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Feeling Overwhelmed: The Lived Experience of Nurse Managers

A dissertation
presented to
the faculty of the College of Nursing
East Tennessee State University

In partial fulfillment
of the requirements for the degree
Doctor of Philosophy in Nursing

by
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May 2008

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Keywords: Nurse Manager, Overwhelmed, Lived Experience

ABSTRACT

Feeling Overwhelmed: The Lived Experience of Nurse Managers

by

Teresa Potter England

Multiple studies have addressed registered nurse turnover in recent years. There is little research specifically addressing nurse manager turnover. The nurse manager is addressed in current research as being in a pivotal position to affect nurse retention. Research has focused on the skills necessary for nurse managers to affect turnover; however, there is little research addressing the pressure placed upon the nurse manager as he or she struggles to maintain the nursing workforce. This qualitative study explored the lived experience of feeling overwhelmed by 6 nurse managers currently working in an inpatient hospital environment. Interviews were analyzed using a modified version of the descriptive-interpretive phenomenological method as described by van Manen. Four essential themes were identified: *there is nobody there*, *caught in the middle*, *feeling that you are a failure*, and *the inability to do*. One paradigm case exhibited all of the essential themes. The essence of the nurse manager's lived experience of feeling overwhelmed is helplessness evidenced by constant unresolved conflicts in a complex, chaotic organization with changing expectations, unmet personal fulfillment, and constant turbulence. It is personal conflict related to the desire to impact positive patient and staff outcomes--to make a difference, while feeling that they fall short of the organization's and their own personal expectations. Theoretical implications related to Quantum theory,

Emotional Intelligence, and Roger's Science of Unitary Human Beings are discussed in order to highlight current theoretical literature pertinent to the nurse manager's experience of feeling overwhelmed. Implications for research, practice, and education are discussed as facility leadership considers the experiences of this group of nurse managers. This study will better inform hospital administrators, nursing leadership, and staff nurses of the lived experience of this group of nurse managers.

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DEDICATION

I would like to dedicate this research to my wonderful daughter, Abby England, who has had the patience and maturity to recognize the importance of higher education as her parents have labored to complete their educational goals throughout Abby's life.

I love you Abby and hope you will forgive the time we have spent together doing research that could have been spent with you, playing at home. You are truly the best gift I have ever received. I hope your experiences with us as we have completed our educational pursuits will serve you well in the future.

To my husband Tony, through thick and thin, we have survived so much. Our commitment to family has ensured that we will continue to survive and raise our beautiful daughter together.

To my parents and my in-laws, thank you for always supporting and encouraging me.

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CHAPTER 1

INTRODUCTION

Background of the Problem

As of December, 2006, U.S. hospitals needed approximately 116,000 Registered Nurses (RNs) to fill vacant positions nationwide (American Hospital Association, 2007a). The Health Resources and Services Administration projects a shortfall of one million RNs by 2020. It is estimated that by 2020 only 64% of the projected demand for registered nurses will be met (American Hospital Association, 2007b; American Hospital Association, 2006; Biviano, Fritz, & Spencer, 2004; Buerhaus, Needleman, Mattke, & Stewart, 2002). Registered nurse employment growth has slowed, remaining about the same in 2001 as it had been since 1993. Buerhaus (1998) attributed the decrease in employment growth of registered nurses to a stagnation of registered nurses' wages and increased economic growth, which strengthened consumer confidence. Increased consumer confidence has resulted in fewer women entering the workforce and even fewer entering nursing, which is historically a female-dominated profession (Buerhaus, 1998). With fewer nurses entering the workforce, there will be a serious shortfall of nurses in the next 20 years. With patients becoming sicker and older and with baby boomers retiring, including baby boomer nurses, the long-term outlook is uncertain for an adequate nursing workforce (American Association of Colleges of Nursing, 2002; Buerhaus, 2001; White, Kim, & Deitz, 2001).

Pay and benefits may be an obvious indicator of why nurses leave their workplace, but other factors should also be taken into consideration. One factor

contributing to the shortage is that the demand for nurses is rising due to an increase in the number of sicker and older inpatients (Buerhaus et al., 2002). Another influencing factor is that inflation-adjusted wages for registered nurses fell substantially in the mid-1990s and has risen only slightly since then. A strong national economy in the 1990s may have reduced the number of registered nurses in the workforce as many nurses are married and with increased spousal income, nurses may have chosen to leave the workforce completely. In addition, there are also fewer nurses under the age of 30 entering the workforce and lastly, poor working conditions are a strong indicator of why nurses are leaving the workforce (Buerhaus, 2001).

Significance of the Problem

The literature has been inundated with research in the past several years documenting the need for nurse retention due to the nursing shortage (American Association of Colleges of Nursing, 2002; American Hospital Association, 2006; Buerhaus & Needleman, 2000; Buerhaus et al., 2002; Joint Commission on Accreditation of Healthcare Organizations, 2003; Prestholdt, Lane, & Matthews, 1988; White et al., 2001); however, there is very little documentation regarding the workplace stressors that contribute to the turnover of nurse managers. Parsons and Stonestreet (2003) identified several factors that support nurse manager retention. They include the quality of relationships, administrative systems, work-life balance, and the most pervasive factor, quality of care. This important factor was a common theme between nurse managers and staff nurses who intend to leave the profession. Nurse managers have been identified as being responsible for creating an atmosphere for nurses where professionalism and professional nursing practice can succeed (Englehardt, 1993). Expectations for the nurse

manager are to sustain a quality workforce, ensure cost savings, provide unit leadership, and maintain a high standard of quality care (Parsons & Stonestreet).

Intention to remain in the workplace can be associated with nurses' feelings of working in a challenging and interesting job, a sense of worth and accomplishment, and the belief that they are providing quality care to patients (Prestholdt et al., 1988). Half of the nurses surveyed in a national study indicated that they had considered leaving the workforce in order to seek better staffing levels, attractive hours, and higher salaries (Peter Hart Research, 2001). These figures are similar to another study done by Aiken et al. (2001). One consistent finding was that nurses were dissatisfied with staffing levels. Increased patient loads, understaffing, decreased time spent with patients, and increased paperwork were all related to decreased preservation of the workforce and, in turn, negatively impacting the quality of patient care (Aiken et al., 2001; Peter Hart Research, 2001).

The Aiken et al. study (2001) reported nurses performing tasks such as delivering and retrieving food trays (43% of nurse responses), housekeeping (34.3% of nurse responses), transporting patients (45.7% of nurse responses), and ordering, coordinating, and performing duties that ancillary staff could do (68.6% of nurse responses). The nurses in this study reported nursing tasks such as oral hygiene, skin care, teaching patients and families, comforting patients, developing care plans, and preparing for discharge as being left undone, which overburdens an already stressed workforce, not to mention contributing to poorer patient outcomes (Aiken, 2006; Sales et al., 2005).

The burden to perform adequately in a profession tasked with the role of saving, or maintaining lives is phenomenal. To perform adequately requires the attention of

strong leaders who are given the authority and ability to lead a workforce fraught with increasing responsibilities outside the realm of patient care. To date, the research on the nurse manager role has been narrowly focused, as evidenced by the following topics: (a) finding the right leader and (b) the attributes of leaders and middle managers who possess the necessary strength of character to lead nurses at the bedside. Yet nurses still report dissatisfaction after decades of study.

Leading and managing in this era of unrest and uncertainty in nursing places the nurse manager in a precarious position. By being the first line manager, responsible for patient care at a time when the lack of adequate resources to provide patient care is of national concern, the nurse manager can be the turning point in a staff nurses' decision to remain in the organization or the workforce. Nurses have been found to favorably view the nurse manager who "valued staff contributions, promoted information sharing and exerted influence for a stable work environment" (Trofino, 2003, p. 64). Job satisfaction improved when nurses were held accountable for their work environment by promoting shared governance, professional practice partnerships, and teamwork (Hocker & Trofino, 2003). First line managers are key to promoting positive work environments that value the contribution of staff. According to Skelton-Green (1995), "Theorists agree that most North American organizations are currently over managed and underled... nursing administrators find themselves practicing in an environment of... chaotic change" (p. 8). Trofino (1995) agreed that "One of the most important evolutionary forces in transforming health care is the shift from management to leadership in nursing" (p. 42).

Examination of nursing staff satisfaction research concludes the following:
Slaviff, Stamps, Piedmonte, and Hasse (1978) began testing the Index of Work

Satisfaction among nurses in 1972. Stamps (1997) identified several factors that predict nurse staff satisfaction: pay, autonomy, task requirements, professional status, and organizational policies. The majority of nurse satisfaction studies completed during the 1980s and 1990s used the Index of Work Satisfaction (Stamps, 1997). Those studies indicate that pay and autonomy are the two prevalent factors that can predict nurse satisfaction.

Leadership styles also made a difference. Boumans and Landeweerd (1993) found that leadership styles should be varied in order to meet the needs of the individuals involved. Some nurses may require a manager who values structure; some nurses may require a manager who provides autonomy. Overall, nurses are most satisfied when the nurse manager demonstrates both styles of leadership: social (i.e. consideration) and instrumental (initiating structure and production-orientation). The results indicate that the nurse manager must have a flexible style of leadership depending on the situation. Bratt, Broome, Kelber, and Lostocco, (2000) concluded that job stress and leadership behaviors determine job satisfaction among nurses. Drews and Fisher (1996) found a relationship between nurses' perceptions of leadership style and registered nurse satisfaction. Nurses became more satisfied as participatory management styles of leadership were practiced. This confirms findings by Lucas (1991) who specified that a participatory management style was associated with registered nurse job satisfaction.

Kovner, Hendrickson, Knickman, and Finkler (1994) studied the work environment of nurses. They discovered that pay, autonomy, and professional status impact satisfaction. Kovner et al. also indicated that changes in the work environment affect nurse satisfaction. Nurse satisfaction initially decreased significantly with new

environmental changes aimed at improving work processes. Morrison, Jones, and Fuller (1997) studied transformational leadership styles and found that transformational leadership affected job satisfaction. Dunham-Taylor (2000) agreed with Morrison et al. (1997). According to Dunham-Taylor, "One of the key elements of successful transformational leadership is the ability of empowerment. Highly transformational leaders have found that the more power they give away, the more power they will have" (para. 10). Moss and Rowels (1997) found that staff nurse job satisfaction improves as participatory management styles are practiced.

Adding to this knowledge, Duxbury, Armstrong, Drew, and Henley (1984) found that "head nurse consideration was clearly related to staff nurse satisfaction" (p.97). McNeese-Smith (1993) determined that nurse managers' behaviors impact productivity, job satisfaction, and commitment among nurses. If managers desire productivity among employees, they must set the same example. Trust and mutual respect were cited as important behaviors to promote organizational commitment and job satisfaction. Employees were shown to be "more likely to commit to an organization if their manager challenges the job, questions the status quo, handles stress well, experiments, and takes risks" (p. 39). A later study by McNeese-Smith (1997) found that being a good role model, treating employees with respect, focusing on tasks, and relationship building were important leadership skills necessary to enhance organizational commitment and satisfaction among staff nurses.

In light of these interesting findings that have been well studied over time, this research focuses on the nurse manager who has been identified as the leader responsible for influencing nurse satisfaction, therefore, retention of a workforce in great demand.

Justification for Studying the Phenomenon

Past research has pointed to the nurse manager as being “key to promoting satisfaction” (Jezuit, 2002, p. 26), being “in a position to influence” (Pinkerton, 2003, p. 45), and being the one “who should promote support and autonomy” (Mrayyan, 2004, p. 326) but there is something conspicuously absent in all the research regarding nurse managers and their influence to improve the present crisis in nursing recruitment and retention. One must ask the following questions: How do nurse managers feel? How do they manage? How is life for them? How do they handle stress? What are their experiences? What is the lived experience of feeling overwhelmed? Current research has not recognized the importance of retaining the nurse manager; instead, the focus has been on the importance of the nurse manager working to retain nurses. In this scenario, the pressures that staff nurses feel on a daily basis must be translated to the manager who is tasked with organizing at the unit level. One study suggested that nurse managers work "with the expectation and acceptance of work stress" (Rodham & Bell, 2002, p. 5). However, research into the experience of that stress, once it reaches the point of feeling overwhelmed, should be undertaken in order to gain an understanding from nurse managers' perspectives of what feeling overwhelmed means to them so that healthcare leaders and nurse managers may begin to understand themselves.

Definition of the Phenomenon of Interest

Research exploring the concept of feeling overwhelmed is noticeably absent in the literature. Feeling overwhelmed is a universal phenomenon that needs clarification from the group experiencing that phenomenon. To overwhelm is "to upset or overthrow... to overcome by superior force or numbers... to overpower in thought or

feeling" (Merriam-Webster, 2004, p.1). A more focused definition of the phenomenon of feeling overwhelmed resulted from a method of concept inventing (Parse, 1997) by the author, and fieldwork studies by the author, focusing on nurse managers who were asked the question, "Tell me your experience of feeling overwhelmed" (England, 2004). The result of this fieldwork analysis and concept inventing was a definition of feeling overwhelmed. Feeling overwhelmed is the feeling of stress building to turbulence that reaches an endpoint; a feeling of tumultuous disquiet (England, 2004).

Definitions

Nurse Manager

The nurse manager develops objectives, policies, and procedures for department cost centers to formalize and implement the mission, vision, and values of the hospital. This individual maintains the standards, customer relations, and practice in a designated service line. Accountabilities include: quality of services; short and long range planning to achieve goals and objectives; fiscal control; physician and interdepartmental/intradepartmental relations; personnel management. (The Advisory Board Company, 2006, p. 2)

Phenomenology

Phenomenology is the study of structures of experience, or consciousness. Literally, phenomenology is the study of "phenomena": appearances of things, or things as they appear in our experience, or the ways we experience things, thus the meanings things have in our experience. Phenomenology studies conscious

experience as experienced from the subjective or first person point of view.

(Smith, 2006, para. 4)

Lived Experience

"Lived Experience is experience as we live through it and recognize it as a particular type of experience" (Phenomenology Online, 2006, para. 11).

My Story

I have felt overwhelmed as a nurse and as a nurse manager. I have felt overwhelmed due to life stressors, work stressors, and physical stressors. Many times I have felt that I live to be stressed and overwhelmed. In my entire life as a professional nurse, I have rarely felt calm inside. This did not mean that I hated my job. In fact, I loved my job. I loved caring for patients. I loved feeling that extra taste of adrenaline that occurs when you are at the end of your rope. I love the feeling of accomplishment that occurs when I manage to complete a task that had appeared insurmountable.

Although I feel quite comfortable under stress, I do believe that there is a moment when you simply cannot deal with another problem. I believe there is a moment when you feel like you are on the edge of a cliff and a feather could push you over. I have been there and it does not feel the same. It is not as simple as being stressed out, burned out, or overburdened. It is that moment in time where you cannot continue to do what you have been doing. It is a sick feeling inside. It is a feeling I hate to have.

I want to know how others define "feeling overwhelmed." I can not deny that I have my own ideas; however, I am interested in nurse managers' experiences because I

have been there and I would like their experiences to guide nursing administrators and health care personnel to gain understanding from their unique perspective.

