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Frontline and Middle-Level Nursing Leader Transition Within the Military Health System

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This is to certify that the doctoral study by

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Abstract

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MSN, Walden University, 2009

Project Submitted in Partial Fulfillment

of the Requirements for the Degree of

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Abstract

Healthcare delivery within the military requires a multifaceted approach to achieve the desired outcomes of safe, effective, patient-centered, timely, efficient, and equitable health care. The prospect of maintaining a cycle of continuous process improvements within military clinical settings hinge on frontline leaders and middle-level managers who must be prepared to execute the mission and motivate, supervise, coach, and mentor the staff. This project showcases a review of current literature translated into the development of an evidence-based Transformational Leadership Induction Program (TLIP) module that consisted of 4 subsections: the environment of care, clinical decision support systems, human resources management, and change management as well as resources for successful leadership within the organization. The training is designed to bridge the transition gap, facilitate role orientation and induction, and socialize frontline and middle-level managers during their role transition. The results of a need assessment survey, approved by the organization, were completed by 30 incumbents and resulted in 57% (17) providing feedback and role-specific contents that were integrated into the development of the TLIP module. The overall response to the survey was positive with 82% (14) of the respondents either agreeing or strongly agreeing with the items that they reviewed. The TLIP module provides a medium that translates current evidence into a succinct training platform capable of enhancing leadership transition and handoff. The TLIP module enables a culture of trust, enhances staff satisfaction, and fosters change management and succession planning within the military healthcare system.

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Dedication

This work is dedicated to my two children, Nicholas and Angelle, who have challenged me to be a better person and my wife Shamane who has been there every step of the way. To all my colleagues, military, and civilians whom day after day give their all to make Military Healthcare the best. To the front-line and middle-level nurse leaders who are tasked with managing, leading, directing, and balancing the triad of patients, staff, and institutional requirements on a daily basis. It is my hope that this work will make a valuable contribution to your role transition.

Acknowledgments

Without the grace of God, nothing would be possible. Thanks to Dr. Eileen Fowles, the project committee chairperson who has been an active mentor and coach throughout my project development process. Many thanks to my dissertation committee members Dr. Mary Terese Verklan and Dr. Paula Marie Stechulte for your support and insights in making this project a reality.

Thanks to my family (Shamane, Nicholas, Angelle, and my furry running friend Duke). I could not have done this without your support. To my Chief Nursing Officer - Colonel Corina Barrow, Deputy Commander for Inpatient Services- Colonel Spencer Dickens. To my preceptor Lieutenant Colonel Terri Holloway-Petty, my colleague Ms. Natalie Chambers, my supervisors, Lieutenant Colonel John Kulig and Ms. Maria Rivera, and the staff of Dwight David Eisenhower Army Medical Center, who kept me busy and challenged me every step of the way.

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Section 1: Nature of the Project

Introduction

The landscape of healthcare delivery is changing rapidly. Thus, it requires a multifaceted approach to achieving the desired outcomes of safe, effective, patient-centered, timely, efficient, and equitable health care (Institute of Medicine [IOM], 2001). There are no programs or handoff processes within the organization to assist the newly assigned frontline leaders and middle-level managers in the transition to their new roles and functions. These individuals rarely have meaningful contact with their outgoing counterparts. Maintaining a cycle of continuous process improvements within the clinical setting hinges on frontline leaders and middle-level managers, who are prepared to execute the mission, motivate, supervise, coach, and mentor the staff. The clinical leadership challenge that currently exists is an environment in which frontline leaders and middle managers frequently transition in and out of leadership and management positions without receiving an orientation to their new duties.

Problem Statement

The current environment of care requires nurse leaders who are prepared to lead collaborative efforts and develop meaningful partnerships, strategies, and policies that are evidence-based in an attempt to reduce errors and aid in complex decision-making (Porter-O'Grady, 2011). Compounding factors such as the lack of a proper handoff mechanism, role orientation, and constant mission changes leave the newly assigned frontline leaders and middle-level managers unprepared to meet the clinical, administrative, and human resources demands of their positions. The resultant effects of the break in communication continue to challenge staff morale, create gaps in the standards of care, and reduce staff trust in leadership (Knudson, 2014).

