A Study of Leadership Training Programs for Charge Nurses in Nursing Homes

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A STUDY OF LEADERSHIP TRAINING PROGRAMS
FOR CHARGE NURSES IN NURSING HOMES

by

Joanne Esther Smith

A Dissertation
Submitted to the
Faculty of The Graduate College
in partial fulfillment of the
requirements for the
Degree of Doctor of Education
Department of Educational Leadership

Western Michigan University
Kalamazoo, Michigan
April 1983
The purpose of this study was to develop leadership training program components for charge nurses in nursing homes and to learn if there were differences in the perceptions of the directors of nursing and the charge nurses concerning the proposed components.

Three research questions were developed for consideration. The first question was concerned with the perceptions of the directors of nursing and the charge nurses concerning the need for the proposed 14 leadership components, while the second question was concerned with the present status of these components in training programs in their respective nursing homes. The third question was concerned with the relationship of the relative rankings of these 14 components by the directors of nursing and the charge nurses.

A population of 268 individuals was drawn from 67 nursing homes located in west central Michigan, a 12-county area. A questionnaire survey was utilized resulting in a 48% return rate. The questionnaire was divided into two parts, the first part dealt with the 14 components of the leadership training program, and the second part dealt with demographic, academic, and professional experience information.
Questions 1 and 2 were addressed using descriptive statistics, while Question 3 used the Spearman rank (rho) statistic for testing the null hypothesis of no relationship between the relative ranking of these 14 components by the directors of nursing and the charge nurses.

Findings reported in this study showed that both the directors of nursing and charge nurses supported the need for these 14 components in leadership training programs, and that most of these components were not offered in the present training programs. A .90 correlation coefficient was calculated for the relative ranking of these components by these two groups. This value was significant at the .05 level.

This study has definitely substantiated the notion that the proposed leadership training components are lacking in training programs for charge nurses in nursing homes. It was also established that the directors of nursing and charge nurses both agree that the proposed leadership program content and emphasis should be a necessary part of a leadership training program for charge nurses.
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ACKNOWLEDGMENTS

And the Lord shall guide thee continually. Isaiah 58:11

I give thanks to the Lord God Almighty for His divine guidance and blessings throughout my academic career and the writing of this dissertation.

I also want to thank my husband, William Sr., and children, Susan, William Jr., and Gregory, for their support and encouragement. To my committee, Dr. R. Munsterman, Dr. S. VanHoeven, and Dr. U. Smidchens, I give my sincere gratitude for their willingness to guide me through this academic achievement.

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Joanne Esther Smith
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CHAPTER I

THE PROBLEM AND ITS BACKGROUND

Introduction

Care in nursing homes is currently a major concern of the gerontologist, of the aged, and of those who provide support for the aged in the community and nursing homes. According to Crandall (1980), it is difficult to think of a topic in gerontology that has as much literature or controversy as that of nursing homes. Nursing homes represent an area in which many gerontologists set aside scientific objectivity and tend to launch into an emotional verbal assault against the horror, abuse, and neglect they have seen and heard about.

The lack of concern for poor leadership in the nursing home has come to an end. Society is becoming aware of this concern and the many tales of abuse and horror are being brought to the public's attention. The inadequate and incompetent facilities are being scrutinized and demands are being made upon the facilities to correct program inadequacies existing within the facilities.

Crandall (1980) stated,

However, it must be recognized that although there are many nursing homes that do provide excellent care for their residents, there are others that exploit the aged. Nursing homes will generally not improve unless they are pressured by the public. As more and more Americans learn that they stand an excellent chance of being placed in a nursing home at some point in the future, public pressure will increase. (p. 329)

1

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Hedman, Thatcher, Givner, and Erixon (1976) brought out the fact that the key nurse (nurse in charge) in nursing homes has been a long neglected person. In 1972, in the state of Nebraska, an ad hoc committee, established under Nebraska's Comprehensive Health Planning Agency, voiced concern over the educational qualifications of the key nurse working in nursing homes throughout the state. The committee referred to the term key nurse as those nurses having decision-making responsibilities regarding direct patient care within the nursing home and whose positions frequently have been denoted by such titles as charge nurse, nursing supervisor, and nursing administrator.

The problem identified by this committee was that the key nurse was much in need of some form of educational upgrading to help him/her become more knowledgeable in the field and to increase his/her expertise in caring for the elderly. In part, the reasons for this were that the key nurse in many homes had obtained little education beyond their 3-year diploma program completed 15 to 20 years ago and had little opportunity to keep abreast of current trends and developments in the care of the aged through relevant educational programs and courses. The task of providing relevant educational programs to this group was viewed as most important since the key nurse was seen as an extremely influential person in directing and communicating to others such as the type and quality of care provided in the homes.

According to Almquist and Bates (1980), as the complex problems of the aged become key social issues in contemporary American life,
the importance of the field of gerontology is becoming widely recog-
nized. The situation is further complicated by certain negative
attitudes toward the aging that penetrate our national psyche. Many
times these attitudes surface among those who must help the aged in
the professional setting. Hospitals, nursing homes, and social ser-
vice agencies are slow to integrate a geriatric expertise and a
sensitivity to the realities of the aged into the basic processes of
their services. Almquist and Bates (1980) also alluded to the fact
that one of the realities of situations in nursing homes is that
licensed practical nurses function as charge nurses with no prepara-
tion, especially in the area of leadership.

Levenstein (1981b), when discussing leadership, pointed out the
fact that by any of the definitions of the term leadership, nurses
on every level qualify for the role. Bennis (cited in Levenstein,
1981b) stated that leadership is "the process by which an agent in-
duces a subordinate to behave in a desired manner" (p. 15). Hersey
and Blanchard (cited in Levenstein, 1981b) call it "the process of
influencing the activities of an individual or a group in efforts
toward goal achievement in a given situation" (p. 15). The defini-
tion of leadership that will be used in this study was offered by
David (cited in Levenstein, 1981b), a noted expert on human rela-
tions in industry:

the ability to persuade others to seek defined objectives
enthusiastically. It is the human factor which binds a
group together and motivates them toward goals. Manage-
ment activities, such as planning, organizing, and deci-
sion making are dormant cocoons until the leader triggers
the power of motivation in people and guides them toward
goals. (p. 15)
Charge nurses are the ones who plan, direct, and guide the care of the residents and who are ultimately responsible and accountable for the care of the residents. In the course of a normal working day, every nurse is engaged in activities aimed at influencing the behavior of others—ranging from residents to physicians, subordinates to administrators, and peers to heads of other departments. They are the ones that should be acquiring the necessary skills in leadership to adequately initiate the programs and care that the residents should be getting.

Statement of the Problem and Purpose

There is little doubt that the nursing home industry has become a complex state of affairs. Also, the charge nurse as a responsible and accountable part of this industry has great influence on this state of affairs. It therefore follows that herein lies the problem that lack of leadership skills could be the main deterrent in this situation. According to Kron (1976), leadership is needed in every activity. Every nurse, whether staff nurse, team leader, head nurse, supervisor, or nursing director, must perform administrative and managerial functions. The only difference lies in the scope of practice required by the job. Leadership is required if the nurse is to be effective in the management of patient care (p. 75).

Society is demanding that nursing homes provide competent services to the community. Competence cannot be obtained without professional training and development of expertise by the personnel in the nursing home. Therefore the purpose of this study was to
develop leadership training program components for charge nurses in nursing homes and to learn if there were differences in the perceptions of the directors of nursing and the charge nurses concerning the proposed components.

Kron (1976) also stated that the intent of a leadership training program is effective leadership which leads to several results: a spirit of cooperation and enthusiasm based on good human relationships; well-trained, skilled workers; and an efficiently run organization, able to meet its goals. Good leadership improves job performance which leads to improved patient care.

Research Questions

In order to accomplish the above stated purpose, the following research questions were developed.

1. How do the directors of nursing compare the 14 components of the proposed leadership training program with what they perceive as needed for a leadership training program, and how do the charge nurses compare the 14 components of the proposed leadership training program with what they perceive as needed for a leadership training program?

2. How do the directors of nursing compare the 14 components of the proposed leadership training program with their perceptions of what is being offered in their present leadership training program, and how do the charge nurses compare the 14 components of the proposed leadership training program with their perceptions of what is being offered in their present leadership training program?
3. Will there be a difference in the perceptions of the director of nursing and the charge nurses about the content of a leadership training program?

In order to answer these questions one has to assess the perceptions of the directors of nursing and the charge nurses about the content of a leadership training program. This was accomplished by a survey questionnaire which was presented to the directors of nursing and the charge nurses in nursing homes in central western Michigan, a 12-county area.

The survey questionnaire contained a list of components pertaining to leadership training needs which were obtained through a literature review. Current leadership training program content being offered was addressed as well as responses concerning differences in perceptions regarding what program content is needed for a leadership training program for charge nurses in nursing homes.

Rationale and Significance of the Study

The specific role of the charge nurse was selected for study due to its importance or stand in the hierarchy of the nursing home. The nursing home does vest considerable responsibility in the charge nurse for proper patient care and the directing of employees in this care. Some of these responsibilities are: assessing patient care needs, planning nursing care, and evaluating the effectiveness of the nursing care. As a manager the charge nurse also has the responsibility to plan, organize, staff, direct, coordinate, and control.
Following an extensive review of the literature found in the Psychological Abstracts, Education Index, Business Periodical Index, Dissertation Abstracts, Medical Journals and Publications, Social Science Index, and the use of the on-line Automated Reference Services, it was found that the role of the charge nurse in nursing homes has received very little discussion or research, especially in the area of leadership.

There has been considerable discussion (Boles & Davenport, 1975; McGee, 1976; Stoops, 1963) regarding the influence of leadership styles and behavior on subordinates, but there is also evidence (Fiore, 1971; Greene, 1975; Herold, 1974; Hersey & Blanchard, 1976; Hilgendorf & Irving, 1969) that subordinate style and behavior influence leaders. By increasing the awareness of leaders as to which variables influence motivation and perhaps increase positive job performance, they may also be able to determine which of these variables enhance their leadership styles or find leadership areas that are in need of alteration. This can be accomplished by identifying variables that significantly influence the leader as he/she relates to the followers and assists those in the leadership role to make decisions used in the selection, improvement, or development of programs. These decisions would then be used on the individual level or have implications toward the nursing home policies and the leadership role.

However, with these reasons in mind, limitations of this study should also be stated.
Limitations of the Study

Several things will limit the conclusions that may be drawn from this study and some of the variables that will not be studied but logically influence the leadership role are: the economy of the country, individual personality characteristics of the charge nurse or director of nursing, geographic norms or influence on the role of the nursing home charge nurse and director of nursing, and health factors. Reasons for not studying these variables are: time, expense, resources, and other types of research necessary to explore such variables.

The findings should be considered associative rather than causal. No causal claims can be made from the correlational investigation that is planned because association among variables does not prove causation. Because the study will be conducted in central western Michigan, only Michigan laws will be dealt with limiting generalizations with other areas.

Summary

The importance of the role of the charge nurse in the nursing home was established through the literature review, along with the findings that motivation and quality of patient care may be related to the leadership abilities of the charge nurse. This leads to the problem of how an awareness of leadership training programs may be initiated or improved, and therefore possibly increase motivation that leads to quality patient care.
Organization of the Dissertation

This study is organized into five chapters. The first of these is the introduction and problem statement, which explains the rationale for the study. Chapter II digresses initially to establish background information for the reader to better understand the study. Within this chapter a historical overview of the charge nurse in the nursing home as well as the director of nursing will be presented. The rest of the chapter will be a presentation of a model for a leadership training program, focusing on current curriculum, format, and presentation. This will be based on a review of programs nationally and statewide which is the basis of the review of literature. Included in this review is material from the fields of education and nursing.

The emphasis in Chapter III will be on the methodology. After an introduction to this chapter, the population and sample will be discussed. Following this the instrument development concerning validation, reliability, and administration will be presented. Survey methodology will then be addressed, followed by mailing, follow-up, and nonrespondent concerns. Chapter IV will relate the results of the survey. The study is then completed in Chapter V with a presentation of the conclusions and recommendations for future research developed by the writer.
CHAPTER II

REVIEW OF SELECTED RELATED LITERATURE

Introduction

This chapter will digress initially to establish background information for a better understanding of the study. Within the chapter a historical overview of the charge nurse in the nursing home as well as the director of nursing will be presented. The remainder of the chapter will be a presentation of a model for a leadership training program, for charge nurses in nursing homes, focusing on current curricula, format, and presentation. This model was based on a review of programs nationally and statewide which was the basis of the review of literature. Included in this review is material from the fields of education and nursing.