Statement of the Problem

The purpose of this phenomenological study is to discover the lived experience of feeling overwhelmed among nurse managers in Eastern Tennessee in order to gain an understanding of that experience and be sensitive to the experiences of this group of individuals.

Research Questions

The initial research question was: What is your experience of feeling overwhelmed? There was only one research question planned for the unstructured interviews. The participants were nurse managers and were asked to clarify answers and to describe in detail certain aspects of their answer or how aspects of the answer felt for them. A form of dialogic engagement using true presence as described in the Parse research method (Parse, 2004) guided the interviews as they developed between the participants and the researcher.

Delimitations and Limitations

This study focused on males or females over the age of 21 who were working as a nurse manager in a hospital setting. Managers were asked if they are currently seeking psychological counseling for stress-related problems, or if they have suffered recent disturbing life events such as divorce, death of a child or spouse, or other criteria determined to be significant by the researcher. If they answered yes to either of these questions, they were excluded from the study. The limitations of this phenomenological

study, as with any exploratory study, are that the findings are tentative and not generalizable. The exclusion of certain potential participants who have had recent disturbing life events or who are seeking counseling could result in the loss of potentially rich descriptions of feeling overwhelmed.

Research Perspective

Nurse managers' lived experiences of feeling overwhelmed is the phenomenon of interest for this study. A phenomenological approach was felt to be the most appropriate method to discover the participants' lived experiences. In doing phenomenological research, one seeks to question the nature of the phenomenon we are interested in. "Research is a caring act: we want to know that which is most essential to being" (van Manen, 1990, p. 5). Human science research is interested in explaining the meaning of human phenomena and at understanding the lived structures of meaning (van Manen). Phenomenology does not seek to be introspective, but, rather, it seeks to be retrospective, to focus on experiences that have occurred in the past in order to allow reflection on lived experiences. Therefore, phenomenology was felt to be the best method to answer the question posed by the researcher in order to come to know the nature of feeling overwhelmed as experienced by nurse managers in this study.

Human science comes from the translation of the German word *geistwissenschaften*, which basically means the opposite of natural science (Cohen, 2000). Spiegelberg (1984) has written extensively about the history of phenomenology and divided the phenomenological movement into three phases: the preparatory phase, the German phase, and the French phase (Cohen, 2000).

Phenomenology, as a form of qualitative inquiry, investigates the *lived experience* of the individual. The reality of the individual is in the meanings of the experience (Omery & Mack, 1995). Phenomenology has its roots in 19th century European philosophy as a rejection to the mind-body dualism of the period (Spiegelberg, 1971).

Franz Brentano and his student Carl Strumpf were among the first to study experience. Brentano intended to make psychology scientific by basing it on descriptive psychology. Strumpf founded experimental phenomenology as he conducted experiments to study the psychological effects of sounds and the influences of experiences on sound (Strumpf, 1912).

Edmund Husserl, who was also a student of Brentano, began the 20th century movement of phenomenology (Welch, 1999). Phenomenology is both a philosophical point of view and a research methodology. For Husserl, scientific knowledge was flawed and lacked rigor because it had failed to make sure of basic concepts (Omery & Mack, 1995). It had neglected to describe the immediate phenomena (Spiegelberg, 1984). Husserl suggested that theories and studies of theories should take second place to the actual phenomenon of question. To describe the experience of the other, Husserl offered *eidetic reduction*, the reduction of information to its general essence (Moran, 2000). He also asserted that the researcher must be able to set aside all ontological assumptions and bracket the outer world. What is left are the given process of human consciousness and their intended objects (Omery & Mack). Husserl indicated that science and phenomenology were compatible. Giorgi, Colaizzi, and van Kaam are modern philosophers from the Duquesne school who have followed the basic belief structures of

Husserl (Polit, Beck, & Hungler, 2001). This method of phenomenology is considered descriptive.

Martin Heidegger was a student and assistant to Husserl for some time. Heidegger rejected Husserl's major tenets and moved from a descriptive phenomenological approach to an interpretative one (Cohen, 2000) that dealt with *being and time*. Heidegger's contemporary followers include Benner, Tanner, and Dickelmann (Cohen). A third common approach is hermeneutical phenomenology, which is also known as "The Dutch phenomenology of the Utrecht School," is a blend of descriptive and interpretative phenomenology. This method of phenomenology arose out of the Dutch school, Utrecht. Its followers included Langeveld, Buitendijk, Linschoten, and van Manen (Cohen). For the purpose of this study, the hermeneutic phenomenological method as interpreted by van Manen will be used. Hermeneutic phenomenology is descriptive in order to allow the participants to speak for themselves; however, it is also interpretive at the same time because it recognizes that there are no such things as uninterpreted phenomena. In order to capture the lived experience, the experience must be interpreted and written (Phenomenology Online, 2005).

Significance

This study explored the lived experience of feeling overwhelmed as described by nurses in the nurse manager role in hospital settings. By increasing knowledge about this particular phenomenon and how it is experienced by nurse managers, health care administrators, health care policy makers, and health care workers can begin to understand the experiences of this group. Phenomenology does not problem solve and that is not the intent of this study. This study is not seeking results, but, rather, it is

seeking greater understanding so that on the basis of that understanding, nursing administrators, public officials, and health care workers in general can act more thoughtfully and tactfully in certain situations that may be related to the nurse manager role. The aim of this study is to gain understanding of the phenomenon as experienced by this particular group so that perhaps future decisions will be made with a better understanding of the phenomenon experienced by the participants in this study.

Summary

In this chapter, I have focused on the problems currently being faced in the nursing workforce and the need for greater understanding of the nurse manager role, the stresses involved in that role, and the need to discover the lived experience of feeling overwhelmed among this professional group. Chapter 2 focuses on the literature review related to the phenomenon on interest and the nurse manager role.

CHAPTER 2

LITERATURE REVIEW

Current Nursing Crisis

Nursing turnover has been studied for decades (American Association of Colleges of Nursing, 2002; American Hospital Association, 2006; Buerhaus & Needleman, 2000; Buerhaus et al., 2002; Joint Commission on Accreditation of Healthcare Organizations, 2003; Prestholdt et al., 1988; White et al., 2001). One of the important reasons for the extensive, historical studies is that health care organizations have been struggling to fill nursing vacancies from a dwindling supply of registered nurses.

The demographics of the nursing profession are an aging workforce, aging nursing faculty, and fewer new entries into the profession coupled with a society that is aging, but intent upon living longer. This has forced organizations to change the way they do business (Joint Commission on the Accreditation of Healthcare Organizations, 2003). Hospitals must now create an atmosphere that rewards retention. Creation of desirable work environments is important in that effort (American Association of Colleges of Nursing, 2002). An organization that realizes nurses are performing under a great deal of stress every day and takes measures to decrease that stress level may see some improvement in registered nurse retention (Callaghan, 2003).

Pay and benefits seem to be an obvious indicator of why nurses leave their workplace. Inflation-adjusted wages for registered nurses fell substantially in the mid 1990s and have risen only slightly since then (Buerhaus, 2001). However, less obvious factors should be taken into consideration. Several of these factors have led to the current

shortage. One factor is that demand is rising due to an increase in the number of sicker and older inpatients. Another factor is that a strong national economy in the 1990s may have reduced the number of registered nurses in the workforce. Many nurses are married, thus a strong economy and increased spousal income may have led nurses to leave the workforce completely (Buerhaus). A third factor is that there are fewer nurses under the age of 30 entering the workforce and, lastly, working conditions are strong indicators of why nurses are leaving the workforce (Buerhaus). Carr and Kazanowski (1994) cited the following factors: being treated with lack of dignity and respect, feeling frustrated, thinking their manager is unable to understand the needs of nurses giving patient care, and feeling lack of trust by administrators with regard to nurse decision-making abilities. The presence of these negative factors, of course, increased stress and decreased retention.

Once registered nurses are recruited, nurse administrators must do “whatever it takes” (Tuttas, 2002, p. 39) to create a positive work environment; “a magnetic environment that not only attracts, but also retains staff nurses” (Tuttas, p. 39). A method of retention should focus on stress reduction among nurses in light of the considerable research indicating stress as a factor in nurses who leave. Nurses' intention to leave or stay in the workplace has been found to be based on feelings of working in a challenging and interesting job, a sense of worth and accomplishment, and the belief that they were providing quality care to patients. (Prestholdt et al.,1988).

Stress and Nursing

Inadequate staffing, work overload, awareness of tremendous responsibility, feelings of incompetence, lack of support from superiors, role conflict, new technology, perceived lowering of standards, tight resources, and interpersonal conflicts were some of the stressors found in nursing today (Boey, 1999; Tovey, & Adams, 1999). Other sources of stress among nurses included dealing with death and dying, conflicts with physicians, and workload issues (Bratt et al., 2000; Douglas, Meleis, Eribes, & Kim, 1996; Evans, 2002; Gowell & Boverie, 1992). This increased stress has been linked to decreased job satisfaction and nurses' intent to leave an organization (Boyle, Bott, Hansen, Woods, & Taunton, 1999; Fimian, Fastenau, & Thomas, 1988). Stresses such as the lack of professional latitude and role problems were also predictors of the intention to quit (Dolan, Van Ameringen, Corbin, & Arsenault, 1992). Qualitative analysis findings included nurses feeling isolated, overworked, and underpaid with little support (Joshua-Amadi, 2003).

Symptoms of extended job-induced stress have been found to be predictors of intentions to quit (Dailey, 1990). One meta-analytic study found that work content and work environment variables had a stronger relationship to nurse satisfaction than economic variables (Irvine & Evans, 1995). This finding supported previous findings of stress as a mediator for leaving. It also reinforced the idea that nurses want to provide good care but have difficulty coping with the large amounts of paperwork and the difficulties of working in a rapidly changing, highly stressful environment (Buerhaus et al., 2002).

The medical-surgical nurse has been identified as experiencing more stress than intensive care nurses. In the past, intensive care nurses have been identified to be at the highest stress levels among hospital nurses (Leveck & Jones, 1996). Leveck and Jones attributed this change to the shift in acuity of patient characteristics that has occurred in the past decade. In recent years, there has been a change in working conditions within hospitals due to downsizing, budget cuts, and reimbursement methods (Buerhaus, 2001). This has placed patients with higher acuity needs on medical and surgical floors, thus shifting the stress to medical-surgical nurses. The data provided by Leveck and Jones described a direct and indirect link between high levels of stress and staff retention. Although there were some methodological issues apparent in Leveck and Jones with regard to content validity, they detailed those concerns and gave suggestions for future studies. The misconception that medical-surgical nurses experienced less stress than operating room nurses was refuted in another study that discovered that quantitative work load, role conflict, and supervisor relations were all identified as stressful indicators, thus decreasing nurse job satisfaction, especially among medical-surgical nurses (Ivancevick, Matteson, & Preston, 1982).

Consequences of stress have caused decreased morale and performance, “hence quality of client care” (Brown & Eldemann, 2000). Freudenberger (1974) described these reactions as “burnout”. Developing an understanding of the psychological needs of nursing may help resolve recruitment and retention problems (Tovey & Adams, 1999).

Nurse Manager Role Expectations

Noticeably absent in the nursing research are published studies seeking to understand the experience of the nurse manager with regard to feeling overwhelmed.

Generally, the literature has had very little to contribute regarding the stress nurse managers experience as they seek to maintain a workforce. The maintenance of that workforce continues to garner considerable attention as the nursing shortage gains press (Aiken et al., 2001; Peter Hart Research, 2001).

A dominant theme in the research related to nurse managers was their critical role in retaining staff nurses. Retaining the manager has taken a second seat to retaining staff nurses; however, the critical role of the nurse manager has not been overlooked. The research has not contradicted the importance of the role, in fact, the research has made a direct link between staff nurse retention and the role of the nurse manager as being a critical link (Anthony et al., 2005; Demerouti, Bakker, Nachreiner, & Schaufeli, 2000; Force, 2005; Kleinman, 2004; Ma, Samuels, & Alexander, 2003; Rafii, Oskouie, & Nikraves, 2004; Wells, Roberts, & Medlin, 2002).

Nurse Manager Role and Stress

Researchers suggested that the nurse manager has been pivotal in retention efforts for new and experienced nurses, and they should plan interventions aimed at supporting new graduate nurses in their efforts to overcome the stress associated with orientation (Oermann & Garvin, 2002). Satisfaction of RNs has been shown to be linked with retention efforts (Fletcher, 2001). A collaborative environment between nurses and managers has been shown to decrease job stress, therefore increasing job satisfaction (Stichler, 1990).

Clinical nurse managers feel clinically competent; however, were generally less confident in their ability to deal with human resource issues, managing budgets, and information technology (Gould, Kelly, Goldston, & Maidwell, 2001). Nurse manager

roles must be clearly defined for the organization if the role is to be considered as a significant one in hospital organizations (Hall & Donner, 1997)

Sources of stress for nurse managers included lack of nursing resources, workload, and powerlessness (Frisch, Dembeck, & Shannon, 1991). The study by Frisch et al. indicated that a perceived lack of control and feelings of incompetence contributed to nurse managers' stress.

Johnstone (2003) found that the main reason nurse managers left their jobs was to enhance career development. A second finding of that study was that nurse managers left due to the dissatisfying aspects of the job and work environment. One limitation of the study was that it was conducted in New South Wales and may not be generalizable to the nurse manager population in this country.

The only qualitative study related to nurse manager stress used an open-ended interview approach that was aimed at gaining insight into factors that contribute to nurse manager retention (Parsons & Stonestreet, 2003). This study found that the most dominant theme for nurse manager retention was the accessibility of a supervisor to offer listening and guidance, effective communication, clear expectations, and feedback. Other themes included participative leadership in planning and decision making, effective administrative systems for managing staff, professional development and manager compensation, worklife balance, providing quality care, and retention of staff (Parsons & Stonestreet). In light of the lack of qualitative studies and the absence of studies exploring the lived experience of stress or feeling overwhelmed, more research is needed in order to gain understanding from the nurse manager's unique perspective.

Theoretical Background

Selye (1936) is considered to be the “father of stress” and has written extensively about stress. He began by simply trying to define stress while exploring the effects of noxious agents on organisms. Selye (1973) later came to the realization that stress was simply a response of the body to demands from the environment. Selye (1976) indicated that, under certain circumstances, stress could actually be beneficial when used as a protective mechanism. This response would be known as adaptation. He coined this adaptation as “GAS” or General Adaptation Syndrome. GAS has three stages, alarm (fight or flight), resistance (the ability to withstand additional stressors), and exhaustion (depletion of resources) (Selye, 1976).

Lazarus and Folkman (1984) further explicated Selye’s theory of stress and proposed that a mental process determines whether stress occurs. This process depends on whether or not the stressor is negative (no stress) which gives the person a chance to grow. For a negative stressor, a secondary appraisal is made in which the person experiencing the stress either has adequate coping or they will begin to consider their options. Lazarus and Folkman detailed two types of coping, problem-focused and emotion-focused coping strategies. According to their theory, the level of stress we experience depends on the adequacy of our coping resources.

