to be, it would be escalated to myself in absence of the permanent charge nurse. (NM11P2)

Rotating/relief charge nurses were also not expected to handle conflict by the nurse manager. Instead, they informed the nurse manager so he or she could resolve the conflict. As one rotating charge nurse said, “I believe you’re not responsible for personnel...other than where it affects patient safety. If two people are having trouble, I’m going to bring it to the nurse manager. That is not my job.” (CN4P2)

The rotating/relief charge nurse had a different kind of relationship with the nurse manager than the PCN/ANM. Having fewer interactions with the manager, communications with the rotating/relief charge nurse consist of “updates” of any clinical issues that arise on the unit during the nurse manager’s absence. As one rotating/relief charge nurse on the night shift explained:

I work nights so she doesn’t see what’s going on in the night shift...to know how the crew works, so I give her updates. Whenever I see a problem and whether we...have it resolved or what, I will tell her. This is what happened and this is what we did. (CN10P2)

Most of the time, the rotating/relief charge nurse will inform the nurse manager of anything important, such as a conflict. Rarely does the nurse manager reach out to the rotating/relief charge nurse to provide information or direction, a significant difference from the relationship between the PCN/ANM and the nurse manager. In units that use the rotating charge nurse model, the charge nurse is not included in the communication structure. As shown in figure 5.3, since the rotating/relief charge nurse is not considered
to be part of the chain of command, clinical nurses often bring the information directly to
the nurse manager. Information shared from the executive level is received by the
manager, who then brings it, oftentimes directly, to the unit staff.

Figure 5.3

*Two-way Communication Between Nursing Leaders in the Acute Care Hospital with the
Rotating Charge Nurse Model*

Charge nurses in the rotating/relief charge nurse model are clinical nurses who are
“asked” to do more. They are not considered a leader like the PCNs/ANMs by the nurse
managers and clinical nurses on the unit, as reflected by the minimal similarities to the
AONE Nurse Manager Competencies (AONE, 2015). Additionally, the permanent and
rotating charge nurse models differ in terms of the role they play in patient safety.

**Charge Nurses’ Role in Safety**

The second research question in this focused ethnography asks what the charge
nurse’s role is in keeping patients safe. For all charge nurses, their role as the shift
resource and traffic director encompasses some practices that promote safety. All charge
nurses create safe patient assignments based on adequate staffing levels, clinical nurse
competency, and patient acuity. They also assist the nurse manager in ensuring that the
unit is ready for any regulatory visits by completing checklists of tasks which promote a
safe environment. Even as the go-to resource, the charge nurse provides hands-on assistance to the clinical nurses in emergent issues to ensure the patient is receiving safe care. However, the data revealed subthemes for each of the charge nurse models which were safety practices unique to the PCNs/ANMs and to the rotating/relief charge nurses. As an authority figure on the unit during the shift, the overall subtheme for the PCN/ANM is safety officer, while the subtheme for rotating/relief charge nurses is put out fires.

**Permanent Charge Nurse Model: Safety Officer**

The PCN/ANM in the permanent charge nurse model maintains safety on the unit during his or her shift by playing the role of safety officer. He or she has the authority to monitor patient care, skills and procedures and hold staff accountable for safe practices. As one PCN/ANM described, they are the drivers of patient safety:

> Every nurse has their five, six patients. I have 32 patients. I feel like they’re all mine. So I don’t go in there and give them their meds on a daily basis, but my role is to make sure that overall the nurses are scanning their meds, that they are walking patients to the bathroom and not just leaving them there, that they’re assessing them properly for falls risk and that’s our nursing quality indicators and we come back every month with scores and how well we’re doing scanning medications…If I wasn’t in that role…there wouldn’t be an awareness of a need to improve anywhere. I feel like my role in that is very vital to the drive of patient safety. (CN6P2)

Many PCN/ANMs described their responsibility in facilitating unit meetings during which patient care was discussed and patient safety risks were highlighted to bring
awareness to all staff during the shift. This allows the PCN/ANM to be proactive in addressing risks before errors or patient harm occurs. One PCN articulated, “We do these meetings in the morning and during the meetings we need to report to each other which patients are the most unsafe, meaning at high risk for falls and things like that.” (CN2P1)

In addition, the PCN/ANM monitors practices by observing the unit and scanning the environment. He or she is an “extra set of eyes” for the clinical nurses. Scanning the environment, the PCN/ANM, as a safety officer, is in a position to recognize potential safety hazards and remove the risk for harm. In this way, they were one step behind the nurses, checking to make sure patient safety risks were addressed to prevent errors from occurring.

It’s another check, too, because sometimes because of habit some nurses on nights will leave some SCDs bundled in a corner and if you are so focused or if you’re like doing your assessment and you don’t notice the extra cord, it’s like oh, this extra cord let me remove this from out of the room. Just good to have an extra set of eyes. (CLNP2)

PCNs/ANMs are expected to “be really knowledgeable about the policies” in their organizations, so they can answer questions about current practices or policies and ensure they are being followed at the unit level. If they find that policies are not adhered to, PCNs/ANMs use the opportunity as a “teaching moment” wherein they can review the policy with the clinical nurses to ensure they are aware of the practice.

They always keep an ear open to make sure they hear what’s going on and if they hear something like “Oh, should I really do that?” and they’re really quick to jump in and say “Oh, lets refer to policies and procedures on the internet
together.” So I do think they are looking for like teaching moments to help other people and also go like by guidelines, whether it’s AWOHNN or whatever.

(CLNP2)

As a safety officer who monitors and enforces safe practices, it is the role of the PCN/ANM to counsel or coach staff in a non-punitive manner when an opportunity for improvement presents itself. A PCN shared her safety rounds at the start of the shift:

I do a safety check to make sure like the IVs are not infiltrated, they’re dated, everything is labeled, from foleys to IVs to everything. Then I make sure that the bed alarms are on and my carts are locked. This is just like basic. This is what I do on every single patient. If it’s not labeled or so, I usually do label it. But I will speak with the nurse later and say ‘Listen like just make sure, when you do bedside report that you also review the IVs and like the drips and everything.’

(CN2P2)

When an error or patient harm does occur, the PCN/ANM investigates the occurrence and ensures the proper documentation has been completed. After ensuring the patient’s safety, the PCN/ANM speaks with the staff involved and obtains details surrounding the event. The goal is to create a learning opportunity and “prevent it from happening again.” Then, the information is discussed with the nurse manager and collaboratively they decide on a plan.

They find out what truly happened. Then they bring it to me, we review, we talk about it…if it’s a [permanent charge nurse] or myself, we address the employee who may have been involved in the event that some counseling may need to be
done…and then we use those examples in staff meetings…use it as a safety story.

(NM11P2)

By monitoring and enforcing best practice at the bedside, the PCN/ANM positions her/himself as a safety officer; when an error does occur, using the chain of command, the clinical nurses bring the issue to the PCN/ANM who manages the situation immediately and collaborates with the nurse manager on a prevention plan. The rotating/relief charge nurse keeps patients safe in a different way--He or she puts out fires.

Rotating Charge Nurse Model: Put Out Fires

Unlike the PCN/ANM, the charge nurses in the rotating charge nurse model did not have the time to spend doing patient rounds or proactively observing for safety risks. As clinical nurses with a patient assignment as well as the rotating charge nurse assignment, they spent their time caring for their patients and completing the “housekeeping tasks” required of all charge nurses. They did not have the authority to monitor and counsel unit staff when safety issues were found; instead, they were recognized as a peer to whom the clinical nurses go to when problems surfaced. Ingrained in their go-to resource role was another role responsibility labeled “put out fires.” The rotating/relief charge nurses was notified when a problem or safety concern arose and he or she “fixed the problems of the day,” especially when the nurse manager or ANM was unavailable. A nurse manager verbalized, “They help put out some fires…if myself or the assistant isn’t around. They’ll play that role… like intervening.” (NM9P2)

Rotating/relief charge nurses were involved in situation management and reacted to situations as they occurred. They stepped in to assist a nurse with a skill that he or she
was uncomfortable with or intervened with a patient complaint when the patient asked to speak with the person in charge.

They’re there to kind of put out fires…they’ll do hands on teaching, if necessary, if there’s just a skill a nurse needs and they’re not comfortable with, they’ll assist with that. And they’ll also just kind of putting out fires all day long, too.

(CLN3P1)

Rotating/relief charge nurses encourage clinical nurses to come to them with problems or questions even when they have a patient assignment because they understand the risk of patient harm if the clinical nurses do not reach out.

So because I said I have my own patients, they understand. Sometimes, it’s hard for them to come to me because they understand. They have five patients, I have five patients. So they know, sometimes they are hesitant. I said I’d rather have you come and talk to me and if I cannot handle it, then I’ll have to find a way, rather than finding out it’s too late...I just wish I had some more time to talk to them and stay with them until they really realize, you know show them everything, just it’s hard. (CN10P2)

Rotating/relief charge nurses reacted to make sure the proper process steps were followed and the patient was safe. Another charge nurse shared how they may be called to assist if a patient wanted to sign out of the hospital without a discharge order. She said, “Say that someone signs against medical advice, you have to make sure that we did all possible to make them stay or any other safety issues we are involved.” (CN1P1)

When an error occurred, unlike the PCN/ANM, the rotating/relief charge nurse was not expected to investigate the error. “If they were notified,” they reminded the
clinical nurse to complete the necessary documentation, inform the physician and ensure that the patient was unharmed. Rotating/relief charge nurses often did not have the time to perform the investigation when they had a full patient assignment.

Just to make sure if she needs anything or has questions about what to do next. They call the doctor…a lot of people just jump in and do things, too. It’s not like the charge nurse has to do everything because we have our own patients, too. So sometimes something might happen that I don’t even know about at the time or later on. (CN9P2)

Instead, for units that had an ANM, they, along with the nurse manager, investigated the error to learn from it and prevent its reoccurrence. Though errors or patient harms were not always communicated to the rotating/relief charge nurse, emergency patient situations requiring immediate actions were always shared with her/him. As the go-to resource on the unit, the rotating/relief charge nurse provides the assistance when needed and solicited; however, they generally were just trying to “get through the shift” and “make sure the workflow is okay and the unit functions” by putting out fires.

**Summary**

Hospitals in New Jersey utilize one of two charge nurse models, permanent or rotating, to ensure the basic charge nurse tasks are completed. Regardless of the model used, all charge nurses are shift resources and traffic directors. They are the go-to resources for assistance and information for staff on the unit, as well as for clinicians and administrators throughout the hospital. Role responsibilities include managing the flow of patients in and out of the unit, creating a safe patient assignment, and ensuring regulatory readiness.
Separate subthemes, categories, and subcategories emerged from the data for the PCNs/ANMs in the permanent charge nurse model and for the rotating and relief charge nurses in the rotating model. PCNs/ANMs are unit shift leaders and extensions of the nurse manager, assisting in tasks when he or she is absent from the unit. The PCN/ANM manages information flow both to and from the nurse manager and assists him or her in handling human relations tasks. As a leader, the PCN/ANM is also a safety officer, scanning the environment for potential safety issues and addressing the safety risks with staff in a non-punitive way.

The rotating/relief charge nurse, on the other hand, is considered a peer by fellow nurses and a clinical nurse + with extra responsibilities in the role. The rotating/relief charge nurse cares for his or her patient assignment in addition to the charge responsibilities. Rotating/relief charge nurses “put out fires” and are reactive to situations on the unit. Both the PCN/ANM and rotating/relief charge nurse roles vary, including their role in patient safety.
Chapter VI

DISCUSSION OF FINDINGS

This two-phase focused ethnography study sought understanding of the role and safety practices of the acute care hospital charge nurse. Through interviews and focus groups, the perspectives of charge nurses, clinical nurses, and nurse managers were elicited to explore their expectations of the acute care hospital charge nurse, which was a gap in the empirical literature. The data revealed that in acute care New Jersey hospitals, two different charge nurse models exist, permanent and rotating. The participants’ perceptions of the charge nurse responsibilities were related to the enactment of the charge nurse in this role. While the data from this study supports the fact that the charge nurse role is situated between the nurse manager and the staff on the unit, literature suggests that the charge nurse fulfills a leadership role at the unit level (Kalisch, Weaver & Salas, 2009; Krugman & Smith, 2003; Krugman, Heggem, Judd Kinney & Frueh, 2013; Sherman, Schwarzkopf & Kiger, 2011; Cathro, 2016; Connelly, Yoder & Miner-Williams, 2003); however, data from this study also proposes that only those in the permanent charge nurse model are viewed as leaders. Supported in the empirical literature (Zydziunaite, Lepaite & Suominen, 2013; Suominen, Savikko, Puuka, Doran & Leino-Kilpi, 2005; Connelly et al., 2003), charge nurses balance dual role responsibilities, which are clinical and administrative. This study also found that both clinical and administrative responsibilities are encompassed in each of the charge nurse models, though differing greatly in degree. In this chapter, through the lens of the Nurse Manager Leadership Partnership (NMLP) Learning Domain Framework, the clinical and administrative components of each of these models will be further discussed.
**Shift Resource and Traffic Director**

As a shift resource and traffic director, charge nurses in the permanent and rotating charge nurse models are responsible for shared role responsibilities and practices. They are expected to be the go-to resource, manage the flow of the unit activities, create safe patient assignments with adequate staffing levels and ensure regulatory readiness.

Charge nurses have been recognized since the 1970s as the “go-to” resource (Homer & Ryan, 2013; Cathro, 2016; Eggenberger, 2012; Connelly et al., 2003; Hinkle & Hinkle, 1977a; Hinkle & Hinkle, 1977b), the nurse who prepares the patient assignment based on staffing (Connelly et al., 2003; Hughes & Kring, 2005; Homer & Ryan, 2013; Eggenberger, 2012; Cathro, 2016), as well as the nurse who manages the flow (Krugman et al., 2013; Krugman & Smith, 2003; Patrician, Oliver, Miltner, Dawson & Ladner, 2012; Lewis, 1990; Eggenberger, 2012). Extant literature also confirmed this study’s findings that charge nurses have dual components of their role—clinical and administrative (Sorensen, Delmar & Pedersen, 2011; Connelly et al., 2003); however, the degree of each component varies with the permanent and rotating charge nurse models, a new finding in this study.

**Dual Roles: Clinical and Administrative**

Charge nurses in both permanent and rotating models take on common responsibilities, known as the “housekeeping tasks,” which are associated with the role, as well as acting as shift resources. These ”housekeeping tasks” are included in the overarching theme of shift resource and traffic director and have either clinical, administrative or both components.
The overarching theme of shift resource includes only clinical responsibilities or tasks associated with the category of go-to resource. The charge nurse, as the shift resource, is called upon by clinical nurses on the unit, as well as clinical staff and administrators such as the hospital supervisor, for information and clinical assistance. Because the charge nurse has general knowledge about the unit activities, when requested, he or she provides information regarding patient care. Providing hands-on help to another clinical nurse also requires clinical knowledge and skill. As the go-to resource, if staffing is not adequate, the charge nurse may take a patient assignment, which requires her/him to use clinical knowledge and skills to deliver patient care. Although the role of shift resource is not new to the charge nurse literature, it is an important role to note. With the healthcare system undergoing drastic changes and admitted patients having higher acuities (Sherman et al., 2011; Germain & Cummings, 2010), whether or not a resource nurse is available to assist the clinical nurse may impact patient outcomes.

The overarching theme of traffic director includes categories which have both clinical and administrative components. Managing flow by facilitating patient admissions, discharges and transfers, as well as assigning beds to patients by coordinating with the bed control department, requires some administrative skill, as well as clinical knowledge, about diagnoses and compatibility. As an administrative component of the charge nurse’s role, maximizing care efficiency and throughput is a financial management strategy in the NMLP Learning Domain Framework as important to the nurse manager’s role, but is used by the charge nurse while managing the flow. Assigning beds to patients and managing discharges and transfers is an important role that affects not only the safe flow of patients on the unit, but it also supports the flow of patients
throughout the hospital. If the charge nurse neglects this duty or incorrectly assigns a bed to a patient, delays in hospital patient flow occur and/or the delivery of safe patient care may be disrupted.