Purpose Statement

Frontline and middle-level managers in nursing execute their roles and functions in complex environments (Baker et al., 2012). The multiplicity of roles includes managing clinical systems, human capital, the environment of care processes, and ensuring that the environment of care supports positive patient outcomes. According to Baker et al. (2012), nurse managers spend a quarter of their time performing their actual duties. The other three-quarters of their time are spent on activities that are difficult to quantify (Baker et al., 2012). For the frontline leaders and managers who do not have the privilege of receiving a handoff during their transition the situation is, even more, daunting. The majority of the frontline leaders and clinical nurse managers within the Military Healthcare System (MHS) are active duty registered nurses and noncommissioned officers. These nursing professionals are required to assume leadership roles at a moment's notice.

Furthermore, the MHS is a multilayered enterprise. There is a high turnover rate within the organization, and successors can originate from a multitude of locations within the organization as well as from any other health readiness platforms (HRP) in the world. The departing managers and leaders usually do not get the opportunity to handoff to their predecessors. The replacement manager received either inadequate handoff or no orientation to their roles and duties, relegating them to self-reliance, and trial and error. The overarching purpose of this project was to create a practical guide to facilitate frontline leaders and middle-level managers in transitioning to their positions in the MHS.

Project Objectives

The project's aim was to develop a transformational Leadership Induction Program (TLIP) module (Figure 1) to bridge the transition gap, and facilitate role orientation, induction, and socialization for frontline and middle-level managers during their role transition.

Supporting objectives include:

1. Developing a training module that addressed the environment of care, clinical nursing systems, and human resource management within the organization.

2. Propose initial policy for leadership handoff and succession planning at the unit level.

Outcomes of the project include:

1. Increased compliance with human resources standards (staff evaluation and counseling conducted within the specified timeframe, time schedules completed on time, and order of merit list is posted and maintained).

2. Senior leader validates competency alignment of the transitioning leader within 90 days of assuming a leadership position.

3. Increased communication within the nursing unit (assessed through staff survey and leadership rounds).

4. Increased uptake of evidence-based practice (EBP) (evidenced by unit engagement in EBP and performance improvement projects).

5. Improved staff morale and job satisfaction, and decreased staff turnover (assessed through staff survey and exit interviews).

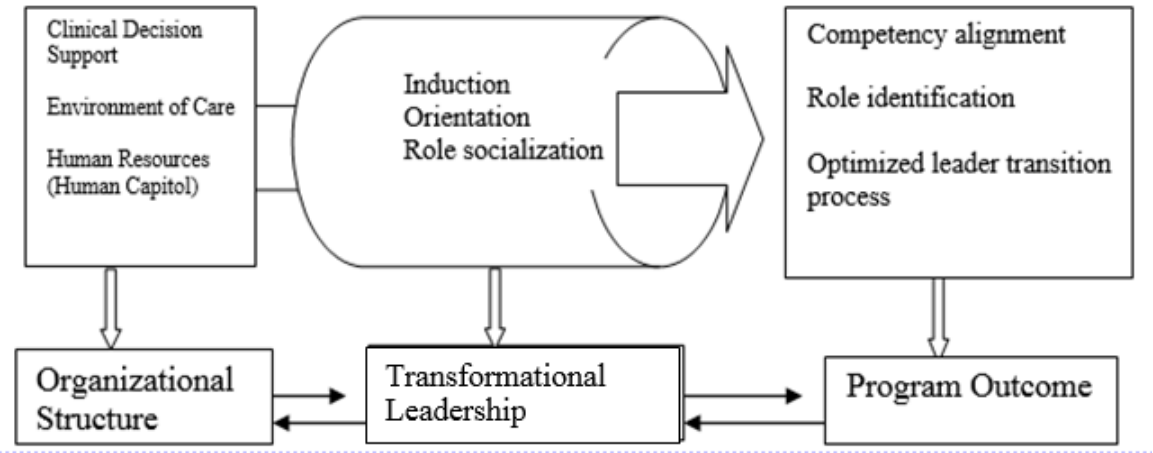

Figure 1. Concept Diagram for a Transformational Leadership Program (TLIP) module.

Frontline leaders and middle-level managers are responsible for promoting and establishing practice environments that balance complex demands and perspectives (Laschinger & Wong, 2010). Within the organizational structure, the incumbent leader needs working knowledge of the clinical decision support systems (CDSS). The first core component of the TLIP, the CDSS comprise the information technology infrastructure that supports evidence-based decision-making through data management. Primarily, the CDSS facilitate the provision of care in complex work environments through the point of care testing, alerts and reminders, treatment order sets, and real-time information for clinicians to engage in patient-care decisions (HealthIT.gov., 2013).