Summary

Research indicates that the role of the nurse manager is important to organizations as they strive to maintain a competent workforce in the face of national nurse shortages. The nurse manager has been reported to be key in retaining nurses who are documented as experiencing workload stress and perceived lack of support. Little research has

focused on the role of the manager who is placed in the difficult role of maintaining and managing this valuable workforce. Chapter 2 detailed the state of nursing science related to the stress experienced by the nursing workforce and the responsibilities of the nurse manager role attempting to maintain nursing resources. Chapter 3 describes the methodology used in order to study the phenomenon appropriately based upon the research question being asked.

CHAPTER 3

METHODOLOGY

Design

Hermeneutic Phenomenology was chosen as the method of inquiry for this study due to the scarcity of published information about nurse managers feeling overwhelmed. Hermeneutic phenomenology studies how people make meaning of what they experience (Cohen, 2000). It is an appropriate method to answer the research question for this study. Other qualitative methods were considered, but given the state of the science regarding the phenomenon, it was felt the *lived experience* should be explored.

Hermeneutic phenomenology does not attempt to distance the researcher from the research. In fact, philosophical hermeneutics assumes that bias is uncontrollable; therefore, to attempt to deny this prejudice is attempting to do something of which we as humans are incapable (Schwandt, 2000). Life brings historical perspectives to everything we do. Life defines the reality of who we are. To deny that life has an influence is to deny that we are living. Hermeneutic phenomenology as a method, described by van Manen (1990) as descriptive-interpretive, is congruent with my beliefs of the importance of going beyond the words of the participants to achieve abstraction through interpretation.

Van Manen (1990) gave no real method or strict model to follow; he simply guided the researcher in discovering the lived experience of participants. “This is a method that tries to ward off any tendency toward constructing a predetermined set of fixed procedures, techniques, and concepts that would rule-govern the research project” (van Manen, p. 29). Researchers should pursue a phenomenon of interest through the

lived experience rather than conceptualization (van Manen). Reflection of the phenomenon, through *dwelling with* the data and writing and rewriting are key components of the process. Van Manen did list six research activities that he sees as dynamically interrelated in interpretive research. They are:

1. Turning to a phenomenon, which seriously interests us and commits us to the world;
2. Investigating experience as we live it rather than as we conceptualize it;
3. Reflecting on the essential themes, which characterize the phenomenon;
4. Describing the phenomenon through the art of writing and rewriting;
5. Maintaining a strong and oriented pedagogical relation to the phenomenon; and
6. Balancing the research context by considering parts and whole. (pp. 30-31)

Frank (2004) stressed the significance of making the research tell its story and van Manen's position is that human science writing is an "original activity" (van Manen, p. 173). Hermeneutic Phenomenology was selected as the appropriate methodology because it was most likely to reveal ontological understandings of the phenomenon, therefore, tell the story.

Researcher as Instrument

In qualitative research, the researcher is the instrument used to collect and analyze data. In hermeneutic phenomenology, the investigator "lays out preconceptions, biases, past experiences, and perhaps even hypotheses that make the project significant for the investigator and that may affect how the interpretation takes shape" (Benner, 1994, p. 72). I am a nurse administrator and former nurse manager. I deal closely with the issues brought forward by nurse managers on a daily basis. I am interested in gaining

understanding of their experiences when they feel overwhelmed. By researching their lived experiences, I hope their experiences will be understood by nursing administrators, patient care providers, and the general public in order to increase awareness for this important member of the health care administration team. I believe that nurse managers who feel overwhelmed may reach a point where they wonder if their contribution really makes a difference. In my experience, the nurse manager is pivotal to providing excellent patient care and retaining staff. The recent crisis in nursing with regard to staffing inadequacies and the focus on patient outcomes leads me to believe that this group of professionals is the cornerstone to an atmosphere of excellent patient care and staff satisfaction.

My experience has led me to believe that the nurse manager is the middle person, taking on the demands of hospital administration while ensuring staff are providing appropriate patient care. They are the nurturers, disciplinarians, confidants, and the organizers. They are also the responsible party when patient care comes into question. Sentinel events, staffing crises, budgetary imbalances, teamwork, and problem employees are their responsibility. To balance all these responsibilities takes coordination and perseverance. Many demands are impossible to meet. I am specifically interested in understanding their experiences when it all becomes too much to bear. I am interested in their experiences of feeling overwhelmed.

Sampling and Procedure

For this study, a theoretically-based purposive sampling method was used to locate nurse managers from Eastern Tennessee. The participants met inclusion-exclusion criteria as discussed in Chapter 1. The researcher presented at a local educational

conference aimed specifically at improving the skills of nurse managers. The researcher met several local nurse managers and contacted them after Institutional Review Board (IRB) approval was obtained from East Tennessee State University. A local nurse manager who had access to nurse managers from several facilities also provided potential participants to be contacted as a secondary measure to gain participants for the study. After the first participant was contacted from a local facility, a snowball method of sampling was used as a tertiary measure to gain participants.

In hermeneutic phenomenological research, the sample size is determined by “the intensity of the contact needed to gather sufficient data regarding a phenomenon or experience” (Steeves, 2000, p. 56). The amount of intensity can be determined by reviewing “extant studies and clinical experience” (Steeves, p. 56).

Prior to the actual study, three field work interviews, as part of a course requirement, were conducted. The purpose of these interviews was for the researcher to develop interview skills, to refine the research question, and to gain access to the population being studied. The initial interview question was, “Tell me about your experience of feeling overwhelmed.” There were no other questions planned. As the interviews progressed, the researcher simply asked for more information regarding certain events mentioned by asking the participant to “tell me more about that” or “how did that make you feel,” “go on,” “can you think of anything else to describe your experience of feeling overwhelmed,” etc. This method of interview was a form of dialogic engagement where the researcher is in true presence with the participant (Parse, 2004).

As a result of these interviews, the initial question was found to be sufficient and rich descriptions were obtained. The interviews, field notes, and transcripts were reviewed by nursing faculty and were felt to be adequate for the method selected. After each interview, detailed field notes were composed immediately and the transcription of the interviews was done by the researcher.

Video was used in one of the three interviews which added to the depth and substance of the field notes. There are definite advantages to videotaping the interview in that the subtle body language and emotion that comes through is more apparent in the video than may have been noticed in the audio-taped interview. Supplementing field notes with videotaped recordings can give details that may have been too complex for the observer to initially discover. They can give a more detailed retrospective review (Paterson, Bottorff, & Hewat, 2003).

These unrecorded nuances were missed, especially when emotions became apparent in the third interview and when the participant could not seem to relax in the second interview. "Reading into what is not there with the same sensitivity as reading into the words that are spoken" (Poirier & Ayres, 1997, p. 556) would have been much easier to analyze with videotaped interviews throughout the process.

However, during the field work interview with the one participant who was videotaped, logistics of seating arrangements and equipment setup and functioning became issues that created an atmosphere which this researcher felt detracted from the dialogic engagement. The participant seemed to focus on the video as did the researcher. Due to these problems, voice recordings supplemented by field notes were used for the participants in this study.

Setting

Interviews were conducted in a quiet, confidential location requested by the participants. The researcher and the participant discussed potential locations and mutually determined the best location to ensure privacy and comfort. Four interviews were conducted in the offices of the participants. One interview was conducted in the researcher's office at that participant's request. Another interview was conducted in a private room at a local library.

Participants

There were six participants for this study. All participants were female nurse managers in Eastern Tennessee. Participants were selected in order to gain a wide spectrum of experiences and specialties. One nurse manager was from a long-term care facility. One was from a psychiatric hospital. Four were from an acute care hospital. All four were from different acute care settings. One was in a very large hospital and the other three were from smaller facilities. All were from either not-for-profit or governmental agencies. Three of the six nurse managers were relatively new to the position (less than 1 year). The other three nurse managers had been in their current position greater than 2 years. All the nurse managers interviewed had been in their position for less than 5 years.

Protection of Participants

The rights of participants in this study were protected in several ways. IRB approval was obtained through East Tennessee State University. The purpose of the study was disclosed prior to the interview. Interviews were scheduled at a location with areas

for privacy at the convenience of the participant. Voluntary informed consent was obtained from the potential participant after allowing the participant to read the consent form. A copy of the consent form was given to the participants. The consent form contained contact information for the researcher and her dissertation advisor. Participants were informed that they could refuse to answer any questions that make them uncomfortable or that they could withdraw from the study at any time without penalty. Participants were assured confidentiality by the use of pseudonyms in the interview transcription, analysis, and dissemination of results. Permission to audiotape the interviews was obtained. Transcription was performed by the researcher. The tapes of the interviews were demagnetized (erased) and discarded at the end of the study. The consent forms and the interview transcripts will be stored in separate locked filing cabinets in the Center for Nursing Research at East Tennessee State University for 10 years, according to IRB requirements.

Data Collection

The only pre-planned interview question was, "Tell me about your experience with feeling overwhelmed." The interview was unstructured and progressed from the initial interview question. This process allowed the interviewer and participant to "grasp the core topic" (Thomas & Pollio, 2002, p. 23) and allow the world to be seen from our joint perspective of understanding each other. Immediately after an interview was conducted, the researcher recorded initial thoughts and impressions about the interview in private. These field notes became part of the data.

Data Management

For management of the data, a computer word-processing program was used to transcribe the interview. Individual interviews were copied onto color-coded paper to keep the interviews separate. A qualitative data management program was not used. In phenomenological interviews, large amounts of information are accumulated. The researcher must manage the data by the process of data reduction, which is the sorting of relevant data from the irrelevant data. This was done by reading and re-reading all interviews and identifying and color-coding significant statements again and again. Once data reduction was accomplished, the data were analyzed based upon the process described by van Manen (1990).

Analysis

A modified version of the descriptive-interpretative analysis process described by van Manen (1990) was used in this study. The process is a recursive one, rather than linear. In qualitative research, analysis begins with data collection and continues throughout the study (Cohen, Kahn, & Steeves, 2000). The goal of analysis is to develop thick descriptions that portray the lived experiences of individuals who experience a particular phenomenon (Cohen et al., 2000). Individual interviews were read, line by line, for significant statements and groups of meaningful words and phrases.

Findings in the form of meaningful statements were highlighted and recorded in a separate word processing document that led to thematic discovery and analysis. In phenomenological description and interpretation, the process of thematic analysis is often thought of as frequency counting or coding of words that are found in transcripts or texts; however, the process of thematic analysis in lived experience is a "process of insightful

invention, discovery or disclosure. It is a free act of seeing meaning" (van Manen, 1990, p. 79). "Phenomenological themes may be understood as the structures of experience. When we analyze a phenomenon, we are trying to determine what the themes are, the experiential structures that make up that experience" (van Manen, 1990, p. 79).

The thematic statements were color-coded using the word processing text editor function. Data immersion occurred by *dwelling with the data* through continual reading, and writing processes (Russell, 1999). Writing and rewriting about the data, according to van Manen (1990), is essential to find meaning in the data. Emerging themes were evaluated within and across interviews.

Initially, each interview transcript was read several times in order to identify lines of inquiry or meaningful statements that emerged with some consistency from the data. "Strong instances of a particular pattern of meanings" (Benner, 1985, p. 9) gave rise to paradigm cases. Paradigm cases are further analyzed to distinguish between what van Manen terms incidental and essential themes (1997). He argues that only some meanings that are gleaned from a given phenomenon are unique to it – these are the essential themes (the phenomenon would not exist if this theme is not present), while other themes may be incidentally related (the phenomenon would still exist if we delete the theme) to the phenomenon. Field notes and journals were used to connect the researcher's observations to the transcribed interviews and to continue the explorative process.

Through the process of *intuiting*, the data were pushed to go beyond the words of the participants to a level of abstraction (van Manen, 1990). This level of abstraction presented in the form of essences is necessary to make the data meaningful to nursing and other disciplines. Van Manen describes an essence as "that what makes a thing what it is

(and without which it would not be what it is). The essence or nature of an experience has been adequately described in language if the description reawakens or shows us the lived quality and significance of the experience in a fuller or deeper manner" (p. 10). "A good description that constitutes the essence of something is construed so that the structure of a lived experience is revealed to us in such a fashion that we are now able to grasp the nature and significance of this experience in a hitherto unseen way" (van Manen, p. 39).

The findings presented represent the researcher's attempt to capture the findings in a "holistic and analytical, evocative and precise, unique and universal, powerful and sensitive" (van Manen, 1990, p. 39) manner. Throughout the analysis, two experienced nurse researchers were available for consultation to strengthen the rigor of the study.

Trustworthiness and Accuracy

In qualitative research, rigor is established through credibility, auditability, applicability, and confirmability (Appleton, 1995; Guba & Lincoln, 1981; Russell, 1999; Sandelowski, 1986). Following the recommendations of Morse, Barrett, Mayan, Olson, and Spiers (2002), data quality was maintained throughout the research process, not just at the end. This was done by keeping notes of the decision-making process that impacted analysis. Credibility was maintained by keeping a journal-audit trail reviewed by committee members throughout the research process detailing insights, content, and observations. Transferability was maintained in that the findings of the research will have meaning for practicing nurses and nursing administrators.

Credibility requires truthfulness of the data (Sandelowski, 1986). To maintain credibility, participants were invited to review their transcripts, to add, change, or clarify their stories within a week of their interview and again after tapes were transcribed. This

ensured that the researcher built trustworthiness into each phase of the research, not just focusing on it at the end (Morse et al., 2002). The participants were not allowed to validate the findings. Allowing validation of the research findings is not recommended by van Manen (1990) so that the interpretation of the findings will be as interpreted by the researcher. This ensures that the findings remain separate and are not a product of the participants' analysis of their individual interviews rather than a product of the whole. A journal was kept to document the researcher's experiences during the data collection and analysis processes (Russell, 1999).

Auditability is the establishment of a research or audit trail that documents the decisions made through the entire study. The researcher kept a journal and field notes of the research process beginning with the initial reasons for study interest, through the interview phase, and later the interpretation and analysis phases (Russell, 1999; Sandelowski, 1986). This audit trail should allow another experienced researcher to follow these processes and have similar conclusions about the findings (Burns, 1989; Lincoln & Guba, 1985; Russell, 1999; Sandelowski, 1986).

Applicability, or *fittingness* (Guba & Lincoln, 1981), occurs when the data fit in contexts beyond the original study. Nurse managers will be able to relate to the data if applicability has occurred. To enhance applicability, peer debriefing with an experienced nurse researcher was used to identify potential biases and review interpretative processes (Appleton, 1995; Sandelowski, 1986).

Confirmability is the process of minimizing bias during the research process and in the final product (Kahn, 2000; Sandelowski, 1986). However, this in no way suggests that the researcher will not have influence on and be influenced by the data (Sandelowski,

1986). Objectivity is not the goal of qualitative research. The researcher is expected to purposefully engage with the participants. Confirmability of the data is considered to have been achieved when the three previous elements of credibility, auditability, and applicability have been reached (Guba & Lincoln, 1981; Russell, 1999).

Summary

Interviews were conducted with six nurse managers in Eastern Tennessee to discover the lived experience of feeling overwhelmed. Prior to the interviews, three fieldwork interviews were conducted with three people who met the inclusion criteria for the study. Following interviews, participants were asked if they would like to add or clarify any part of the interview. Analysis was shared with an experienced nurse researcher in order to enhance the rigor of the study. Chapter 4 presents the results of the study.