Creating a safe patient assignment according to staffing needs and completing checklists of tasks to ensure regulatory readiness, both of which are included in the NMLP Learning Domain Framework within The Science domain, have an administrative component; yet, understanding the complexity of each patient’s needs is a clinical responsibility in order for the charge nurse to create the most equitable and safe patient assignment. Although documenting the check of the regulatory tasks is an administrative duty, understanding what best practices to observe in order to prevent infections is a clinical responsibility. As shown in table 6.1, the overarching theme, subthemes, categories, and subcategories identified in this study correlate with either clinical or administrative work; some have both clinical and administrative components associated with the task as well.
Table 6.1

**Overarching Theme, Subthemes, Categories and Subcategories Linked to Clinical or Administrative Components**

<table>
<thead>
<tr>
<th>Permanent Charge Nurse Model</th>
<th>Rotating Charge Nurse Model</th>
</tr>
</thead>
<tbody>
<tr>
<td>Unit Shift Leader</td>
<td>Clinical Nurse +</td>
</tr>
<tr>
<td>Extension of Nurse Manager</td>
<td>Put Out Fires**</td>
</tr>
<tr>
<td>Manage Information Flow</td>
<td></td>
</tr>
<tr>
<td>Human Resource Management</td>
<td></td>
</tr>
<tr>
<td>Safety Officer**</td>
<td></td>
</tr>
<tr>
<td>Shift Resource*</td>
<td>Manage the flow**</td>
</tr>
<tr>
<td>-Go to Resource*</td>
<td>-Regulatory readiness</td>
</tr>
</tbody>
</table>

Note: *=Clinical, **=Both clinical and administrative, No asterisk=Administrative

All of the role responsibilities associated with the overarching theme, shift resource and traffic director, contain a clinical component; but not all of them contain an administrative part. Sharing these responsibilities, charge nurses in both models have dual components of their role; however being viewed as leaders, PCNs/ANMs in the permanent charge nurse model have significantly more administrative responsibilities than do rotating/relief charge nurses in the rotating model.

**A Tale of Two Models**

This study was the first to define two different charge nurse models, permanent and rotating, in acute care hospitals in New Jersey. Charge nurses in both models acted as shift resources and traffic directors, while accomplishing the “housekeeping tasks,” with
both clinical and administrative components of their role; however, the “leader” that the charge nurse has been known to be only applies to those in the permanent charge nurse model. Table 6.2 shows the role responsibilities applicable to each model which emerged from the findings. Attributes of each model shown in the table stem from the leadership, or lack thereof, encompassing those in the role within each model.

Table 6.2

Comparison of Permanent and Rotating Charge Nurse Models

<table>
<thead>
<tr>
<th>Permanent Charge Nurse Model</th>
<th>Rotating Charge Nurse Model</th>
</tr>
</thead>
<tbody>
<tr>
<td>Unit Level Nurse Leader—“administrator”</td>
<td>Lack of leadership—not an administrator</td>
</tr>
<tr>
<td>• Legitimate power</td>
<td>• Powerless</td>
</tr>
<tr>
<td>• Positioned for succession planning</td>
<td>• Not positioned for succession planning</td>
</tr>
<tr>
<td>• Anticipatory/Proactive</td>
<td>• Non-anticipatory/Reactive</td>
</tr>
<tr>
<td>Relationship-focused</td>
<td>Task-focused</td>
</tr>
<tr>
<td>• Gatekeeper/Buffer</td>
<td>• Not a Gatekeeper/Not a buffer</td>
</tr>
<tr>
<td>• Credibility</td>
<td>• Variable credibility</td>
</tr>
<tr>
<td>Lack of standardized orientation/training</td>
<td>Lack of standardized orientation/training</td>
</tr>
<tr>
<td>Role Conflict</td>
<td>Role Conflict, Role Ambiguity and Role Overload</td>
</tr>
</tbody>
</table>

Table 6.2 also reflects the lack of standardized orientation and training for charge nurses in both models. The empirical literature on charge nurses is repetitive in discussing the gap in orientation and training for the role, specifically in the administrative skills (Patrician et al., 2012; Krugman et al., 2013; Krugman & Smith, 2003; Schwarzkopf, Sherman & Kiger, 2012). This study validates this gap as it found that charge nurses enter the role without a formal orientation program and do not receive ongoing training or professional development, even though they have voiced an interest in receiving education. In a study by Wojciechowski et al., (2011) charge nurses reported their learning needs included the development of leadership skills such as communication, being assertive, knowing resources, and multi-tasking. They also were
interested in another important skill for charge nurses, managing behaviors through human resource management skills such as conflict management and employee performance issues. In order to be effective in the role, the charge nurse requires role training with an emphasis on the competencies pertinent to the charge nurse model, including those identified in Appendix K based on the NMLP Learning Domain Framework. Education for PCNs/ANMs should focus on more administrative role responsibilities, while the rotating/relief charge nurse education should focus less on administrative responsibilities and more on the tasks. In this study, PCNs/ANMs suggested ways they could learn the role such as shadowing another PCN/ANM for a period of time, being mentored by the nurse manager, attending a formal class or being provided with a packet of materials to read. Rotating/relief charge nurses articulated that, if they did receive orientation, it involved learning the role from the rotating charge nurse while on orientation; otherwise, no orientation was received.

Another concept that is not included in table 6.2, but has been mentioned in the charge nurse literature (Connelly et al., 2003; Lewis, 1990), is “establishing the weather.” Though it was discussed by clinical nurses and nurse managers as a competency of charge nurses, it did not clearly fit in the model nor was it found in the NMLP Learning Domain Framework as a necessary component of the nurse manager’s role; however, as a recurrent concept recognized by charge nurses, nurse managers, and clinical nurses in subsequent interviews, it is an important concept to discuss as it relates to the flow of the day-to-day operations of the unit, as well as staff attitudes and behaviors. Establishing the weather may be a dispositional or situational attribute of the charge nurse role, which applies to those in both charge nurse models (Malle, 2011). As a dispositional attribute,
which reflects the internal characteristics of a person, establishing the weather, albeit positive or negative, affects the attitudes of all staff that the charge nurse comes in contact with, which is then reflected in their behaviors and actions (Malle, 2011). The charge nurse’s attitude and personality affects the weather that is created, which may differ from day to day. As a situational attribute, reflecting circumstances external to the person, the positive or negative weather can also be due to the situations that the charge nurse has encountered (Malle, 2011). For example, the rotating and relief charge nurses who are being assigned to the charge nurse role without any desire for the role, may reflect that situation in the weather they establish on the unit during the shift. If a charge nurse has a negative attitude, he or she could be abrupt and pessimistic in her/his responses. Clinical nurses will not approach this charge nurse to ask questions about a new skill, report an error or request an extra pair of hands and the charge nurse will not be the go-to resource; they will be unhelpful. This could potentially affect staff outcomes such as satisfaction, morale, intent to leave, burnout and compassion fatigue, as well as patient outcomes; therefore, the weather created by all charge nurses is one important attribute that may affect the process of getting through the shift and the smooth functioning of the unit as a whole.

**The Charge Nurse: A Unit Nurse Leader**

Hired into their role, PCNs/ANMs are in formal leadership positions because they chose those roles. Empirical literature since the 1970s has referred to the charge nurse as a clinical professional and frontline leader who leads the team during the shift (Cathro, 2016; Hinkle & Hinkle, 1977a; Drach-Zahavy, 2002; Eggenberger, 2012; McCallin, 2010). This study confirmed that both clinical nurses and nurse managers, in addition to
charge nurses, perceive the PCN/ANM to be part of the unit leadership with administrative responsibilities unique to their role, including being an extension of the nurse manager, managing information flow in the unit leadership hierarchy, and managing human relations. Connelly et al. (2003, p. 300) suggests that the charge nurse is an “administrator” who oversees the work of other persons and assumes responsibility for achieving objectives through this oversight. This study supports the fact that only the PCN/ANM is considered an administrator by this definition and that he or she oversees the work of the staff on the unit during the shift with the overall goal of managing the flow and delivery of safe, high quality patient care.

The PCN/ANM can only achieve these goals by looking ahead. Because the PCN/ANM is a nurse leader who wants to be in his or her role and is vested in the interests of the unit, he or she would consider the big picture and look ahead at staffing, staff schedule, plans for patient care, and unit needs. This concept is new to the charge nurse literature. The PCN/ANM would anticipate any needs or potential problems on the unit and, if possible, prevent those issues from occurring. For example, when reviewing staff schedules, he or she would look ahead to view several weeks of the schedule to ensure proactively that any staffing needs were filled before the day of the deficiency arrived; by taking a preemptive approach to troubleshooting situations on the unit ahead of time as part of the routine for the PCN/ANM, the PCN/ANM promoted the smooth flow of the unit activities.

This study also confirmed what other studies since the 1970s have described (Hinkle & Hinkle, 1977a; Hinkle & Hinkle, 1977b; Connelly et al., 2003) in that the PCN/ANM is significantly involved in managing relationships and human resources
among the staff on the unit during the shift. Empirical studies have demonstrated the influence that nursing leadership has on relationship building (Germain & Cummings, 2010); however, no study to date have been conducted in the United States with PCNs or ANMs. Consistent with the literature, participants described how PCNs/ANMs build mutual respect and trust with the nurses from their units in order to promote a cohesive, smooth running unit (Lewis, 1989; Connelly et al., 2003; Patrician, et al., 2012). Nurse managers and clinical nurses expect the PCN/ANM to frequently interact with the staff by managing conflict, counseling, coaching, and mentoring staff to ensure the day-to-day operations of the unit flow efficiently, which are competencies identified by AONE for Nurse Managers (AONE, 2015). The PCN/ANM who is perceived to be a leader by the clinical nurses performs these administrative tasks as an extension of the nurse manager. Having a close interdependent relationship with the nurse manager, the PCN/ANM shares some administrative responsibilities within The Science, The Art and The Leader Within domains of the NMLP Learning Domain Framework. The literature discusses the charge nurse’s role evolving to meet the demands on the nurse manager, by sharing responsibilities and being the leader who is present when the nurse manager was not (Connelly et al., 2003; Wojciechowski, Ritze-Cullen & Tyrrell, 2011). However, today’s charge nurses, either permanent or rotating, are available 24/7 as a visible presence on the unit.

As shown in Appendix L, based on data from phases one and two, the AONE Nurse Manager Competencies (AONE, 2015), which are grounded in the NMLP Learning Domain Framework, are applied to nurse managers, PCNs/ANMs, and rotating/relief charge nurses. Within the Performance Improvement section,
inter/intradepartmental communication is an important competency for the PCN/ANM as he or she plays the role of “gatekeeper,” a theme found in Eggenberger’s (2012) and Lewis’ studies (1990). As a gatekeeper, the PCN/ANM, who is known by name, is sought out by staff both inside and outside of the unit for information regarding patients, staff or the unit activity. As such, he or she controls access to information. Inside of the unit, the PCN/ANM plays a similar role in acting like a buffer to shield the nurse manager from information that he or she does not need to know while ensuring communication of important unit level data. Usually staff, clinical nurses, and nursing assistants bring information to the PCN/ANM as the in-between leader instead of bringing it to the nurse manager. Besides being a buffer between the staff and nurse manager, the PCN/ANM was also a buffer between the clinical nurses and other professionals, including physicians, who would share information or problem solve with the PCN/ANM instead of searching for the clinical nurse, recognizing the PCN/ANM as the unit shift leader. As a gatekeeper and a buffer, the PCN/ANM has control on the unit during the shift because of his or her legitimate or positional power (Basaran & Duygulu, 2015; Lewis, 1990). This power results from being hired into a leadership position and recognized as someone in the chain of command. As such, staff on the unit have a supervisory relationship with the PCN/ANM, but those outside of the unit have a mutually respectful relationship with the PCN/ANM that includes open communication and recognizing her/him as the leader, which maintains the flow of the unit activities.

Through these relationships, the PCN/ANM builds their credibility as a leader. When he or she is called by unit staff, other clinicians or administrators for information and the PCN/ANM reliably provides it, his or her credibility grows stronger. The
PCN/ANM, being interviewed and hired, most likely has a job description with qualifications, though this could not be verified in this study. Interviews in this study with nurse managers, clinical nurses, and PCNs/ANMs supported the fact that hired PCNs/ANMs are usually experienced nurses who are considered the clinical expert on the unit. By having the power of knowledge and the ability to provide solutions to problems, PCNs/ANMs are perceived as someone who is credible (Ernst, 1995). A study by (Marshall, West & Aitken, 2013) showed that, in order to use a nurse as a source of information or resource, clinical nurses consider key features which include experience, clinical role, trust, and approachability. They place more emphasis on the individual who is the source for information than on the information itself, taking the key features for the individual into account when deciding whether or not to ask for information (Marshall, et al., 2013). In this case, if the PCN/ANM is experienced, in a leader role, trustworthy, and approachable to the clinical nurse, he or she will ask her/him for the information. If there is a lack of trustworthiness or approachability, perhaps due to the “weather” on the unit that day, the clinical nurse will not approach the PCN/ANM; however, this study found the PCN/ANM to be perceived as the credible source for information as the unit shift leader and the knowledgeable go-to resource.

As suggested in the literature, the PCN/ANM is in a key leadership role in the unit leadership hierarchy, wherein he or she could be proactively included in the nurse manager’s succession plan (Patrician et al., 2012). With the nursing workforce average age being 48, it is time for nurse managers and administrators to look to their PCNs/ANMs when developing their succession plans (New Jersey Collaborating Center for Nursing [NJCCN], 2018); however, this study revealed that, while the ANMs were
clearly on a path for nursing administrative positions, the PCNs were not included in succession plans. It has been suggested that charge nurses were not groomed into nurse manager roles because they were perceived to be “task masters,” instead of recognizing the administrative role responsibilities they have assumed (Patrician, et al., 2012); however, as a unit shift leader with legitimate power due to their position (Basaran & Duygulu, 2015) and significant administrative responsibilities, PCNs/ANMs are in a pivotal position to be developed into future nurse managers. Studies have focused on the need for such training for charge nurses specifically to develop them to be transformational leaders (Krugman & Smith, 2003; Krugman et al., 2013; Schwarzkopf et al., 2012; Zydziunaite et al., 2013). Instead, mentoring programs, which have been shown to be beneficial, may be helpful in providing PCNs/ANMs with some insight into the nurse manager’s role (Vitale, 2018).

Although transformational leadership training has been promoted in the literature in an effort to improve the skills of the charge nurse in being a leader and champion for change (Duygulu & Kublay, 2011; Krugman et al., 2013; Krugman & Smith, 2003; Schwarzkopf et al., 2012), no publications have discussed how the charge nurse facilitates changes at the unit shift level. As an administrative role, the change agent is a component within the Relationship Management and Influencing Behaviors section of The Art domain of the NMLP Learning Domain Framework. The data from the study shows that PCN/ANM have the authority as a unit shift leader to act as a “messenger” by “trickling” information down from the nurse manager to the clinical nurses. Regardless of whether or not the PCN/ANM agrees with the message, he or she relays the message to the unit staff during the shift, monitors to ensure the practices are in place, and has the
legitimate power to counsel and coach employees when practices are not carried out. As a leader who is visibly present on the unit, the PCN/ANM supports the staff. Positive, trusting relationships between PCNs/ANMs, as well as the presence of a supportive leader, increases the likelihood that the changes initiated by the PCN/ANM on the unit will be followed (Germain & Cummings, 2010). Empirical literature has examined the relationships between nursing leadership and staff and organizational and patient outcomes, but the term “nurse leader” has not always been clearly defined. Although a systematic review by Germain and Cummings (2010) showed that nursing leadership directly affects autonomy, resource accessibility, and nursing leadership practices, all of which clinical nurses felt influenced their motivation to perform, whether or not the PCN/ANM directly impacts these areas as the nurse leader closest to the patient care is still to be determined.

Although the PCN/ANM has a clear role with hybrid clinical and administrative responsibilities, data from this study suggests that role conflict may still exist, which is a concept in the extant literature on charge nurses (Ernst, 1995; Admi, Moshe-Eilon, 2010). Role conflict exists when there are “mutually contradictory expectations for role performance” (Ernst, 1995, p.50). Clinical nurses and nurse managers had different expectations on the amount of time that the PCN/ANM spends on the clinical and administrative tasks. Though the distribution could vary from day to day, most of the PCNs/ANMs felt they spent 50% of their time on clinical tasks and 50% on administrative tasks; whereas the clinical nurses and nurse managers perceived that the PCN/ANM spends 10 to 25% of their time on clinical tasks and 75 to 90% performing administrative tasks. Clearly, the reality of what the charge nurse is experiencing is not
what the clinical nurses and nurse manager, who work closest with the charge nurse, expect. Perhaps this suggests that, because the clinical nurses and nurse manager view the PCN/ANM as a leader, they expect more of their time to be spent performing administrative tasks assisting the nurse manager. The reality may be that the PCN/ANM is spending more time than expected in clinical tasks, leaving less time for administrative duties; this, in turn, may be why some mentioned that they need an “administrative day” to catch up on those leadership tasks. With unclear expectations of the role responsibilities, the PCN/ANM may perform ineffectively and experience role stress, job dissatisfaction, and burnout (Ernst, 1995; Rizzo, House & Lirtzman, 1970).