The CDSS is one component within the organizational structure that is interrelated to the second component, the environment of care. The environment of care processes included The Joint Commission's (TJC) standard requirements for safety, security, hazards and material waste, fire safety, medical equipment, and utilities (Mills, 2013). Orienting the transitioning leader to the roles and responsibilities of the position includes the environment of care systems process, policies, and procedures critical to the unit/organizational success.

The third underlying component of the conceptual TLIP model encompasses human resources management (HRM) and human capital management (HCM). Armstrong (2006) referred to the HRM and HCM components as people management. Frontline leaders and middle-level managers are responsible for pulling together the philosophies, strategies, policies, processes, practices, and programs essential to the daily operations of the organization's human resources assets (Armstrong, 2006). Some of the policies and practices of governing people management include: (a) scheduling multiple types of leave policies, (b) equal opportunity and equal employment opportunity, (c) workers compensation, (d) union rules and practices, (e) hiring practices, (f) disciplinary practices, (g) pay and compensation, (h) conflict management, (i) performance evaluation, and (j) promotion. According to the Office of Personnel Management, (n.d.a) "Results-oriented, high-performance workforce involves a succinct orientation to performance appraisals, communication, awards, pay-for-performance, diversity management, and labor/management relations within the organization" (para. 3).

Practice Question

The PICOT format, developed by Richardson, Wilson, and Hayward (1995) stands for (P) the population under scrutiny (I) issue or intervention (C) the comparison with the current process (O) the outcome desired (T) the time required to achieve the results. This format is used to develop the evidence-based practice question as follows:

P: For frontline leaders and middle-level managers assuming new practice positions.

I: Would implementing a transformational leadership program module facilitate the standardization and handoff approach for the induction of new clinical leader/manager to their assignment?

C: Compared to not receiving an handoff.

O: Improve clinical systems management, the environment of care, and human resources management.

T: Completed within the first 45 days of and assignment to a new leadership role.

For frontline nurse leaders and middle-level managers transitioning to new practice roles, would implementing a transformational leadership program module within 45 days facilitate the standardization and handoff approach to the induction of new clinical leaders/managers compared to receiving no handoff training?

Significance of the Project

In 2008, the Surgeon General of the Army, Lieutenant General Horoho, while serving as Chief Nursing Officer of the Army Nurse Corps, began work on a patient-centered care model (Army Nurse Corps [ANC], 2013). The system of care, Patient CaringTouch System (PCTS) was introduced into the practice setting in 2011 to reduce variances in patient care delivery (Horoho, 2011). The PCTS created a new paradigm for patient-centered care within the MHS. This transformational care delivery model consisted of five major components and ten elements that support the patient who is situated in the center of a five-point star (ANC, 2013, Horoho, 2011). Talent management and leader development are two of the ten components of the PCTS. The emphasis on the two identified components is having the right person positioned to take the lead in achieving success within the PCTS. However, leadership tenures are short-lived, and successors in most instances are not familiar with the culture of the organization or are not adequately acclimated to the new leadership roles and management functions within the PCTS. The author posited that developing and conducting leadership transition/induction, orientation,

and the handoff training is part of the system of care that would benefit the newly assigned leader, staff, and improve patient outcomes, resulting in a safer and healthier work environment.

The proposed TLIP can build trust on three levels between the frontline and middle-level nursing leadership and their stakeholders. The three levels of trust explicated in the Reina Trust and Betrayal model included communication trust (trust of disclosure), which is the capacity leaders contribute to the organization's outcomes through supporting a culture of trust (Reina, Reina, & Rushton, 2007). The second level of trust is a contractual trust (trust of character) (Reina et al., 2007). With contractual trust, the new leader must exhibit self-assurance, consistency, and dependability to assure the support of the staff. The third level of trust is competence trust (trust of capability) (Reina et al., 2007). In this category, the unprepared leader is challenged in their role transition if not supported in gaining role specific skills. The lack of trust in the leaders capability exposes the leader to questionable job performance during their attempts to build the interpersonal skills necessary for success (Reina, Reina, & Rushton, 2007; Rushton, Reina, Francovich, Naumann, & Reina, 2010). The call for a safer health care system (IOM, 2001) is an appeal for the integration of high-reliability principles into practice. The high-reliability principles include preoccupation with failure, reluctance to simplify, sensitivity to operations, resilience and deference to expertise (Chassin & Loeb, 2013) focused on safe patient outcomes.