CHAPTER 4

RESULTS

This study used a phenomenological method to describe nurse managers' lived experience of feeling overwhelmed. Transcripts of six participants were analyzed in order to develop emerging essential themes. Initially, each interview transcript was read several times in order to identify lines of inquiry. Meaningful statements that describe the structures of experience emerged with some consistency to describe the experience of feeling overwhelmed. "Strong instances of a particular pattern of meanings" (Benner, 1985, p. 9) gave rise to one paradigm case. This paradigm case was further analyzed to distinguish between what van Manen terms incidental and essential themes (1997).

Generally, the data flowed into categories. The researcher moved back and forth between the data, making notes through journaling, and also using the text editor function on each interview as decisions were made in order to keep an audit-decision trail. The researcher began with excerpts of significant statements, which led back to the original transcripts, which then led to organizing excerpts again. From that point, the researcher went back to the transcripts, read and re-read, and formulated categories of meaning that best represented the excerpts that had been organized into meaningful units. After organizing categories, the researcher then searched for meaning among those categories in order to develop final meaning in the form of themes based upon the interpretation of the data, careful to use the participant's words. After final themes were interpreted, the researcher then determined whether the themes were essential or incidental by looking at the data as a whole and asking if the themes were removed from the phenomenon, could

the phenomenon stand without that defining theme. When the themes were analyzed according to Van Manen's (1990) method of "free imaginative variation" (p. 107), the researcher was able to verify themes that belong to the phenomenon essentially.

Interpretation required abstraction from the themes containing the participant's words to meanings that were derived while looking at the themes as a whole. This final abstraction yielded the true essence of the phenomenon of interest, feeling overwhelmed. Through the process of *intuiting*, the data were pushed to go beyond the words of the participants to a level of abstraction (van Manen, 1990). This level of abstraction, presented in the form of essences, is necessary to make the data meaningful to nursing and other disciplines. Field notes and journals were used to connect the researcher's observations to the transcribed interviews and to continue the explorative process.

Demographics

The six nurse managers who participated in the study were all from inpatient hospitals with a variety of clinical settings being represented. One participant was a nurse manager in an acute psychiatric setting (free standing facility owned by a large multi-hospital organization), one was from a long-term care inpatient setting (free standing facility owned by a large multi-hospital organization), one managed a critical care unit (large facility owned by a large multi-hospital organization), one managed an acute medical unit (moderate size facility in a large national organization), one managed an acute surgical unit (moderate size facility in a large national organization), and one managed a critical care unit at a small free-standing facility (owned by a large multi-hospital organization).

Three of the nurse managers had been in their current role less than 1 year. Two of the three had prior nurse manager experience. One nurse manager interviewed indicated that she was a new nurse manager (less than 1 year). This was a deviation from the research protocol. The researcher notified the Institutional Review Board of this deviation. The results of the study were not impacted.

All of the nurse managers were female. Five of the nurse managers were married. One nurse manager did not disclose marital status or family responsibilities during the interview. Two nurse managers had adult children. Three nurse managers had children under age 10 living in the home.

Themes

In the interview, each of the six participants was simply asked what it was like for her to feel overwhelmed. Based on their response to the first question, open-ended interview questions emerged. Four essential themes emerged from the interviews: *there is nobody there*, *caught in the middle*, *a sense of failure*, and *the inability to do*. Subthemes related to the theme *there is nobody there* and *feeling that you are a failure* also emerged.

There is Nobody There

All the participants interviewed indicated a feeling of being "thrown in" to their current position without an orientation in some cases or a mentor in other cases. The prevalent feeling of *there is nobody there* was evident throughout the interviews either through the lack of someone to support them as new nurse managers learning the organization or someone to simply be there to guide them through routine expectations and difficult decisions.

The lack of a mentor or identified preceptor was discussed by Participant A.

PART A: There is really nobody you can walk up to and say, hey, so and so, how did you deal with this or where do you find this? There is nobody there to do that so you either have to make phone calls or you have to look on line and there being started into that, you didn't have all the resources that you need. There was no one there to kind of take you under their wing and say, "OK, well this is where we find this report, this is where you find this report, and you need to be available to get to these reports so we have to contact this person so that you can get all these reports." So, it was very overwhelming.

INT: So, you are new?

PART A: Uh huh.

INT: Your sort of there as far as not having that direct link for learning?

PART A: Correct.

INT: So, how does that work for your day to day?

PART A: Kind of doing it piece mill and picking up things as I go. I'm asking a lot of questions to the staff out on the floor. I'm like, what do you routinely do with this? What do you routinely do with that? And how are you guys doing with this? And then I'm also talking to our VP person, and you know, telling them, you know, its like been what two-three years since I've done a budget or looked at one; you need to walk me through this, help me understand how the budget's working, what do these numbers mean? Where can I pull these numbers from to make sure I'm covering the bases that I need to be covering? What I basically walked in and started doing is taking care of staffing.

Participant B described her experience with being new in a position with very little experience. She depended on other managers to guide her; however, had no real preceptor and little experience with the specific population she was now responsible for.

PART B: My stress mostly came from going into the manager's position with no guidance and no preceptor, so, and because of that, it's overwhelming because I came from med-surg to [named specialty] unit so I had to learn all the [named specialty] and then plus the management part of it. So that was overwhelming for me.

I just wish that there was some way to help managers. I'm not the only one I'm sure. I'm sure. To have side by side guidance as you are going from one job to another in management. I don't know how that could be. Because when a manager

leaves, they've got their own job that they want to go to and just, I don't know, just need more supervision. At least for a week or two.

Being Thrown In. A sub-theme of the theme, *there is nobody there* emerged related to *being thrown in* to the nurse manager position and being expected to perform. Participant A described her initial orientation and her method of coping related to finding routine budgetary information, staffing guidelines, and insecurity related to being new in the position and wanting to perform well, while depending on the staff she is supervising to guide her. As Participant A previously said:

INT: So, you are new?

PART A: Uh huh.

INT: Your sort of there as far as not having that direct link for learning?

PART A: Correct.

INT: So, how does that work for your day to day?

PART A: Kind of doing it piece mill and picking up things as I go. I'm asking a lot of questions to the staff out on the floor. I'm like, what do you routinely do with this? What do you routinely do with that? And how are you guys doing with this? And then I'm also talking to our VP person, and you know, telling them, you know, it's like been what two-three years since I've done a budget or looked at one; you need to walk me through this, help me understand how the budget's working, what do these numbers mean? Where can I pull these numbers from to make sure I'm covering the bases that I need to be covering? What I basically walked in and started doing is taking care of staffing.

Participant A added:

And when you are new, you feel like everybody is watching you and you feel like you have to do everything all at once. You can't just focus on one thing and say, well, I'll get to that or yes I know that's there but I haven't done anything with it. You know, sometimes they make you feel like that you've just got to do something with everything when you are new because they are watching you so close.

Participant C described her orientation and how it was basically non-existent.

PART C: [Named facility] does not have a management orientation. They threw me in this job and said here, here, here and call me if you need anything. I had no idea. I had no idea how to make out a PO. I had no idea. And people would say, "Oh, don't you know that?" No (answering self); which made us know that in [named department], we are going to do a management orientation if the organization will accept it. Because we have a new manager in the [named department] and now [new nurse manager for a separate department] and they both feel the same way and both of them have been managers for over 10 years. And that made me feel better. And that new manager in [named department], [new nurse manager 2] she felt the same way. So, that makes me feel like, oh, maybe I'm not as like unqualified as I thought. Because they have experienced this. So that has helped me.

When describing her experience in more detail, she mimics administration and says:

"Here you go, here is your office, see you (laughs)."

Participant B also describes her feeling of incompetence related to asking colleagues for their assistance with simple tasks such as computer resources, routine deadlines, and her feelings related to intruding upon other managers' time for routine education and assistance. She describes her situation as "keeping her head above water" until help comes (she is expecting a second nurse manager to take some of her workload very soon). Her feelings of inadequacy are evident in the following dialogue.

PART B: I guess that is where it comes into play, you know where I said I felt like I just was not competent, just overwhelmed I guess. But I had other leaders that would kind of show me different things on the computer that you did as managers. And they also offered me leadership meetings and meetings for management, how to deal with the management part as far as conflict, to give me management skills in how to deal with that. I just had to learn like something I was supposed to do; something that I didn't know, and it was late and I just had to learn that way. OK, I didn't know I had to do that but I'll know the next time, you know [describing her response]. I just had to learn like that a lot. Like another manager would be with me, would come down and check on me, but she had her own unit. So, it was just a lot of me out learning stuff on my own, by messing up, and learning not to do it again. Reports, documents, things like that.

I guess I'm the one that hates to ask for help. You know I just try to figure it out on my own. But every time I went to someone they have been very helpful. And I always feel like I was bothering them but they would reassure me that I wasn't, that was what they were there for. I guess the [nurse manager] that was in the

position that I'm in now; she was starting a new job in the outpatient [area]. She made a few comments that she was starting a new job, like, don't bother me. When I actually did talk to her she would help me out, show me where things were at, where to go to or who to talk to, where I could find the answer. They all helped me. I guess there were like three or four different managers. We all had managers' meetings and they were very supportive. "If I can help you with anything," what reports, or things like that, they were very helpful. But I guess I could say, now that I think about it, it's probably more me than them. I just felt like I didn't want to bother them. Cause I know they had their own units to run. They had their own things and maybe I didn't go to them as much as I could have I guess. They would probably have been able to help me. Me being on a [named unit], they would say, I don't know much about how your unit runs but any management reports or anything that you do, or computer things, I will help you.

INT: When you think about feeling overwhelmed and the support you have had, what is the support like to help you with that? What do you think about that relationship?

PART B: I guess, what I'm saying is that it doesn't matter who all's there to help you, you are still going to feel overwhelmed. I mean, it's just, for me, it's just a feeling I have. It's just the way I am. I know they were there. The relationship was good. It was there. I still felt overwhelmed. I guess I've just... being a nurse, I'm used to that one-to-one orientation. You know what I mean? It's just so different. But everyone was supportive. I guess I'll have to blame myself. Because I guess I didn't ask enough and I let myself be overwhelmed. Here in this job that I'm in now, I mean there's just there's just no, I mean it's just (unfinished sentence). Now they have another [nurse manager] here to help me which has taken away one whole unit. I'm over one unit. Now I'm getting organized and everything. But when I first came it was always in the back of my mind. Help is coming. Help is coming. Just keep my head above water here.

Participant D describes the orientation process and how it could have been better organized to give her an idea of the expectations related to her role. Routine reports, access to data, and general day-to-day expectations were things she felt could have been better outlined for her needs.

PART D: But coming into a new facility, not knowing anything about the facility and the management role, I truly feel that the orientation should have been different and that would have alleviated some of the problems that I have had. I think that there should be a uniform structure of what is expected from your role whether you are a staff nurse or a nurse manager or whatever you are and that should be the structure that you can base your daily activities on. And know how to do those things. When I first came in here, yeah, I had an orientation period and

I went around and I met everyone under the sun and that was great because you need those people to network with and as resource people but you need to know what is expected of you. And that part I don't think I received. And I still don't. Sometimes, I still think, well, I didn't know that I was supposed to do that. You know? And I have been here two years. So, just a structured orientation that lays on the line that this is what you have to do. As far as, you know, monthly reports, keeping up with different things like that. Now, taking care of your people, that's not a problem for me. Other people, you know, may see it differently. But those are the things that get me a little more overwhelmed, when things crop up.

INT: Anything else you can tell me about orientation?

PART D: The length is fine. I felt comfortable, you know, fairly comfortable, taking care of my [unit], dealing with my own people, in the 90 day period. I think that's adequate. I just think that there just needs to be a structure. This is what is expected of you. These are the dates every month that it is due or that type of thing. That these are what you have to do.

Participant E describes her experience orienting in a new organization.

PART E: I think you need a good year. I heard that from the day I walked it. You need a good year before you know anything. And that's the truth. And even today, I still learn things. And that's what I hear from other people too, and they have been here for many years because the way changes are. So, I totally believe in that. I think that in many things, the more comfortable you become in it, then the more you know about it, you become knowledgeable, you know the system, you know the tools that are used, you know the resources you can and can't use and then you get to know the people you work with, you know what you can ask, what you can delegate, what people you can trust, what you can ask of them, what you can delegate, what people you can trust.

Upheaval in Administration. *Upheaval in administration* contributed significantly to the theme *there is nobody there* and was described as a significant barrier to several participants detailing their entry into the organization and the turnover in administration that seemed to be prevalent. Several participants relay coming into an organization or performing in an organization with turnover in critical leadership positions. Participant A, who has been in her position less than 3 months, describes her situation related to the lack of direct leadership and its effect related to feeling overwhelmed.

PART A: We've got a lot of new managers coming in. The director's position is open. The Vice President's position has been open. And that one has just recently been closed. The director's position is still open.

The director's spot is still open so the person directly above me who I would go to ask questions with and work with has been empty since I've been there.

Well, when I walked into the facility, there was no DON (Director of Nursing). There was a director there and he had been there not quite a year. When it came time for his evaluation, they fired him and walked him out.

INT: Hmm

PART A: So, it's been upheaval since I've been there. So, you've got nurses who are used to a director that they didn't always agree with and then all the sudden he's being walked out and no one knows what is going on so you've got that issue that you're having to be united even though you yourself don't know what is going on and try to stay calm with that and then you're having meetings with the VP that you haven't seen very much and don't work very much with, and trying to figure out where he is coming from. And so he is starting to take over so you're switching your management style and who you are talking to based on what he wants to see done and how he wants things done, and he turns his notice in and he is gone.

Participant B described the absence of the former nurse manager whose position she was filling. She expected this manager to be there for some period during the transition. She indicates that some time with this manager to understand the system, routine reports, and general guidance would have been helpful.

When I came to this position too, the manager was done gone. So, you know, there I was, you know, just day by day. Of course, I did have the director, of course, she is at a lot of meetings, but she would always check on me. We would try to have a talk at least every other day.

Participant F described her feelings related to picking up significant workload due to the absence of a director although having little support while serving in that role.

Honestly, I'm playing a director and a [nurse manager] role but I don't get paid the money to do the director role. I would also ask them that they look at their [nurse managers] and, something as simple as having a laptop to go home with or giving them a cell phone. You know, I use my own cell phone. I use, there's just not that support there.

Participant D described the absence of higher level administration being involved in the unit level manager or her sense that she could discuss her feelings of feeling overwhelmed.

Well to be quite honest, my immediate boss, I have a good relationship with. And my extended boss, her boss, I really don't have a relationship with. I don't see that person very often other than just our monthly meetings with the entire management group. So I don't feel like I can go to him and talk to him about pressures that I'm feeling.

Overall, most of the participants described feelings of incompetence related to being placed in a position of considerable responsibility without, what they felt, were the necessary tools, education, or mentorship to be effective. The theme *there is nobody there*, and the feelings the nurse manager participants exhibit depict the essence of feeling overwhelmed as being thrown in and expected to perform without guidance or mentorship with all the responsibility of a seasoned manager.