The Charge Nurse: A Clinical Nurse Assignment

In contrast to the PCNs/ANMs, the rotating/relief charge nurses are assigned to be in the role while usually also carrying a patient assignment. Though their role includes both clinical and administrative responsibilities consistent with the literature (Sherman, Schwarzkopf & Kiger, 2011; Sorensen et al., 2011), their role is predominantly clinical, therefore, the number of administrative competencies they enact are much fewer than those carried out by PCN/ANM as indicated in Appendix L. Rotating/relief charge nurses in the rotating charge nurse model may also experience role conflict like the PCNs/ANMs, but they also experience role ambiguity and role overload. Without a job description, rotating/relief charge nurses also lack clarity about the expectations of them in the role and, as such, they experience role ambiguity. They may not be sure if they have any authority to make decisions on the unit, though their title may imply this. Having received little to no orientation in the tasks required of them in this role, the rotating/relief charge nurse is not made aware of how the nurse manager expects the tasks
to be performed and whether or not the rotating/relief charge nurse has any authority when in the role, which creates role ambiguity (Rizzo et al., 1970).

Rotating/relief charge nurses experience role conflict due to the contradictory messages about being in “charge.” Although their title is suggestive of a leader role, rotating/relief charge nurses, nurse managers, and clinical nurses all agree that their role is one of a clinical nurse. They are considered as “peers” by the clinical nurses and staff nurses who often assist the rotating/relief charge nurses with the “housekeeping tasks” required of the charge nurse. Their limited administrative responsibilities also imply that they are not leaders.

Role conflict is also apparent in the rotating charge nurse model because the rotating/relief charge nurses are not included in the chain of command. When the nurse manager is present on the unit, staff often will approach her/him about questions instead of asking the rotating/relief charge because they are not recognizing this individual as next in line. When the nurse manager, on the other hand, is absent from the unit, unity of command does not exist. Unity of command is a principle that states that there should be only one leader who provides “orders” or actions to an employee (Rizzo et al., 1970). With the chain of command structure in the permanent charge nurse model, the PCN/ANM is the perceived next highest leader in the organization’s hierarchical leadership structure. In the rotating charge nurse model, however, there is some ambiguity in the chain of command structure if the nurse manager is absent. The confusion in the chain of command when the nurse manager is absent could lead to poor staff performance (Rizzo et al., 1970).
In addition, overwhelmed by the increased workload incurred because of the added charge nurse role assignment, this study data suggests that the rotating/relief charge nurse experiences role overload. Clinical nurses, at times, hesitated to use the rotating/relief charge nurse as their go-to clinical resource, “extra pair of hands” or the expert nurse because they know that the charge nurse is balancing his or her own full patient assignment along with the housekeeping tasks associated with the charge nurse role. Rotating/relief charge nurses experience role overload because they are taking on the workload for two different roles, the charge nurse and the clinical nurse (Rizzo et al., 1970). Nurses who experience unknown or unclear role expectations feel unable to and unconfident about performing their job well, which then results in the same negative outcomes from role conflict (Germain & Cummings, 2010).

The additional workload that the clinical nurse was responsible for in the rotating/relief charge nurse role differed significantly from the PCN/ANM role as shown in table 6.2, with much of their role responsibilities being counterparts of each other. Many of the responsibilities of the rotating/relief charge nurse were task-focused, including the “housekeeping tasks.” Creating the assignment, completing the checklist of items for regulatory readiness, and assigning beds to admissions were tasks that were designated to the charge nurse. Lacking many of the administrative responsibilities, as well as a leadership position, rotating/relief charge nurses lacked legitimate power (Basaran & Duygulu, 2015). They were also not identified as clinical nurses aspiring to be nurse leaders; thus, succession planning with these charge nurses for nurse manager roles was not found in this study. Without being hired into the role, qualifications for anyone assigned to the rotating/relief charge nurse role were relatively nonexistent.
Therefore, leader attributes such as proficiency in communication skills, organizing, and human relationship management skills were not considered for the rotating/relief charge nurse assigned to the role. Furthermore, since they were not considered to be a leader among clinical nurses and nurse managers, data from this study suggests that the rotating/relief charge nurse may not have a “role,” but rather only has responsibilities. As defined, a role encompasses a pattern of behaviors, beliefs and norms, while responsibilities are specifically the tasks (Kivak, 2017). As such, the rotating/relief charge nurse may be a clinical nurse who, in addition to his or her regular workload, is only assigned more responsibilities to complete during the shift. He or she may be missing the attributes, behaviors, beliefs, and norms that encompass the true role. They carry the “charge phone,” but do they really fulfill the identified role of a charge nurse?

Along with the assignment of tasks, the rotating/relief charge nurse was also informally designated to be the go-to resource nurse for the shift. To be the go-to resource, the charge nurse must have the nursing experience and clinical expertise to be able to provide the answers and assist with clinical problems. In the rotating charge nurse model, however, clinical nurses entered into the rotating charge nurse pool by the end of their first year. Nurses with only a year’s experience have limited expertise and, therefore, can only be a limited clinical resource for the unit nurses needing support and assistance with questions and problem solving. Additionally, having a patient assignment as well as extra tasks to complete left little time for the the rotating/relief charge nurse to assist others, which caused clinical nurses to identify the rotating/relief charge nurse as lacking credibility (Ernst, 1995). In contrast to the PCNs/ANMs, the rotating/relief charge nurse lacked three of the four key features, specifically experience, the clinical
role of nurse leader and availability due to having his or her own patient assignment. Clinical nurses would believe that they could turn to the rotating/relief charge nurse for assistance if he or she consistently could “have their backs” and provide answers to questions. The negativity among clinical nurses who do not feel that they have a shift resource may factor into the weather of the unit. Instead of the rotating/relief charge nurse being the go-to resource, clinical nurses hesitate in approaching her/him because of his or her negative attitude or their perceived lack of time to assist. This could also potentially lead to a lack of reporting of errors by clinical nurses who feel the rotating/relief charge nurse is too busy to help. The powerlessness of the rotating/relief charge nurse has also been shown to impact his or her ability to use resources (Basaran & Duygulu, 2015). When the rotating/relief charge nurse lacks the power to access resources needed for patient care, this could potentially impact staff satisfaction because he or she cannot be the go-to shift resource needed. It may also impact the rotating/relief charge nurse’s job satisfaction and turnover (Basaran & Duygulu, 2015).

As noted in the data, most rotating/relief charge nurses interviewed receive no additional compensation for the time they are in the role and yet many do receive compensation to precept a novice clinical nurse. This incongruency suggests that the hospital administration may not value the rotating/relief charge nurse role and the work they do. Rotating/relief charge nurses do not always want to be in the rotation to take on the added responsibilities, especially without compensation. Some were approached about being in charge during their performance evaluation, at which time they felt that they were expected to be included in the rotation. “Volunteering” clinical nurses into the role because it was “expected” caused great resentment among the nurses.
What’s In a Name?

Data from this study revealed many titles for the position or person who was in charge of overseeing the patient care, the staff, and the activities of the unit during the shift. Titles, formal and informal, including Relief Charge Nurse, Assistant Nurse Manager, Clinical Care Coordinators, Clinical Shift Supervisors, Charge Nurses, Resource Nurses, and Clinical Patient Care Coordinators, differ by hospital and most denote a position of authority using terms such as coordinator, supervisor and charge; however, this study proposes that all charge nurses are not alike. Despite the significant emphasis in the literature about the charge nurse being a leader and due to the emergence of the permanent and rotating charge nurse models in New Jersey, only those hired into a nursing leadership position in the permanent charge nurse model can be recognized as a nursing unit leader who is part of the unit leadership team. In this study, nurse managers and clinical nurses saw the PCN/ANM as part of the chain of command, with clinical nurses reporting issues to the PCN/ANM before going to the nurse manager; the same did not occur with the rotating/relief charge nurse. Though hospital organizational charts and job descriptions were not reviewed in this study nor in any others regarding charge nurses published to date, PCNs/ANMs should be included in the leadership structures, reporting up to the nurse manager of each inpatient unit.

Despite some literature on the charge nurse claiming that the role evolved from a need for a charge nurse to be present in the absence of the nurse manager (Wojciechowski, Ritze-Cullen & Tyrrell, 2011; Connelly et al., 2003), this study suggests that this role expectation has evolved into a charge nurse being present on the unit every shift. In the state of New Jersey, per the New Jersey Administrative Code 8:43G-17.1, the
nursing unit leadership structure in each hospital must consist of, at minimum, a nurse manager and a nurse in charge (State of New Jersey Office of Administrative Law, 2019); however, have some hospitals using the rotating charge nurse model watered down the nurse in charge by stripping them of the authority to lead? This study suggests that those in the rotating charge nurse model do not have the authority to either make decisions on the nurse manager’s behalf or lead the unit staff and, as such, their role in maintaining patient safety is limited.

**Safety Practices and Outcomes**

Patient safety is a top priority for all personnel working in hospitals, but especially for nurses who have strong influence over patient safety outcomes. Though the literature claims that charge nurses play a role in the quality of patient care (Sherman et al., 2011; Krugman & Smith, 2003; Normand, Black, Baldwin & Crenshaw, 2014; Connelly et al., 2003; Cathro, 2016), this study provides evidence to understand the safety practices they engage in to affect patient safety. Approaches to keep patients safe varied widely between PCNs/ANMs and rotating/relief charge nurses. This study suggests that it is the role of the PCN/ANM to be a change agent by enforcing and monitoring safe practices to reduce the risk of patient harm. Though the literature has suggested that the role of the charge nurse is to promote quality of care and patient safety, few have researched this specific topic (Cathro, 2016; Squires, Torrangeau, Spence Laschinger & Doran, 2010). Cathro (2016) published one of the only articles found to date which studied the link between the charge nurse role and patient safety. Though the charge nurse’s role in monitoring safety practices by “maintaining a watchful eye” (Cathro, 2016, p. 210) was present in the literature, which is similar to the PCN/ANMs’
role as a safety officer in this study, the charge nurse’s role as a change agent was lacking.

Through the attribute of “establishing the weather,” this study suggests that PCNs/ANMs and rotating/relief charge nurses may influence safety climate. First mentioned in the Connelly et al. (2003) study on charge nurses’ competencies as “determining the atmosphere,” (p. 302) it was again found in this focused ethnography study. PCNs/ANMs and rotating/relief charge nurses establish the weather by setting the tone, through internal and external factors, for the shift. The weather created by the charge nurse, whether positive or negative, influences the nurse managers’ and clinical staffs’ attitudes during the shift, thereby impacting the flow of work on the unit. The charge nurses, especially PCNs/ANMs, also collaborate with the nurse manager to create the safety climate on the unit by communicating practice changes and monitoring them at the unit level.

PCNs/ANMs may play a more significant role in developing the climate due to his or her relationships with the unit staff. As suggested by Squires et al. (2010), the climate is affected by an important part of the PCNs/ANMs role, human interactions. Positive, trusting, and respectful relationships between nursing leaders, such as the PCN/ANM and the unit staff, contributes to the development of the safety climate. This study suggests that the climate set by the charge nurse impacts the attitudes of the clinical staff, which may affect their behaviors and potentially the unit’s safety culture. Safety climate influences employee outcomes such as intent to leave, emotional exhaustion, and sick hours. It also affects patient outcomes such as pressure ulcer development and medication errors (Squires
et al., 2010). No study to date has specifically linked the charge nurse to the safety climate or these outcomes.

Stemming from organizational culture, safety culture is the safety norms, developed from the employees’ values and beliefs about patient safety that shape their behaviors and actions (Feng et al., 2008). However, as Feng et al. (2008, p. 316) point out, “immediate supervisors” are among the many factors that support the development of safety culture. As the unit shift leader who perform many administrative tasks, the PCN/ANM is an immediate supervisor. As a safety officer, the behaviors of the PCN/ANM, such as making environmental/patient rounds, scanning the environment for safety hazards, having an open door policy, and using non-blame counseling techniques for safety issues, all reflect their beliefs in having a positive safety culture. With authority, this safety officer engages in activities that proactively prevent errors and patient harm. As more efforts are put forth towards patient safety, positive safety culture develops (Feng et al., 2008). Therefore, PCNs/ANMs, as an “immediate supervisor,” play an important role in developing the safety climate and culture on the unit during their shift.

Having no responsibility to round, scan the environment or counsel, rotating/relief charge nurses have no part in shaping the safety culture at the unit level. With a full patient assignment, there is little time for her/him to spend in activities identifying safety risks. They also did not think ahead or look at the big picture in order to proactively anticipate and mitigate safety risks. If a problem does come to his or her attention, their lack of involvement in counseling means that the problem is brought to the nurse manager for follow-up counseling. Rotating/relief charge nurses do not have this
responsibility of counseling nor do they want the task. Other than providing the clinical nurse with instructions on how to handle the situation and ensuring the patient is safe, the rotating/relief charge nurse does not take any further actions to ensure the error is not repeated. The rotating/relief charge nurse can only put out fires by being reactive after an error already has occurred. Though this was a subtheme also identified by Eggenberger (2012), her study did not interpret this subtheme in the safety context. “Putting out fires” in Eggenberger’s (2012, p. 505) study only viewed the charge nurse as a go-to resource for anything needed. In the context that put out fires was used in this study, rotating/relief charge nurses managed safety issues as they occurred and were brought to his or her attention. If a clinical nurse called the rotating/relief charge nurse for an emergent patient concern, the rotating/relief charge nurse perceived this as a potential patient safety issue and reacted as quickly as possible. A key finding in this study is the reactive nature of the rotating/relief charge nurse’s role and the proactive nature of the PCN/ANM’s role, which may impact patient safety differently at the unit level.

The Institute of Medicine (US) Committee on the Work Environment for Nurses and Patient Safety (2004) reports that organizations with a positive safety culture are characterized by communications founded on mutual trust, by a commitment to the importance of safety, and by confidence in their efficacy of preventative measures. As discussed, as a unit shift leader, the PCN/ANM role is heavily based on human relations skills, forming relationships with the clinical staff on the unit and building trust through a reciprocal relationship. The two-way communication that the PCN/ANM has with the nurse manager and clinical nurses promotes the safety culture on the unit. With a strong professional relationship between the PCN/ANM and the clinical nurses, built on trust
and respect, if the PCN/ANM values patient safety and his or her actions reflect those values, a positive safety culture may result on that shift. With patient safety being on the forefront of most every hospitals’ goals and objectives, this research study suggests that PCNs/ANMs may play an influential role in shaping the safety culture of a unit and reducing patient harms.

Conclusion

This focused ethnography study is the first to uncover the complexity of the charge nurse role in acute care hospitals and brings to light two models, permanent and rotating. Congruent with past literature are the dual responsibilities that are encompassed in both charge nurse models; however, the degree to which the charge nurse enacts these components differs greatly depending on the model. The PCN/ANM is perceived to be an authority figure and the unit shift leader who, as the extension of the nurse manager, encompasses many administrative competencies identified in the NMLP Learning Domain Framework. As a change agent, the PCN/ANM communicates changes from the nurse manager to the clinical staff and monitors behavior changes, counseling when necessary. The PCN/ANM’s administrative role also includes a human relations component including having positive interactions with the unit staff, as well as staff outside of the unit, that are built on trust and respect; however, this study suggests that role conflict still exists with this model due to the contradictory expectations of charge nurses, clinical nurses, and nurse managers regarding the administrative and clinical workload.

The rotating/relief charge nurse, on the other hand, is not a unit leader and, as such, has considerably less administrative responsibilities in this role. This study suggests
that being “expected” to be included in the rotation by their first year of hire, rotating/relief charge nurses do not always have the clinical expertise that clinical nurses expect to assist them as the go-to resource. Furthermore, this study proposes that rotating/relief charge nurses experience role conflict, role ambiguity, as well as role overload, as they try to manage both the role of a clinical nurse and a charge nurse.

When it comes to patient safety, approaches to keep patients safe differ according to charge nurse model; however, this study suggests that both PCNs/ANMs and rotating/relief charge nurses may influence the safety climate of the unit during the shift. Being an authority figure who engages in behaviors to prevent errors and counsels and coaches clinical nurses in a non-blaming way, the PCN/ANM may play a more significant role in safety through his or her relationships with the unit staff. Nurse leader-staff relationships have been shown to influence the safety climate which affects employee and patient outcomes (Squires et al., 2010). Rotating/relief charge nurses do not have the time or authority to proactively manage situations; instead, they react to issues as they are presented to her/him by putting out fires.

This study also has led to questions about whether the title provided to charge nurses matches the expectations for the role. Referring back to the definitions for role and responsibilities provided for this study, the data suggests that the rotating/relief charge nurse may not have a role at all, but rather responsibilities or tasks added to their workload as a clinical nurse. This study has provided some insight into the expectations for the role of charge nurses, regardless of their titles, that are based on each identified model.
Chapter VII

CONCLUSION

Summary

An organization’s safety culture has been shown to impact errors and patient harm in acute care hospitals. A strong influencer of the safety culture is the leadership team, including “immediate supervisors” and “frontline leaders,” such as the charge nurse and nurse manager (Feng, 2008 p.316; Firth-Cozens, 2003); however, discrepancies exist in the few empirical research studies published to date which have examined the nurse manager’s impact on patient safety, leaving their influence questionable (Warshawsky, Lake & Brandford, 2013). Working alongside clinical nurses, the charge nurse is the closest leader to patient care; however, little is known about how this clinical leader role influences patient safety care (Sherman et al., 2011; Krugman & Smith, 2003; Normand et al., 2014; Connelly et al., 2003; Cathro, 2016) . In response to the need for additional research about the charge nurse role and its relationship to patient safety, this research study explored the charge nurse role and safety practices.