Historical Perspective of Directors of Nursing and Charge Nurses

According to Holle and Blatchley (1982), in nursing's long history there have been many leaders and managers. Florence Nightingale's ability to make things happen through leadership was a primary component of her success as the founder of modern nursing. Other early leaders, such as Isabel Hampton Robb, Adelaide Nutting, and Anne Goodrich, are recognized mainly as names heard in history of nursing classes. The importance of their work is not often considered, perhaps because the activities of women in the past have
usually been less highly valued than those of men. More recent nursing leaders fare better in this respect as women become more assertive about themselves and their value to society (p. 2).

Leadership ability and management skills are necessary elements in all positions held by professional nurses, from the director of the nursing services to the staff nurse who functions as a team leader or primary nurse. All job specifications in nursing are oriented toward the management of people and things. The principles of management and the techniques used to implement these principles are the same for all nurse managers; the differences among the staff nurse, head nurse, supervisor, and the director are based upon the job description and its position on the organizational chart.

Holle and Blatchley (1982) reported that according to the American Nurses Association (ANA), the director of nursing carries ultimate administrative authority and responsibility in a health care facility for the nursing service provided individuals and families. As a member of the administrative staff, such a person participates in formulating agency policy, in devising procedures essential to the achievement of objectives, and in evaluation of policies (p. 2).

The head nurse, or charge nurse, usually viewed as a middle manager, is in the pivotal position linking nursing management with nursing care. This nurse usually functions as a provider/manager depending upon the organization of the nursing service department. He/she may serve as a medicine or treatment nurse, team leader, or primary nurse. The leadership that all of these nurses must
demonstrate is an intangible quality, perhaps easier to recognize than define.

Yura, Ozimek, and Walsh (1981) discussed the fact that during the 1950's education for professional nurses was emphasized. Before this most of the leadership behaviors employed by professional nurses were learned "on the job," through the apprentice system, and by trial and error. Despite the inadequacies inherent in this type of preparation, many fine managers evolved. However, many nurses were lost to the profession because of their frustration in having responsibilities thrust upon them that they had not been prepared to meet through education or experience.

Not long after educational programs for administrators got under way, another trend in nursing appeared. Educational programs began to change from a functional to a clinical goal. The shift in direction was not sudden, it was a sure and gradual change that eventually occurred in all accredited educational programs. The intention was not to negate or ignore the need for leadership ability. Not only was it necessary for the nurse to occupy a leadership role, but in order to lead other personnel involved in the care of clients he/she had to be proficient and knowledgeable in clinical nursing, teaching techniques, and curriculum content.

Leadership skills needed by the nurse extended beyond those required to direct only his/her own activities. These include the multifaceted responsibilities of directing the increasing numbers of health oriented personnel with ever widening levels of preparation.
It was further claimed by Yura et al. (1981) that change was taking place in the client population. Historically, clients were a submissive group of persons who followed the directions of professional and ancillary nursing personnel without doubt or question. Today, increased knowledge about health is available to the lay public. As this knowledge has accumulated and been made available, health care consumers have become responsible for an increased amount of their own care. This has changed the type of client with whom the nurse functions; it has brought a new challenge to nursing and has given a different dimension to health care than was present in the past. The nurse continues to function as the leader of health care practices for clients, but he/she is not followed blindly, rather he/she has followers who are knowledgeable, alert, and questioning, who know they have legal rights—and who are not reluctant to exercise these rights. The pace of change today continues to accelerate. Changes are occurring so rapidly that it is difficult to precisely ascribe one or even a few causes to any one change.

The setting in which the client is located is of major importance to the nurse. Hospitals are focusing more directly on care of the acutely ill, and the role of this client is less powerful than that of clients outside the hospital walls. Because the client is acutely ill, the nurse acts as leader of the health group by performing as a client advocate. In the role of leader, he/she is performing acts for the client which because of his/her illness he/she is unable to do for him/herself. This requires astute perception of
the client's needs as well as the ability to accurately communicate those needs to other persons involved in his/her care.

On the other hand, many settings exist outside the hospital where the role of the client is more autonomous and more independent than in the hospital settings. These may include a clinic, the client's home, a physician's office, a community nursing home, or a variety of settings. In such settings, the nurse accepts the role of leader using the same skills of leadership as in the hospital setting, but adapting these skills to the language, interests, and needs of the client, according to variables in the environment.

As the human life span continues to increase, the nurse is confronted with the need to adapt leadership behaviors to a growing number of older persons. The physical and behavioral changes that occur with aging are well known. Changes in vision, hearing, mobility, circulation, digestion, elimination, and in the nervous system create a different focus and pace for the client. Mood swings and emotional responses present patterns with which the client's family is trying to cope. The nurse faces the challenge of helping the client to cope with his/her own needs and of helping the family to understand what is happening and why, as well as how best to adapt and adjust to evidences of health deviations.

Difficult decisions laden with emotional impact and psychological trauma are often more stressful than responsibility for physical care. Family members are faced with deciding whether a nursing home would be better than their own home for a disabled or older family member. Providing support and empathy as family members labor
through such a difficult process requires more conscious leadership than is often required in administering physical care. Through careful deliberate leadership, the nurse can be helpful to the client and family. He/she can also set the important standards of quality care by seizing this opportunity to demonstrate positive and constructive leadership ability.

In the study of leadership positions in nursing, Moloney (1979) reported that leadership or the lack of it has a definite bearing on the effectiveness of the society in which it exists. This is true of nursing leadership since it affects the quality of care for clients and the contributions made by nurses in nursing service, nursing education, and health care in general.

In many of our health care institutions remarkable progress has been made in quality care improvement programs and, more recently, instituting primary nursing. These results require effective leadership, risk taking, and innovations. Although leadership is expected of all nurses, it is to the administrators of nursing services and educational programs that we continue to look for forward movement. These nurses are in an excellent position to greatly affect the advancement of nursing as a professional discipline by encouraging the efforts to those practitioners and researchers who are endeavoring to provide a sound theoretical base for clinical practice.

According to Stevens (1978), the area that has received by far the least amount of attention and can have the greatest impact on changes in the system is bringing to bear sufficient organizational
structures and management expertise to cause needed changes in the system, as it relates to nursing. The system has tended to promote individuals who possess excellent capabilities in the care of patients to a position where management of care-giving resources is a principal activity. This change in role has occurred without extensive training for the individual nurse to meet these new and quite different demands.

For those nurses who assume greater managerial responsibility, there must be provision in curriculum for management and organization theory, so that the nurse as a manager can be more comfortable and confident in that role. Douglass and Bevis (1974) expressed this problematical situation:

Education of nurses has traditionally emphasized the study of knowledge and skills of patient care with a minimum of preparation. This preparation was expected to be provided by the employer, who in turn anticipated that the graduate would be able to function in a leadership capacity from the first day of employment with only brief orientation to agency routine and policy. Lack of sufficient leadership preparation has resulted in the nurse's frustration and disenchantment with leadership activities and disillusionment on the part of the employer whose expectations have not been met. (p. 7)

What then can leaders do, and what are their responsibilities in their leader role? Gardner (cited in Moloney, 1979) indicated that they "can conceive and articulate goals that left people out of their petty preoccupations, carry them above the conflicts that tear a society apart, and unite them in the pursuit of objectives worthy of their best efforts" (p. 13). Moloney (1979) alludes to the fact that a scarcity of educationally qualified leaders exists in nursing services at every level. These leaders are not only lacking in
educational preparation but also in knowledge of what the nursing leadership process entails. This is true of nurse educators as well. Moloney (1979) also stated that the nurse educators do not emphasize the nursing leadership process despite the fact that they have made substantial progress in including material on leadership in management courses offered to undergraduate and graduate nursing students.

Moloney (1979) brought out the fact that leadership as a concept is often delayed until the senior year in the nursing curriculum which is very unfortunate. Ideally, nurse leaders should be developed from their earliest contact with the profession. Leadership content should be emphasized during all of the nursing courses and clinical experiences so that students understand theories of leadership and the nursing leadership process prior to their first contact with clients.

From Moloney (1979), one also learns that informative material is not enough. Nursing students and all nurses must be taught the true nature of leadership and how they can improve their leadership skills through implementing the nursing process. Opportunities for practical experience in implementing this process are available in clinical contacts with clients and in other interactions that occur between nurse executives and their facility and staffs.

Moloney (1979) further discussed the fact that nursing educators have been remiss in not providing a theoretical base for nursing leadership in their curricula. Some graduate programs in nursing administration provide instruction on leadership; however, it
should be included in undergraduate programs and then further developed at the graduate level. How can we expect the bulk of our profession to accept change and unite in moving forward on goals when they have not been taught the concepts necessary for change and why they should be knowledgeable about leadership to accomplish these goals?

In the past, continued Moloney (1979), nursing students were encouraged to be obedient, compliant, docile, and humble. Now they are beginning to learn how to be assertive, to use the power that is theirs, and not to fear it or believe that it is wrong for professional nurses to use power in influencing change in a health system badly in need of change. They recognize that as nurses they cannot afford to abstain from using a confrontation-negotiation approach—the price of obtaining or remaining inert is indeed too high. Nurse leaders must recognize and pay special attention to the emergent aspects of their own behavior and that of others, as they fulfill their leadership roles.

It appeared to Moloney (1979) that research literature on leadership is voluminous, especially in professions such as business, education, industry, and the military. Interest in this concept as a subject of inquiry continues to attract many research scholars. This is not true of the nursing profession, however. Literature on the technical and organizational aspects of nursing abounds. Nursing research has also increased substantially in recent years (Carnegie, cited in Moloney, 1979). But there is little evidence to indicate that research on nursing leadership is being conducted.
Efforts to improve and develop nursing leadership through continuing education programs have produced only a minimal amount of research literature on leadership.

Researchers have studied the administrative functions of nurse executives or supervisory personnel in leadership positions, but research on their leadership effectiveness in nursing service or educational settings is not being conducted. Throughout this past decade, nursing research has concentrated on clinical nursing practices and rightly so. No one questions this effort, since the lack of research on clinical nursing practice continues to be one of nursing's pressing problems (Carnegie, cited in Moloney, 1979). However, since leadership is an important part of nursing practice, both clinical and educational, it seems reasonable to expect that some nurse researchers would choose to explore this concept more thoroughly.

Use of Theory and Process in Implementing the Leadership Role

As set forth by Moloney (1979), crisis intervention as a method of problem solving becomes a day-to-day experience for some nurse leaders. This factor may account for some of the frustration and discontent existing in some of our nursing schools and nursing service departments. Unfortunately, too many nurse leaders rely on intuition rather than theories in analyzing problems and arriving at solutions. Decisions made in these crises situations are seldom as effective as those reached after thoughtful deliberation. No theory can substitute for the judgment required to make sound
decisions. However, the nurse who functions on a hit-or-miss basis, one whose professional arsenal consists merely of routine techniques for specific situations, is operating in intellectual low gear and is denied the self-initiated, self-critical inquiry and innovation that are possible with the wide frame of reference available to the theory-conscious or thoughtful practitioner (Coladarci & Getzels, cited in Moloney, p. 16).

Several theorists, according to Maloney (1979), are attempting to describe, explain, and predict phenomena about human behavior involved in the process of accomplishing organizational goals. Examining such concepts as perception, motivation, and communication is very important in the study of leadership and leader behavior. Reflecting on the lack of theory, Argyris (cited in Moloney, 1979) commented that "partially because of the enormous complexity of the subject matter, there are few theories that purport to mirror the worlds of 'organizational behavior' to the extent that concrete predictions can be made" (p. 16). Argyris's concern about the need for theory to predict organizational behavior is equally true for leadership behavior.

According to Moloney (1979), in spite of the lack of adequate nursing leadership theory, the "signs of the time" in nursing are evidence that progressive forward movement is occurring and that it is not too late for the nursing profession, even though a few pessimistic nurses would like to convince us otherwise.