Caught in the Middle

The theme *caught in the middle* describes the feelings of many nurse managers who are placed in a situation of incredible responsibility with performance expectations coming from executive management on one end and the needs of staff on the other end. The theme *caught in the middle* describes the manager's responsibility as an administrator charged to ensure an outstanding level of care that the entire hospital depends upon for satisfaction and quality measurement and how that dependence leads to unreal pressures for the managers at the front line. Being *caught in the middle* describes their struggle to: 1) be there to support, encourage, and ensure staff are performing at an expected level

and 2) ensure administration is satisfied with the performance reports provided by that front line staff.

Participant E described her frustration related to being placed in a position of affecting the facility's overall performance by meeting performance measurement expectations, while at the same time knowing that she is placing an additional burden on an already burdened staff. Her frustration related to understanding the constant demands being placed upon staff in her role as a manager and also being in a position to affect the facility's overall performance indicates a relentless cycle of demands that affect her personally. She feels overwhelmed when staff feel overwhelmed. She is placed in a difficult position, maintaining her role as a staff advocate. In addition, she is under the expectation that she will affect performance to maintain the facility's standing with regard to comparative healthcare outcomes.

Participant E describes her struggle to find the way to do that with the resources she has in place. Her internal struggle related to leading the staff in order to support the demands placed upon them is overwhelming. The fact that she is the one placed in the difficult position of placing those demands upon them is overwhelming because she is unsure that she has asked them to do what is possible to be done with the resources they have.

PART E: You are caught in between the executive team, caught right in the middle. You have to face that. You know, get these performance measures done. Sometimes the reality factor for them is not there. Because reality is that sometimes it can be impossible to get done without either a) extra help or [b] completely re-designing the system or looking at it in a different way. So it can be overwhelmed anyway. Anytime, any fashion, any how. It just varies day by day, depending on what the topic of the day is, or what the concern for the day or week or when Joint Commission is coming, and those kinds of things. You know, employees are tired, they are overwhelmed.

I get overwhelmed when they're [staff] overwhelmed. You know, when they come to you, because you feel helpless because you can't help them. I think that's what stresses me out the most when I go home the most is, did I help them? Did I do everything possible I can do to help them to provide the care that our [patients] need? You know that is frustrating at times. Because you know, you walk out of here and ask, "Did I do everything I could have done?"

And you have to fight for things here. You know, linen on the weekend. How many times have I called laundry over the weekend? [Supplies], you know just those little things. It will drive you crazy.

I'm the type of person, you know, I don't really wad too easily. I know I've done the best that I can for the day and that's the best I can do. I've looked at every angle. I've tried to look outside the box. I've tried to get everyone's opinion. I realize I'm not going to make everybody happy. And that took me a long time to get used to here.

I'm not going to make everyone happy. As long as I made the best decision at the time that I made it. And I did it for the right reasons. For the patient and for the facility. You have to live with knowing that you have done the best you can

For the most part, your staff, as you well know, they can make or break you.

INT: How do you feel they are making or breaking you?

PART E: I feel like they are making me right now (laughs). If not, I would be fired, I guess. We did well during [named inspection]. Kudos to them. They knew what to do. They knew how to perform. You know, we did very well. They can make it horrible for you. They can not do what they have been asked to do. They could not be receptive to any new ideas. They could give you resistance all the time. They could call in all the time.

You get the best of both worlds but then again you get it from both ends. As the old saying goes, you get it from both ends. You are crunched right in the middle. But I really enjoy what I do. You have to become thick. As a strong leader you have to come to that point where you make those decisions. You can't let things overwhelm you or it will suck the life right out of you and then you can't be effective.

Participant A described vividly her mental struggle as she is being pulled in different directions by staff and hospital administration. Added to that is her stress related to the unknown. A new program director will be arriving. Then the nurse manager will not have the direct reporting relationship she has had to the Chief Nurse Executive

(CNO). Priorities she has set, supported by the CNO, could conflict with the priorities the new program director will set. She considers her position as a buffer between facility administration and her staff. This theme *caught in the middle* is also closely related to the theme *there is nobody there*.

Thousands of people, even though that's an exaggeration, but it feels like that at times, coming to you and saying, "I need this" and "I need this" and "this is going on" and you feel pulled like all your arms and legs are out stretched and stretched tight and somebody is up there pulling at your head next (laughter). You know, that's sometimes what it feels like.

And it's now like I'm a buffer between the upper management, the VP and there is going to be a new [program] director coming in, and I will interact with them and the staff will interact more with me than they will with the director. Even though he will be out and about and he will be my direct boss. So there will be some stress for me and some feelings of feeling overwhelmed with that not knowing where this person will be coming from and trying to learn the ropes that they expect so that's going to increase my feelings of what do I need to do and what hours do I need to put in. Gosh, are they going to be understanding that I'm in school and that I'm being backed by the CNO because it's one of her goals? And are they going to understand that? So there are things like that. And they are going to, every director comes in and approaches things from a different perspective and they see different things as the issues.

Participant A also describes staff expectations and the expectations placed upon her by facility resources. She struggles with team building, how to make staff feel that she cares about them, and the effort involved in making staff feel appreciated while at the same time giving them expectations that translate to additional workload.

So, you are having them be mad at you because you are saying that they have to do this and I think you have to end up coming around to the point where, gosh, I can't please everybody and I need to fall within certain parameters that have been set for me as a nurse manager to maintain my FTEs and my budget but yet you have to be friendly with your staff, you have to recognize your staff because if you are not doing that, then they are going back and saying well, I don't feel like I am part of this team. Nothing's happening here. No one's saying thank you very much.

Being the responsible party for all issues related to patient care on the unit is prevalent in the following excerpt from Participant B. Her feelings of being there for every issue related to patient care, whether a patient complaint or a staffing problem, is evident in the following dialogue. The necessity of being able to prioritize is an obvious determinant of success that this participant describes.

We are responsible for staffing, making the schedule, issues [that] come up on the unit, and try to help out on the unit. Even though you are a [nurse manager], you are responsible for what goes on on the floor and try to help them with the flow of the floor. And then patient complaints, family complaints, just a lot of things you have to prioritize. You know, you just put things on the backburner, deal with this and then go back to it. A lot of [named unit] safety issues and things that I'm still learning. You know, just employees just having complaints and daily, daily things come up that you have to face.

Participant B also described the expectation of staff related to having a new nurse manager on board and her feeling related to being there for them to support them while she was still learning the role.

When a new leader comes on board, they tell you all their problems. They want you to solve everything. And so, I was just bombarded with a lot. You know, like I said, 50 employees coming at you with things. So, I just tried to deal with the most emergent things and told them they just have to be patient with me, you know, I've learned. I've had to learn a lot of new things. And if something didn't get taken care of, it didn't mean it wasn't going to get taken care of.

One nurse manager, Participant E, detailed her perspective related to being *caught in the middle* as she describes an understanding of the business of healthcare and the fact that she is in a position where she is responsible for taking care of issues related to quality and performance. How she gets there and the struggles she experiences as she works to get there seem to be details that don't interest upper administration. The directive to get it done without some recognition of the struggles she faces in order to get it done distresses her. She is faced with issues that seem to be present on two levels. The

staff issues are day to day and seem to be the things she is prepared to deal with effectively.

The directives from administration without her input are at a different level and seem to be an area that she is uncomfortable with implementing because they do affect the staff that she has focused her attention on for some time. Adding tasks to the already burdened staff without taking away tasks resonates with the first manager, Participant A, who described feeling overwhelmed related to *being caught in the middle*. Both managers obviously care about the staff they manage and feel powerless to prevent the constant demands being placed upon them.

Participant E reflects upon this struggle:

I feel like you need to be a yes person because you want to be known as a positive person, making positive changes for the facility whichever way it is for performance measures, for customer service. You want to be able to provide those things that the medical center has a vision and direction for. But then you've got to make it happen and from that to reality on the floor is just sometimes not easy to do. You know, disrupting a lot of people. Adding a lot of tasks. What I seem to find out here is that we add a lot on to nursing but we don't take anything away from them. We continue to add. We may eventually take it away six months from now if we are doing well on something or whatever. But we don't take everything into consideration. I'm in the middle because what reality is on the floor some days, there are some days that you have time to do all the things you need to do and you feel good about what you have done. You feel like you have had time to develop [a good relationship] with the patient, to give great patient care, you've done a great job for the patient, you've done great documentation, and you've done it all. But then there are days you can't get there and you have to choose. Am I going to give the care or am I going to document? And you give the care. Every nurse, and you know it as well as I do, gives the care. They don't document. But here I come along. Even though I know reality. Even though, I know reality, I know they have had a horrible day. They have had four patients on that team, giving blood, you had someone in restraints giving them a fit, giving pain medicine, there is something, but then I'm still forced to give them disciplinary actions when I know what reality is.

My job is to make those changes happen. This is reality. What I do at this point is ask myself, "What did I do that put them in the position to do this? How can I change workflow issues." So, I think I go into that mode. OK, now it's my job to

fix this problem. Because I don't want to do that. Because I'm setting them up for failure. And I don't want to set them up for failure. Because they have worked too hard and too long to get their license and then to have this job. Sometimes it's just education. You can fix that easily. And sometimes it is a workflow issue and I have to totally think about how we have things set up to get that done. So, you know.

And sometimes, I think it's up to your discretion and if it's a true honest, "I couldn't get that done." Then you know your employees, who are honest and who are slackers, and they have to have that written warning to make them do better. And then you have your constant naggers that do nothing but bring your unit down. You know, I've learned you can't focus on them because you will spend 95% of your energy on them to do that and you can't. You have to focus on the other 45% that are doing so well and keep them motivated and going. And you hope the 95% [that are doing well] will work on the five percent [that are not doing well]. Either way, they will get the picture when you start rating them and riding them. You have a few. And some of them have legitimate concerns when they come to you. And then you have those that totally just blah, blah, blah. And back to you're caught in the middle. You understand the staff's point of view. It is hard. Because you've been there, you've done that. You understand the workload.

And then you have administration, do more with less perspective. And here lately, there is hope at the end of the tunnel. We are better than we have ever been. It's been great. We finally have people who love what they are doing. They are laughing, cutting up. We are retaining. People are staying longer. We have the retention bonus. All the little things we have done are working. Right now, for my unit. It's still there. You have those that want to. You are kind of caught in the middle when it comes to that. Sometimes you feel reluctant to tell administration all of the issues.

I'm talking about the Executive team. You feel like you are caught in the middle. They don't want to hear all of the issues. They want to hear how you are going to get it done (laughing) sometimes. But, you know, there are five steps in between getting it done and they don't want to hear that. And I understand. It's still a business. Sometimes you feel that you want to express it out. But I feel like I can tell [my supervisor] what I need and I feel that she has an honest grip on what she is doing with it [the issue]. The only thing is I don't know what she is doing because we don't see the other side. We only see this side as the nurse manager. I only know what I tell her. I don't see what she tells [the nurse executive] at this point. I don't know what happens once I tell her.

You know, you try to balance it and think, "Well, that can wait because it's not really a priority," and then you think, "Well, this is a priority, I want that done." And you are angry with yourself because you didn't stay and get it done. That's what's overwhelming I guess. Those day-to-day issues.

The same nurse manager describes being *caught in the middle* between making decisions about work and family. Conflict between work and life balance are apparent in the following dialogue. This nurse manager describes her efforts of trying to be available as the manager while also recognizing the importance of family. She relays a sense of "banging her head against the wall" as she describes the frustrations of meeting expectations in her work role and how that affects her family role. She also describes the effect the role has on her collegial relationships. She describes the detrimental effects stress has on the nurse managers who leave the role. This nurse manager's description of the theme being *caught in the middle* also describes another theme, *the inability to do*. She is caught in the middle of being a nurse manager and a parent.

You feel like you are banging your head against the wall. I don't think I get overwhelmed to the point that I can't sleep, I can't eat. I can't do that because you have to take time. I realize family is very important. You have to do your priorities in life. And that's what I've learned. It took me two years here to realize that. In the last two years I've realized that it's going to kill me in that role or I have to let it go.

So, that keeps going. Until you don't realize you have six months worth of staff meeting minutes you haven't typed up yet. And they are not providing me anybody to help me with the typing so, it's you either take it home and do it which is, you know, with kids, hard to do, or stay over and do it. Which there again, you have ballgames and things. I think it's overwhelming when you have a family in this role because you have to balance. That right balance between family and work. It's a fine line and you've got to draw it. And you still let that get away from you, being here to six and seven o'clock every night and then you realize, I don't know my child.

I know friends who are nurse managers who are on blood pressure pills, who take anti-anxiety medications to help them sleep at night. And then they left that job, went back into a staff nurse role and guess what? They came off all those medications.

The Inability to Do

The *inability to do* is related to the overwhelming demands and priorities that the nurse manager is experiencing. Those overwhelming demands and priorities are described in their stories.

Participant A described *the inability to do* as *putting out fires*. It is a day-to-day routine she is dealing with while trying to affect the facility at a higher level.

PART A: They showed [me] a staffing grid to make sure we are not overstaffed; that we are not understaffed. So, I started with that and just doing day-to-day, putting out fires.

INT: Putting out fires. I hear that a lot. As far as putting out fires and then getting back to feeling overwhelmed, how does that go together? Is there a relationship there? Putting out fires all day. What does that do to you?

PART A: When you put out fires all day, sometimes you cannot get to some of the other issues that need to be addressed. Say, like, for instance, your documentation. You know in the facility is off and things are getting documented as well as they need to. But when you are having a lot of fires to put out, be it with either with the patients and families that you are having to deal with because the nurse hasn't done something that they felt that they should have done or between nursing staff themselves. There are issues that you just kind of have to learn that you just have to let go

INT: Like?

PART A: Sometimes you feel like there are not enough hours in the day. Cause I sometimes come in at five o'clock in the morning and sometimes I don't leave until seven or eight o'clock.

Participant F described feeling the never-ending pressures being placed upon her, the lack of support, and a consuming feeling of failure. This participant's story is described in the paradigm case as well as detailed here in order to illustrate the theme of *the inability to do*.

The failure's almost a consuming type thing, that if I'm not here, taking care of my team, or if I'm not available on my phone 24/7, that you're not doing what you need to be doing, thus you fail. There is so much, there's the CMS [Centers

for Medicare and Medicaid Services], the CSR [Continuous Survey Readiness], the JCAHO [The Joint Commission] thing, the [named patient satisfaction] scores. Once you don't meet those numbers and you try to hold people accountable, those are numbers that reflect on you as a manager.

As a [Nurse Manager] for a smaller facility, you're kind of on your own. Not only am I leading two teams now, but I'm the sole provider of [clinical procedures in my area]. I do all the [clinical procedures], I do all the scheduling, and I do all the calling. I do all the staffing changes. I do all the timekeeping. I don't have a secretary, nor do I have someone that I can spare to pull off the floor to deal with those tasks. When I go home on Saturdays, I usually clean out my email so I can be prompt in responding to people. I [do the] counseling, I hire, interview, everything, I do it all. I'm paged continuously throughout the night and if you were a Nurse Manager at the larger hospital, you have a department that does your [clinical procedures]. You have a department that does your staffing. You have a department that does your timekeeping. [You have] a secretary on your floor. You are rarely out on the floor with your patients or your staff. You pretty much do the meetings and the counseling sessions and things like that. But I don't have those. And they make the same as I do. And they don't do call. They're not on call on the weekends. They can go home and leave their pager on the desk. And if they're short on their floor, they don't have to come in and work. I do.