Although the literature on the charge nurse dates back to more than 40 years ago, empirical research on the acute care charge nurse in the United States is lacking. Therefore, a qualitative approach was taken to better understand the charge nurse role through the eyes of the nurse manager, clinical nurses, and the charge nurse her/himself. And, even though a multi-perspective approach had been used before to understand the competencies of the charge nurse (Connelly et al., 2003), this study was the first to explore the multi-perspective view of the role of the charge nurse, as well as safety practices, in acute care hospitals. Studying a specific micro-culture within an acute care
hospital, a concentrated ethnography approach was taken to focus on a topic with which the researcher had some familiarity. The overarching research questions for this study were: 1) What are the role responsibilities of the hospital acute care charge nurse? And 2) How does the hospital acute care charge nurse contribute to patient safety?

Using the Nurse Manager Leadership Practices (NMLP) Learning Domain Framework to guide the study, leadership practices performed by a successful nurse manager provided a comparison for another frontline clinical leader, the charge nurse. In a two phase study, using the NMLP Learning Domain Framework and the accompanying AONE Nurse Manager Competencies (AONE, 2015), the role responsibilities of the charge nurse were explored. In phase one, three charge nurses, three nurse managers, and three clinical nurses rated the items on the competency list as relevant or not to the charge nurse role on a five-point Likert scale. Subsequently, they participated in individual audio recorded interviews with the researcher to discuss their ratings, as well as discuss competencies not included in the list. The ratings and interview data provided baseline information, as well as a focus for broader based individual interviews and focus groups in phase two. Eleven nurse managers and 15 charge nurses participated in individual audio recorded interviews with the researcher in phase two using an interview guide derived from existing literature. Also in phase two, four audio recorded focus groups were conducted using a focus group guide with a total of 13 clinical nurses. Verbatim transcriptions of all interviews and focus groups were completed by the researcher, including coding and thematic analysis. The validity of the data was established using triangulation, respondent validation (member check), reflexivity, and thick description.
This is the first charge nurse study in the United States to have used a variety of hospitals to help to understand the diverse perspectives of participants from across the state of New Jersey. Phase one included four hospitals, three not for profit and one for profit. Three hospitals were Magnet® designated and one was on the journey to designation. Three hospitals were non-union and one was unionized. In phase two, 11 hospitals were included, three of which were also included in phase one. In this sample of hospitals, two were unionized, five of the hospitals were teaching hospitals, and six were non-teaching hospitals. Five hospitals were Magnet® designated facilities, another three were on the journey to designation, and three were not designated. With 41% of the hospitals in New Jersey recognized as being Magnet® designated, it was challenging to recruit participants from non-Magnet® designated hospitals (American Nurses Credentialing Center, 2019). There is an opportunity for future research on the charge nurse using a more robust sample of non-Magnet® facilities to explore the charge nurse structure in designated and non-designated hospitals.

In order to understand the expectations of clinical nurses and nurse managers of those in the charge nurse role, clinical nurses, nurse managers and charge nurses nurses working in acute care hospitals across New Jersey were recruited to participate in this study. In phase one, three female nurse managers with a mean age of 53.7 (4.2), three female charge nurses with a mean age of 40.3 (4.7), and three female clinical nurses with a mean age of 50.3 (7.5) with either permanent or rotating charge charge nurse models participated. In the nurse manager group, two worked with a rotating charge nurse model and one had a permanent model. In the charge nurse group, two were rotating and one was in the permanent model. All three of the clinical nurses who participated worked in
hospitals with the permanent charge nurse model. Education varied as well. Phase two participants, both male and female, had slightly different demographics with slightly lower mean ages and higher degrees. Eleven nurse managers (73% female, 27% male) who participated in individual interviews had a mean age of 43(9.4), held higher nursing degrees of baccalaureate (45%) and master level (55%). Fifteen charge nurses (87% female, 13% male) who participated in individual interviews had a mean age of 40.3 (11.8) also held higher nursing degrees ranging from diploma to doctorate in nursing practice. Thirteen clinical nurses (100% female) who participated in focus groups had a mean age of 31.7 (10.5) and their highest nursing degree range, which spanned from diploma to masters degrees, matched those clinical nurses in phase one.

Thematic analysis of the data from phases one and two revealed a complex role with hospitals adopting one of two different models–either a permanent or rotating charge nurse. No other empirical literature has discussed these two charge nurse models to date. Permanent charge nurses (PCNs) and assistant nurse managers (ANMs) both have the same role responsibilities in the permanent charge nurse model; rotating and relief charge nurses have the same role responsibilities in the rotating charge nurse model. Regardless of the model, charge nurses have dual components to their role, clinical and administrative. However, the degree to which nurses within each model perform clinical and administrative tasks varies. Common to all charge nurses are the roles of unit shift resource and traffic director, as they are the “go-to” resource nurses on the unit for the staff. They assist with patient care and sometimes have their own patient assignment for the shift. Charge nurses have a general idea of the activities of the unit so that they can “get a pulse” for the unit and direct the flow of patients both entering and exiting from
the unit. As traffic director, charge nurses ensure the smooth flow of day-to-day operations at the unit shift level and complete the “housekeeping tasks” assigned to them, including completing a list of environmental and documentation checks to ensure regulatory preparedness. These responsibilities are clinical and administrative as some deal with clinical knowledge and hands on patient care, while others involve paperwork, critical thinking, and collaboration with different departments outside of the unit. Most of the responsibilities in their shift resource and traffic director role are task-based, requiring a one time action which can be completed in a checklist.

Data also revealed that PCNs/ANMs and rotating/relief charge nurses “establish the weather” for the shift by setting the tone for the environment. Whether the attitude was positive or negative, this tone was felt by clinical nurses, as well as the nurse manager, and it affected their work and their shift. A gap in the charge nurse literature still exists in understanding the impact of the charge nurse, particularly within each model, on safety culture and patient safety outcomes. Knowing that they influence the environment and that PCNs/ANMs act as change agents plants the seed for future research to explore their impact on safety culture compared to other nurse leaders.

The administrative role responsibilities for the permanent and rotating charge nurse models differed. PCN and ANMs in the permanent charge nurse model had many more administrative responsibilities than the rotating and relief charge nurses in the rotating charge nurse model. Each had some administrative responsibilities in The Science, The Art and The Leader Within domains of the framework. In The Science, PCNs/ANMs had responsibilities including maximizing throughput, managing staffing and staff selection through their involvement in interviews, promoting patient/workplace
safety, promoting intra/interdepartmental communication, and facilitating change. In The Art domain, PCNs/ANMs were involved in human leadership skills, facilitating staff development, managing conflict, and influencing others. In The Leader Within, they practiced ethical behavior. On the other hand, rotating/relief charge nurses had fewer responsibilities. In The Science, they also focused on maximizing throughput and staffing, but had no involvement in interviews, facilitating change or monitoring safety. In The Art domain, they are involved with situation management wherein they identify issues that require immediate attention and react to them. They are not involved in the human resource leadership competency. In The Leader Within domain, rotating/relief charge nurses were also expected to practice ethically. Both models of charge nurses are expected to have expert clinical knowledge, though in the rotating charge nurse model, nurses are assigned the charge position by one year of hire. Both models also lack many of the competencies in The Leader Within domain because they are missing a focus on their own professional development and career path.

Subthemes, categories, and subcategories emerged from the data specific to each model which provide further insight into the role responsibilities specific to the charge nurse based on the charge nurse models used within the hospital and the models that emerged from the study. PCNs/ANMs are seen by nurse managers and clinical staff as unit shift leaders who are extensions of the nurse manager and, as such, share administrative tasks. Hired into a formal leadership position with significant administrative responsibilities, they are considered part of the “chain of command” and are viewed as a leader with authority. Working closely with the nurse manager, PCNs/ANMs have an interdependent relationship with them as PCNs/ANMs are
delegated tasks by the nurse manager. This relationship, however, differs by the shift because the day shift was found to have the closest relationship with the nurse manager. Because the PCN/ANM is the first person the staff approach prior to talking with the nurse manager, he or she acts like a buffer in managing the information flow between the staff and manager. This study confirmed that the ANM has the same role responsibilities as the PCN. However, although the ANMs clearly were in the succession plans of the nurse manager, the PCNs did not seem to be on the same trajectory. The PCNs/ANMs also have collegial relationships with staff inside and outside of the unit that are built on trust and respect. Because they know their staff well, they are not only involved with interviewing potential new hires, but they are also responsible for performing evaluations for existing staff. PCNs/ANMs also play an important role as a change agent, “trickling” information down from the nurse manager to the staff, monitoring changes at the unit level, and counseling employees when needed.

In contrast, the rotating/relief charge nurses are clinical nurses who are assigned to be the charge nurse for the shift. Relief charge nurses share the same responsibilities as the rotating charge nurse. The relief charge nurse is a clinical nurse who is assigned the charge role as a substitute for the PCN when he or she is not there. Essentially balancing the workload of two roles, the charge nurse and their clinical nurse role, rotating and relief charge nurses are usually responsible for a full patient assignment, as well as the additional “housekeeping tasks” associated with the charge nurse role. Instead of being viewed as a leader, rotating/relief charge nurses are viewed as “peers” by other clinical nurses who often assist the charge nurse in completing the charge nurse tasks. In contrast to the PCN/ANM, the rotating/relief charge nurse’s role is task-focused instead of
relationship-focused because her/his role responsibilities only include completing the administrative and clinical tasks “just to get through the shift.” Using the NMLP Learning Domain Framework as a guide, they do not have the significant administrative responsibilities that the PCNs/ANMs are assigned to complete; however, because they have a full patient assignment, they do not have the time to complete all of the responsibilities that the PCN/ANM are able to complete. Instead, the rotating/relief charge nurse manages the situations that are brought to her/him and only deal with the activities of the shift.

With contradictory expectations of the charge nurse role among charge nurses, clinical nurses, and nurse managers, this study validated that role conflict is still a problem in this role, regardless of whether the charge nurse is in the permanent or rotating model. For PCNs/ANMs, clinical nurses and nurse managers perceived that the role encompassed higher amounts of time spent in administrative responsibilities than the PCNs/ANMs did. PCNs/ANMs felt that they spent half of their time in clinical work and half in administrative, revealing a discrepancy in role expectations from all three groups. Although the rotating/relief charge nurse is known as the “charge” nurse, he or she lacks the authority to make decisions on the nurse manager’s behalf and does not have a formal leadership role. Therefore, both PCNs/ANMs and rotating/relief charge nurses experience role conflict. In addition, because the rotating/relief charge nurse is expected to play the role of both the clinical nurse as well as the charge nurse by completing “housekeeping tasks,” they experience role overload. They are confused by the two roles, clinical nurse and charge nurse, assigned to them; this is further complicated by the fact that the charge nurse role is sometimes assigned to them unwillingly. As someone who works closely
alongside staff present on the unit, it would be beneficial to quantitatively measure role conflict and overload among charge nurses in order to better understand the impact this may have on patient and employee outcomes.

Additionally, this study sought to explore how charge nurses keep patients safe. Nurses in each charge nurse model enact different behaviors to keep patients safe. As leaders, PCNs/ANMs are safety officers who scan the unit environment for safety hazards and proactively correct them, while also counseling employees if necessary and using “teaching moments” to coach staff. Additionally, they act as change agents, influencing the climate of the shift and potentially the attitudes and behaviors of other staff. In contrast, rotating/relief charge nurses merely put out fires, reacting to problems as they are presented to them by the staff. In their situation management role, they are only thinking about the short term work and seek to mitigate the consequences of errors or unit issues. They often assist if a patient is in distress and clinical nurses call them to assist in managing the emergency situation, or if there is a patient complaint that immediately needs to be addressed. Rotating/relief charge nurses only react to the situations of the day. The data revealed that all charge nurses are not alike. There is variation in the role and responsibilities of the charge nurse based on the permanent and rotating charge nurse models.

**Strengths and Limitations**

Guided by the NMLP Learning Domain Framework, this focused ethnography provided insight into the role of the hospital acute care charge nurse through the eyes of the nurse manager, clinical nurses, and charge nurses in the state of New Jersey. Recruiting charge nurse participants from the permanent and rotating charge nurse model
allowed for the emergence of two distinct charge nurse models that are new to the empirical literature. This study also included a variety of different types of hospitals to help frame the charge nurse models in the context of the nursing leadership structure. Though efforts were made to recruit more participants from unionized hospitals, only two hospitals were represented in the study, making any broad assumptions about union hospitals unverified. Due to the large percentage of Magnet® designated hospitals in New Jersey, a lack of non-designated hospitals were included in this study, making assumptions about the charge nurse role in Magnet® hospitals unjustified. Because this study included many hospitals from across New Jersey, a state with a high percentage of Magnet designated hospitals, these findings are applicable to hospitals only across New Jersey. They may not be applicable to charge nurses in other states. A strength of the study is that the findings were reviewed by charge nurses, nurse managers, and clinical nurses, which served to validate the results. During the review, they validated the “bickering” that sometimes happens at the nurses’ station when a charge nurse needs to be assigned for the shift. They also agreed that the permanent charge nurse is undeniably a leader.

**Recommendations**

**Implications for Knowledge Generation**

This foundational study defined two charge nurse models, permanent and rotating, and described the shared role responsibilities and those role responsibilities that are unique to each model. This study lays the foundation for future research regarding the charge nurse in the United States. Expanding on this work, there is an opportunity for future research to compare the charge nurse model in Magnet® designated and non-
designated hospitals using a more robust sample. Future research may also expand upon this work to determine if other models exist within the United States and may include a larger sample of male charge nurses to determine their perception of the role.

Additionally, there is a need for instrument development to be able to measure charge nurse practices in future research. Some tools of measurement might include those to measure charge nurse leadership practices, the charge nurse work environment or charge nurse safety practices.

Recognizing that the charge nurse role is more complicated than once thought, this research should help nurse scientists better pinpoint the similarities and differences between the two models in research outcomes. With the empirical literature on charge nurses lagging behind the research efforts towards other nurse leaders, outcomes research related to the charge nurse is very much needed. Opportunities exist for research that will focus on better understanding the relationship between each model and staff outcomes. It is important for nurse administrators to understand how the charge nurse, as a unit shift leader or clinical nurse plus, influences staff satisfaction, turnover, intent to stay, burnout, and staff engagement. What is the impact of the rotating charge nurse role on clinical nurse turnover, for example? It is also important to know how the role affects these concepts for the charge nurse her/himself. Knowing how each role impacts those in the role may be a crucial variable in examining the workplace environment and/or the unit climate. An opportunity for research also exists in examining the relationships between the charge nurse models and patient outcomes, such as nosocomial infection rates, patient falls, medication errors, pressure ulcer development, and restraint usage. Because some acute care hospital data is publically reported and available for consumers to use when
deciding which hospital to choose for their care, nursing administrators would be interested in knowing the variables that impact these data. Ultimately, we may be able to determine if one model enhances patient and nurse outcomes more than the other, adding additional data for decisions on safe staffing. Opportunities for research also exist in exploring the relationships between the charge nurse and the nurse manager, as well as with the clinical nurses, to better understand how these human interactions and relationships affect unit level staff and patient outcomes.

**Implications for Practice**

**Nursing Administrators:** This study provides a description for hospital nursing administrators of the two charge nurse models, permanent and rotating, in New Jersey. It also gives administrators a better understanding of how charge nurses in each model impact patient safety so they can examine their own model and apply the evidence to their own systems. Nursing administrators may look to develop standardized charge nurse orientation programs specific to the model in their hospitals, as well as to find opportunities for ongoing professional development for charge nurses. This training may also include succession planning, which includes PCNs and ANMs as leaders in training. As figures of authority, PCNs/ANMs should be included in the organizational chart that shows the leadership hierarchy. For those with rotating/relief charge nurses, nursing administrators should understand that the assigned work they give to those in role is in addition to their current clinical nurse role and requires recognition and compensation. Nursing administrators should also recognize the connotations of the titles for different position, perhaps questioning whether charge nurses who are PCNs/ANMs should just be called charge nurses on the shift. This study also sheds light on role conflict, role
ambiguity, and role overload. It would greatly benefit nursing administrators to examine their own systems in light of these findings, recognizing that, if present, poor patient and employee outcomes may result.

**Charge Nurses:** This study gives a voice to the charge nurse in each of the models as it provided insights into understanding their role from their perspective. It also better defines the two charge nurse models so that they may better understand the role they are supposed to play based on the expectations of clinical nurses and nurse managers; specifically, the blending of the two components, clinical and administrative.