A renaissance, a reawakening of what can be not what is, should be the prevailing attitude among nurses. Focusing constantly on the
profession's resistance to change is to misdefine the problems that confront us. According to Drucker (1974), "the right way to define the problem so as to make it capable of resolution is as a challenge to create, build, and maintain the innovative (profession), the (profession) for which change is norm rather than exception, and opportunity rather than threat" (p. 797).

Creativity, innovation, change, and challenge result when effective leadership is demonstrated. As Bennis (1976) remarks, "it is both an irony and a paradox that precisely at the time when trust and credibility in leaders are lowest . . . this is precisely the time when the nation and the nursing profession most needs people who can lead and who can transcend that vacuum" (p. 134). Nursing has those leaders, but it needs to foster them and continue to augment the supply to meet the ever-increasing demands.

Toward a Curriculum Design

According to Colton (1976), it is because of poor leadership that we are unable to protect professional nursing from the onslaught of aging and institutional administrative power blocs and from the many groups who dispense various kinds of patient care with little or no control over the quality. Colton stated:

Let the nurses be united in strength and courage, with a strong and vital professional organization; leaders who are courageous, capable, intelligent should be in leadership positions. Let the profession stand up with a bold new blueprint for nursing, nursing education, and nursing administration for the future. Let us stop sneveling. If we can create a good case of Nursing Shock, we can build a profession that is current, and rewarding for those who choose to practice it as a lifetime commitment. (p. 37)
The nurse leaders, as set forth by Colton (1976), should carry the ultimate administrative authority and responsibility in the health care system for all nursing service, nursing education, and nursing administration provided to individuals, families, and groups. As a member of the administrative staff he/she must participate in formulating policy, originating procedures essential to achievement of objectives toward long- and short-term goals, and in developing, implementing, and evaluating programs and services. They must be able to assume full authority and responsibility for defining and developing nursing and related policies. They must also assume full responsibility for planning, organizing, directing, and evaluating the nursing professionals. Finally, they must have a position equal to that of anyone else in the corporate organizational structure. This implies accountability of the nursing leader for creating a social system which fosters the participation of nursing staff in defining, planning, implementing, utilizing, and evaluating professional nursing practice to insure safe, efficient, and therapeutically effective care to patients, families, and communities.

Colton (1976) continued to discuss that today leadership in professional nursing requires awareness and comprehensive of political, legal, social, cultural, technological, fiscal, professional conditions, and labor relations which influence and affect all programs of health care. It also requires courage, competence, moral integrity, and the political shrewdness to deal with problems in the area of complex relationships of a group of highly skilled and knowledgeable professional people who practice nursing within a very
complex and changing social system.

From Plachy (1976a), one learns that strong independent nurses are needed for the leadership positions. These should be people who are willing to stand up for what they believe and yet who are not so rigid that they cannot be told that there are better ways. No longer does the nursing profession want head nurses, nurses who are merely better at rendering nursing care than other nurses. The need is for patient care managers, positive thinking leaders who inspire others to strive and achieve their best.

Plachy (1976a) further discussed the qualities that administrators should look for in the potential leaders. We want technical knowledge, an action-oriented personal outlook, a way with people which wins respect, an absence of rigidity, an openness to surrounding experiences, an inquisitiveness, and a sureness of place and purpose. No one is suggesting that it is easy to identify this kind of person, but we must look for the right attitude from the beginning. Looking in the wrong place, with the wrong criteria, doesn't equate with a successful search.

Nursing administrators also have to find concrete ways to help potential leaders, according to Plachy (1976a). These people need learning experiences and opportunities in which they can openly, actively express ideals of leadership, ideas formed over the years but which require testing in a safe environment of a classroom rather than in situations where mistakes can be costly.

It was maintained by Cuthbert (1979) that the nurse must be concerned with continuing education if he/she wishes to upgrade
his/her skills and keep pace with the changes in the nursing profession.

The charge nurse, according to research which was done by Cuthbert (1979), experiences many problems related to general responsibilities within a medical setting. Some of the problems were: charting, evaluating and updating nursing care plans, directing staff members, communicating with physicians, organizing work, developing leadership and supervisory qualities, and making sound decisions. "How do I handle my workers?", "sometimes they won't do what I ask," or "how do I make the right decisions?", and "sometimes I have trouble getting my work done!"; these are areas of concern that the nurses felt would augment their skills already learned in basic nursing education. The charge nurses expressed a desire to be able to understand the expectations of the nurse in the leadership role and to identify the qualities of leadership such as: self-motivation, honesty, concern for others, discretion in relationships with others, professional and ethical conduct, reliability, accuracy, and tact. Personal traits included health, stamina, personal grooming, and the ability to set examples for co-workers. Conceptual, cognitive, and technical skills along with empathy skills were also included.

Cuthbert (1979) also noted that the charge nurses must combine his/her supervisory skills with his/her functions as a leader in order to be effective. Setting priorities of care and adequate preparation for emergencies were described as functions of a leader. Legal aspects and making assignments according to legally defined
levels of function were also included along with rules and regulations governing the practice of nursing and the delegation of responsibility. Standards of care, accountability, legal ordering, patient safety, and problems with staffing need to be addressed. Assessment, planning, implementation, and evaluation were stressed as integral parts of the leadership process. These are all responsibilities and functions that are necessary for development of a competent charge nurse.

A Model for a Leadership Training Program for Charge Nurses in Nursing Homes

The following components for a leadership training program for charge nurses in nursing homes were compiled from a review of the literature (Colton, 1976; Cuthbert, 1979; Holle & Blatchley, 1982; Moloney, 1979; Plachy, 1976a; Schmidt & Ayers, 1967; Stevens, 1978; Yura et al., 1981) which was very fragmented and sparse. There are 14 components, each one having various items which best describe the curriculum content of each component.

1. Leadership responsibility: Persuading, counseling, joining, delegating, telling.

2. Group effectiveness: Participation, communication, cohesion, atmosphere, standards.

3. Communication: Organizational position, commitment to the ideas, cultural conditioning, meanings are in people.

4. Decision-making: Background factors, perception, analytical process, action and reaction.

5. Individual motivation: The person and the environment, behavior—what makes sense, perception of situation, influenced by needs.
6. Planning for change: How to analyze change, communication, power, decision making, examination of alternatives.

7. Appraisal of personnel: Establishing objectives, setting targets, evaluation progress, feedback.

8. Authority and hierarchy: The leader's role, perceptions, reality testing.

9. Creativity: Sensitivity to surroundings, mental flexibility, ability to abstract, ability to synthesize.

10. Consultive process: Diagnosing the situation, identify readiness for change, developing plan for change, the change goals.

11. Self-development: Learning is internal, learning efficient when goals are clear, change in behavior, self-assessment.

12. Problem solving: Defining the problem, working on the problem, testing and action, assessment and re-planning.


14. Learning climate: Lifetime learning, physiological changes, interest changes, learning involves the whole person.

Successful Curriculum Building

Research Question 3 asks the question, is there a difference in the perceptions of the director of nursing and the charge nurses about the content of a leadership training program. For the purposes of this study the premise was taken that there would be a relationship in the perceptions of the directors of nursing and the charge nurses about the content of a leadership training program for charge nurses in nursing homes. This premise was based on 10 years' experience of the researcher working in a nursing home as a nurse.
and administrator only, due to the lack of literature relating to this area of the study. This will be the impetus for the following discussion.

In order to achieve successful curriculum building, Bevis (1982) discussed the facts that the curriculum builder must assume that the key to successful curriculum building, or change, is the involvement of all those who must live and work with the changes. The decade of the 1970's saw an explosion of nursing theories. The 1980's is bringing the generation of many more nursing theories, and their sum will make curriculum content in nursing easier to form into nursing practice patterns.

Torres and Stanton (1982) related the facts that development of curricula in nursing programs has been given a great deal of attention in recent years. The faculty of any given program or department is responsible for the development and implementation of the curriculum. In order to engage in curriculum development as an ongoing process, a commitment is needed on the part of the nursing administrator, the faculty, and the students. Without this commitment, time and energy are wasted. Torres and Stanton (1982) stressed the fact that the curriculum process becomes an academic exercise instead of a useful and productive tool. It is essential that both administration and faculty of the nursing programs are committed to the activity. If either is not committed, implementation is almost impossible. The administration provides the resources, especially in terms of the quality and quantity of the faculty, and it should provide leadership in the role of a catalyst.
The faculty offers its expertise both in the areas of practice and education and it has the major role in the total development and maintenance of any program. It also has the responsibility of implementing the curriculum. If students do not know their role in the process, they become frustrated. Their major role is to provide the input which assists in ongoing evaluation. Failure is inevitable unless everyone involved accepts responsibility and views such an activity as a priority.

Summary

This chapter digressed initially to establish background information for a better understanding of the study. Within the chapter a historical overview of the charge nurse in the nursing home as well as the director of nursing was presented. The remainder of the chapter was a presentation of a model for a leadership training program for charge nurses in nursing homes, focusing on current curricula, format, and presentation. This was based on a review of programs nationally and statewide which was the basis of the review of literature. Included in this review was material from the fields of education and nursing.

Chapter III will follow with the emphasis being the methodology of the study. After an introduction to this chapter, the population and sample will be discussed, followed by the instrument development and survey methodology.
CHAPTER III

METHODOLOGY

Introduction

This document was developed to study the components of leadership training programs for charge nurses in nursing homes. The three areas that were researched were: (1) the content of present leadership training programs, (2) what content is needed for a leadership training program for charge nurses in nursing homes, and (3) will there be differences in the perceptions of the director of nursing and the charge nurses about the content of a leadership training program.

This chapter will focus on a description of the population, instrument development, and the survey methodology for accomplishing the assessment. Additional discussion will review the pilot study that was conducted prior to this investigation along with the methods for analysis.

Area

The west central Michigan area, as shown in Figure 1, is made up of 12 counties which are: Allegan, Ionia, Kent, Lake, Mason, Mecosta, Montcalm, Muskegon, Newaygo, Oceana, Osceola, and Ottawa. Within these 12 counties is Grand Rapids, the second largest metropolitan area in the state, an industrial and port area on the Great
Figure 1

West Central Michigan Area
Lakes, sparsely-populated rural areas, tourist attractions, agriculture using migrant workers, and state and national forests. This is only part of the demographics of the area. Neither extreme poverty nor great affluence are characteristic of the area, but there are pockets of each. However, the area as a whole falls into the mid-range of health areas across the country. No unique problems or situations exist, according to the West Michigan Regional Planning Commission (Area Profile, 1981).

The Planning Commission did allude to the fact that one population group requires special attention. According to current and projected population figures, west central Michigan now has and will continue to have an older population than the rest of the state. This trend should last into the 1990's; therefore, careful consideration must be given to the older population of this region.

Population

In the central western Michigan area there are 67 nursing homes that primarily provide care for the aged population, as shown in Figure 2. The 67 nursing homes comprise a total of 6,605 beds. The projected population in the central western Michigan area for 1980 was 1,071,356, as shown in Table 1. Therefore, .62% of the population in this area are occupying the nursing home beds.