And I need you to make sure staffing is right (mocking a supervisor). Oh, by the way, there are eight evaluations past due. Can you make sure those get done? I just, I mean, I guess when I get the most tearful in feeling, and I don't like to cry in front of anyone, when I get the most tearful is when I've been up most of the night being paged and, of course, the lack of sleep. You know? But because I feel like I can't get anywhere. I don't have the help. [Named organization] talks really, really big and we are doing these management classes and stuff. We are going to support our [nurse managers]. But they don't have the first clue. And I don't know if I can even offer them a suggestion what to start to look at. You know?

Well, I have seven loads of laundry in my laundry room in the floor that haven't been folded. I have a [small child] who sees me from probably six to eight or nine o'clock every day and that's it. Except for weekends, and that's usually at night, I'm paged or called about staffing or something like that so they get a little bit of my time there. There is not enough money to drag you away from that (sarcastically). So why do you stay in a [nurse manager] position? I think it's the need to achieve. The need to know that you are climbing up those ranks. But honestly, I've evaluated that and I'm not sure that I'll be a [nurse manager] much longer.

Participant B describes simply feeling incompetent related to the inability to handle all the things coming at her.

Just a lot of stress comes on. And it makes you feel like you are not competent at times to do things or to handle things. I guess you can't make proper decisions, proper decisions, it kind of feels like you have everything coming at you at once.

Participant D describes in detail the overwhelming demands on her time and the fact that she never seems to have enough time for important tasks due to the monotony of paperwork, filing, and routine business that could be handled at a lower level. She also describes the many daily tasks that can go awry by having a staff member absent. She describes getting to a certain point where she has to back away from the constant demands and prioritize.

You just can't really focus on one thing because you've got 12 more that you're being called about or being asked to do or you've got deadlines and you just feel, it's a feeling of not getting anything accomplished and I don't tolerate that feeling very well.

You start getting that dread of going in the next day about how many people are not going to be there. How am I going to cover that? You know? And I know I have to do this, that, and the other thing that is due. Trying to keep these employee files (pointing at files) up to date, it's pretty much a nightmare. You know, trying to get ready for Joint Commission and all that stuff. It just builds up. It just builds up and I pretty much just keep doing my thing, doing it the best I can until I get to a certain point and then that's when I'm at the end of my rope and I just can't deal with it anymore so then I have to step back away from it.

We try to set priorities. That's my biggest thing. You know, I have these, so many things to do. I can't do them all. What is it that I really need to be focusing on right now?

I have my school life and my home life. You know, I have a family and that plays into the stressors. You know, this job, it can really consume you 24-7, especially if you let it and I have a tendency to, you know, not just say I'm done for the day and not just walk away.

You know, typing up minutes. I'm a committee chairperson on one committee. The minutes just from the staff meetings. You know, stuff like that. It's just time consuming. Stuff is just time consuming. From letters that you have to send out ever so often, you know they could do that and be done. Filing is huge. This place is just overwhelmed with paperwork. You know so that's a huge problem. That in and of itself, I've spent this morning, an hour and a half working on five people's charts, just getting them put together. You know, and stuff like that. Interruptions

in between it but... Having a true charge nurse on the floor because the charge nurse can take away a lot of the employee's issues and a lot of the patients' issues just by being available where they are not available if they are in staffing. And that's a large part of my day. I go and I round and I spend... it takes me usually at least an hour to go and round on my floor.

Feeling That You are a Failure

The final theme is *feeling that you are a failure*. This theme has two sub-themes: *disappointing self and others* and *the need for recognition and respect*. The theme, *feeling that you are a failure* is powerfully described by these nurse managers as the point where they feel that they have exhausted their energy and are powerless.

Disappointing Self and Others. Participant C concisely described the sub-theme *disappointing self and others*. She is now feeling the personal loss of success in her role.

When I feel overwhelmed I feel like I'm disappointing myself and disappointing others. That's how I feel when I feel overwhelmed. I don't want to disappoint people. It used to be just people and I never put myself into the mix. Now I'm to the point that I don't want to disappoint myself.

The following describes Participant F's experience related to *feeling that you are a failure* that she is experiencing. She describes the process of being humbled. She is used to achieving success and in this role she finds herself failing her own high standards. Her heart is broken, her pride is hurt, and the standards she has set for herself are not being met. She describes barriers that she cannot overcome. This dialogue is powerful and gives details that many participants may have felt but did not verbalize. The nervousness apparent in some participants and their pride may not have allowed such candor. This participant's story is also described in the paradigm case.

In order to illustrate the theme *feeling that you are a failure* and her feeling of *disappointing self and others*, the following dialogue is provided.

PART F: Feeling overwhelmed just kind of gives you a sense of failure. You know, almost like, you are out of control. And, as someone who is a high achiever, who has to have everything A, B, C, you know I have to be the top of the class. I have to do it bigger and better than anyone else. And almost being a [nurse manager] is kind of humbling at times.

INT: Uh, huh.

PART F: Because no matter how many books you read, no matter how many classes you take on dealing with people, you are always surprised that that you, you're always thrown into situations where, I don't know, your always thrown into situations where your heart is broken and so your pride is hurt and you are humbled continuously. You [listen to] tapes like that Studer guy who talks about how wonderful management is and different things of that nature and it's not. Being a manager is not this warm, fuzzy feeling of leading these people into battle. And you're going to win the battle if you do the right thing by everybody. I can do the right thing by every person back there and I'm having to fire one today. Just, you know, I'm told that people need a leader. And I believe that. And I am told sometimes that bad eggs need to go and I pretty much buy into some of the philosophies that we talked about in nursing school.

For me, this week, it's been a very tearful experience. It's been very [difficult], seeing another [nurse manager] who wasn't doing her job being let go, not only for that, but just seeing the upheaval that her team is experiencing and the dysfunction. Trying to rally around for this [nurse manager] who doesn't give a crap. It's just been really hard this week and you are trying to get your arms around I guess everything that has to be done and making sure your patients get quality care.

Am I overwhelmed? Absolutely. Does [named organization] and them think I'm overwhelmed? I will tell them sometimes, this is a little much, but if you show them that you are overwhelmed and that sometimes you feel like things are getting out of control you are bad. Bad [nurse manager] (tapping on desk in a scolding manner). So, you have to be very careful on how you portray your suggestions. On how you show certain things.

Feelings of incompetence in leading a staff with more clinical knowledge than she felt she had mastered has Participant B describing *feeling that you are a failure*. She seems disappointed in herself and although she indicates that the staff on the unit were helpful, she doesn't feel comfortable being placed in a dependent position.

My employees knew more than I did and I just kind of felt weird leading them and being a leader for them and they knew more about the floor, about the

[clinical specialty] part of it. I was learning from them, which was good. It just made me feel incompetent because I didn't know a lot about [the clinical area]. I don't guess that's a word I'm using right, incompetent. But I learned from them. They were good about helping me. Learning [the clinical area] issues, the charting, and all the rules. And the rules were completely different as far as safety issues. So, I was learning from them but yet leading them. I guess that is hard to say. I'm learning from them and I'm supposed to be leading them.

Participant D describes the constant demands on her time and her disappointment in herself that she is unable to accomplish everything, to be everything, to do everything. She describes in detail the tasks that seem to monopolize her time and her disappointment in being unable to get past that. She feels that she *should* be able to do all the important things on her unit; however, there is never enough time. She continually experiences *shoulds* that she does not have time to do. She works to complete the goals administration places before her and the tasks that come up day to day. Neither gets the full attention needed. She blames herself as well as the job.

I should be able to do more chart reviews on my employees. I should be able to just spend some time out there with them, monitoring what they are doing. And I don't do a lot of that. I do some of it, but I don't do a lot of it. I should be able to track and trend things that I'm interested in on my particular floor but I don't have the time, or maybe it's some of my time management skills. I won't blame it all on the job, you know, some of it is probably me. Those are some of the things that I would like to do. There are programs I would like to implement; to make sure the education that needs to be given down here [is done]. I don't feel like we can accomplish it. Everyone is so busy. You know, I don't have a charge nurse anymore because she is constantly on the floor. So, I don't have somebody to help, you know, get all that stuff rolling, to make sure it is done. Getting people to volunteer to do education, that's a big thing that I'm very disappointed in myself in being unable to accomplish here.

I just feel like I have too many things going on and I can't accomplish any of them. I work on all of them and but don't accomplish any of them. And there are things that I truly want to do here. I just can't get my teeth around them and do it.

I spend so much time throughout the day. Some days I can't even tell you what I've done. You know, but I've worked all day long. And that's a dissatisfaction to me. I think the nurse managers at this facility, you know, we are expected to manage our units and we are also expected to do a lot with the management of the

facility, which is great experience, but it is sort of hard to do both jobs and do either one of them well.

Participant E describes her frustration related to constant negative feedback and the need for positive reinforcement. Her description is rich, providing a realistic perspective of the frustration she feels. She describes the constant tasks that get in the way of making meaningful changes, and, at the same time, she describes her need for some recognition of the job she is doing. She does not consider herself blameless but describes her need for support. She describes working herself to death, getting to the burnout stage, and having very little to show for that. She came into her facility with the hope of doing great things and the disappointment in the reality of what she has produced is evident.

I felt like [named Boss] supports you more when she gets to know what I can do and not do. And she has been very good, wonderful about telling me what you can do better. Now, I still need to, I feel like nurse managers need to hear that more from administration, the great things that you do. That's the only thing I never hear. I never hear anything good. I only hear, your unit sucks and you need to do this. Sometimes, not always, but for the most part. You know. And I understand that. But like anyone else, to keep you motivated, you need to know you're doing OK. Or, have you thought about doing this, you know to help you get on track where you want to go, your goals. You know, to sit down and help you get where you want to go in the [named organization]. You know, I've not seen that really here. And that's just frustration, it's not really being overwhelmed. The overwhelming thing is trying to get it all done in a day. Your emails, which are very important because it's the communication tool of choice in this facility, the phone calls, the schedule changes, making sure you get everyone here, to make sure you have enough to take care of the patients. Those are the things you spend time spinning your wheels on all day. And then you have to focus your day on who is barking the most; who needs what and you need to prioritize what you do. I have some great projects but I seem like I can't ever, you know I feel like I need to get a move on them but I can't because I feel like I do day-to-day operations. If I had someone to help you with those day-to-day things, it would free you up to implement the ideas that you have or, the true meaning of the nurse manager.

I think, as a new leader, you want to come in, you want to make such a change, such a difference. Then you realize, I've got to know what I'm doing first, I've got to know the system. You realize, you get at that burnout stage, where you've

worked yourself to death and haven't gotten a lot of gratification back from it. That's when you make those decisions in your life, how you balance, how you balance.

The Need for Recognition and Respect. A second sub-theme of *feeling that you are a failure* is *the need for recognition and respect*. This theme is related to *disappointing self and others* in that as the managers describe the disappointment, they also describe the need for someone, somewhere to acknowledge their efforts. This sub-theme portrays their frustration of working in an organization where they feel completely helpless. They have done all they can do to affect positive patient care and are frustrated by the fact that recognition of that hard work is absent.

Participant C describes her feelings related to *the need for recognition and respect*:

I don't want them to...you don't have to like me to respect me. I guess I want your respect. You don't have to approve of me but I do want your respect.

And then I was at a meeting with a bunch of people and when [center director] looked over at me and said we need someone to head these units and she looked over at me and said, "And we want you." And I said, "OK. I'll try anything," like I said, I mean, "I'll do it. I'll try it."

Participant F describes her frustration related to *disappointing self and others* and *the need for recognition and respect*. The more work she gives the organization; the more work the organization gives her to do. There is no appreciation or respect for the sacrifices she has made for the organization. She desires recognition that is not forthcoming.

There's never, there's hardly any, any more successes to celebrate. Once you try to celebrate things for your people, like for Christmas, I got them all stockings. We did the gift a day. But nobody really nurtures you. You see what I'm saying? You are the all nurturing and it's almost, well, and they try. They take you out to dinner. They get paid to do that and things like that. But it's almost... I didn't get

a raise for getting my Masters. I didn't, won't get a raise as a [nurse manager] for being certified. Because I'm a [nurse manager] I get less than the PRN [as needed or non benefitted] people that are paid to work. They make 30 dollars per hour and I make 28.

I want my people to give quality care. I want to be known as, not I necessarily, but my team, to be known as the people who give the best care, who do it all right, you know. And as far as you know, as you get [patient satisfaction] scores that suck. I don't know, I don't really think you ever know where you stand as a [nurse manager] as far as that goes because I think no matter how hard you try, this is how I feel, I feel that if you are one of those people like me that you feel like you've got to do it and you've got to do it right. The more you do, the more you get to do. Whether you want it or not.

Participant F's interview exhibited all the essential themes and is presented as Sallie's story. Sallie's story (the paradigm case) best represents the meanings, concerns, and issues that were evident throughout the interviews.

Paradigm Case

Sallie's story begins with an immediate reference to the participant's sense of *feeling that she is a failure*. Feeling overwhelmed to her means she is unable to control her surroundings and, to her, control seems to be an important aspect of being successful in the Nurse Manager role. She mentions being a high achiever, accustomed to being the best at what she does.

PART F: Feeling overwhelmed just kind of gives you a sense of failure. You know almost like, you are out of control. And, as someone who is a high achiever, who has to have everything A, B, C, you know I have to be the top of the class, I have to do it bigger and better than anyone else. And almost being a [nurse manager] is kind of humbling at times.

INT: Uh, huh.

PART F: Because no matter how many books you read, no matter how many classes you take on dealing with people, you are always surprised that that you are thrown into situations where your heart is broken and your pride is hurt and you are humbled continuously. You have tapes, like that Studer guy who talks about how wonderful management is and different things of that nature and it's not.

Being a manager is not this warm, fuzzy feeling of leading these people into battle. And you're going to win the battle if you do the right thing by everybody. I can do the right thing by every person back there and I'm having to fire one today. Just, you know, I'm told that people need a leader. And I believe that. I am told sometimes that bad eggs need to go and I pretty much buy into some of the philosophies that we talked about in nursing school and some of the theories [her professor] has about being a leader, I truly believe. But you are still dealing with so many old school managers, vice presidents, and an ever changing work ethic in people. The work ethic in people is decreasing. By the time you've listened or read a book on the philosophy of how to maintain those people from a different generation, you already have a different generation coming in.

INT: Yes (nodding).

PART F: For me this week, it's been a very tearful experience. It's been very [difficult] seeing another [nurse manager] who wasn't doing her job being let go, not only for that, but just seeing the upheaval that her team is experiencing and the dysfunction. Trying to rally around for this [nurse manager] who doesn't give a crap. It's just been really hard this week and you are trying to get your arms around everything that has to be done and making sure your patients get quality care.