**Clinical Nurses:** For clinical nurses, this study sheds light on the competencies, clinical and administrative, that the charge nurse performs based on each model. It may also provide clinical nurses with insight into the role to make informed decisions about whether they want to assume the charge nurse role in their own hospitals.

**Nurse Managers:** This study provides nurse managers with the evidence to understand the charge nurse role based on not only the nurse manager’s expectations, but also those of the charge nurse and clinical nurses. Nurse managers should recognize their PCN/ANM as a leader in the organization who should be considered for succession planning and groomed for nurse manager or director roles in the organization. They should be offered ongoing professional development opportunities including leadership training. In addition, nurse managers may use the findings from this study to develop standardized orientation programs for their charge nurses based on the competencies pertinent to their charge nurse model. Knowing what to do and how to do it, the charge nurse will be more confident and efficient in the role, preventing role conflict and ambiguity.
**Nursing Organizations:** National, as well as New Jersey local nurse leader organizations, may use the findings from this study to invite PCNs and ANMs to join their groups. This would allow the PCN and ANMs to be recognized as nurse leaders, affording them the opportunity to network with other leaders from across the state or country. Nursing leadership meetings and conferences would provide the PCNs/ANMs with ongoing professional development opportunities in leadership skills pertinent to their role. In addition, administrative nursing organizations such as the American Organization of Nurse Executives may not only expand their membership to include these nurse leaders, but also consider developing a list of competencies specific to their role, just as has been developed for nurse executives and nurse managers. Through their membership, nurse leader organizations may also use this study to realize and embrace the opportunity to groom PCNs and ANMs into future nurse leaders.
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Appendix A: Acute Care Hospital Nurse Manager Demographic Form

1) What is your gender?
   _____ Male  _____ Female  ____ Transgender  _____ Do not wish to answer

2) What is your age? _____________________________________

3) What is your title? _____________________________________

4) What is your highest nursing degree? ______________________

5) How long have you been in this role? ______________________

6) Do you have a charge nurse report to you on an inpatient acute care hospital unit?
   _____Yes    ___ No

7) How many charge nurses report to you directly? ________________

8) How often does the charge nurse take a patient assignment?
   ____Always  ____ Almost Always  ___ Sometimes  ____ Almost Never  ___ Never

9) How often are nurses in the charge nurse role? (Select one)
   ____We have permanent charge nurses who are hired into the role.
   ____Nurses rotate in and out of the role
   ____ Other (Please Specify) ____________________

10) What is the name of the hospital you are a nurse manager in?
    ______________________________________________________

11) Is this a Magnet® designated hospital? _____Yes  _____ No  ____ On Magnet journey

12) Please describe the hospital selecting all that apply:  ___ unionized ___ non-unionized ___ teaching ___ non-teaching ___ non-profit  ___ for profit
Appendix B: Acute Care Hospital Clinical Nurse Demographic Form

1) What is your gender?

______ Male  _____ Female  _____ Transgender  _____ Do not wish to answer

2) What is your age? ________________________________

3) What is your highest nursing degree? ______________________

4) How long have you been a nurse? _______________________

5) Do you have a charge nurse working on the inpatient acute care hospital unit you
primarily work on during your shift? ___Yes   ___ No

6) How often are nurses in the charge nurse role? (Select one)

___ We have permanent charge nurses who are hired into the role.

___ Nurses rotate in and out of the role

___ Other (Please Specify) ____________________

8) How often does the charge nurse take a patient assignment?

___Always   ___ Almost Always   ___ Sometimes   ___ Almost Never   ___ Never

9) What shift do you primarily work on? ___ Days   ___ Evenings   ___ Nights

10) Have you ever worked in the charge nurse role? ___ Yes   ___ No

11) What is the name of the hospital you are a clinical nurse in?

_____________________________________________________________________

12) Is this a Magnet designated® hospital? ___Yes   ___ No   ___ On Magnet
journey

13) Please describe the hospital selecting all that apply: ___ unionized ___ non-
unionized ___ teaching ___ non-teaching ___ non-profit ___ for profit
Appendix C: Acute Care Hospital Charge Nurse Demographic Form

1) What is your gender? ___ Male ___ Female ___ Transgender ___ Do not wish to answer

2) What is your age? __________________________________________

3) What is your highest nursing degree? ________________________

4) Do you hold a national certification? ___ Yes ___ No

5) If you hold a national certification, please identify certification: __________________

6) How long have you been a nurse? _____________________________

7) How long have you been in the charge nurse role? ________________

8) How often are you in the charge nurse role? (select one) ___ When on shift (permanent) ___ Rotating in and out of the role ___ Other (please specify) _______________________

9) *If you rotate in and out of the role, how often are you in the charge nurse role? (select one) _____ At least once a week _____ Several times each month _____ Less than once a month ____ Every few months

10) What shift do you primarily work on? __ Days ___ Evenings ___ Nights

11) How often do you take a patient assignment when you are in the charge nurse role? __ Always ___ Almost Always ___ Sometimes ___ Almost Never ___ Never

12) Is there a job description for the charge nurse role in your hospital? ___ Yes ___ No ___ I don’t know

13) Did you have an orientation or training for the charge nurse role? ___ Yes ___ No ___ I don’t know

14) What is the name of the hospital you are a charge nurse in? __________________________

15) Is this a Magnet designated® hospital? ___ Yes ___ No ___ On Magnet journey

16) Please describe the hospital selecting all that apply: ___ unionized ___ non-unionized ___ teaching ___ non-teaching ___ non-profit ___ for profit
Appendix D: Acute Care Hospital Nurse Manager Interview Guide

Tell me about the nurse manager job. How did you become a nurse manager? (Ice breaker)

Now I am going to switch subjects and ask you some questions about the acute care hospital CHARGE NURSE role.

1) What has been your experience working with charge nurses?
2) Tell me about what charge nurses do.
   a. Tell me how charge nurses are involved in the financial management of the unit. (The Science)
   b. Tell me about the tasks the charge nurse does that are clinical. (The Science)
   c. What percentage of time does he/she spend doing administrative vs. clinical tasks?
3) Tell me about how nurses become charge nurses.
   a. What kind of orientation does a nurse receive to be a charge nurse?
   b. What kind of ongoing education specific to the charge nurse role do they receive?
   c. What skills are required for a charge nurse to be successful in this job?
   d. What does the charge nurse do to promote their own professional development? (The Leader Within)
4) What is the charge nurses’ role in patient safety? (The Science)
   a. Tell me what they do when an error occurs. (The Science)
   b. Tell me how they prevent errors from occurring. (The Science)
5) Tell me how you interact with the charge nurse.
   a. Tell me how you work together with the charge nurse. (The Art)
   b. Tell me about a positive experience you have had with the charge nurse. (The Art)
   c. Tell me about a negative experience you have had with the charge nurse. (The Art)
   d. How does the charge nurse role differ from your role (the nurse manager)?
6) Give me an example of when you were supported by the charge nurse? (The Art)
7) Give me an example of when the charge nurse supported the clinical nurses’ work on the unit during the shift?
8) How is the charge nurse involved in the development of the staff? (The Art)
9) Is there anything else you want to talk about?
Appendix E: Acute Care Hospital Clinical Nurse Focus Group Discussion Guide

Tell me about your role. What do you do? (Ice breaker)

Now I am going to switch subjects and ask you some questions about the acute care hospital CHARGE NURSE role.

1) What is your experience working with charge nurses?
2) Tell me about what charge nurses do.
   a. Tell me how charge nurses are involved in the financial management of the unit. (The Science)
   b. Tell me about the tasks the charge nurse does that are clinical. (The Science)
   c. What percentage of time does he/she spend doing administrative vs. clinical tasks?
3) Tell me how nurses become charge nurses.
   a. What kind of orientation does a nurse receive to be a charge nurse?
   b. What kind of ongoing education specific to the charge nurse role do they receive?
   c. What skills are required for a charge nurse to be successful in this job?
   d. What does the charge nurse do to promote their own professional development? (The Leader Within)
4) What is the charge nurses’ role in patient safety? (The Science)
5) How do they keep patients safe? (The Science)
   a. Tell me what they do when an error occurs. (The Science)
   b. Tell me how they prevent errors from occurring. (The Science)
6) Tell me how the nurse manager interacts with the charge nurse.
   a. Tell me how the nurse manager works together with the charge nurse. (The Art)
   b. Tell me about a positive experience you have had with the charge nurse. (The Art)
   c. Tell me about a negative experience you have had with the charge nurse. (The Art)
   d. How does the charge nurse role differ from the nurse manager role?
7) Give me an example of how the charge nurse supports the clinical nurses’ work on the unit during the shift? (The Art)
8) How is the charge nurse involved in the development of the staff? (The Art)
9) Is there anything else you want to talk about?
Appendix F: Acute Care Hospital Charge Nurse Individual Interview Discussion Guide

Tell me about how you became a charge nurse. (Ice breaker)
   a. Is this the usual way nurses become charge nurses?
   b. Did you receive an orientation to the role? What kind?

1) What is your experience being a charge nurse?

2) Tell me about what you do in the charge nurse role.
   a. What skills are required for a charge nurse to be successful in this job?
   b. Tell me how you are involved in the financial management of the unit.
      (The Science)
   c. Tell me about the tasks you do that are clinical. (The Science)
   d. What percentage of time do you spend doing administrative vs. clinical tasks?

3) Tell me about professional development for your charge nurse role. (The Leader Within)
   a. What kind of ongoing education specific to your role do you receive?
   b. Tell me about the differences between permanent charge nurses and those nurses who rotate in and out of the charge nurse role.

4) What is your role in patient safety? How do you keep patients safe? (The Science)
   a. Tell me what you do when an error occurs. (The Science)
   b. Tell me how you prevent errors from occurring. (The Science)

5) Tell me how the nurse manager interacts with the charge nurse.
   a. Tell me how you work with the nurse manager. (The Art)
   b. Tell me about a positive experience you have had with the nurse manager. (The Art)
   c. Tell me about a negative experience you have had with the nurse manager. (The Art)
   d. How does the charge nurse role differ from the nurse manager role?

6) Give me an example of how you support the clinical nurses’ work on the unit during the shift? (The Art)

7) How are you involved in the development of the staff? (The Art)

8) Is there anything else you want to talk about?
Appendix G

American Organization of Nurse Executives (AONE) Nurse Manager Competencies

AONE Nurse Manager Competencies, Copyright 2015, by the American Organization of Nurse Executives (AONE). All rights reserved.
Nurse managers—nurse leaders with 24-hour accountability and responsibility for a direct care unit or units—provide the vital link between the administrative strategic plan and the point of care. The nurse manager is responsible for creating safe, healthy environments that support the work of the health care team and contribute to patient engagement. The role is influential in creating a professional environment and fostering a culture where interdisciplinary team members are able to contribute to optimal patient outcomes and grow professionally.

The Nurse Manager Competencies are based on the Nurse Manager Learning Domain Framework and capture the skills, knowledge and abilities that guide the practice of these nurse leaders. The successful nurse leader must gain expertise in all three domains.

In 2004, the American Association of Critical-Care Nurses (AACN) the American Organization of Nurse Executives (AONE), and the Association of Post-Operative Registered Nurses (AORN) formed the Nurse Manager Leadership Collaborative for the purpose to identify and organize the skills required to perform the job of the nurse manager. In 2006, AONE and AACN formed the Nurse Manager Leadership Partnership (NMLP) to continue this leadership work.

Reliability and validity for the Nurse Manager Competencies is established by periodic job analysis/role delineation studies. These competencies are based on the A National Practice Analysis Study of the Nurse Manager and Leader (2014).
A. FINANCIAL MANAGEMENT
1. Recognize the impact of reimbursement on revenue
2. Anticipate the effects of changes on reimbursement programs for patient care
3. Maximize care efficiency and throughput
4. Understand the relationship between value-based purchasing and quality outcomes with revenue and reimbursement
5. Create a budget
6. Monitor a budget
7. Analyze a budget and explain variance
8. Conduct ongoing evaluation of productivity
9. Forecast future revenue and expenses
10. Capital budgeting
   » Justification
   » Cost benefit analysis

B. HUMAN RESOURCE MANAGEMENT
1. Staffing needs
   » Evaluate staffing patterns/needs
   » Match staff competency with patient acuity
2. Manage human resources within the scope of labor laws
3. Apply recruitment techniques
4. Staff selection
   » Apply individual interview techniques
   » Apply team interview techniques
   » Select and hire qualified applicants
5. Scope of practice
   » Develop role definitions for staff consistent with scope of practice
   » Implement changes in role consistent with scope of practice
   » Orientation
   » Develop orientation program
   » Oversee orientation process
   » Evaluate effectiveness of orientation

C. PERFORMANCE IMPROVEMENT
1. Performance improvement
   » Identify key performance indicators
   » Establish data collection methodology
   » Evaluate performance data
   » Respond to outcome measurement findings
   » Comply with documentation requirements
2. Customer and patient engagement
   » Assess customer and patient satisfaction
   » Develop strategies to address satisfaction issues
3. Patient safety
   » Monitor and report sentinel events
   » Participate in root cause analysis
   » Promote evidence-based practices
   » Manage incident reporting
4. Maintain survey and regulatory readiness
5. Monitor and promote workplace safety requirements
6. Promote intra/interdepartmental communication

D. FOUNDATIONAL THINKING SKILLS
1. Apply systems thinking knowledge as an approach to analysis and decision-making
2. Understand complex adaptive systems definitions and applications
E. TECHNOLOGY
1. Information technology—Understand the effect of IT on patient care and delivery systems to reduce workload
   » Ability to integrate technology into patient care processes
   » Use information systems to support business decisions

F. STRATEGIC MANAGEMENT
1. Facilitate change
   » Assess readiness for change
   » Involve staff in change processes
   » Communicate changes
   » Evaluate outcomes
2. Project management
   » Identify roles
   » Establish timelines and milestones
   » Allocate resources
   » Manage project plans
3. Contingency plans
   » Manage internal disaster or emergency planning and execution
   » Manage external disaster or emergency planning and execution
4. Demonstrate written and oral presentation skills
5. Manage meetings effectively
6. Demonstrate negotiation skills
7. Influence the practice of nursing through participation in professional organizations
8. Collaborate with other service lines
9. Shared decision-making
   » Establish vision statement
   » Facilitate a structure of shared governance
   » Implement structures and processes
   » Support a just culture
10. Support a culture of innovation

G. APPROPRIATE CLINICAL PRACTICE KNOWLEDGE
(Determined by specific role and institution)
1. Each role and institution has expectations regarding the clinical knowledge and skill required of the role. These expectations should be established for the specific individual based on organizational requirements.
2 THE ART

A. HUMAN RESOURCE LEADERSHIP SKILLS
1. Performance management
   » Conduct staff evaluations
   » Assist staff with goal-setting
   » Implement continual performance development
   » Monitor staff for fitness for duty
   » Initiate corrective actions
   » Terminate staff
2. Staff development
   » Facilitate staff education and needs assessment
   » Ensure competency validation
   » Promote professional development of staff
   » Facilitate leadership growth among staff
   » Identify and develop staff as part of a succession planning program
3. Staff retention
   » Assess staff satisfaction
   » Develop and implement strategies to address satisfaction issues
   » Promote retention
   » Develop methods to reward and recognize staff

B. RELATIONSHIP MANAGEMENT AND INFLUENCING BEHAVIORS
1. Manage conflict
2. Situation management
   » Identify issues that require immediate attention
   » Apply principles of crisis management to handle situations as necessary
   3. Relationship management
      » Promote team dynamics
      » Mentor and coach staff and colleagues
      » Apply communication principles
   4. Influence others
      » Encourage participation in professional action
      » Role model professional behavior
      » Apply motivational theory
      » Act as change agent
      » Assist others in developing problem solving skills
      » Foster a healthy work environment
   5. Promote professional development
      » Promote stress management
      » Apply principles of self-awareness
      » Encourage evidence-based practice
      » Apply leadership theory to practice

C. DIVERSITY
1. Cultural competence
   » Understand the components of cultural competence as they apply to the workforce
2. Social justice
   » Maintain an environment of fairness and processes to support it
3. Generational diversity
   » Capitalize on differences to foster highly effective work groups
A. PERSONAL AND PROFESSIONAL ACCOUNTABILITY

1. Personal growth and development
   - Manage through education advancement, continuing education, career planning and annual self-assessment and action plans
2. Practice ethical behavior
   - Including practice that supports nursing standards and scopes of practice
3. Involvement in professional associations
   - Including membership and involvement in an appropriate professional association that facilitates networking and professional development
4. Achieve certification in an appropriate field/specialty

B. CAREER PLANNING

1. Know your role
   - Understand current job description/requirements and compare those to current level of practice
2. Know your future
   - Plan a career path
3. Position yourself
   - Develop a career path/plan that provides direction while offering flexibility and capacity to adapt to future scenarios

C. PERSONAL JOURNEY DISCIPLINES

1. Apply action learning
   - Apply techniques of "action learning" to problem solve and personally reflect on decisions
2. Engage in reflective practice
   - Includes knowledge of, and active practice of reflection as a leadership behavior
The Leader Within

Reflective Practice Reference Behaviors/Tenets

Utilizing a set of guidelines and tenants that facilitate reflective practice; these may be individually developed or can be based on specific models developed by others; below are the "Dimensions of Leadership" developed by the Center for Nursing Leadership, which offer an example of a set of guidelines/tenants that can be used as a tool to guide personal reflection of an individual's leadership behaviors.