The term nursing home can be interpreted many different ways and so for this study the following definition will be used: According to Section 20109 of the State of Michigan, Act No. 368, Public Acts of 1978, nursing home means a nursing care facility, including
Figure 2

Nursing Homes in the WMHSA Area, 1979

Table 1

Projected Population Figures by County, 1980 Through 2000

<table>
<thead>
<tr>
<th></th>
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</thead>
<tbody>
<tr>
<td>Allegan</td>
<td>77,245</td>
<td>84,074</td>
<td>90,914</td>
<td>97,168</td>
<td>102,484</td>
</tr>
<tr>
<td>Ionia</td>
<td>49,974</td>
<td>52,819</td>
<td>55,665</td>
<td>58,319</td>
<td>60,675</td>
</tr>
<tr>
<td>Kent</td>
<td>436,689</td>
<td>453,629</td>
<td>469,697</td>
<td>482,497</td>
<td>492,026</td>
</tr>
<tr>
<td>Lake</td>
<td>7,618</td>
<td>9,034</td>
<td>11,130</td>
<td>13,260</td>
<td>14,921</td>
</tr>
<tr>
<td>Mason</td>
<td>25,816</td>
<td>27,938</td>
<td>30,665</td>
<td>32,978</td>
<td>34,665</td>
</tr>
<tr>
<td>Mecosta</td>
<td>37,961</td>
<td>43,895</td>
<td>49,832</td>
<td>54,488</td>
<td>58,373</td>
</tr>
<tr>
<td>Montcalm</td>
<td>47,547</td>
<td>51,313</td>
<td>55,462</td>
<td>59,692</td>
<td>63,742</td>
</tr>
<tr>
<td>Muskegon</td>
<td>157,491</td>
<td>157,765</td>
<td>157,074</td>
<td>154,717</td>
<td>150,709</td>
</tr>
<tr>
<td>Newaygo</td>
<td>34,173</td>
<td>37,606</td>
<td>41,012</td>
<td>43,844</td>
<td>45,912</td>
</tr>
<tr>
<td>Oceana</td>
<td>23,246</td>
<td>25,718</td>
<td>28,305</td>
<td>30,638</td>
<td>32,324</td>
</tr>
<tr>
<td>Osceola</td>
<td>18,882</td>
<td>20,984</td>
<td>22,972</td>
<td>24,183</td>
<td>24,845</td>
</tr>
<tr>
<td>Ottawa</td>
<td>154,714</td>
<td>170,227</td>
<td>185,342</td>
<td>199,084</td>
<td>210,120</td>
</tr>
<tr>
<td>WMHSA area</td>
<td>1,071,356</td>
<td>1,135,002</td>
<td>1,198,070</td>
<td>1,250,868</td>
<td>1,290,796</td>
</tr>
<tr>
<td>Michigan</td>
<td>9,357,740</td>
<td>9,702,684</td>
<td>10,045,753</td>
<td>10,324,901</td>
<td>10,504,537</td>
</tr>
</tbody>
</table>

a county medical care facility, but excluding a hospital or a facility created by Act No. 152 of the Public Acts of 1885, as amended, being Sections 36.1 of 36.12 of the Michigan Compiled Laws, which provides organized nursing care and medical treatment to seven or more unrelated individuals suffering or recovering from illness, injury, or infirmity.

This study will be concerned with two types of nursing homes: skilled and intermediate or basic.

**Skilled Nursing Facility**

According to the State of Michigan, Act No. 368, Public Acts of 1978 (Enrolled House Bill No. 4070), a hospital long-term care unit, nursing home, county medical care facility, or other nursing care facility, or a distinct part thereof, certified by the Department of Public Health to provide skilled nursing care by licensed personnel shall be called a skilled nursing facility.

According to Rogers (1971), the following personnel make up the staff of a skilled nursing facility.

- Administrator, full time
- Assistant in the absence of the Administrator
- Director of Nurses, Registered Nurse
- 7-3 charge nurse, Licensed Practical Nurse
- 3-11 charge nurse, Licensed Practical Nurse
- 11-7 charge nurse, Licensed Practical Nurse
- Aides and orderlies, sufficient in number
- Laundry personnel
- Office staff
- Cooks and dietary aides
- Social worker
- Consultants, pharmacy, dietition
- Therapist
- Technicians (p. 222)
Intermediate/Basic Nursing Home

According to the State of Michigan, Act No. 368, Public Acts of 1978 (Enrolled House Bill No. 4070), a hospital long-term care unit, nursing home, county medical care facility, or other nursing care facility, or distinct part thereof, certified by the Department of Public Health to provide intermediate care or basic care that is less than skilled nursing care but more than room and board shall be called an intermediate or basic nursing home.

According to Rogers' (1971), the following personnel make up the staff of an intermediate/basic nursing facility.

Administrator, full time
Assistant in the absence of the Administrator
Director of Nurses, Licensed Practical Nurse
7-3 charge nurse, may be Director of Nursing
3-11 charge nurse, may be by waiver
11-7 charge aide, experienced and competent
Non-nursing personnel as needed (p. 222)

The nursing personnel that this study will be concerned with will consist of the director of nursing and the charge nurses that are employed in the 67 nursing homes in the central western Michigan area.

According to the Michigan Health Occupation Survey of the Michigan Department of Public Health and the Michigan Cooperation Health Information Systems (1979), 6.8% of all registered nurses in the state of Michigan are employed in the nursing homes. In the central western Michigan area, as of 1979, there is a total of 6,823 registered nurses, with 72%, or 4,643, actively employed. The total of the licensed practical nurses is 4,153, with 69.4%, or 2,814,
actively employed. The data regarding the number of nurses that are employed in the central western Michigan area nursing homes are not available at this time.

Definitions taken from Rogers (1971) concerning the director of nursing and the charge nurse will follow.

**Director of Nursing**

The director of nursing has supervisory responsibility for delivery of nursing care for all of the patients of the nursing home. The director shall have direct responsibility for liaison and coordination with the medical staff, therapy department, dietary department, and many other areas. The director answers directly to the administrator of the nursing home for his/her actions and the actions of his/her subordinates.

The general responsibilities of this position are: (a) supervision of all nursing department personnel including hiring, promotion, and discharge recommendation responsibility; (b) development and implementation of a nursing care plan with each patient; (c) involvement in the development and administration of patient care policies; (d) management of the delivery of health care including staffing; and (e) cooperation with state officials and agencies, professional relations, and patient and family relations. The director shall develop and implement orientation and continuing education programs for the nursing department personnel.

The director of nursing shall work a minimum of 40 hours per week, either in the office or in the nursing area proper. Primarily
the hours will be hours that constitute the day shift, Monday through Friday, but he/she will be expected to make periodic inspections of the evening and night shift nursing activities.

Qualifications for the position of director of nursing are: graduate of an accredited school of nursing, hold a current state license as a professional registered nurse, and meet the continuing education requirements of the license.

**Charge Nurse**

The charge nurse has direct and supervisory responsibility for the delivery of nursing care on a specified patient unit(s) on a specified shift of duty. The charge nurse answers directly to the director of nursing for the actions of the subordinates and for him/herself.

The general responsibilities of this position are: (a) supervision of nursing personnel assigned to his/her shift; (b) responsibility for the provisions of patient care as prescribed by the attending physician, the nursing care plan, and in accordance with the written patient care policies and written and oral directions of the director of nursing; and (c) direct responsibility for the administration of pharmaceuticals and prescribed treatment as directed by the attending physician's written orders in compliance with the Nursing Practice Act. The charge nurse will also participate in the continuing education program both as a teacher and a student as described to the director nursing, and he/she will make out work assignments for the subordinates on a daily basis.
The qualifications for the charge nurse position are: (a) to be a graduate of an accredited school of nursing, (b) to hold a current state license as either a registered nurse or a licensed practical nurse and meet the continuing education requirements of that license, (c) to be capable of making mature judgments, (d) to be of sound physical and mental capabilities, and (e) to maintain a life and character that reflects a genuine love and concern for the patients and their families.

Survey Sample Size

For this study the director of nursing and one charge nurse from each shift of each nursing home was surveyed. This sample was nonrandom due to the fact that no list of names of respondents was available. The administrator of each nursing home selected the respondents for this study.

A cross section of all training experience levels, due to employment patterns, was assured by surveying each shift. For example, most older nurses work the 11:00 p.m. to 7:00 a.m. shift, not having responsibilities during the day enabling them to sleep. A younger group is usually on the 3:00 p.m. to 11:00 p.m. shift when babysitters are available and spouses are home to take over the household. The 7:00 a.m. to 3:00 p.m. shift is a mixture of young and old nursing personnel, each having various reasons for working this shift.

In order to reduce any bias of the directors of nursing and charge nurses (not from the same nursing home), the sampling was
comprised of matched pairs from each nursing home with the director of nursing and one charge nurse from any of the three shifts. If only the director of nursing from one nursing home responded and a charge nurse from another nursing home responded, these were not used in the study. Due to the fact that all nursing homes are not managed the same, the director of nursing and charge nurses would have to be from the same nursing home so that their perceptions would be based on the same environment, giving validity to the study.

Instrument Development

The questionnaire format was developed by Karns (1981) and revised by the writer. This questionnaire is divided into two parts.

The first part deals with the components of the leadership training. There is one topic area dealing with the program content of the leadership training program for charge nurses in nursing homes. In the questionnaire 14 components are presented with each broken down into items representative of the components. The respondent was asked the same two questions concerning each of the 14 components. The first question asked whether the component should be a part of a leadership training program. The second question asked if the component is a part of the present nursing home leadership training program.

Rank ordering occurs in the questionnaire to distinguish the importance of each component. A respondent could answer yes to all components in an attempt to be thorough and complete, making each as
important as the next one. Rank ordering determined the importance of each component.

An additional section for comments was included. In this section the respondent was free to add additional items or further comment on existing items or components.

In the second part of the questionnaire demographic, academic, and professional experience information was gathered. These demographic data were used to gain insight into the training and experience levels of the directors of nursing and the charge nurses. This information was used to develop profiles of the respondents.

Validity of the Questionnaire

In developing the questionnaire the writer sought to insure the validity of the instrument, and in doing this two steps were taken. First, the questionnaire was developed with material taken directly from the leadership training components as presented in Chapter II of this study. Each component was broken down into items which together made up the component. These items were placed individually in the questionnaire to be tested directly. Secondly, 10 individuals with differing educational backgrounds and work experience were chosen to discuss the components and items. The impetus for this discussion was for clarity of the components and to ascertain if the items describing the components were representative of the components. These individuals all work within the health care system at Saint Mary's Hospital, Grand Rapids, Michigan. Some of the positions represented were: President of the hospital, Director of
Pilot Study

A pilot study was conducted to test reliability, clarity, and understanding of the questionnaire. The questionnaire (Appendix A) was distributed to five individuals who were registered nurses working in various areas of the medical field. Their titles were: Nursing Supervisor of a hospital, Supervisor of a home health care agency, Supervisor of a visiting nurses agency, and two nurses that have charge positions in two different hospitals. All of the individuals were working in area hospitals in Grand Rapids, Michigan, and experience and educational background varied from respondent to respondent. After interviewing each respondent concerning the task of completing the instrument, some changes were necessary. The changes were: (a) restating some of the items so that they better represent the components and (b) putting the questionnaire on one sheet so that when ranking the importance of each component, all of the components could be seen, eliminating turning pages back and forth assuring better comprehension of the components.

Distribution of the Questionnaire

The population to which the questionnaires were distributed was the director of nursing and three charge nurses from each of the 67 nursing homes in the west central Michigan area, with the assistance of the administrator of each nursing home. The name of the
administrator of each nursing home was obtained from the 1979 Directory of Hospitals, Nursing Care Facilities, Homes for the Aged, and from the Michigan Department of Public Health. Each administrator received a packet and a cover letter requesting their assistance with the distribution of the survey (Appendix B). The packet contained cover letters (Appendix B) and questionnaires (Appendix A) for the director of nursing and the charge nurses, these to be distributed at the discretion of the nursing home administrator.

Collection of the Data

Following the granted approval of the Human Subjects Review Board of Western Michigan University, each respondent was sent a cover letter (Appendix A), a copy of the questionnaire, along with a self-addressed stamped envelope and a postcard via the United States Mail. One new dimension was included here that was not part of the pilot study. The respondents were told that along with each questionnaire, a postcard was included (Appendix B). The purpose of this postcard was to generate a list of nonrespondents, should it be needed for follow-up purposes. The postcard did seek the identity of the nursing home, the respondent's title, and the shift worked. The questionnaires did not seek the identity of the respondents or the nursing homes.

Respondents were then told that their responses would be kept strictly confidential and to further insure confidentiality, the results of the survey would be compiled along with other respondents resulting in a group score. The respondents were urged to
participate and simultaneously, but separately, return the completed
survey and postcard within 2 weeks.

The follow-up procedure was conducted at the end of the 2-week
period from the initial mailing. Due to the large number of non-
respondents, each nursing home administrator or director of nursing
received a personal telephone call in an attempt to determine why
they did not respond. Based on this determination another set of
questionnaires were again sent out to specific nursing homes, along
with another letter asking for assistance in order to complete the
survey. Respondents were also provided the opportunity to call the
researcher if they had any questions or concerns regarding the sur-
vey. Two more weeks were allotted for return of the survey.

Hypothesis and Statistical Analysis

The research questions addressed in this investigation are
found in Chapter I. Data gathered in previously described processes
were used in descriptive analysis (Questions 1 and 2) and hypothesis
testing (Question 3).