Reduction of Gaps

The ANC leadership capability map outlined the requirements for leadership succession planning for the ANC officer (ANC, 2015). The ANC leadership capabilities map requires the leader to develop a continuity book for their position and to groom subordinates for succession

planning (ANC, 2015). The orientation process for incoming leaders does not provide information to assist the nurse manager transitioning into the organization. Likewise, managers and leaders indigenous to the organization do not receive role orientation, induction, or socialization. The average leadership turnover within the organization is 18-24 months. Thus, there is an increased need for orientation, handoff, role socialization training, and tools to assist the incumbent in their role transition. The proposed TLIP module helped in closing the gap and standardizing the leadership transition of frontline and middle-level managers. Additionally, beyond closing the knowledge gap that currently exists, the TLIP model provided a structured approach to facilitate the leadership capabilities identified within the ANC nursing care delivery model.

Implications for Social Change

This project is an integral component in the leadership knowledge and management system cycle aimed at formalizing succession planning. The future of nursing campaigns calls for expanded opportunities in which nurses are leaders in collaborative improvement efforts and are leaders in advancing health (Institute of Medicine, 2010). Standardizing the leadership transition process is a first step to ensuring continuity in nursing leadership. Nurse leaders will need to embrace the transition to an adaptive staffing system in which nursing schedules and shift managements are flexible to accommodate non-traditional staffing patterns. The return on investment of HCM and the cost of training new nurses who leave the job shortly after or during orientation has serious implications for the future of the profession. Ultimately, this project is foundational to leadership stability that will strengthen talent management by fully optimizing staff support to achieve patient safety and a healthy work environment. According to Tillott and

Walsh (2013), "Creating healthcare environments that are conducive to providing and promoting optimal patient and staff outcomes requires a change in the systems and structures that govern the existing culture, with an emphasis on cultural change" (p. 29). Social change cannot be realized without commitment to leadership.

Definition of Terms

Environment of care (EOC): A combination of systems and programs aimed at providing a safe, functional, and efficient environment for patients, staff, and visitors. The EOC consists of fire safety, personnel safety, hazardous waste, utility systems medical equipment, customer focus, open communication, collaboration, authentic leadership, trust, and emergency management. "The Environment of Care consists of three basic components: the building or space where the care occurs, the equipment used to provide care, and the people involved in the care, including the patients and their caregivers" (Guerrero, Puls, & Andrew, 2014, p. 31).

Leadership knowledge and management system: "A system that ensures continuity of leadership by identifying and addressing potential gaps in effective leadership, implements, and maintains programs that capture the organizational knowledge and promote learning" (Office of Personnel Management, n.d. a, para. 2).

Clinical decision support systems: Refers to health information and other technology support that "Provides clinicians, staff, patients or other individuals with knowledge and person-specific information, intelligently filtered or presented at appropriate times, to enhance health and health care" (HealthIT.gov, 2013, para. 1).

Return on investment (ROI): "A comparison of the monetary value of the business impact of the costs for a given human capital program'(Office of Personel Management, n.d.b, para. 43).

Talent management: "A system that addresses competency gaps, particularly in mission-critical occupations, by implementing and maintaining programs to attract, acquire, develop, promote, and retain quality talent" (Office of Personnel Management, n.d. c, para. 1).

Human capital management (HCM): Encompasses a systematic approach to managing people through the use of metrics, performance evaluations, policies, and practices that adds value to the organization. Human capital management involves recruiting, training, and retaining the talents to meet the business needs of the organization (Armstrong, 2006; Hart, 2006).

Human resource management (HRM): Is defined as "A strategic and coherent approach to the management of an organization's most valued assets – the people working there who individually and collectively contribute to the achievement of its objectives" (Armstrong, 2006, p. 3).

Assumptions, Limitations, and Delimitations

Assumptions

This project was based on the assumption that current frontline leaders and nurse managers would be willing to participate in the project and would respond honestly to survey questions. The researcher also assumed that senior executives would fully support the piloting of the project. To mitigate the eventuality of the assumptions, the survey instrument had clear instructions and outlined the need and benefits of the project. Secondly, no personally identifiable information, town hall meetings, or focus group were part of the data collection process. For continued assurance and executive leadership support, key leaders must be kept abreast of the project and reminded periodically of the outcomes to the organization.