1. **Holding the truth**
   - The presence of integrity as a key value of leadership

2. **Appreciation of ambiguity**
   - Learning to function comfortably amidst the ambiguity of our environments

3. **Diversity as a vehicle to wholeness**
   - The appreciation of diversity in all its forms: race, gender, religion, sexual orientation, generational, the dissenting voice and differences of all kinds

4. **Holding multiple perspectives without judgment**
   - Creation and holding a space so that multiple perspectives are entertained before decisions are rendered

5. **Discovery of potential**
   - The ability to search for and find the potential in ourselves and in others

6. **Quest for adventure towards knowing**
   - Creating a constant state of learning for the self, as well as an organization

7. **Knowing something of life**
   - The use of reflective learning and translation of that learning to the work at hand

8. **Nurturing the intellectual and emotional self**
   - Constantly increasing one's knowledge of the world and the development of the emotional self

9. **Keeping commitments to oneself**
   - Creating the balance that regenerates and renews the spirit and body so that it can continue to grow
Appendix H

Phase One Consent

Title: A Multi-Perspective Study Exploring the Charge Nurse Role and Safety Practices
PT: Lora Bognar, MSN, RN, ANP-BC

RUTGERS
School of Nursing
Rutgers, The State University of New Jersey
199 University Avenue
Newark, NJ 07102-1897
https://nursing.rutgers.edu

CONSENT TO TAKE PART IN A RESEARCH STUDY

TITLE OF STUDY: A Multi-Perspective Study Exploring the Charge Nurse Role and Safety Practices—Phase I Consent
Principal Investigator: Lora Bognar, MSN, RN, ANP-BC

This consent form is part of an informed consent process for a research study and it will provide information that will help you to decide whether you wish to volunteer for this research study. It will help you to understand what the study is about and what will happen in the course of the Study.

If you have questions at any time during the research study, you should feel free to ask them and should expect to be given answers that you completely understand.

After all of your questions have been answered, if you still wish to take part in the study, you will be asked to sign this informed consent form.

You are not giving up any of your legal rights by volunteering for this research study or by signing this consent form.

Who is conducting this research study?

Lora Bognar, MSN, RN, ANP-BC is the Principal Investigator of this research study. A Principal Investigator has the overall responsibility for the conduct of the study. However, there are often other individuals who are part of the research team.

Lora Bognar, MSN, RN, ANP-BC may be reached at 201-446-0278, 21 Hirth Drive, Newfoundland, NJ 07435
The principal investigator or another member of the study team will also be asked to sign this informed consent. You will be given a copy of the signed consent form to keep.

Who might benefit financially from this research?

No one will benefit financially from this research.

1
Version #: 2
Date: 10/21/17
Title: A Multi-Perspective Study Exploring the Charge Nurse Role and Safety Practices  
Pt: Lora Bogner, MSN, RN, ANP-BC

Why is this study being done?

This study is being done to understand the role of the acute care hospital charge nurse in New Jersey and how the charge nurse keeps patients safe.

Why have you been asked to take part in this study?

You are being asked to take part in this study because you are either a charge nurse or a clinical nurse or nurse manager who works alongside charge nurses and are currently working in an acute care hospital in New Jersey.

Who may take part in this study? And who may not?

New Jersey acute care hospital inpatient charge nurses who are able to speak and read in English, have charge nurse experience minimally over the past 6 months, have worked in the charge nurse role within the past week may take part in this study. Any charge nurse who does not work in a New Jersey acute care inpatient unit, is unable to speak and read in English, does not have at least 6 months experience in the charge nurse role and has not worked in the charge nurse role in the past week, is unable to participate.

New Jersey acute care hospital inpatient nurse managers who are able to speak and read in English, have nurse manager experience minimally over the past year and have 24 hour responsibility over at least one unit/department with a charge nurse are able to take part in the study. Any nurse manager who does not work in a New Jersey acute care hospital and is able to speak and read in English, who does not have 24 hour responsibility of at least one inpatient unit with a charge nurse is unable to participate in this study.

New Jersey acute care hospital inpatient clinical nurses who are able to speak and read in English, have at least one year of clinical nurse experience, work alongside a charge nurse, and have never been in the charge nurse role, are able to take part in this study. Any clinical nurse who does not work on an inpatient unit in a New Jersey acute care hospital, is unable to read and speak in English, does not have at least one year of clinical nurse experience, does not work alongside a charge nurse, and has had charge nurse role experience, is unable to take part in this study.

How long will the study take and how many subjects will participate?

A total of 18-28 charge nurses will be recruited to take part in this study. However, a maximum of only 3 clinical nurses from any one hospital may participate. Participation in the study will involve an individual interview with charge nurses which will last 30-60 minutes. Each charge nurse will only be interviewed once.

A total of 18-28 nurse managers will be recruited to take part in this study. However, a maximum of only 3 nurse managers from any one hospital may participate. Participation in the
Title: A Multi-Perspective Study Exploring the Charge Nurse Role and Safety Practices
Pt: Lora Bogner, MSN, RN, ANP-BC

The study will involve an individual interview with nurse managers which will last 30-60 minutes. Each nurse manager will only be interviewed once.

A total of 43 clinical nurses will be recruited to take part in this study. However, a maximum of only 8 clinical nurses from any one hospital may participate. Participation in the study will involve being part of a discussion group called a focus group which will last 30-60 minutes. Each clinical nurse will only participate in one focus group session.

What will you be asked to do if you take part in this research study?

Charge nurses, nurse managers, and clinical nurses who participate in this study, will be asked to complete a demographic data form after reading and signing consent to participate. Charge nurses, nurse managers, and clinical nurses will be asked to rate items on a survey called the Nurse Manager Competencies according to how relevant they are for charge nurses. They will then be asked to participate in one audio recorded individual interview with the Principal Investigator of this study and share their ratings and perspectives about the charge nurse role and safety practices.

What are the risks and/or discomforts you might experience if you take part in this study?

There are no anticipated risks and/or discomforts if you take part in this study. Should you experience any emotional discomfort when answering the questions, you may withdraw from the study at any time.

Are there any benefits for you if you choose to take part in this research study?

There is no direct personal benefits from taking part in this study.

What are your alternatives if you don’t want to take part in this study?

Your alternative is not to take part in this study.

How will you know if new information is learned that may affect whether you are willing to stay in this research study?

During the course of the study, you will be updated about any new information that may affect whether you are willing to continue taking part in the study. If new information is learned that may affect you after the study or your follow-up is completed, you will be contacted.

Will there be any cost to you to take part in this study?

There will be no cost to you to take part in this study.

Will you be paid to take part in this study?
Title: A Multi-Perspective Study Exploring the Charge Nurse Role and Safety Practices
Pt. Lora Bognar, MSN, RN, ANP-BC

You will not be paid for your participation in this research study. However, as a thank you for your time, you will receive a $10.00 VISA gift certificate.

How will information about you be kept private or confidential?

All efforts will be made to keep your personal information in your research record confidential, but total confidentiality cannot be guaranteed. The recordings on the digital recorder will be deleted after all data is verified to be accurately uploaded into the computer. Electronic records of the data will be maintained on a password protected laptop computer. Backup copies of the computer files will be saved on a thumb drive and secured in a locked file cabinet to which the PI will only have access. Signed consent forms will be maintained in another locked file cabinet, separate from the demographic forms and job descriptions. The electronic files and paper documents, including consents and job descriptions will be destroyed after 5 years.

What will happen if you do not wish to take part in the study or if you later decide not to stay in the study?

Participation in this study is voluntary. You may choose not to participate or you may change your mind at any time.

If you do not want to enter the study or decide to stop participating, your relationship with the study staff will not change, and you may do so without penalty and without loss of benefits to which you are otherwise entitled.

You may also withdraw your consent for the use of data already collected about you, but you must do this in writing to Mrs. Lora Bognar, 21Hirth Drive, Newfoundland, NJ 07435

Who can you call if you have any questions?

If you have any questions about taking part in this study, you can call the Principal Investigator:

Mrs. Lora Bognar  
201-446-0278

If you have any questions about your rights as a research subject, you can call:

IRB Director  
(973)-972-3608 Newark  
And  
Human Subject Protection Program  
973-972-1149 - Newark

What are your rights if you decide to take part in this research study?
Title: A Multi-Perspective Study Exploring the Charge Nurse Role and Safety Practices
PI: Lora Bognar, MSN, RN, ANP-BC

You have the right to ask questions about any part of the study at any time. You should not sign this form unless you have had a chance to ask questions and have been given answers to all of your questions.

Permission to contact after the completion of the study.

☐ Yes, I permit the principal investigator to contact me after the study.

At the conclusion of the study, the principal investigator will contact six participants and meet with them to review the identified codes and themes and to provide feedback. If you AGREE to be contacted by the principal investigator after the study, please MARK the box.

Permission for Audio Recording
We are asking for your permission to allow us to audiotape as part of that research study. You do not have to agree to be recorded in order to participate in the main part of the study.

The recording(s) will be used for analysis by the research team.

The recording(s) will include perspectives of charge nurses, nurse managers and clinical nurses on the role and safety practices of charge nurses shared during individual interviews. The recordings will also include the unique number identifier provided to each participant, which will be verbalized by the participants during the start of the interviews.

The recording(s) will be stored in a locked file cabinet with no link to subjects’ identity. The recordings on the digital recorder will be deleted after all data is verified to be accurately uploaded into the computer. Electronic records of the data in excel, SPSS and Word will be maintained on a password protected laptop computer. Signed consent forms will be maintained in another locked file cabinet, separate from the demographic forms and job descriptions. The electronic files and paper documents, including consents and job descriptions will be destroyed after 5 years.

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Version #: 2
Date: 10/21/17

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APPROVED
IRB ID: Pro20170001055
Approval Date: 10/12/2017
Expiration Date: 10/11/2018
Title: A Multi-Perspective Study Exploring the Charge Nurse Role and Safety Practices  
PI: Lora Bognar, MSN, RN, ANP-BC

Your signature on this form grants the investigator named above permission to record you as described above during participation in the above-referenced study. The investigator will not use the recording(s) for any other reason than that/those stated in the consent form without your written permission.

AGREEMENT TO PARTICIPATE

1. Subject consent:
I have read this entire form, or it has been read to me, and I believe that I understand what has been discussed. All of my questions about this form or this study have been answered. I agree to take part in this research study.

Subject Name: ______________________________ ______________________________ Date: __________________

Subject Signature: ______________________________ Date: __________________

2. Signature of Investigator/Individual Obtaining Consent:
To the best of my ability, I have explained and discussed the full contents of the study including all of the information contained in this consent form. All questions of the research subject and those of his/her parent or legally authorized representative have been accurately answered.

Investigator/Person Obtaining Consent (printed name): ______________________________

Signature: ______________________________ Date: __________________

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Version #: 2
Date: 10/21/17
Appendix I

Phase Two Consent (Focus Groups)

Title: A Multi-Perspective Study Exploring the Charge Nurse Role and Safety Practices
PI: Lora Bognar, MSN, RN, ANP-BC

CONSENT TO TAKE PART IN A RESEARCH STUDY

TITLE OF STUDY: A Multi-Perspective Study Exploring the Charge Nurse Role and Safety Practices—Phase II Consent (Focus Groups)
Principal Investigator: Lora Bognar, MSN, RN, ANP-BC

This consent form is part of an informed consent process for a research study and it will provide information that will help you to decide whether you wish to volunteer for this research study. It will help you to understand what the study is about and what will happen in the course of the Study.

If you have questions at any time during the research study, you should feel free to ask them and should expect to be given answers that you completely understand.

After all of your questions have been answered, if you still wish to take part in the study, you will be asked to sign this informed consent form.

You are not giving up any of your legal rights by volunteering for this research study or by signing this consent form.

Who is conducting this research study?

Lora Bognar, MSN, RN, ANP-BC is the Principal Investigator of this research study. A Principal Investigator has the overall responsibility for the conduct of the study. However, there are often other individuals who are part of the research team.

Lora Bognar, MSN, RN, ANP-BC may be reached at 201-446-0278, 21 Hirth Drive, Newfoundland, NJ 07435
The principal investigator or another member of the study team will also be asked to sign this informed consent. You will be given a copy of the signed consent form to keep.

Who might benefit financially from this research?

No one will benefit financially from this research.

1
Version #: 2
Date: 10/21/17
Title: A Multi-Perspective Study Exploring the Charge Nurse Role and Safety Practices
Pt: Lora Bognar, MSN, RN, ANP-BC

Why is this study being done?
This study is being done to understand the role of the acute care hospital charge nurse in New Jersey and how the charge nurse keeps patients safe.

Why have you been asked to take part in this study?
You are being asked to take part in this study because you are a clinical nurse who works alongside charge nurses and are currently working in an acute care hospital in New Jersey.

Who may take part in this study? And who may not?
New Jersey acute care hospital inpatient clinical nurses who are able to speak and read in English, have at least one year of clinical nurse experience, work alongside a charge nurse, and have never been in the charge nurse role, are able to take part in this study. Any clinical nurse who does not work on an inpatient unit in a New Jersey acute care hospital, is unable to read and speak in English, does not have at least one year of clinical nurse experience, does not work alongside a charge nurse, and has had charge nurse role experience, is unable to take part in this study.

How long will the study take and how many subjects will participate?
A total of 43 clinical nurses will be recruited to take part in this study. However, a maximum of only 8 clinical nurses from any one hospital may participate. Participation in the study will involve being part of a discussion group called a focus group which will last 30-60 minutes. Each clinical nurse will only participate in one focus group session.

What will you be asked to do if you take part in this research study?
Clinical nurses who participate in this study, will be asked to complete a demographic data form after reading and signing consent to participate.

Clinical nurses will be asked to participate in one focus group composed of 5-8 clinical nurses in each. Clinical nurses will also be asked to share their perspectives on the role and safety practices of the acute care hospital charge nurse. Prior to the interviews and focus group, each participant will be assigned a unique number by the Principal Investigator to protect participants’ identities. The unique number will only be used in transcribing the digital recordings.

What are the risks and/or discomforts you might experience if you take part in this study?
There are no anticipated risks and/or discomforts if you take part in this study. Should you experience any emotional discomfort when answering the questions, you may withdraw from the study at any time.

Are there any benefits for you if you choose to take part in this research study?

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PI: Lora Bogner, MSN, RN, ANP-BC

There is no direct personal benefit from taking part in this study.

What are your alternatives if you don’t want to take part in this study?

Your alternative is not to take part in this study.

How will you know if new information is learned that may affect whether you are willing to stay in this research study?

During the course of the study, you will be updated about any new information that may affect whether you are willing to continue taking part in the study. If new information is learned that may affect you after the study or your follow-up is completed, you will be contacted.

Will there be any cost to you to take part in this study?

There will be no cost to you to take part in this study.

Will you be paid to take part in this study?

You will not be paid for your participation in this research study. However, as a thank you for your time, you will be given a $10.00 Visa gift card.

How will information about you be kept private or confidential?

All efforts will be made to keep your personal information in your research record confidential, but total confidentiality cannot be guaranteed. The recordings on the digital recorder will be deleted after all data is verified to be accurately uploaded into the computer. Electronic records of the data will be maintained on a password protected laptop computer. Backup copies of the computer files will be saved on a thumb drive and secured in a locked file cabinet to which the PI will only have access. Signed consent forms will be maintained in another locked file cabinet, separate from the demographic forms and job descriptions. The electronic files and paper documents, including consents and job descriptions will be destroyed after 5 years.

What will happen if you do not wish to take part in the study or if you later decide not to stay in the study?

Participation in this study is voluntary. You may choose not to participate or you may change your mind at any time.

If you do not want to enter the study or decide to stop participating, your relationship with the study staff will not change, and you may do so without penalty and without loss of benefits to which you are otherwise entitled.