Research Question 1

How do the directors of nursing compare the 14 components of
the proposed leadership training program with what they perceive as
needed for a leadership training program, and how do the charge
nurses compare the 14 components of the proposed leadership training
program with what they perceive as needed for a leadership training
program?
This question was addressed using a descriptive table of frequencies comparing the 14 components of the proposed leadership training program, as perceived by the directors of nursing and charge nurses, with their present leadership training program.

**Research Question 2**

How do the directors of nursing compare the 14 components of the proposed leadership training program with their perceptions of what is being offered in their present leadership training program, and how do the charge nurses compare the 14 components of the proposed leadership training program with their perceptions of what is being offered in their present leadership training program?

This question was addressed the same as Question 1, using a descriptive table of frequencies dealing with what is currently being presented in a leadership training program, as perceived by the directors of nursing and charge nurses.

The conclusions drawn from these data were based on a simple majority of the respondents who participated in the questionnaire survey.

**Research Question 3**

Research Question 3 was concerned with the relationship between the relative ranking of the 14 components by the directors of nursing and charge nurses. The research hypothesis is stated as follows: There is a relationship between the ranking of the 14 components of the leadership training program by the directors of nursing and
charge nurses. The average ranking was compiled from the data obtained from the questionnaires, as perceived by the directors of nursing and charge nurses. The Spearman Rank (rho) statistic was used for computation of the ranked data to test the null hypothesis that the Spearman Rank (rho) correlation coefficient is equal to zero. For the purposes of rejection, the null hypothesis at the .05 alpha level was used.

Summary

In this chapter the methodology of the study was presented. The methodology dealt with the development of the survey by the writer, the survey procedures, and data collection steps, including follow-up procedures.

The chapter concluded with an explanation of the statistical analysis for testing the hypothesis and computation of the ranked data. In the following chapter, the results of the statistical analysis will be presented. Chapter V will follow this with a summary and recommendations for further research in this area of study.
CHAPTER IV

STATEMENT OF RESEARCH FINDINGS

Introduction

The purpose of this study was to develop leadership training program components for charge nurses in nursing homes and to learn if there were differences in the perceptions of the directors of nursing and the charge nurses concerning the proposed components. The population was comprised of the director of nursing and three charge nurses from 67 nursing homes in west central Michigan, a 12-county area.

Chapter IV provides a description of the findings in terms of the participants and nonrespondents. These data were analyzed through descriptive techniques (Questions 1 and 2) and through hypothesis testing (Question 3).

Profile of the Respondents

The information here includes, initially, some pertinent characteristics of the nursing homes represented in the study and a general profile of questionnaire respondents. Next, more specific information is provided relative to the demographic data obtained from the directors of nursing and charge nurses.
General Profile

The research population for this study consisted of the directors of nursing and three charge nurses, one from each shift, of 67 nursing homes in west central Michigan, a 12-county area. The data for this study were gathered through the use of a questionnaire. Following the general procedure outlined in Chapter III, each nursing home was initially sent four questionnaires totaling 268. One to each of the directors of nursing and three to the charge nurses, one from each shift. During the first 2-week period, 82 questionnaires were returned.

Due to the large number of nonrespondents, each nursing home administrator or director of nursing, received a personal telephone call in an attempt to determine why they did not respond. At this time, 17 administrators felt that they were too busy and did not want their staff to take the time to fill out the questionnaires. Only one administrator alluded to the fact that this questionnaire was invading their privacy. Most were of the opinion that the questionnaire was a useful tool for future use, but the nurses just had not found the time to fill them out. This left 200 potential respondents.

Another set of questionnaires were again sent out to specific nursing homes, which resulted in 21 more questionnaires being returned, bringing the total to 103, with 97 others having various reasons for not returning them. Seven questionnaires were eliminated due to missing data or because only one questionnaire was
received from a nursing home. This left 96, or 48%, usable questionnaires for data analysis. This caused some concern of bias toward the survey. Additional contacts by telephone showed the administrators and directors of nursing were in agreement that the survey was something that was needed and then alluded to the fact that the nurses were too busy to fill them out, resulting in a low rate of response. There was no indication that the nonrespondent group was not supportive of this study and that no evidence surfaced leading to any directional bias in their responses when contacted by telephone; therefore, the respondent group appears to represent the population of the study. However, due to lack of respondents, no conclusions will be made about the respondent group representing the population surveyed.

**Demographic Profile**

The directors of nursing and the charge nurses were asked to provide specific demographic data in order to gain insight into their training and experience. This was to assist in developing profiles of the respondents for interpretation of data.

The following tables are a summation of the demographic data obtained from the questionnaire survey. Table 2 is a summation of the program demographics, and Tables 3 and 4 are a summation of the respondent demographics.

In Table 2, the majority, 22 (64.7%) of the directors of nursing and 47 (78.3%) of the charge nurses, indicated their nursing homes do not have leadership training programs for all nurses.
Again with regard to leadership training programs for new nurses, 28 (82.4%) of the directors of nursing and 47 (78.3%) of the charge nurses indicated their nursing homes do not have these programs. The directors of nursing indicated that 13 (38.2%) of their nursing homes do have ongoing leadership training programs and the charge nurses responded with 19 (32.2%) affirmations that their respective nursing homes also offer ongoing leadership training programs for charge nurses. Only 13 (41.9%) of the directors of nursing and 4 (6.8%) of the charge nurses are responsible for leadership training programs in their nursing homes.

Table 2

Leadership Training Program Characteristics of Nursing Homes

<table>
<thead>
<tr>
<th></th>
<th>Director of nursing</th>
<th>Charge nurse</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Freq.  %</td>
<td>Freq.  %</td>
</tr>
<tr>
<td>Programs for all nurses</td>
<td>Yes   12 35.3</td>
<td>Yes 13 21.7</td>
</tr>
<tr>
<td></td>
<td>No     22 64.7</td>
<td>No 47 78.3</td>
</tr>
<tr>
<td>Programs for new nurses</td>
<td>Yes   6 17.6</td>
<td>Yes 13 21.7</td>
</tr>
<tr>
<td></td>
<td>No     28 82.4</td>
<td>No 47 78.3</td>
</tr>
<tr>
<td>Ongoing programs</td>
<td>Yes   13 38.2</td>
<td>Yes 19 32.2</td>
</tr>
<tr>
<td></td>
<td>No     21 61.8</td>
<td>No 40 67.8</td>
</tr>
<tr>
<td>Responsible for programs</td>
<td>Yes  13 41.9</td>
<td>Yes 4 6.8</td>
</tr>
<tr>
<td></td>
<td>No     18 58.1</td>
<td>No 55 93.2</td>
</tr>
</tbody>
</table>

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Table 3
Respondent Demographics--Years of Employment, Years in Present Position, and Age

<table>
<thead>
<tr>
<th></th>
<th>Director of nursing</th>
<th>Charge nurse</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Mean</td>
<td>SD</td>
</tr>
<tr>
<td>Years of employment</td>
<td></td>
<td></td>
</tr>
<tr>
<td>before present position</td>
<td>1.75</td>
<td>2.62</td>
</tr>
<tr>
<td>Years in present position</td>
<td>5.65</td>
<td>4.99</td>
</tr>
<tr>
<td>Age</td>
<td>41.46</td>
<td>11.62</td>
</tr>
</tbody>
</table>

Table 4
Respondent Demographics--Education Level, Sex, and Employment Status

<table>
<thead>
<tr>
<th></th>
<th>Director of nursing</th>
<th>Charge nurse</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Freq.</td>
<td>%</td>
</tr>
<tr>
<td>Education level</td>
<td></td>
<td></td>
</tr>
<tr>
<td>RN</td>
<td>30</td>
<td>90.9</td>
</tr>
<tr>
<td>BS/BA</td>
<td>1</td>
<td>3.0</td>
</tr>
<tr>
<td>BSN</td>
<td>2</td>
<td>6.1</td>
</tr>
<tr>
<td>LPN</td>
<td>--</td>
<td>--</td>
</tr>
<tr>
<td>Missing data</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Sex</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Male</td>
<td>1</td>
<td>2.9</td>
</tr>
<tr>
<td>Female</td>
<td>33</td>
<td>97.1</td>
</tr>
<tr>
<td>Missing data</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Employment status</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Full time</td>
<td>34</td>
<td>100.0</td>
</tr>
<tr>
<td>Part time</td>
<td>--</td>
<td>--</td>
</tr>
<tr>
<td>Missing data</td>
<td>--</td>
<td>1</td>
</tr>
</tbody>
</table>

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In order to test for reliability of the statistics shown in Table 2, a comparison was made between the director of nursing and charge nurse of each of the 34 nursing homes surveyed in this study. The comparison for the first question which asked if leadership training programs were presented for all nurses in their respective nursing homes revealed that 27 out of 34, or 79.4%, of the directors of nursing and charge nurses were in agreement as to their perceptions of what was being presented in their nursing homes. The second question asked if programs for new nurses were being offered. The directors of nursing and charge nurses responded to the question with 27 out of 34, or 79.4%, agreement as to their perceptions of what was being offered for new nurses. The third question was concerned with whether there was ongoing leadership programs in the respective nursing homes, and 23 out of 34, or 67.6%, of the directors of nursing and charge nurses were in agreement as to their perceptions of ongoing leadership programs being available; therefore, the reported data on leadership training programs in the nursing homes appears to be reliable.

In Table 3 three areas of demographic data will be discussed. The first area concerns the years of employment at their present place of employment before obtaining their present position. The directors of nursing presented a mean of 1.75 years with the charge nurses .71 years. The second area deals with years of employment in their present positions. The directors of nursing have a mean of 5.65 years and the charge nurses 6.32 years. The third area shows the mean age of the directors of nursing as 41.46 years and the
charge nurses as 40.95 years.

Examination of the survey data from 96 respondents (see Table 4) indicated that of the 34 directors of nursing, 30 (90.9%) were registered nurses, with 1 (3.0%) having a BS/BA degree and 2 (6.1%) revealed that they had a BSN degree. The charge nurses indicated that 22 (36.1%) were registered nurses with 2 (3.2%) having a BSN degree and 37 (60.71%) being licensed practical nurses. The directors of nursing indicated that 1 (2.9%) was a male and 33 (97.1%) were female. The director of nursing is a full-time position, but the charge nurses indicated that 33 (54.1%) worked full time and 28 (45.9%) worked part time.

Data Analysis

Research Question 1

The first research question addressed in this study was how do the directors of nursing compare the 14 components of the proposed leadership training program with what they perceive as needed for a leadership program, and how do the charge nurses compare the 14 components of the proposed leadership training program with what they perceive as needed for a leadership training program?

The data shown in Table 5 indicated that the range of support for each of the components was 75.9% to 96.7% for the directors of nursing and 82.4% to 100% for the charge nurses. There is an indication, based on these data, that the 14 components presented should definitely be a part of a leadership training program for charge
Table 5

Should These Components Be a Part of a Leadership Training Program

<table>
<thead>
<tr>
<th>Component</th>
<th>Director of nursing</th>
<th>Charge nurse</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Freq.</td>
<td>%</td>
</tr>
<tr>
<td>Leadership responsibility</td>
<td>Yes</td>
<td>29</td>
</tr>
<tr>
<td></td>
<td>No</td>
<td>1</td>
</tr>
<tr>
<td>Group effectiveness</td>
<td>Yes</td>
<td>28</td>
</tr>
<tr>
<td></td>
<td>No</td>
<td>2</td>
</tr>
<tr>
<td>Communication</td>
<td>Yes</td>
<td>29</td>
</tr>
<tr>
<td></td>
<td>No</td>
<td>1</td>
</tr>
<tr>
<td>Decision making</td>
<td>Yes</td>
<td>25</td>
</tr>
<tr>
<td></td>
<td>No</td>
<td>4</td>
</tr>
<tr>
<td>Individual motivation</td>
<td>Yes</td>
<td>25</td>
</tr>
<tr>
<td></td>
<td>No</td>
<td>2</td>
</tr>
<tr>
<td>Planning for change</td>
<td>Yes</td>
<td>26</td>
</tr>
<tr>
<td></td>
<td>No</td>
<td>3</td>
</tr>
<tr>
<td>Appraisal of personnel</td>
<td>Yes</td>
<td>28</td>
</tr>
<tr>
<td></td>
<td>No</td>
<td>3</td>
</tr>
<tr>
<td>Authority and hierarchy</td>
<td>Yes</td>
<td>28</td>
</tr>
<tr>
<td></td>
<td>No</td>
<td>3</td>
</tr>
<tr>
<td>Creativity</td>
<td>Yes</td>
<td>22</td>
</tr>
<tr>
<td></td>
<td>No</td>
<td>7</td>
</tr>
<tr>
<td>Consultive process</td>
<td>Yes</td>
<td>29</td>
</tr>
<tr>
<td></td>
<td>No</td>
<td>2</td>
</tr>
<tr>
<td>Self-development</td>
<td>Yes</td>
<td>27</td>
</tr>
<tr>
<td></td>
<td>No</td>
<td>3</td>
</tr>
<tr>
<td>Problem solving</td>
<td>Yes</td>
<td>29</td>
</tr>
<tr>
<td></td>
<td>No</td>
<td>2</td>
</tr>
<tr>
<td>Ethics</td>
<td>Yes</td>
<td>27</td>
</tr>
<tr>
<td></td>
<td>No</td>
<td>3</td>
</tr>
<tr>
<td>Learning climate</td>
<td>Yes</td>
<td>27</td>
</tr>
<tr>
<td></td>
<td>No</td>
<td>3</td>
</tr>
</tbody>
</table>
nurses in nursing homes.