Sallie then details the workload she is expected to carry. She details the constant demands and responsibilities and her thoughts regarding leadership support and recognition (or lack of) related to those expectations. The essential themes of *I do it all*, *caught in the middle*, and *there is nobody there* are apparent in this dialogue. Throughout the dialogue, she discusses the lack of support staff and administrators available to show support or shared responsibility for the various roles she is leading.

INT: You said, in the beginning that feeling overwhelmed is like failure. Tell me more about that.

PART F: If you were to look at my house 5 years ago, my home, it's a very neat, very organized place. If you were to look at my life 5 years ago, it's a very neat, organized place, A, B and C. Not that I'm anal by any means but the failure is almost a consuming type thing. That if I'm not here taking care of my team; or if I'm not available on my phone 24/7, you're not doing what you need to be doing, thus you fail. There is so much. There's the CMS (Centers for Medicaid/Medicare), the CSR (Continuous Survey Readiness), the JCAHO (The Joint Commission) thing, the [patient satisfaction] scores...once you don't meet

those numbers and you try to hold people accountable, those are numbers that reflect on you as a manager.

INT: Uh, huh.

PART F: I don't spend time with my family without being paged because you are that you are scared that (pause) I have to be the best manager. Do I have to have everyone like me? No. And I've kind of grown out of that too. But, I mean, there's never, there's hardly any, any more successes to celebrate. Once you try to celebrate things for your people, like for Christmas, I got them all stockings. We did the gift a day. But nobody really nurtures you. You see what I'm saying? You are the all nurturing and it's almost, well, and they try. They take you out to dinner. They get paid to do that and things like that. But it's almost... I didn't get a raise for getting my Masters. I didn't, won't get a raise as a [nurse manager] for being certified. Because I'm a [nurse manager] I get less than the PRN [as needed/non benefited] people that are paid to work. They make 30 dollars per hour and I make 28.

INT: How do you feel about that? Not getting raises for the achievements that you have accomplished?

PART F: Well, I don't think it's fair but then again, it's an expectation of our job and do you request that you do get paid more? I guess the problem with that is that you have to be consistent all down the line. If you have [nurse managers] within the system that [clock out] at five o'clock every day and don't take call on the weekends and are [Associate Degree] nurses, and you have nurses that are working 12 and 13 hours a day who are on call every weekend and are Master's prepared, there is no differential type.

INT: Tell me a little bit more about that process as far as the differences in people and the expectations.

PART F: As a [nurse manager] for a smaller facility, you're kind of on your own. Not only am I leading two teams now but I'm the sole provider of [clinical procedures in my area]. I do all the [clinical procedures]. I do all the scheduling. I do all the calling. I do all the staffing changes. I do all the timekeeping. I don't have a secretary, nor do I have someone that I can spare to pull off the floor to deal with those tasks. When I go home on Saturdays, I usually clean out my email so I can be prompt in responding to people. I [do the] counseling. I hire, interview, everything, I do it all. I'm paged continuously throughout the night and if you were a [nurse manager] at the larger hospital; you have a department that does your [clinical procedures]. You have a department that does your staffing. You have a department that does your timekeeping. [You have] a secretary on your floor, you are rarely out on the floor with your patients or your staff, you pretty much do the meetings and the counseling sessions and things like that. But I don't have those. And they make the same as I do. And they don't do call.

They're not on call on the weekends. They can go home and leave their pager on the desk. And if they're short on their floor, they don't have to come in and work. I do.

INT: Why is it like that?

PART F: I'm not really sure...I guess just because we are a smaller facility. I don't know. I don't know.

INT: You said that you're the type that likes to be the best at everything.

PART F: Uhm hum.

INT: So how does that relate to this role?

PART F: Well, it relates because I want my people to give quality care. I want to be known as, not I necessarily, but my team to be known as the people who give the best care, who do it all right, you know? [Then] you get [patient satisfaction] scores that suck. I don't really think you ever know where you stand as a [nurse manager] as far as that goes because I think no matter how hard you try, I feel that if you are one of those people like me that feel like you've got to do it and you've got to do it right, the more you do; the more you get to do. Whether you want it or not.

INT: Uhm Hum (nodding).

PART F: I did get a small increase for taking two departments. Like a three percent increase (laughs). It was almost humorous. Not only do you now not have a partner to help you with this, you are going to be doing it all (laughing out loud).

INT: Oh?

PART F: "And I need you to make sure staffing is right (mocking another person). Oh, by the way, there's eight evaluations past due. Can you make sure those get done?" I guess when I get the most tearful and I don't like to cry in front of anyone; when I get the most tearful is when I've been up most of the night being paged and of course, the lack of sleep, you know. But because I feel like I can't get anywhere. I don't have the help. [The organization] talks really, really big and we are doing these management classes and stuff. [They say] we're going to support our [nurse managers] but they don't have the first clue. And I don't know if I can even offer them a suggestion what to start to look at.

INT: So, when you don't know. You said you didn't know how to suggest where to look... do you have ideas?

PART F: Well, I think the first thing I would say is to look at your [Nurse Managers] across the system and is there equality on the standard you've set? Are you truly setting that standard for all [nurse managers]? Honestly, I'm playing a director and a [nurse manager] role but I don't get paid the money to do the director role. I would also ask that they look at their [nurse managers]. Something as simple as having a laptop to go home with or giving them a cell phone. You know, I use my own cell phone. There's just not that support there. I don't think they have a clue as to how much some of the [nurse managers] do. And I have no problem telling you that being overwhelmed and showing it are two different things. Am I overwhelmed? Absolutely. Does [my director] and [administration] think I'm overwhelmed? I will tell them sometimes that this is a little much, but if you show them that you are overwhelmed and that sometimes you feel like things are getting out of control [then] you are bad (pause). "Bad [nurse manager] (tapping on desk in a scolding manner)." So, you have to be very careful on how you portray your suggestions. On how you show certain things.

INT: So, you work at home. How does that work?

PART F: Well, I have seven loads of laundry in my laundry room in the floor that haven't been folded. I have a 15 month old and a seven year old who see me from probably six to eight or nine PM a day and that's it. Except for weekends and usually, at night, I'm paged or called about staffing or something like that so they get a little bit of my time there. There is not enough money to drag you away from that. So why do you stay in a [nurse manager] position? I think it's the need to achieve. The need to know that you are climbing up those ranks. But honestly, I've evaluated that and I'm not sure that I'll be a [nurse manager] much longer.

Essences

Through the process of *intuiting*, the data were pushed to go beyond the words of the participants to a level of abstraction (van Manen, 1990). This level of abstraction, presented in the form of essences, is necessary to make the data meaningful to nursing and other disciplines.

The essence of the lived experience of feeling overwhelmed is defined by the researcher as follows: Feeling overwhelmed for the nurse managers who described their stories in this research is helplessness evidenced by constant unresolved conflicts in a complex, chaotic organization with changing expectations, unmet personal fulfillment,

and constant turbulence. It is personal conflict related to the desire to impact positive patient and staff outcomes--to make a difference, while feeling that they fall short of the organization's and their own personal expectations.

The stories of the nurse managers interviewed for this study demonstrate constant unresolved conflict as they struggle to balance life, work, and their professional goals. They seem to have had so many things they wanted to impact as a nurse manager and become overwhelmed when they face the many obstacles present in the system. Some are hurt. Some are frustrated. Most are disillusioned by what they imagined they could do and what is actually happening in their role. The nurse managers in this study are relatively new in the role. None have been nurse managers more than 5 years. They are eager to accomplish so much. The reality of getting things done and of being successful is not all they thought it would be.

Summary

The nurse managers interviewed had a vision of leading in a changing healthcare environment; however, many times they felt paralyzed by the lack of initial support, orientation, role expectations, and the conflicting-competing priorities of life. They are caught in the middle of staff who look to them as their leader and the constant demands to improve performance at the point of care. Many times, they felt that they were alone in their struggles, as if they were solely responsible for the success of the organization. The organizations' success being measured at the point of care that they most influence and, the impact of that responsibility, was overwhelming to the nurse managers who participated in this research. Chapter 5 discusses theoretical, practice, research, and educational implications resulting from this research.

CHAPTER 5

DISCUSSION

The purpose of this study was to discover the lived experience of feeling overwhelmed by nurse managers. Six nurse managers participated in open-ended interviews with one pre-planned interview question, "What is your experience with feeling overwhelmed." This chapter discusses theoretical implications relevant to the results of the study and links to current theoretical literature that may be impacted as organizations consider the stories of the participants. Implications for research, practice, and education related to the lived experience of feeling overwhelmed by this group of nurse managers are also discussed in order to inform healthcare administrators, educators, and practitioners of the experiences of this group of participants. They can then consider these results as they make decisions that could impact this group. Lived experience does not seek to change theory and practice. It seeks to inform others of the phenomenon of interest so they are sensitive to the experience of this group.

Four themes were identified, *there is nobody there*, *caught in the middle*, *feeling that you are a failure*, and the *inability to do*. Sub-themes of *there is nobody there* and *feeling that you are a failure* were also identified. The sub-themes of *there is nobody there* are *being thrown in* and *upheaval in administration*. Sub-themes of *feeling that you are a failure* are *disappointing self and others* and *the need for respect*. The essence of the nurse manager's lived experience of feeling overwhelmed is helplessness evidenced by constant unresolved conflicts in a complex, chaotic organization with changing expectations, unmet personal fulfillment, and constant turbulence. It is personal conflict

related to the desire to impact positive patient and staff outcomes--to make a difference, while feeling that they fall short of the organization's and their own personal expectations.

The participants for this study were all female. All of the participants with the exception of one indicated that they were married with children. Two of the participants had adult children. Three participants had children under age 10 at home. The participants all worked in inpatient settings. Those settings included four from acute medical-surgical settings, one long-term care, and one psychiatric setting.

Theoretical Implications

It is important to note that the perspectives of the participants of this research are their truth as interpreted by the researcher. Van Manen indicates that "there is one word that most aptly characterizes phenomenology itself...thoughtfulness... in the words, or perhaps better, in spite of the words, we find 'memories' that paradoxically we never thought or felt before" (van Manen, 1990, pp. 12-13).

"The center of the world can be anywhere the person is" (Black Elk as cited in Campbell, 1988, p. 89). Campbell is referring to truth as each person's truth. Seeing things from our perspective is essentially who we are. In hermeneutic phenomenology, "the human being is seen and studied as a 'person' in the full sense of that word, a person who is a flesh and blood sense maker" (van Manen, 1990, p. 14). For the researcher, using van Manen's approach to hermeneutic phenomenology, "theory and research does not stand before practice in order to inform it. Rather, theory enlightens practice. Practice (or life) always comes first and theory comes later as a result of reflection" (van Manen,

p. 15). This section seeks to inform the reader of theories related to the themes and essences of the lived experience of feeling overwhelmed by this group of nurse managers.

Quantum Physics and Emotional Intelligence

Zimmerman-Jones defines quantum physics as "the relationships between matter and energy at the molecular, atomic, nuclear, and even smaller microscopic levels. Quantum is Latin and means 'how much.' Even space and time, which appear to be extremely continuous, have smallest possible values" (Zimmerman-Jones, 2008, para. 1).

When referring to *being*, Wheatley describes our perception of what we see as really a series of individual actions (Wheatley, 1994). Wheatley refers to the "continuous dance of energy" (Capra 1990, p. 27 cited in Wheatley, p. 32) as she describes our thoughts and how that shapes the reality around us. Dunham-Taylor, Malcolm, and Calhoun (2006) refer to Ecclesiastes 3:15, "That which is, already has been; that which is to be, already is" (p. 97) as they construct a view of reality based upon quantum physics. Their interpretation of reality in the workplace is based upon the reality of those working and their thought processes. The idea is that "our thoughts create our reality" (p. 97). For the nurse manager, feeling overwhelmed, the *sense of failure*, of being *caught in the middle*, of feeling as if *there is nobody there*, and *the inability to do* may well predict their success in the organization. Using the theory of quantum physics, the negative emotions present in the themes for these nurse managers when they feel overwhelmed will translate to their future reality.

The theory of emotional intelligence evolved from work in the 1920s on social intelligence models (Thorndike, 1920). It has since evolved and has theories of emotional intelligence within models of intelligence (Mayer, Salovey, & Caruso, 2000), models of

well-being (Bar-On, 2000), and models of performance (Goleman, Boyatris, & McKee, 2002). Theories of emotional intelligence that have been linked to organizational performance suggest that the success of the organization is based upon the leader's attitudes (Goleman et al., 2002; Snow, 2001; Vitello-Cicciu, 2002). According to theories of emotional intelligence, the leader "acts as the group's emotional guide" (Goleman et al., p. 5). If the leader exhibits self confidence, is conscious of his or her limitations, remains poised, welcomes new ideas, and displays integrity, employees will aspire to embody those characteristics. If leaders manage their emotions positively, they will be more effective and motivate the employees they lead (Snow, 2001; Vitello-Cicciu, 2002).

Emotional intelligence is closely related to the work of quantum physics in that "energy fields can be affected by our thoughts" (Dunham-Taylor et al., 2006, p. 97). Dunham-Taylor et al. suggest that care should be taken with regard to what we are thinking. For the nurse managers in this research, the constant turmoil related to being overwhelmed gives energy to that phenomenon. This could predict more of the same. Goleman et al. (2002), describing emotional intelligence, suggest training our minds to see things differently. As in, the glass is half full rather than half empty.

Exploring the phenomenon of feeling overwhelmed, it seems to be a natural tendency for the participants to view the phenomenon negatively, therefore, viewing the glass half empty rather than half full. In order to manage effectively in the face of so much change, the theory of emotional intelligence, specifically, theories of emotional intelligence based upon organizational effectiveness and performance, may assist

organizational leaders as they develop strategies to develop leaders, including nurse managers in all levels of the organization.

Quantum theory has made a great impact on Newtonian science which strives to reduce everything to quantifiable parts in the search for meaning and causal relationships (Wheatley, 1994). Quantum theory asserts that relationships are the foundation to reality. One cannot assume they will always have the same result due to a stimulus. The constant evolution of particles and their unexplainable, constant change are really all we can count on according to quantum theorists (Wheatley). Quantum Theory (Porter-O'Grady & Malloch, 2003) is an important theoretical perspective related to the results of this study. "We now live with the knowledge that everything is linked, and that parts of events in one part of the universe have some kind of impact on what happens in other parts. Our understanding of the linkage between events is the basis for complexity science and has led to changes in the conceptual foundations of the sciences and their social application" (pp. 5-6).

Quantum theory has emerged as the science of work in the 20th century and has undergone great change related to the new technology of the 21st century. This has forced organizations to change their focus from process to outcomes. The healthcare field is one area where leaders have seen rapid changes in technology in recent years. Nurse managers have been placed in a position to either move with the technology and change or be left behind to flounder. "Furthermore, the discoveries and innovations are occurring faster than the rate of adaptation. In this transformational time between two ages, the leader's primary role is to live fully in the realm of potential reality" (Porter-O'Grady & Malloch, 2003, pp. 6-7).