You may also withdraw your consent for the use of data already collected about you, but you must do this in writing to Mrs. Lora Bogner, 21Hirth Drive, Newfoundland, NJ 07435

Version #: 2
Date: 10/21/17

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IRB ID: Pro201700001055
Approval Date: 10/12/2017
Expiration Date: 10/11/2018
Title: A Multi-Perspective Study Exploring the Charge Nurse Role and Safety Practices  
PT: Lora Bognar, MSN, RN, ANP-BC

Who can you call if you have any questions?
If you have any questions about taking part in this study, you can call the Principal Investigator:

Mrs. Lora Bognar  
201-446-0278

If you have any questions about your rights as a research subject, you can call:

IRB Director  
(973)-972-3608 Newark  
And  
Human Subject Protection Program  
973-972-1149 - Newark

What are your rights if you decide to take part in this research study?
You have the right to ask questions about any part of the study at any time. You should not sign this form unless you have had a chance to ask questions and have been given answers to all of your questions.

Permission to contact after the completion of the study.

☐ Yes, I permit the principal investigator to contact me after the study.

At the conclusion of the study, the principal investigator will contact six participants and meet with them to review the identified codes and themes and to provide feedback. If you AGREE to be contacted by the principal investigator after the study, please MARK the box.

Permission for Audio Recording
We are asking for your permission to allow us to audiotape as part of that research study. You do not have to agree to be recorded in order to participate in the main part of the study.

The recording(s) will be used for analysis by the research team.

The recording(s) will include perspectives of clinical nurses on the role and safety practices of charge nurses shared during focus groups. The recordings will also include the unique number identifier provided to each participant, which will be verbalized by the participants during the start of the focus groups.

The recording(s) will be stored in a locked file cabinet with no link to subjects’ identity. The recordings on the digital recorder will be deleted after all data is verified to be accurately uploaded into the computer. Electronic records of the data in excel, SPSS and Word will be maintained on a password protected laptop computer. Signed consent forms will be maintained in another locked file cabinet, separate from the demographic forms and job descriptions. The

Version #: 2
Date: 10/21/17
Title: A Multi-Perspective Study Exploring the Charge Nurse Role and Safety Practices
Pt: Lora Bognar, MSN, RN, ANP-BC

electronic files and paper documents, including consents and job descriptions will be destroyed after 5 years.

Your signature on this form grants the investigator named above permission to record you as described above during participation in the above-referenced study. The investigator will not use the recording(s) for any other reason than that/those stated in the consent form without your written permission.

AGREEMENT TO PARTICIPATE

1. Subject consent:
I have read this entire form, or it has been read to me, and I believe that I understand what has been discussed. All of my questions about this form or this study have been answered. I agree to take part in this research study.

Subject Name: ____________________________

Subject Signature: ____________________ Date: ______________

2. Signature of Investigator/Individual Obtaining Consent:
To the best of my ability, I have explained and discussed the full contents of the study including all of the information contained in this consent form. All questions of the research subject and those of his/her parent or legally authorized representative have been accurately answered.

Investigator/Person Obtaining Consent (printed name): ____________________________

Signature: ______________________ Date: ______________

Version #: 2
Date: 10/21/17

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IRB ID: Pro20170001055
Approval Date: 10/12/2017
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Appendix J

Phase Two Consent (Individual Interviews)

Title: A Multi-Perspective Study Exploring the Charge Nurse Role and Safety Practices
PI: Lora Bognar, MSN, RN, ANP-BC

CONSENT TO TAKE PART IN A RESEARCH STUDY

TITLE OF STUDY: A Multi-Perspective Study Exploring the Charge Nurse Role and Safety Practices—Phase II Consent (Individual Interviews)
Principal Investigator: Lora Bognar, MSN, RN, ANP-BC

This consent form is part of an informed consent process for a research study and it will provide information that will help you to decide whether you wish to volunteer for this research study. It will help you to understand what the study is about and what will happen in the course of the study.

If you have questions at any time during the research study, you should feel free to ask them and should expect to be given answers that you completely understand.

After all of your questions have been answered, if you still wish to take part in the study, you will be asked to sign this informed consent form.

You are not giving up any of your legal rights by volunteering for this research study or by signing this consent form.

Who is conducting this research study?
Lora Bognar, MSN, RN, ANP-BC is the Principal Investigator of this research study. A Principal Investigator has the overall responsibility for the conduct of the study. However, there are often other individuals who are part of the research team.

Lora Bognar, MSN, RN, ANP-BC may be reached at 201-446-0278, 21 Hirth Drive, Newfoundland, NJ 07435
The principal investigator or another member of the study team will also be asked to sign this informed consent. You will be given a copy of the signed consent form to keep.

Who might benefit financially from this research?
No one will benefit financially from this research.

Why is this study being done?

Version #: 2
Date: 10/21/17

RUTGERS eIRB APPROVED
IRB ID: Pro20170001055
Approval Date: 10/12/2017
Expiration Date: 10/11/2018
Title: A Multi-Perspective Study Exploring the Charge Nurse Role and Safety Practices  
Pt. Lora Bogunar, MSN, RN, ANP-BC

This study is being done to understand the role of the acute care hospital charge nurse in New Jersey and how the charge nurse keeps patients safe.

Why have you been asked to take part in this study?

You are being asked to take part in this study because you are either a charge nurse or a nurse manager who works alongside charge nurses and are currently working in an acute care hospital in New Jersey.

Who may take part in this study? And who may not?

New Jersey acute care hospital inpatient charge nurses who are able to speak and read in English, have charge nurse experience minimally over the past 6 months, have worked in the charge nurse role within the past week may take part in this study. Any charge nurse who does not work in a New Jersey acute care inpatient unit, is unable to speak and read in English, does not have at least 6 months experience in the charge nurse role and has not worked in the charge nurse role in the past week, is unable to participate.

New Jersey acute care hospital inpatient nurse managers who are able to speak and read in English, have nurse manager experience minimally over the past year and have 24 hour responsibility over at least one unit/department with a charge nurse are able to take part in the study. Any nurse manager who does not work in a New Jersey acute care hospital and is able to speak and read in English, who does not have 24 hour responsibility of at least one inpatient unit with a charge nurse is unable to participate in this study.

How long will the study take and how many subjects will participate?

A total of 18-28 charge nurses will be recruited to take part in this study. However, a maximum of only 3 clinical nurses from any one hospital may participate. Participation in the study will involve an individual interview with charge nurses which will last 30-60 minutes. Each charge nurse will only be interviewed once.

A total of 18-28 nurse managers will be recruited to take part in this study. However, a maximum of only 3 nurse managers from any one hospital may participate. Participation in the study will involve an individual interview with nurse managers which will last 30-60 minutes. Each nurse manager will only be interviewed once.

What will you be asked to do if you take part in this research study?

Charge nurses and nurse managers who participate in this study, will be asked to complete a demographic data form after reading and signing consent to participate. Charge nurses and nurse managers will also be asked to provide the Principal Investigator with a copy of a charge nurse job description if there is one available from the hospital in which they work.

Charge nurses and nurse managers will also be asked to participate in one digitally recorded individual interview with the Principal Investigator of this study and share their perspective.

Version #: 2  
Date: 10/21/17
Title: A Multi-Perspective Study Exploring the Charge Nurse Role and Safety Practices

Pt. Lora Bogner, MSN, RN, ANP-BC

about the charge nurse role and safety practices. Prior to the interviews, each participant will be assigned a unique number by the Principal Investigator to protect participants’ identities. The unique number will only be used in transcribing the digital recordings.

What are the risks and/or discomforts you might experience if you take part in this study?

There are no anticipated risks and/or discomforts if you take part in this study. Should you experience any emotional discomfort when answering the questions, you may withdraw from the study at any time.

Are there any benefits for you if you choose to take part in this research study?

There is no direct personal benefit from taking part in this study.

What are your alternatives if you don’t want to take part in this study?

Your alternative is not to take part in this study.

How will you know if new information is learned that may affect whether you are willing to stay in this research study?

During the course of the study, you will be updated about any new information that may affect whether you are willing to continue taking part in the study. If new information is learned that may affect you after the study or your follow-up is completed, you will be contacted.

Will there be any cost to you to take part in this study?

There will be no cost to you to take part in this study.

Will you be paid to take part in this study?

You will not be paid for your participation in this research study. However, as a thank you for your time you will be given a $10.00 Visa gift card.

How will information about you be kept private or confidential?

All efforts will be made to keep your personal information in your research record confidential, but total confidentiality cannot be guaranteed. The recordings on the digital recorder will be deleted after all data is verified to be accurately uploaded into the computer. Electronic records of the data will be maintained on a password protected laptop computer. Backup copies of the computer files will be saved on a thumb drive and secured in a locked file cabinet to which the PI will only have access. Signed consent forms will be maintained in another locked file cabinet, separate from the demographic forms and job descriptions. The electronic files and paper documents, including consents and job descriptions will be destroyed after 5 years.

3
Version #: 2
Date: 10/21/17
Title: A Multi-Perspective Study Exploring the Charge Nurse Role and Safety Practices  
PT: Lora Bognar, MSN, RN, ANP-BC

What will happen if you do not wish to take part in the study or if you later decide not to stay in the study?

Participation in this study is voluntary. You may choose not to participate or you may change your mind at any time.

If you do not want to enter the study or decide to stop participating, your relationship with the study staff will not change, and you may do so without penalty and without loss of benefits to which you are otherwise entitled.

You may also withdraw your consent for the use of data already collected about you, but you must do this in writing to Mrs. Lora Bognar, 21Hirth Drive, Newfoundland, NJ 07435

Who can you call if you have any questions?

If you have any questions about taking part in this study, you can call the Principal Investigator:

Mrs. Lora Bognar  
201-446-0278

If you have any questions about your rights as a research subject, you can call:

IRB Director  
(973)-972-3608 Newark  
And  
Human Subject Protection Program  
973-972-1149 - Newark

What are your rights if you decide to take part in this research study?

You have the right to ask questions about any part of the study at any time. You should not sign this form unless you have had a chance to ask questions and have been given answers to all of your questions.

Permission to contact after the completion of the study.

☐ Yes, I permit the principal investigator to contact me after the study.

At the conclusion of the study, the principal investigator will contact six participants and meet with them to review the identified codes and themes and to provide feedback. If you AGREE to be contacted by the principal investigator after the study, please MARK the box.

Permission for Audio Recording

We are asking for your permission to allow us to audiotape as part of that research study. You do not have to agree to be recorded in order to participate in the main part of the study.

The recording(s) will be used for analysis by the research team.

Version #: 2  
Date: 10/21/17
Title: A Multi-Perspective Study Exploring the Charge Nurse Role and Safety Practices
Pt. Lora Bognar, MSN, RN, ANP-BC

The recording(s) will include perspectives of charge nurses and nurse managers on the role and safety practices of charge nurses shared during individual interviews. The recordings will also include the unique number identifier provided to each participant, which will be verbalized by the participants during the start of the interviews.

The recording(s) will be stored in a locked file cabinet with no link to subjects’ identity. The recordings on the digital recorder will be deleted after all data is verified to be accurately uploaded into the computer. Electronic records of the data in excel, SPSS and Word will be maintained on a password protected laptop computer. Signed consent forms will be maintained in another locked file cabinet, separate from the demographic forms and job descriptions. The electronic files and paper documents, including consents and job descriptions will be destroyed after 5 years.

Your signature on this form grants the investigator named above permission to record you as described above during participation in the above-referenced study. The investigator will not use the recording(s) for any other reason than that/those stated in the consent form without your written permission.

AGREEMENT TO PARTICIPATE

1. Subject consent:

I have read this entire form, or it has been read to me, and I believe that I understand what has been discussed. All of my questions about this form or this study have been answered. I agree to take part in this research study.

Subject Name:__________________________________________
Subject Signature:_____________________________________ Date:___________

2. Signature of Investigator/Individual Obtaining Consent:

To the best of my ability, I have explained and discussed the full contents of the study including all of the information contained in this consent form. All questions of the research subject and those of his/her parent or legally authorized representative have been accurately answered.

Investigator/Person Obtaining Consent (printed name):________________________
Signature:____________________________________________ Date:____________

Version #: 2
Date: 10/21/17
### Appendix K

Average Ratings of AONE Nurse Manager Competencies (AONE, 2015) by Participant Group

<table>
<thead>
<tr>
<th>AONE Nurse Manager Competencies (AONE, 2015)</th>
<th>Charge Nurse Responses (n=3) Mean (SD)</th>
<th>Nurse Manager Responses (n=3) Mean (SD)</th>
<th>Clinical Nurse Responses (n=3) Mean (SD)</th>
</tr>
</thead>
<tbody>
<tr>
<td>THE SCIENCE</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Financial Management</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>o Recognize the impact of reimbursement on revenue</td>
<td>2.33 (2.31)</td>
<td>1.00 (0)</td>
<td>4.00 (1.73)</td>
</tr>
<tr>
<td>o Anticipate the effects of changes on reimbursement programs for patient care</td>
<td>1.33 (0.58)</td>
<td>1.33 (0.58)</td>
<td>3.00 (1.73)</td>
</tr>
<tr>
<td>o Maximize care efficiency and throughput</td>
<td>2.33 (0.58)</td>
<td>1.67 (1.15)</td>
<td>5.00 (0)</td>
</tr>
<tr>
<td>o Understand the relationship between value-based purchasing and quality outcomes with revenue and reimbursement</td>
<td>1.67 (0.58)</td>
<td>1.33 (0.58)</td>
<td>3.67 (1.15)</td>
</tr>
<tr>
<td>o Create a budget</td>
<td>1.00 (0)</td>
<td>1.00 (0)</td>
<td>1.00 (0)</td>
</tr>
<tr>
<td>o Monitor a budget</td>
<td>1.00 (0)</td>
<td>1.00 (0)</td>
<td>3.00 (1.73)</td>
</tr>
<tr>
<td>o Analyze a budget and explain variance</td>
<td>1.00 (0)</td>
<td>1.00 (0)</td>
<td>3.00 (2.00)</td>
</tr>
<tr>
<td>o Conduct ongoing evaluation of productivity</td>
<td>1.00 (0)</td>
<td>1.00 (0)</td>
<td>2.33 (1.15)</td>
</tr>
<tr>
<td>o Forecast future revenue and expenses</td>
<td>1.33 (0.58)</td>
<td>1.00 (0)</td>
<td>1.00 (0)</td>
</tr>
<tr>
<td>o Capital budgeting: justification, cost benefit analysis</td>
<td>1.33 (0.58)</td>
<td>1.00 (0)</td>
<td>1.33 (0.58)</td>
</tr>
<tr>
<td>• Human Resource Management</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>o Staffing needs-evaluate staffing patterns/needs; match staff competency with patient acuity</td>
<td>3.67 (1.53)</td>
<td>4.33 (1.15)</td>
<td>4.33 (1.15)</td>
</tr>
<tr>
<td>o Manage human resources within the scope of labor laws</td>
<td>3.33 (2.08)</td>
<td>1.00 (0)</td>
<td>1.67 (1.15)</td>
</tr>
<tr>
<td>Role</td>
<td>Charge Nurse Role and Safety Practices</td>
<td>Performance Improvement</td>
<td></td>
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<td>----------------------</td>
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<tr>
<td>Apply recruitment techniques</td>
<td>1.00 (0) 1.00 (0) 1.33 (0.58)</td>
<td>3.00 (1.73) 2.33 (2.31) 2.33 (0.58)</td>
<td></td>
</tr>
<tr>
<td>Staff selection-apply individual interview techniques; apply team interview techniques; select and hire qualified applicants</td>
<td>2.33 (2.31) 2.00 (1.00) 4.00 (1.00)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Scope of practice-develop role definitions for staff consistent with scope of practice; implement changes in role consistent with scope of practice; orientation; develop orientation program; oversee orientation process; evaluate effectiveness of orientation</td>
<td>1.67 (1.15) 2.67 (1.53) 3.33 (0.58)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Performance improvement-identify key performance indicators; establish data collection methodology; evaluate performance data; respond to outcome measurement findings; comply with documentation requirements</td>
<td>3.00 (1.73) 2.33 (2.31) 2.33 (0.58)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Customer and patient engagement-assess customer and patient satisfaction; develop strategies to address satisfaction issues</td>
<td>3.67 (1.53) 3.67 (1.15) 5 (0)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Patient safety-monitor and report sentinel events; participate in root cause analysis; promote evidence-based practices; manage incident reporting</td>
<td>4.33 (0.58) 4.67 (0.58) 4.67 (0.58)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Foundational Thinking Skills</td>
<td>1.67 (1.15)</td>
<td>2.67 (1.53)</td>
<td>3.33 (0.58)</td>
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<tr>
<td>- Apply systems thinking knowledge as an approach to analysis and decision-making; understand complex adaptive systems definitions and applications</td>
<td>1.67 (1.15)</td>
<td>2.67 (1.53)</td>
<td>3.33 (0.58)</td>
</tr>
<tr>
<td>- Understand complex adaptive systems definitions and applications</td>
<td>2.33 (1.15)</td>
<td>3.33 (2.08)</td>
<td>3.33 (0.58)</td>
</tr>
<tr>
<td>Technology</td>
<td>4.00 (1.00)</td>
<td>4.67 (0.58)</td>
<td>3.00 (0)</td>
</tr>
<tr>
<td>- Information technology: understand the effect of IT on patient care and delivery systems to reduce work load; ability to integrate technology into patient care processes; use information systems to support business decisions</td>
<td>4.00 (1.00)</td>
<td>4.67 (0.58)</td>
<td>3.00 (0)</td>
</tr>
<tr>
<td>Strategic Management</td>
<td>2.67 (0.58)</td>
<td>4.67 (0.58)</td>
<td>4.00 (1.00)</td>
</tr>
<tr>
<td>- Facilitate Change: assess readiness for change; involve staff in change processes; communicate changes; evaluate outcomes</td>
<td>2.67 (0.58)</td>
<td>4.67 (0.58)</td>
<td>4.00 (1.00)</td>
</tr>
<tr>
<td>- Project Management: identify roles; establish timelines and milestones; allocate resources; manage project plans</td>
<td>1.33 (0.58)</td>
<td>1.67 (1.15)</td>
<td>3.00 (1)</td>
</tr>
<tr>
<td>o Contingency plans—manage internal disaster or emergency planning and execution; manage external disaster or emergency planning and execution</td>
<td>1.67 (0.58)</td>
<td>2.67 (1.53)</td>
<td>3.33 (1.53)</td>
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</tr>
<tr>
<td>o Demonstrate written and oral presentation skills</td>
<td>3.00 (1.73)</td>
<td>3.00 (2.00)</td>
<td>3.67 (1.53)</td>
</tr>
<tr>
<td>o Manage meetings effectively</td>
<td>3.00 (2.00)</td>
<td>2.67 (2.08)</td>
<td>4.00 (1.00)</td>
</tr>
<tr>
<td>o Demonstrate negotiation skills</td>
<td>3.67 (1.53)</td>
<td>2.67 (1.53)</td>
<td>4.00 (1.00)</td>
</tr>
<tr>
<td>o Influence the practice of nursing through participation in professional organizations</td>
<td>3.33 (2.08)</td>
<td>1.67 (1.15)</td>
<td>3.33 (0.58)</td>
</tr>
<tr>
<td>o Collaborate with other service lines</td>
<td>3.33 (1.53)</td>
<td>3.00 (2.00)</td>
<td>4.00 (1.00)</td>
</tr>
<tr>
<td>o Shared Decision-Making—establish a vision statement; facilitate a structure of shared governance; implement structures and processes; support a just culture</td>
<td>2.67 (1.53)</td>
<td>4.00 (1.73)</td>
<td>3.67 (1.15)</td>
</tr>
<tr>
<td>o Support a culture of innovation</td>
<td>3.67 (1.15)</td>
<td>3.67 (1.53)</td>
<td>3.67 (1.53)</td>
</tr>
<tr>
<td><strong>Appropriate Clinical Practice Knowledge</strong></td>
<td></td>
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</tr>
<tr>
<td>o Each role and institution has expectations regarding the clinical knowledge and skill required of the role. These expectations should be established for the specific individual based on organizational requirements</td>
<td>4.33 (1.15)</td>
<td>4.33 (0.58)</td>
<td>4.00 (1.73)</td>
</tr>
</tbody>
</table>
### THE ART