Research Question 2

The second research question addressed in this study was concerned with how do the directors of nursing compare the 14 components of the proposed leadership training program with their perception of what is being offered in their present leadership training program, and how do the charge nurses compare the 14 components of the proposed leadership training program with their perception of what is being offered in their present leadership training program?

Table 6, relative to Question 2, presents the responses to this question. The range of responses showing that their programs contain these components was 30.0% to 68.8% for the directors of nursing and 27.8% to 63.6% for the charge nurses. The directors of nursing indicated that the following components were offered in 50% or more cases: (a) appraisal of personnel, (b) problem solving, (c) leadership responsibility, (d) group effectiveness, (e) communication, (f) decision making, and (g) ethics. The charge nurses indicated the following component was offered in 50% or more cases: problem solving.

Both the directors of nursing and the charge nurses indicated they have problem solving as a part of their leadership training programs. They also indicated that creativity, authority and hierarchy, and learning climate were not usually included in their leadership training programs. In conclusion, the majority of the components of the proposed leadership training program for charge nurses
<table>
<thead>
<tr>
<th>Component</th>
<th>Director of nursing</th>
<th>Charge nurse</th>
</tr>
</thead>
<tbody>
<tr>
<td>Leadership responsibility</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>19</td>
<td>23</td>
</tr>
<tr>
<td>No</td>
<td>13</td>
<td>33</td>
</tr>
<tr>
<td>Group effectiveness</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>18</td>
<td>26</td>
</tr>
<tr>
<td>No</td>
<td>14</td>
<td>31</td>
</tr>
<tr>
<td>Communication</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>17</td>
<td>26</td>
</tr>
<tr>
<td>No</td>
<td>15</td>
<td>31</td>
</tr>
<tr>
<td>Decision making</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>16</td>
<td>21</td>
</tr>
<tr>
<td>No</td>
<td>16</td>
<td>34</td>
</tr>
<tr>
<td>Individual motivation</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>15</td>
<td>25</td>
</tr>
<tr>
<td>No</td>
<td>17</td>
<td>29</td>
</tr>
<tr>
<td>Planning for change</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>12</td>
<td>21</td>
</tr>
<tr>
<td>No</td>
<td>19</td>
<td>33</td>
</tr>
<tr>
<td>Appraisal of personnel</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>22</td>
<td>27</td>
</tr>
<tr>
<td>No</td>
<td>10</td>
<td>29</td>
</tr>
<tr>
<td>Authority and hierarchy</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>10</td>
<td>18</td>
</tr>
<tr>
<td>No</td>
<td>20</td>
<td>35</td>
</tr>
<tr>
<td>Creativity</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>9</td>
<td>15</td>
</tr>
<tr>
<td>No</td>
<td>21</td>
<td>39</td>
</tr>
<tr>
<td>Consultive process</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>15</td>
<td>24</td>
</tr>
<tr>
<td>No</td>
<td>16</td>
<td>31</td>
</tr>
<tr>
<td>Self-development</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>12</td>
<td>21</td>
</tr>
<tr>
<td>No</td>
<td>20</td>
<td>33</td>
</tr>
<tr>
<td>Problem solving</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>21</td>
<td>35</td>
</tr>
<tr>
<td>No</td>
<td>11</td>
<td>35</td>
</tr>
<tr>
<td>Ethics</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>16</td>
<td>23</td>
</tr>
<tr>
<td>No</td>
<td>16</td>
<td>31</td>
</tr>
<tr>
<td>Learning climate</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>11</td>
<td>18</td>
</tr>
<tr>
<td>No</td>
<td>20</td>
<td>35</td>
</tr>
</tbody>
</table>
in nursing homes are not being offered as a part of the leadership training programs.

Research Question 3

The third research question addressed in this study sought to examine the hypothesis of will there be a relationship in the perceptions of the directors of nursing and charge nurses about the content of a leadership training program. The null hypothesis stated that no relationship would be found between the two perceptions. The nondirectional alternate hypothesis indicated that a relationship would be found.

The statistical analysis shown in Table 7 indicates that there is a relationship in the perceptions of the directors of nursing and charge nurses about the importance of the rank ordering of the 14 components proposed for a leadership training program for charge nurses in nursing homes. The Spearman Rank (rho) statistic test resulted in a .90 correlation coefficient which was significant at the .05 level. The null hypothesis of zero correlation was rejected.

Summary

This chapter presented a profile of the respondents who participated in this study and a report of the statistical analysis of the results, with reference to each of the three basic research questions.
Table 7
Rank Ordering of Components of Proposed Program Content

<table>
<thead>
<tr>
<th>Component</th>
<th>Director of nursing</th>
<th>Charge nurse</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Mean ranking</td>
<td>Rank order</td>
</tr>
<tr>
<td>Leadership responsibility</td>
<td>1.93</td>
<td>1</td>
</tr>
<tr>
<td>Communication</td>
<td>3.12</td>
<td>2</td>
</tr>
<tr>
<td>Problem solving</td>
<td>5.14</td>
<td>3</td>
</tr>
<tr>
<td>Group effectiveness</td>
<td>5.35</td>
<td>4</td>
</tr>
<tr>
<td>Decision making</td>
<td>5.63</td>
<td>5</td>
</tr>
<tr>
<td>Appraisal of personnel</td>
<td>5.58</td>
<td>6</td>
</tr>
<tr>
<td>Individual motivation</td>
<td>6.23</td>
<td>7</td>
</tr>
<tr>
<td>Ethics</td>
<td>7.71</td>
<td>8</td>
</tr>
<tr>
<td>Planning for change</td>
<td>8.13</td>
<td>9</td>
</tr>
<tr>
<td>Consultive process</td>
<td>8.17</td>
<td>10</td>
</tr>
<tr>
<td>Self-development</td>
<td>8.35</td>
<td>11</td>
</tr>
<tr>
<td>Creativity</td>
<td>9.41</td>
<td>12</td>
</tr>
<tr>
<td>Authority and hierarchy</td>
<td>9.53</td>
<td>13</td>
</tr>
<tr>
<td>Learning climate</td>
<td>10.71</td>
<td>14</td>
</tr>
</tbody>
</table>

Note. Correlation coefficient = .90.
A comparison of the perceptions of the directors of nursing and charge nurses from 34 nursing homes was made. The comparisons were: (a) what leadership program content is currently being presented in nursing homes, (b) what program content should be presented, and (c) a comparison of perceptions concerning the rank ordering of the 14 components proposed for a leadership training program for charge nurses in nursing homes.

Descriptive analysis for the first and second research questions demonstrated that the directors of nursing and charge nurses were in agreement as to their perceptions concerning leadership program content that is currently being offered in the nursing homes. They do, overwhelmingly, support the fact that the proposed 14 components for a leadership training program should be a part of a leadership training program for charge nurses in nursing homes.

Hypothesis testing by the Spearman Rank (rho) statistic was utilized for the third research question which resulted in a positive correlation coefficient of .90 which alludes to the fact that the directors of nursing and charge nurses agree on the rank ordering of the 14 components proposed for a leadership training program.

The next and final chapter provides a summary of the entire study, statements and discussion of conclusions, and recommendations for future research.
CHAPTER V

SUMMARY, CONCLUSIONS, AND RECOMMENDATIONS

Introduction

Chapter V completes the study with a presentation of the conclusions and recommendations for future research. Specifically, this chapter will be divided into several major sections: (a) summary of the study, (b) summary of the findings and conclusions, and (c) recommendations for future research.

Summary of the Study

Purpose and Rationale

Society is demanding that nursing homes provide competent services to the community. Competence cannot be obtained without professional training and development of expertise by the personnel in the nursing homes. Therefore, the purpose of this study was to develop leadership training program components for charge nurses in nursing homes, and to learn if there were differences in the perceptions of the directors of nursing and the charge nurses concerning the proposed components.

The intent of a leadership training program is effective leadership which leads to several results: a spirit of cooperation and enthusiasm based on good human relationships, well-trained skilled workers, and an efficiently run organization, able to meet its goals.
Good leadership improves job performance which leads to improved patient care.

The specific role of the charge nurse was selected for study due to its importance or stand in the hierarchy within the nursing home. The nursing home does vest considerable responsibility in the charge nurse for proper patient care and the directing of employees in this care. Some of these responsibilities are: assessing patient care needs, planning nursing care, and evaluating the effectiveness of the nursing care. As a manager the charge nurse also has the responsibility to plan, organize, staff, direct, coordinate, and control other employees.

A review of literature found that the role of the charge nurse in nursing homes has received very little discussion of research, especially in the area of leadership. This review was accomplished by using the Psychological Abstracts, Education Index, Business Periodical Index, Dissertation Abstracts, Medical Journals and Publications, Social Science Index, and use of the on-line automated Reference Services.

In order to accomplish the stated purpose, the following research questions were developed.

1. How do the directors of nursing compare the 14 components of the proposed leadership training program with what they perceive as needed for a leadership training program, and how do the charge nurses compare the 14 components of the proposed leadership training program with what they perceive as needed for a leadership training program?
2. How do the directors of nursing compare the 14 components of the proposed leadership training program with their perceptions of what is being offered in their present leadership training program, and how do the charge nurses compare the 14 components of the proposed leadership training program with their perceptions of what is being offered in their present leadership training program?

3. Will there be differences in the perceptions of the directors of nursing and the charge nurses about the content of a leadership training program?

The methodology used for this investigation was a mail survey. A population of 268 individuals, the director of nursing and three charge nurses from 67 nursing homes, in west central Michigan, a 12-county area, was utilized. Data were collected by means of a questionnaire with one telephone follow-up call and one mailing follow-up. One instrument was used in the survey.

The Research Questions 1 and 2 were analyzed through descriptive frequencies and Research Question 3 was analyzed using the Spearman Rank (rho) statistic for rank ordering. This was done at an alpha level of .05.

Description of Respondents

A general profile of the questionnaire respondents revealed that 88.3% of the directors of nursing were registered nurses, with only 5.9% of them having a BSN degree and 2.9% of them having a BS/BA degree. The charge nurses indicated that 59.7% are licensed practical nurses, and 35.5% are registered nurses, with only 3.2%
having a BSN degree.

The years of employment in their present positions were very low with the directors of nursing having a mean of 5.65 years, and the charge nurses showing a mean of .71 years. There appears to be a high rate of turnover in these positions. The mean age for the directors of nursing was 41.46 years with the mean age for charge nurses being 40.95 years.

All but one of the directors of nursing indicated they were female, the same being true of the charge nurses. The directors of nursing, by law, are to have a full-time position, but the charge nurses may work full time and part time and were divided with 53.2% full time and 45.2% part time.

These data were compiled with only 48% return of the questionnaires from the population that was surveyed. This did cause some concern of bias toward the survey. When personally contacted the administrators and directors of nursing were in agreement that the survey was something that was needed and then alluded to the fact that the nurses were too busy to fill them out, resulting in a low rate of response. There was no indication that the nonrespondent group was not supportive of this study and no evidence surfaced leading to any directional bias in their responses when contacted by telephone; therefore, the respondent group appears to represent the population of the study. Most respondents were willing to comment beyond the confines of the survey.
Findings and Conclusions

Research Question 1

The first research question addressed the topic of how do the directors of nursing compare the 14 components of the proposed leadership training program with what they perceive as needed for a leadership training program, and how do the charge nurses compare the 14 components of the proposed leadership training program with what they perceive as needed for a leadership training program?