Porter-O'Grady and Malloch (2003) discuss the importance of leaders being adaptable to the new age, to the changes that will constantly impact the day-to-day work, and how they can lead others to embrace this change in order to have a positive impact. For the nurse managers in this study, that ability may serve them well. Feeling overwhelmed is the point in time when the manager is dealing with the inability to positively deal with the rapid demands and changes in the organization. Chaos is inevitable. How the manager deals with the day-to-day chaos is key to managing and leading as the chaos becomes overwhelming. "Chaos challenges us to simultaneously let go and to take on" (Porter-O'Grady & Malloch, p. 23).

Infinity Theory

Although still in its infancy, the Infinity Theory of Leadership (Ghaffari, 2004) based upon the Trinity Paradigm of Intelligence (Ghaffari, 2000, 2007) has applicability to the experiences of this group of nurse managers, particularly because the majority of the nurse managers in this study are from large network hospitals. Infinity Theory recognizes theories of emotional intelligence and the importance of cognitive and intelligent leadership traits. An important aspect of Infinity Theory is acknowledging and emphasizing the transpersonal realm of individuals struggling to lead in the ever-changing, constantly moving, chaotic healthcare environment. The larger the corporation, the less interdependent they have become.

The infinity theory of leadership models a unique leadership strategy, which, by capitalizing on its essence (interdependence), supports, and strengthens strategic alliances and promotes interdependence among individuals, organizations, and systems. Unlike other relationships, interdependent relationships require

exchanges of energy, information, and ideas that lead to entropy, evolution of the system, as well as evolution of individual units. (Ghaffari, 2004, para. 1)

Infinity theory is an interesting perspective that turns the focus from emphasis on the end product and the pieces required to get there to a focus on the process of getting where we want to go in an "intelligent" way. It suggests that interdependent relationships, and how we establish such relationships in the system, may benefit leaders as we continue to evolve and grow in large healthcare corporations. The concepts of infinity theory applied to mentoring relationships, orientation processes, and general organizational dynamics may impact the nurse managers in this study who experience feeling overwhelmed.

Nursing Theory

Rogers' Science of Unitary Human Beings (Rogers, 1970) asserts that causality is an illusion. She asserts through the principle of integrality that "the human and environmental energy fields engage in the continuous, mutual process of change" (cited in Fawcett, 2000, p. 368). The application of the Science of Unitary Human Beings in nursing administration concludes that:

Administrative policies foster an open and supportive administrative climate that enhances staff members' self-esteem, actualization, confidence, available options, and freedom of choice and provides opportunities for staff development and continuing education.

The ultimate goal of all management strategies and administrative policies is the client's well being. This goal is attained by increasing the capacity of each individual involved in the delivery of nursing services to participate knowingly in

change. The nurse administrator's energy, therefore, is directed toward facilitating changes in the environment that will enhance systems of communication and harmonious human-environmental energy field mutual process. (Fawcett, 2000, p. 381)

The applicability of Rogers' Science of Unitary Human Beings to the nurse managers' lived experience of feeling overwhelmed is related to the constant organizational chaos and turmoil that the managers are coping with on a daily basis. Rogers asserts that pattern changes continuously. When discussing life patterns and organization, Rogers states, "the order of the universe is maintained amidst constant change...man's capacity to maintain himself while undergoing continuous change is a remarkable characteristic" (Rogers, 1970, p. 63). The direction and rate of change may vary for each individual over the course of time. The nurse managers in this study are living this change and their experiences of feeling overwhelmed may indicate their need for better understanding of the inevitability of change. Therefore, they must personally develop life skills to manage the eventuality that change will occur.

Summary

Nurse managers are the first line supervisor at a critical point in the healthcare system. According to Porter-O'Grady and Malloch (2003), "if something is wrong at the point of service, the system as a whole will be affected... any break in the simple systems will lead to breaks at all levels of the complex system" (p. 31). The impact of their leadership at the point of service was very evident in stories of the nurse managers in this study. The effect of that responsibility for a single break that can take down the system can be overwhelming. It is like the small hole in the dyke. The responsibility of

implementing change in the constantly changing healthcare environment with staff who may resist or who are unable to adjust makes adaptation more difficult. Time has been compressed as processes have sped up. The nurse managers in this study are acutely affected by the time restraints placed upon them with the expectations to make significant changes that affect the entire organization (Porter-O'Grady & Malloch).

It is important to note how the forces of change, chaos, and quantum leadership are impacting the feelings of the nurse manager. However, it is just as important to note that without senior leadership support, progress can be stagnated as the nurse manager creatively embarks on the challenging road to unit level change. Complexity in organizations can hinder the ability of an organization to thrive in the rapidly changing healthcare environment.

The more structured and detailed an organization is, the more resources become drawn away from the point of impact. "There should be just enough structure to support the integrity of the organization and not an ounce more" (Porter-O'Grady & Malloch, 2003, p. 25). The nurse managers in this study all worked in complex organizations with layer upon layer of reporting requirements. This impacted their ability to function among chaotic changes, to move staff toward a better acceptance of change at the point of service and, for the nurse manager, resulted in frustration and an eventual feeling of being overwhelmed.

Implications for Research

Research related to the nurse manager role has focused on the leadership qualities necessary to retain staff in the organization (Anthony et al., 2005; Demerouti et al., 2000; Force, 2005; Kleinman, 2004; Ma et al., 2003; Rafii et al., 2004; Wells et al., 2002) and

nurse manager stress. The phenomenon of feeling overwhelmed is related to some definitions of stress; however, the experience of stress as a universal phenomenon cannot be confused with the phenomenon of feeling overwhelmed. For this group of nurse managers, feeling overwhelmed is a point they reach when they are unable to cope with stress. They are at an endpoint. They feel helpless.

Nurse manager stress has been studied using qualitative and quantitative techniques (Shirey, 2006). Shirey completed an integrative review of the literature related to nurse manager stress. Shirey found that a large percentage of the studies had issues related to instrumentation, reliability, validity, and the lack of stated theoretical frameworks. Despite these issues, the integrative review did find that the literature from 2000 to 2006 focused on the increasingly complex healthcare environment and its effect on the stress nurse managers are experiencing. These findings, combined with increasing nurse manager vacancies are a cause of concern.

Another important finding in this comprehensive review was the increased research focus outside of the United States on nurse manager stress and the lack of studies in the United States related to this issue. The United States has undergone substantial changes related to the increased workload responsibilities of the nurse manager as hospitals have increased their focus on improved patient outcomes with dwindling nurse staffing resources.

Research related to the role of new nurses in organizations and the reality shock they experience has been enlightening with regard to identification of four predictable phases new nurses experience (Kramer & Schmalenberg, 1977 cited in Dunham-Taylor, 2006). Kramer and Schmalenberg described the initial honeymoon phase a new nurse

experiences where the excitement of introduction into nursing makes "everything wonderful" (cited in Dunham-Taylor, 2006, p. 792). As the new nurse progresses, he or she may become blocked either by incompetence with certain skills or the organizational dynamics. The final two phases, recovery and resolution, describes the new nurse finally adapting to the organization.

Benner's work with Novice to Expert also describes nurses' adaptation and development along the continuum of competency and development (Benner, 1984). The nurse managers in this study seem to evolve along a similar continuum and are in stage two of reality shock as they describe feeling overwhelmed. This does not mean they do not progress or have not progressed along the reality shock continuum; however, their descriptions of feeling overwhelmed indicate that they are caught in phase two when feeling overwhelmed. With regard to the Novice to Expert continuum, the nurse managers who describe feeling overwhelmed could be at any stage; however, it is difficult to assess as they describe feeling overwhelmed.

Research indicates that the role of the nurse manager is important to the organization as the nurse manager strives to maintain a competent workforce in the face of national nurse shortages. The nurse manager has been reported to be key in retaining nurses who are documented as experiencing workload stress and perceived lack of support. Little research has focused on the role of the manager who is placed in the difficult role of maintaining and managing this valuable workforce. Based upon the experiences of the group of nurse managers who participated in this research, the research should not only focus on the application of the skills necessary for effective leadership, it

should search for methods to enhance skills while recognizing the turmoil present in this group of managers.

This research has added to nursing science by giving hospital administrators, directors, and nurse leaders a perspective of the nurse managers' experiences when the multiple tasks and responsibilities these nurses experience become overwhelming. The research may also increase awareness among nurse managers in the field as they strive to maintain balance in their own chaotic healthcare organizations. Nurse managers may gain an understanding of the organizational forces related to constant change and realize that the turbulence they experience is simply a force where they must adapt. This could impact the coping skills these managers strive to develop.

Future research should focus on more than inpatient nurse managers. The lived experience of nurse managers in other settings would be beneficial. An understanding of the experiences of nurse managers at all levels in different types of organizations would contribute to the current research.

Implications for Practice

The nurse managers in this study consistently described their desire to impact nursing practice positively and support their staff in order to enable staff to perform within expected standards for the organization. As the nurse manager on their unit, they felt responsible for giving staff nurses the tools they necessary in order to deliver quality patient care. They became overwhelmed when the competing forces of organizational mandates became unmanageable. The constant demands for improvement, change, and measured standards by external and internal regulations upset the balance they had carefully crafted.

Vestal (2006) describes nurse manager retention and sources of dissatisfaction among nurse managers. Some factors of discontent resonate with the descriptions of the nurse managers in this study. Vestal describes the monotonous activities the nurse manager performs routinely and the fact that nurse executives may consolidate the nurse manager in the category of near burnout. According to Vestal, many of the routine activities nurse managers perform could be mitigated by recognition and identification of the sources of job dissatisfaction. Vestal describes the survival mentality many nurse managers develop as they strive to meet the constant demands of change in the healthcare environment.

One nurse manager's experience described how she was caught in the constant change and how she struggled to meet the expectations of administration without additional resources.

You are caught in between the executive team, caught right in the middle. You have to face that. You know, get these performance measures done. Sometimes the reality factor for them is not there. Because reality is that sometimes it can be impossible to get done without either a) extra help or [b] completely re-designing the system or looking at it in a different way. So it can be overwhelmed anyway. Anytime, any fashion, any how. It just varies day by day, depending on what the topic of the day is, or what the concern for the day or week or when Joint Commission is coming, and those kinds of things. You know, employees are tired, they are overwhelmed.

I get overwhelmed when they're [staff] overwhelmed. You know, when they come to you, because you feel helpless because you can't help them. I think that's what stresses me out the most when I go home the most is, did I help them? Did I do everything possible I can do to help them to provide the care that our [patients] need? You know that is frustrating at times. Because you know, you walk out of here and ask did I do everything I could have done?

My job is to make those changes happen. This is reality. What I do at this point is ask myself, "What did I do that put them in the position to do this? How can I change workflow issues." So, I think I go into that mode, "OK, now it's my job to fix this problem." Because I don't want to do that. Because I'm setting them up for failure. And I don't want to set them up for failure.

This nurse manager's description of being the change agent for practice improvement, and the struggle to do that well, is apparent. The managers in this study did not seem surprised by that expectation, in fact, they seemed eager to be the responsible party who could impact change as they began their nurse manager role. The reality of getting there--to actually realizing the success of impacting the organization positively is overwhelming. One manager's description is powerful. "There's never...there's hardly any, anymore... any successes to celebrate."

This study will inform hospital administrators, nurse managers, staff nurses, and educators of the lived experience of feeling overwhelmed by nurse managers so that they can be informed of the experiences of this group as significant practice changes and mandates occur in the organization. Nurse managers are at the point of care in the organization to impact the organization as a whole. Patient care is the focus of all hospital organizations and performing patient care within acceptable standards is paramount to the success of the organization. Performing well above acceptable standards is the goal of hospital organizations today. Scorecards are the norm. Every hospital dependent on Medicare funding has published performance measures. Failing those measures is not an option. Impacting those measures occur at the patient level. Nurse managers are usually the first line supervisor at that patient level; therefore, the responsibility of the position is significant.

Implications for Education

One theme in this research, "*there is nobody there*" clearly emphasized the need for comprehensive orientation, education, and mentoring for new nurse managers

entering the organization. Experience as a nurse manager does not negate the need for improved orientation which was clearly lacking in every nurse manager interviewed in this study.

Kleinman (2003), in an examination of the perceptions of nurse managers and nurse executives related to the competencies necessary for management roles, found that nurse managers were more prepared to deal with the clinical activities of their unit than the business activities. Rudan, (2002) in a study of the reasons nurses are not interested in nurse manager roles and related educational programs echoes Kleinman. Rudan suggests that educational institutions should collaborate with healthcare facilities to develop educational curricula specifically aimed at improving the management competencies of nurse managers. He states that most nurse managers are clinically competent; however, they lack advanced practice administrative competencies.

Consistently, the participants described being "thrown in" to the nurse manager role, in some cases, shown an office and basically left to figure things out on their own. One nurse manager, who had never practiced as a nurse manager in her facility before, described being taken to her office. "They threw me in this job and said here, here, here and call me if you need anything. I had no idea. I had no idea how to make out a PO. I had no idea. And people would say, oh, don't you know that?" This description was consistent across interviews.

Some had an orientation guide; however, they indicated that the orientation was inadequate. Some had a mentor; however, it was not a true mentor who actually had time to give them. Their mentors and preceptors were usually in a similar role, struggling with their own responsibilities.

One manager described having experience in management but no experience with the current clinical area she was managing. She learned from the staff and felt that impacted her ability to lead them.

My stress mostly came from going into the manager's position with no guidance and no preceptor, and because of that, it's overwhelming because I came from med-surg to [named specialty] unit so I had to learn all the [clinical specialty] and then plus the management part of it. So that was overwhelming for me.

My employees knew more than I did and I just kind of felt weird leading them and being a leader for them and they knew more about the floor, about the [clinical area] part of it. I was learning from them, which was good. It just made me feel incompetent because I didn't know a lot about [the clinical area].

In every interview with every nurse manager, orientation to the role and the availability of a strong mentor who could truly impact their growth was identified as a deficiency. Every nurse manager had suggestions on how their orientation to the role could have been better. Overall, clear expectations of reporting guidelines, expected reports to be completed, resource issues, how to move suggested changes through the chain of command, clear feedback, and overall expectations should be outlined early in the orientation in order to save time and conflicting priorities. Guidelines, mentorship, and a designated mentor who is available for support and education could impact nurse managers' ability to perform well early and feel that they are a significant member of the healthcare team. Many of the managers in this study indicated feelings of incompetence for some time early in their role and then later as they became aware of responsibilities of their role.

Summary

The essence of the lived experience of feeling overwhelmed is helplessness evidenced by unmet expectations in a complex, chaotic organization with changing

expectations, unmet personal fulfillment, and constant turbulence. It is personal conflict related to the desire to impact positive patient and staff outcomes--to make a difference, while feeling that they fall short of the organization's and their own personal expectations.

The nurse managers in this study are clearly essential to organizational success due to their impact on patient outcomes at the point of care. Support for this group of nurse managers in the form of clear orientation procedures, mentorship programs, administrative support, and recognition are essential in order to promote success in the role. Success will likely improve retention and translate to improved patient outcomes as managers become adept at handling the chaotic changes of the new healthcare environment.

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