#### Human Resource Leadership Skills
- Performance management—conduct staff evaluations; assist staff with goal-setting; implement continual performance development; monitor staff for fitness for duty; initiate corrective actions; terminate staff

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<thead>
<tr>
<th></th>
<th>3.00 (1.73)</th>
<th>3.00 (2.00)</th>
<th>4.00 (1.00)</th>
</tr>
</thead>
</table>

- Staff development—facilitate staff education and needs assessment; ensure competency validation; promote professional development of staff; facilitate leadership growth among staff; identify and develop staff as part of a succession planning program

<table>
<thead>
<tr>
<th></th>
<th>2.67 (2.08)</th>
<th>3.00 (2.00)</th>
<th>4.67 (0.58)</th>
</tr>
</thead>
</table>

- Staff Retention—assess staff satisfaction; develop and implement strategies to address satisfaction issues; promote retention; develop methods to reward and recognize staff

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<thead>
<tr>
<th></th>
<th>2.67 (2.08)</th>
<th>3.00 (2.00)</th>
<th>4.33 (1.15)</th>
</tr>
</thead>
</table>

#### Relationship Management and Influencing Behaviors
- Manage Conflict

<table>
<thead>
<tr>
<th></th>
<th>4.00 (1.00)</th>
<th>3.33 (2.08)</th>
<th>4.67 (0.58)</th>
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</thead>
</table>

- Situation management—identify issues that require immediate attention; apply principles of crisis management to handle situations as necessary

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<tr>
<th></th>
<th>4.67 (0.58)</th>
<th>3.67 (2.31)</th>
<th>5.00 (0)</th>
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</thead>
</table>

- Relationship management—promote team dynamics; mentor

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<tr>
<th></th>
<th>3.33 (1.53)</th>
<th>3.33 (2.08)</th>
<th>4.33 (1.15)</th>
</tr>
</thead>
</table>
and coach staff and colleagues; apply communication principles

- Influence others—encourage participation in professional action; role model professional behavior; apply motivational theory; act as a change agent; assist others in developing problem solving skills; foster a healthy work environment

- Promote professional development—promote stress management; apply principles of self-awareness; encourage evidence-based practice; apply leadership theory to practice

### Diversity
- Cultural competence—understand the components of cultural competence as they apply to the workforce

### Social Justice
- Maintain an environment of fairness and processes to support it

### Generational Diversity
- Capitalize on difference to foster highly effective work groups

### THE LEADER WITHIN
- Personal and Professional Accountability
  - Personal growth and development—manage through education advancement, continuing education, career planning and annual self-
<table>
<thead>
<tr>
<th>Assessment and Action Plans</th>
<th>4.67 (0.58)</th>
<th>5.00 (0)</th>
<th>4.00 (1.73)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Practice ethical behavior-</td>
<td>3.00 (0)</td>
<td>2.67 (1.53)</td>
<td>3.67 (1.53)</td>
</tr>
<tr>
<td>Involvement in professional associations-</td>
<td>4.33 (0.58)</td>
<td>3.67 (2.31)</td>
<td>4.00 (1.00)</td>
</tr>
<tr>
<td>Achieve certification in an appropriate field/specialty</td>
<td>4.67 (0.58)</td>
<td>4.00 (1.78)</td>
<td>4.67 (0.58)</td>
</tr>
<tr>
<td><strong>Career Planning</strong></td>
<td>4.67 (0.58)</td>
<td>4.00 (1.78)</td>
<td>4.67 (0.58)</td>
</tr>
<tr>
<td>Know your role- understand current job description/requirements and compare those to current level of practice</td>
<td>3.33 (1.53)</td>
<td>3.67 (1.53)</td>
<td>4.00 (1.73)</td>
</tr>
<tr>
<td>Know your future-plan a career path</td>
<td>3.33 (0.58)</td>
<td>3.67 (1.53)</td>
<td>3.67 (2.31)</td>
</tr>
<tr>
<td>Position yourself-develop a career path/plan that provides direction while offering flexibility and capacity to adapt to future scenarios</td>
<td>3.67 (1.15)</td>
<td>3.33 (1.15)</td>
<td>3.67 (1.53)</td>
</tr>
<tr>
<td><strong>Personal Journey Disciplines</strong></td>
<td>3.67 (1.15)</td>
<td>3.33 (1.15)</td>
<td>3.67 (1.53)</td>
</tr>
<tr>
<td>Apply action learning- apply techniques of “action learning” to problem solve and personally reflect on decisions.</td>
<td>2.67 (0.58)</td>
<td>3.00 (1.73)</td>
<td>3.67 (1.15)</td>
</tr>
<tr>
<td>Engage in reflective practice- includes knowledge of, and active practice of reflection as a leadership behavior.</td>
<td>2.67 (0.58)</td>
<td>3.00 (1.73)</td>
<td>3.67 (1.15)</td>
</tr>
</tbody>
</table>
Comparison Between PCN/ANM and Rotating/Relief Charge Nurses and AONE Nurse Manager Competencies (AONE, 2015)

<table>
<thead>
<tr>
<th>AONE Nurse Manager Competencies (AONE, 2015)</th>
<th>Nurse Manager Responsibilities</th>
<th>PCN/ANM Responsibilities</th>
<th>Rotating/Relief Charge Nurse Responsibilities</th>
</tr>
</thead>
<tbody>
<tr>
<td>THE SCIENCE</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Financial Management</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>o Recognize the impact of reimbursement on revenue</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>o Anticipate the effects of changes on reimbursement programs for patient care</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>o Maximize care efficiency and throughput</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>o Understand the relationship between value-based purchasing and quality outcomes with revenue and reimbursement</td>
<td></td>
<td></td>
<td>X</td>
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<tr>
<td>o Create a budget</td>
<td>X</td>
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<tr>
<td>o Monitor a budget</td>
<td>X</td>
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<tr>
<td>o Analyze a budget and explain variance</td>
<td>X</td>
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<tr>
<td>o Conduct ongoing evaluation of productivity</td>
<td>X</td>
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<tr>
<td>o Forecast future revenue and expenses</td>
<td>X</td>
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<tr>
<td>o Capital budgeting</td>
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<td>Task Description</td>
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<tr>
<td><strong>Human Resource Management</strong></td>
<td></td>
<td></td>
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</tr>
<tr>
<td>o Staffing needs-evaluate staffing patterns/needs; match staff competency with patient acuity</td>
<td>X</td>
<td></td>
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<tr>
<td>o Manage human resources within the scope of labor laws</td>
<td></td>
<td>X</td>
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<tr>
<td>o Apply recruitment techniques</td>
<td></td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>o Staff selection-apply individual interview techniques; apply team interview techniques; select and hire qualified applicants</td>
<td>X</td>
<td>X</td>
<td></td>
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<tr>
<td>o Scope of practice-develop role definitions for staff consistent with scope of practice; implement changes in role consistent with scope of practice; orientation; develop orientation program; oversee orientation process; evaluate</td>
<td></td>
<td></td>
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<tr>
<td>Effectiveness of Orientation</td>
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<tr>
<td><strong>Performance Improvement</strong></td>
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<tr>
<td>o Performance improvement-</td>
<td>X</td>
<td>X</td>
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<tr>
<td>identify key performance</td>
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<tr>
<td>indicators; establish data</td>
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<td>collection methodology;</td>
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<tr>
<td>evaluate performance</td>
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<tr>
<td>data; respond to outcome</td>
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<td>measurement findings; comply</td>
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<td>with documentation</td>
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<tr>
<td>requirements</td>
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<tr>
<td>o Customer and patient</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>engagement- assess customer</td>
<td></td>
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<tr>
<td>and patient satisfaction;</td>
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<tr>
<td>develop strategies to address</td>
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<tr>
<td>satisfaction issues</td>
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<tr>
<td>o Patient safety-</td>
<td>X</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>monitor and report sentinel</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>events; participate in root</td>
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<tr>
<td>cause analysis; promote</td>
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<tr>
<td>evidence-based practices;</td>
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<tr>
<td>manage incident reporting</td>
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<tr>
<td>o Maintain survey and regulatory readiness</td>
<td>X</td>
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<tr>
<td>o Monitor and promote workplace safety requirements</td>
<td>X</td>
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<tr>
<td>o Promote intra/interdepartmental communication</td>
<td>X</td>
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- **Foundational Thinking Skills**
  - o Apply systems thinking knowledge as an approach to analysis and decision-making; understand complex adaptive systems definitions and applications | X |
  - o Understand complex adaptive systems definitions and applications | X |

- **Technology**
  - o Information technology—understand the effect of IT on patient care and delivery systems to reduce work load; ability to integrate technology into patient care processes; use information systems to support business decisions | X | X | X |
<table>
<thead>
<tr>
<th>Strategic Management</th>
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<tbody>
<tr>
<td>Facilitate Change</td>
<td>X</td>
<td>X</td>
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<tr>
<td>- Assess readiness for change; involve staff in change processes; communicate changes; evaluate outcomes</td>
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<tr>
<td>Project Management</td>
<td>X</td>
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<tr>
<td>- Identify roles; establish timelines and milestones; allocate resources; manage project plans</td>
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<td>Contingency plans</td>
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<tr>
<td>- Manage internal disaster or emergency planning and execution; manage external disaster or emergency planning and execution</td>
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<tr>
<td>Demonstrate written and oral presentation skills</td>
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<tr>
<td>Manage meetings effectively</td>
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<td>Demonstrate negotiation skills</td>
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<tr>
<td>Influence the practice of nursing through participation in</td>
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<td>professional organizations</td>
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<tr>
<td><strong>O</strong> Collaborate with other service lines</td>
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<tr>
<td><strong>O</strong> Shared Decision-Making-establish a vision statement; facilitate a structure of shared governance; implement structures and processes; support a just culture</td>
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<tr>
<td><strong>O</strong> Support a culture of innovation</td>
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<tr>
<td><strong>Appropriate Clinical Practice Knowledge</strong></td>
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<tr>
<td><strong>O</strong> Each role and institution has expectations regarding the clinical knowledge and skill required of the role. These expectations should be established for the specific individual based on organizational requirements</td>
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<td><strong>THE ART</strong></td>
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<tr>
<td><strong>• Human Resource Leadership Skills</strong></td>
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<td><strong>O</strong> Performance management-conduct staff evaluations; assist staff with</td>
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<tr>
<td>CHARGE NURSE ROLE AND SAFETY PRACTICES</td>
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<td><strong>goal-setting;</strong>&lt;br&gt;implement&lt;br&gt;continual&lt;br&gt;performance&lt;br&gt;development;&lt;br&gt;monitor staff for&lt;br&gt;fitness for duty;&lt;br&gt;initiate&lt;br&gt;corrective&lt;br&gt;actions;&lt;br&gt;terminate staff&lt;br&gt;Staff development-&lt;br&gt;facilitate staff&lt;br&gt;education and&lt;br&gt;needs&lt;br&gt;assessment;&lt;br&gt;ensure&lt;br&gt;competency&lt;br&gt;validation;&lt;br&gt;promote&lt;br&gt;professional&lt;br&gt;development of&lt;br&gt;staff; facilitate&lt;br&gt;leadership&lt;br&gt;growth among&lt;br&gt;staff; identify&lt;br&gt;and develop staff&lt;br&gt;as part of a&lt;br&gt;succession&lt;br&gt;planning&lt;br&gt;program&lt;br&gt;Staff Retention-&lt;br&gt;assess staff&lt;br&gt;satisfaction;&lt;br&gt;develop and&lt;br&gt;implement&lt;br&gt;strategies to&lt;br&gt;address&lt;br&gt;satisfaction&lt;br&gt;issues; promote&lt;br&gt;retention;&lt;br&gt;develop methods&lt;br&gt;to reward and&lt;br&gt;recognize staff</td>
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<td>Relationship Management and Influencing Behaviors</td>
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<tr>
<td>o Manage Conflict</td>
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<tr>
<td>o Situation management- identify issues that require immediate attention; apply principles of crisis management to handle situations as necessary</td>
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<td>o Relationship management- promote team dynamics; mentor and coach staff and colleagues; apply communication principles</td>
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<td>o Influence others- encourage participation in professional action; role model professional behavior; apply motivational theory; act as a change agent; assist others in developing problem solving skills; foster a healthy work environment</td>
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<td>o Promote professional development- promote stress</td>
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management; apply principles of self-awareness; encourage evidence-based practice; apply leadership theory to practice

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<th>Diversity</th>
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<tr>
<td>Cultural competence - understand the components of cultural competence as they apply to the workforce</td>
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<td>Social justice - maintain an environment of fairness and processes to support it</td>
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<td>Generational diversity - capitalize on difference to foster highly effective work groups</td>
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<th>THE LEADER WITHIN</th>
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<tr>
<td>Personal and Professional Accountability</td>
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<tr>
<td>Personal growth and development - manage through education, advancement, continuing education, career planning and annual self-</td>
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<tr>
<td>assessment and action plans</td>
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<td>Practice ethical behavior-including practice that supports nursing standards and scopes of practice</td>
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<td>Involvement in professional associations-including membership and involvement in an appropriate professional association that facilitates networking and professional development</td>
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<td>Achieve certification in an appropriate field/specialty</td>
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- **Career Planning**
  - Know your role-understand current job description/requirements and compare those to current level of practice | X |  |  |
  - Know your future-plan a career path | X |  |  |
- Personal Journey Disciplines
  - Position yourself-develop a career path/plan that provides direction while offering flexibility and capacity to adapt to future scenarios
  - Apply action learning-apply techniques of “action learning” to problem solve and personally reflect on decisions.
  - Engage in reflective practice-includes knowledge of, and active practice of reflection as a leadership behavior.

*Terminating staff was not applicable to neither PCN/ANM nor rotating/relief charge nurses*