The 14 components presented in this study were necessary components of a leadership training program, according to data analysis presented through frequency distribution. The data (Table 5) indicated a range of support of 75.9% to 96.7% for the directors of nursing and 82.4% to 100.0% for the charge nurses.

Conclusion. The director of nursing and charge nurses overwhelmingly recognized the importance of the proposed components for a leadership training program and indicated that all of these components should be in a program.

Discussion. In the study of leadership positions in nursing, Moloney (1979) reported that leadership or the lack of it has a definite bearing on the effectiveness of the society in which it exists. This is true of nursing leadership since it affects the quality of care for clients and the contributions made by nurses in nursing service, nursing education, and health care in general.
The fact that "all" nurses are perceived to have leadership ability is a disillusion that has plagued the nursing profession for years. For the nurse who assumes managerial and leadership responsibility there must be provision in curriculum for management and organization theory, so that the nurse as a manager and leader can be more comfortable and confident in that role.

Research Question 2

The second research question addressed the topic of how do the directors of nursing compare the 14 components of the proposed leadership training program with their perceptions of what is being offered in their present leadership training program, and how do the charge nurses compare the 14 components of the proposed leadership training program with their perceptions of what is being offered in their present leadership training program?

According to the data (Table 6), the directors of nursing indicated a range of responses from 30.0% to 68.8% and the charge nurses indicated 27.8% to 63.6% that the proposed leadership training program components were presently in their training programs. The directors of nursing indicated that the following components were offered in 50% of the cases: (a) appraisal of personnel, (b) problem solving, (c) leadership responsibility, (d) group effectiveness, (e) communication, (f) decision making, and (g) ethics. The charge nurses indicated that the following component was offered in 50% or more cases: problem solving.
Conclusions. Leadership training needs to be expanded as perceived by the directors of nursing and more important the charge nurses are getting very little of this training. This conclusion was based on the simple majority of the respondents who were surveyed.

Discussion. The data analysis revealed that only a few of the components of the proposed leadership training program were currently being offered in the nursing homes.

According to Moloney (1979), in many of our health care institutions remarkable progress has been made in quality care improvement programs and, more recently, instituting primary care. These results required effective leadership, risk taking, and innovations. Although leadership is expected of all nurses, it is to the administrators of nursing service and educational programs that we continue to look for forward movement. These nurses are in an excellent position to greatly affect the advancement of nursing as a professional discipline by encouraging the efforts of those practitioners and researchers who are endeavoring to provide a sound theoretical base for clinical practice.

It would appear, from the results of this study, that education should be of utmost importance to the directors of nursing and their understanding of the plight of the charge nurse, especially, the difficulty they encounter in management and leadership roles without the necessary expertise to carry out their expected roles.
Research Question 3

The third research question addressed in this study was concerned with will there be differences in the perceptions of the director of nursing and the charge nurses about the content of a leadership training program. Data pursuant to this topic were analyzed through hypothesis testing using the Spearman Rank (rho) statistic, used expressly for rank ordering of items.

The 14 components proposed as content of a leadership training program for charge nurses in nursing homes were ranked in order of importance as perceived by the directors of nursing and charge nurses. The components having the highest mean rankings by the directors of nursing and charge nurses according to the data analysis (Table 7) were: appraisal of personnel, problem solving, leadership responsibility, and group effectiveness.

Conclusion. There is a positive relationship in the perceptions of the directors of nursing and charge nurses about the importance of the rank ordering of the 14 components proposed for a leadership training program for charge nurses in nursing homes.

Discussion. These findings reflect an awareness and comprehension of what is needed in nursing education today. According to Colton (1976), leadership in professional nursing requires a knowledge of political, legal, social, cultural, technological, fiscal, professional conditions, and labor relations which influence and affect all programs of health care. It also requires courage,
competence, moral integrity, and the political shrewdness to deal with problems in the area of complex relationships of a group of highly skilled and knowledgeable professional people who practice within a very complex and changing social system.

Colton (1976) also alluded to the fact that because of poor leadership, we are unable to protect professional nursing from the onslaught of aging and institutional administrative power blocs and from the many groups who dispense various kinds of patient care with little or no control over the quality. Colton stated, "let the nurses be united in strength and courage, with a strong and vital professional organization, leaders who are courageous, capable, and intelligent should be in leadership positions" (p. 37).

It is apparent that the nurses agree on what should be and need to convince administration that continuing education is essential for them to upgrade skills and keep pace with the changes in the nursing profession as it pertains to leadership skills.

Recommendations for Future Research

It has been stated throughout this dissertation that leadership and management skills are necessary elements in all positions held by professional nurses, from the director of nursing services to the staff nurse who functions as a team leader or primary nurse. All job specifications in nursing are oriented toward the management of people and things. The principles of management and the techniques used to implement these principles are the same for all nurse managers; the difference among the staff nurse, head nurse, supervisor,
and the director are based upon the job description and its position on the organizational chart.

This study has definitely substantiated the notion that leadership training programs are lacking for the charge nurses in nursing homes. Hedman et al. (1976) brought out the fact that the charge nurse in the nursing home has been a long neglected person. The charge nurse was much in need of some form of educational upgrading to help him/her become more knowledgeable in the field and increase his/her expertise in caring for the elderly. In part, the reasons for this were that the charge nurse in many homes had obtained little education beyond their 1- or 3-year nursing programs completed 15 to 20 years ago and had little opportunity to keep abreast of current trends and developments in the care of the aged through relevant educational programs and courses.

Moloney (1979) discussed the fact that a renaissance, a reawakening of what can be, not what is, should be the prevailing attitude among nurses. Focusing constantly on the profession's resistance to change is to misdefine the problems that confront us. According to Drucker (1974), "the right way to define the problem so as to make it capable of resolution is as a challenge to create, build, and maintain the innovative (profession), the (profession) for which change is norm rather than the exception, and opportunity rather than threat" (p. 797).

Alluding to the fact that only 48% of the respondents returned the questionnaires demonstrates a concern of bias regarding the proposed leadership training program for charge nurses in nursing homes.
When personally contacted, the administrators and directors of nursing were in agreement that the survey was something that was needed and then brought out the fact that the nurses were too busy to fill them out, resulting in a low rate of response. This area must definitely be addressed in further research.

Also the fact was established that the director of nursing and charge nurses both agree that the proposed leadership program content should be a necessary part of a leadership training program, but presently this was not being offered.

It was the writer's main concern in the undertaking of the study to develop leadership training program components for charge nurses in nursing homes and to compare the perceptions of the directors of nursing and charge nurses as to the need for and availability of these components in their respective nursing homes.

The literature existing is sparse and fragmented. It is hoped that this study can be a beginning not only for development of future research but also for opening the doors of the nursing homes and to be allowed to assess the areas that leadership is lacking; and based on the assessment, to offer the programs needed, helping the nurses gain new skills enabling them to feel confident and become leaders that are role models for others to follow.

A systematic and encompassing needs assessment for all situations should be made to determine the starting point for training development—this to be accomplished by further surveying in an organized fashion for their professional opinion.
The further research must include structuring and development of training programs; such as, surveying, assessment, implementation, and evaluation, as well as continuing in-service education where feedback is obtained, information is given, and progress is measured.

If these recommendations are pursued, additional research can only improve the profession. Ignoring improvements in leadership nursing skills will hinder rather than improve. Failure is inevitable unless everyone involved accepts responsibility for continued improvement in the profession.

The intent is optimum patient care, and unless the leaders are competent to lead, the followers have no role model to pattern after and the status quo stays the same which could prove very costly for the nursing home industry.
Appendix A

Questionnaire
SURVEY QUESTIONNAIRE
FOR
DIRECTORS OF NURSING
IN
NURSING HOMES
PART I
INSTRUCTIONS

1. Read the definition for the topic.
2. Answer Column A by checking box yes or no.
3. Answer Column B by checking box yes or no.
4. Rank order, according to their importance, the items you will check from Column B. When ranking, begin with one (1) as the most important, ending with (14).

EXAMPLE: What are the necessary tasks involved in buying a home?

<table>
<thead>
<tr>
<th>COLUMN A</th>
<th>COLUMN B</th>
<th>COLUMN C (Rank)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Learn the age of home</td>
<td>Yes ☐ No ☐</td>
<td>Yes ☒ No ☐</td>
</tr>
<tr>
<td>Learn of structural problems</td>
<td>Yes ☐ No ☐</td>
<td>Yes ☒ No ☐</td>
</tr>
<tr>
<td>Learn tax problems</td>
<td>Yes ☒ No ☐</td>
<td>Yes ☒ No ☐</td>
</tr>
<tr>
<td>Learn price of home</td>
<td>Yes ☒ No ☐</td>
<td>Yes ☒ No ☐</td>
</tr>
<tr>
<td>Find out names of previous owners</td>
<td>Yes ☐ No ☐</td>
<td>Yes ☐ No ☐</td>
</tr>
</tbody>
</table>

COLUMN A is asking if this item is a part of your present training program for charge nurses in your nursing home. This program must have been presented to your charge nurses within the past 12 months, and must be a formal program. Individual orientation for new employees should not be considered a training program FOR THE PURPOSES OF THIS STUDY.

COLUMN B asks your professional opinion as to whether the component should be a part of training for charge nurses in the nursing home.

PROGRAM CONTENT

Program content is defined as the information presented during training.

The following fourteen components are topics of areas of program content. Note: When doing Column C, rank the importance of the components in Column B from 1 to 14, with 1 being the most important and 14 being the least important.
<table>
<thead>
<tr>
<th></th>
<th>A Is this in your program?</th>
<th>B Should this be a part of your program?</th>
<th>C Rank in order of importance items from Column B</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>Leadership responsibility: persuading, counseling, joining, delegating, telling</td>
<td>Yes □ No □</td>
<td>Yes □ No □</td>
</tr>
<tr>
<td>2.</td>
<td>Group effectiveness: participation, communication, cohesion, atmosphere, standards</td>
<td>Yes □ No □</td>
<td>Yes □ No □</td>
</tr>
<tr>
<td>3.</td>
<td>Communication: organizational position, commitment to the ideas, cultural conditioning, meanings are in people</td>
<td>Yes □ No □</td>
<td>Yes □ No □</td>
</tr>
<tr>
<td>4.</td>
<td>Decision-making: background factors, perception, analytical process, action and reaction</td>
<td>Yes □ No □</td>
<td>Yes □ No □</td>
</tr>
<tr>
<td>5.</td>
<td>Individual motivation: the person and the environment, behavior - what makes sense, perception of situation, influenced by needs</td>
<td>Yes □ No □</td>
<td>Yes □ No □</td>
</tr>
<tr>
<td>6.</td>
<td>Planning for change: how to analyze change, communication, power, decision-making, examination of alternatives</td>
<td>Yes □ No □</td>
<td>Yes □ No □</td>
</tr>
<tr>
<td>7.</td>
<td>Appraisal of personnel: establishing objectives, setting targets, evaluation progress, feedback</td>
<td>Yes □ No □</td>
<td>Yes □ No □</td>
</tr>
<tr>
<td>8.</td>
<td>Authority and hierarchy: the leaders role, perceptions, reality testing</td>
<td>Yes □ No □</td>
<td>Yes □ No □</td>
</tr>
<tr>
<td>9.</td>
<td>Creativity: sensitivity to surroundings, mental flexibility, ability to abstract, ability to synthesize</td>
<td>Yes □ No □</td>
<td>Yes □ No □</td>
</tr>
<tr>
<td>10.</td>
<td>Consultive process: diagnosing the situation, identify readiness for change, developing plan for change, the change goals</td>
<td>Yes □ No □</td>
<td>Yes □ No □</td>
</tr>
<tr>
<td>11.</td>
<td>Self-development: learning is internal, learning efficient when goals clear, change in behavior, self assessment</td>
<td>Yes □ No □</td>
<td>Yes □ No □</td>
</tr>
<tr>
<td>12.</td>
<td>Problem solving: defining the problem, working on the problem, testing and action, assessment and re-planning</td>
<td>Yes □ No □</td>
<td>Yes □ No □</td>
</tr>
<tr>
<td>13.</td>
<td>Ethics: individual, social, organizational</td>
<td>Yes □ No □</td>
<td>Yes □ No □</td>
</tr>
<tr>
<td>14.</td>
<td>Learning climate: lifetime learning, physiological changes, interest changes, learning involves the whole person</td>
<td>Yes □ No □</td>
<td>Yes □ No □</td>
</tr>
</tbody>
</table>

If you have any additional comments, write them here:
PART II
Instructions — Director of Nursing

Check the correct answer, or when necessary, write the correct answer. Please answer all questions.

1. In the past 12 months, has your nursing home had leadership training for all charge nurses employed within the nursing home? Yes □ No □
2. In the past 12 months, has your nursing home had leadership training for new charge nurses only? Yes □ No □
3. Is there an ongoing leadership training program (presented yearly)? Yes □ No □
4. Are you responsible for leadership program training in your nursing home? Yes □ No □
5. What is your education level?
   □ LPN; □ RN; □ BS/BA; □ BSN; □ MS/MA; □ MSN
   □ Other; □ if other, state: __________________________________________
6. How many years have you been employed at the nursing home prior to being a director of nursing? ___________________________________________
7. How many years have you been a director of nursing in a nursing home? ______
8. Age __________ years
9. Sex: □ male □ female
10. Employment status: □ Full time □ Part time
11. Span of control (how many people do you directly supervise?) ___________
12. If you have any additional comments, write them here:
SURVEY QUESTIONNAIRE FOR CHARGE NURSES IN NURSING HOMES
PART I
INSTRUCTIONS

1. Read the definition for the topic.
2. Answer Column A by checking box yes or no.
3. Answer Column B by checking box yes or no.
4. Rank order, according to their importance, the items you will check from Column B. When ranking, begin with one (1) as the most important, ending with (14).

EXAMPLE: What are the necessary tasks involved in buying a home?

<table>
<thead>
<tr>
<th>A</th>
<th>B</th>
<th>C</th>
</tr>
</thead>
<tbody>
<tr>
<td>Is this in your program? (Do you do this?)</td>
<td>Should this be a part of your program?</td>
<td>Rank in order of importance item from Column B</td>
</tr>
<tr>
<td>1. Learn the age of home</td>
<td>Yes Yes □ No □ Yes □ No □</td>
<td>2</td>
</tr>
<tr>
<td>2. Learn of structural problems</td>
<td>Yes Yes □ No □ Yes □ No □</td>
<td>4</td>
</tr>
<tr>
<td>3. Learn tax problems</td>
<td>Yes Yes □ No □ Yes □ No □</td>
<td>5</td>
</tr>
<tr>
<td>4. Learn price of home</td>
<td>Yes Yes □ No □ Yes □ No □</td>
<td>1</td>
</tr>
<tr>
<td>5. Find out names of previous owners</td>
<td>Yes □ No □ Yes □ No □</td>
<td>5</td>
</tr>
</tbody>
</table>

COLUMN A is asking if this item is a part of your present training program for charge nurses in your nursing home. This program must have been presented to your charge nurses within the past 12 months, and must be a formal program. Individual orientation for new employees should not be considered a training program FOR THE PURPOSES OF THIS STUDY.

COLUMN B asks your professional opinion as to whether the component should be a part of training for charge nurses in the nursing home.

PROGRAM CONTENT

Program content is defined as the information presented during training.

The following fourteen components are topics of areas of program content. Note: When doing Column C, rank the importance of the components in Column B from 1 to 14, with 1 being the most important and 14 being the least important.
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<thead>
<tr>
<th>A Is this in your program?</th>
<th>B Should this be a part of your program?</th>
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</tr>
</thead>
<tbody>
<tr>
<td>1. Leadership responsibility: persuading, counseling, joining, delegating, telling</td>
<td>Yes □ No □ Yes □ No □</td>
<td></td>
</tr>
<tr>
<td>2. Group effectiveness: participation, communication, cohesion, atmosphere, standards</td>
<td>Yes □ No □ Yes □ No □</td>
<td></td>
</tr>
<tr>
<td>3. Communication: organizational position, commitment to the ideas, cultural conditioning, meanings are in people</td>
<td>Yes □ No □ Yes □ No □</td>
<td></td>
</tr>
<tr>
<td>4. Decision-making: background factors, perception, analytical process, action and reaction</td>
<td>Yes □ No □ Yes □ No □</td>
<td></td>
</tr>
<tr>
<td>5. Individual motivation: the person and the environment, behavior - what makes sense, perception of situation, influenced by needs</td>
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<td></td>
</tr>
<tr>
<td>6. Planning for change: how to analyze change, communication, power, decision-making, examination of alternatives</td>
<td>Yes □ No □ Yes □ No □</td>
<td></td>
</tr>
<tr>
<td>7. Appraisal of personnel: establishing objectives, setting targets, evaluation progress, feedback</td>
<td>Yes □ No □ Yes □ No □</td>
<td></td>
</tr>
<tr>
<td>8. Authority and hierarchy: the leaders role, perceptions, reality testing</td>
<td>Yes □ No □ Yes □ No □</td>
<td></td>
</tr>
<tr>
<td>9. Creativity: sensitivity to surroundings, mental flexibility, ability to abstract, ability to synthesize</td>
<td>Yes □ No □ Yes □ No □</td>
<td></td>
</tr>
<tr>
<td>10. Consultive process: diagnosing the situation, identify readiness for change, developing plan for change, the change goals</td>
<td>Yes □ No □ Yes □ No □</td>
<td></td>
</tr>
<tr>
<td>11. Self-development: learning is internal, learning efficient when goals clear, change in behavior, self assessment</td>
<td>Yes □ No □ Yes □ No □</td>
<td></td>
</tr>
<tr>
<td>12. Problem solving: defining the problem, working on the problem, testing and action, assessment and re-planning</td>
<td>Yes □ No □ Yes □ No □</td>
<td></td>
</tr>
<tr>
<td>13. Ethics: individual, social, organizational</td>
<td>Yes □ No □ Yes □ No □</td>
<td></td>
</tr>
<tr>
<td>14. Learning climate: lifetime learning, physiological changes, interest changes, learning involves the whole person</td>
<td>Yes □ No □ Yes □ No □</td>
<td></td>
</tr>
</tbody>
</table>
PART II
Instructions — Charge Nurse

Check the correct answer, or when necessary, write the correct answer. Please answer all questions.

1. In the past 12 months, has your nursing home had leadership training for all charge nurses employed within the nursing home? Yes □ No □
2. In the past 12 months, has your nursing home had leadership training for new charge nurses only? Yes □ No □
3. Is there an ongoing leadership training program (presented yearly)? Yes □ No □
4. Are you responsible for leadership program training in your nursing home? Yes □ No □
5. What is your education level?
   □ LPN; □ RN; □ BS/BA; □ BSN; □ MS/MA; □ MSN
   □ Other; □ if other, state: ________________________________
6. How many years have you been employed at the nursing home prior to being a charge nurse? ________________________________
7. How many years have you been a charge nurse in a nursing home? __________
8. Age __________ years
9. Sex: □ male □ female
10. Shift usually worked: □ 7 a.m.-3 p.m.; □ 3 p.m.-11 p.m.; □ 11 p.m.-7 a.m.
11. Employment status: □ Full time □ Part time
12. Span of control (how many people do you directly supervise?) ______________
13. If you have any additional comments, write them here:
Appendix B

Cover Letter
Dear Charge Nurse:

I am a graduate student at Western Michigan University completing doctoral studies involving the study of leadership training programs for charge nurses in nursing homes and the components that make up these programs. To date, research indicates this area of training is very important, but little has been done to determine if these programs are offered, and if offered the content and method of leadership training that evolves out of these programs.

Your assistance is requested to study this topic by completing this questionnaire. Approximately fifteen (15) minutes of your time is needed to complete the survey. The responses are urgently needed. Please do not assume that others will respond and that your responses do not make a difference. The greater number of responses, the greater the accuracy of results. These responses will be kept strictly confidential. All surveys received will be compiled into a group score, further insuring confidentiality.

Enclosed is a questionnaire surveying various components that through research have been proposed as the components that should be a part of a leadership training program. The topic is program content. Also included in this survey are questions concerning demographics, academic and professional experiences. These statistics to be used for profiles ensuring accurate interpretation of data.

Please return the survey within two weeks. A self-addressed stamped envelope is provided for convenience. Also enclosed is a self-addressed stamped postcard. This is for follow-up purposes should this be necessary. Please mail the completed postcard and survey instrument.

If you have any questions regarding the survey, please contact me at Area Code 616-774-6062, during normal business hours.

Thank you for your cooperation.

Sincerely,
Joanne E. Smith, RN, MA, NHA

Richard Munsterman, Ph.D
Doctoral Advisor
Dear Administrator:

I am a graduate student at Western Michigan University completing doctoral studies involving the study of leadership training programs for charge nurses in nursing homes and the components that make up these programs. To date, research indicates this area of training is very important, but little has been done to determine if these programs are offered, and if offered the content and method of leadership training that evolves out of these programs.

Your assistance is requested to study this topic by giving out the questionnaires to the appropriate personnel. I can assure you that all questionnaire responses will be held in the strictest confidence. Data gathered via this instrument and similar ones will be reported only in summary form and in no way will serve to identify individual respondents or their nursing homes. Postcards are used for data management and follow-up purposes only.

Enclosed are questionnaires surveying the Director of Nursing (envelope with yellow label), and one (1) charge nurse from each shift (envelope with blue label).

The survey questions pertain to leadership training program content, demographics, academic and professional experiences.

If you have any questions concerning the survey, please contact me at Area Code 616-774-6062 during normal business hours.

Thank you for your assistance and cooperation.

Sincerely,

Joanne E. Smith, RN, MA, NHA

Richard Munsterman, Ph.D
Doctoral Advisor
October 1, 1982

Dear Director of Nursing:

I am a graduate student at Western Michigan University completing doctoral studies involving the study of leadership training programs for charge nurses in nursing homes and the components that make up these programs. To date, research indicates this area of training is very important, but little has been done to determine if these programs are offered, and if offered the content and method of leadership training that evolves out of these programs.

Your assistance is requested to study this topic by completing this questionnaire. Approximately fifteen (15) minutes of your time is needed to complete the survey. The responses are urgently needed. Please do not assume that others will respond and that your responses do not make a difference. The greater number of responses, the greater the accuracy of results. These responses will be kept strictly confidential. All surveys received will be compiled into a group score, further insuring confidentiality.

Enclosed is a questionnaire surveying various components that through research have been proposed as the components that should be a part of a leadership training program. The topic is program content. Also included in this survey are questions concerning demographics, academic and professional experiences. These statistics to be used for profiles ensuring accurate interpretation of data.

Please return the survey within two weeks. A self-addressed stamped envelope is provided for convenience. Also enclosed is a self-addressed stamped postcard. This is for follow-up purposes should this be necessary. Please mail the completed postcard and survey instrument.

If you have any questions regarding the survey, please contact me at Area Code 616-774-6062, during normal business hours.

Thank you for your cooperation.

Sincerely,

Joanne E. Smith, RN, MA, NHA
Richard Munsterman, Ph.D
Doctoral Advisor
Appendix C

Respondents' Return Postcard
I have completed and returned the Leadership Training Program Survey.

Name of Nursing Home

Title

Shift
Appendix D

Follow-Up Letter
Dear Administrator:

Enclosed are questionnaires surveying the Director of Nursing and three charge nurses from your nursing home. According to my records I only have ______ from your nursing home and should have ______.

On October 22, 1982, I made personal telephone calls to each Administrator or Director of Nursing asking if your personnel would please participate in this survey. Most of you were more than willing to help with this project. At this time I still have not received enough surveys to complete my dissertation. Your assistance in this matter would be greatly appreciated. The postcards mentioned in the cover letters will not be included in this mailing.

If there are any questions regarding this survey, please contact me at Area Code 616-774-6062, during regular business hours.

Thank you for your assistance and cooperation.

Sincerely,

Joanne E. Smith, RN, MA, NHA

Richard Munsterman, Ph.D.
Doctoral Advisor

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