Limitations

Limitations to the study included rapid staff turnover. Staff turnover is not always predictable and is influenced by world events, from a natural disaster response to terrorist activities around the globe. The use of surveys for the sampling methodology was another limitation. Finding a survey instrument that was reliable and had internal validity was highly unlikely. Constraints to surveying a convenient sample will limit the generalizability of survey results. The amount of time available to collect and analyze data is also a limitation because there is no guarantee that the selected participants will complete the survey on time. Another limitation of the project is related to the setting in which the project is proposed. The MHS is not entirely different from the civilian systems. However, operational processes, roles, and responsibilities vary.

Delimitations

Participants in this project were limited to the frontline and middle-level managers in the MHS. Middle-level managers in the MHS are civilian and military registered nurses. The frontline leaders include noncommissioned officers with direct oversight of the nursing unit. The project could be piloted in one medical center with the potential of generalizability to other medical centers within the MHS. The survey methodology could be used as the source of data collection.

Summary

Current and future trends in health care require nurse leaders at all levels to recognize the influence of an unexpected change in the work environment and its effects patient outcomes. Frontline leaders and middle-level managers are responsible for maintaining the environment of

care, influencing the patient outcome within multiple systems of care, and executing human capital management competencies. The absence of succession planning and a standardized transition program with a handoff process leaves these nurse leaders to encounter the daunting tasks of inconsistent and inadequate handoff. Optimization of the ANC system of care involved talent management and succession planning. Full implementation of care system components will increase the return on investment in human capital, reduce staff turnover, build communication trust, contractual trust, and competency trust among all stakeholders (Reina, Reina, & Rushton, 2007; Rushton, Reina, Francovich, Naumann, & Reina, 2010).

Developing an evidence-based TLIP from research evidence within the theoretical framework of transformational leadership has the potential of closing the gap that exists in the leadership transition. Ultimately, this project is foundational to leadership stability that will strengthen talent management by fully optimizing staff support to achieve patient safety and a healthy work environment. Tillott, Walsh, and Moxham, (2013) suggested that the receipt for the sustainment of optimized work environments stems from all employees having shared vision centered on optimal patient outcomes. Section 2 presents a review of the literature within the context of the theoretical framework of transformational leadership, succession planning, and handoff or handover. Contained in this section is an overview of the background and context for the evidence-based TLIP as well as a review of the IOWA model of evidence-based that serves as the conceptual framework for the practice project.

Section 2: Review of Literature and Theoretical and Conceptual Framework

Introduction

Turnover affects an organization in multiple ways. According to Knudson (2014), "Loss of revenue, decreased employee satisfaction, increased operational inefficiencies, and substantial monetary loss associated with the high costs of recruiting and onboarding processes"(p. 1) are delitarious to the organizations achieving its mission. Ineffective leadership handoff, or the lack thereof can create unfavorable outcomes. The absence of programs or handoff processes to assist the newly assigned frontline leaders and middle-level managers in the transition to their roles and functions is inconsistent with the patient safety culture.

The prospect of maintaining a cycle of continuous process improvements within the clinical setting hinges on frontline leaders and middle-level managers, who are prepared to execute the mission, motivate, supervise, coach, and mentor the staff. According to White and Dudley-Brown (2012),"Leaders help organizations cope with change" (p. 94). The clinical leadership challenge that currently exists where frontline leaders and middle managers frequently transition in and out of leadership and management positions without receiving a handoff. The purpose of the literature review is to present a summary of the literature, theoretical framework, and the conceptual framework for the proposed TLIP.

Theoretical Framework

Evidence-Based Practice Model

The IOWA model of evidence-based practice to promote quality of care is the conceptual framework for the practice project. McEwen and Wills (2014) noted that the model was developed in 1994 and was further refined to its current form by the original authors with the

goal of guiding clinicians in their decisions to influence patient outcomes using evidence. According to Grove et al. (2013), the IOWA model provides a path for the development of evidence-based practice in a clinical setting. White and Dudley-Brown (2012) stated, "The IOWA model was developed as a decision-making algorithm to guide nurses in using research findings to improve the quality of care" (p. 14). The IOWA model presents a logical algorithm with triggers that guides the practitioner in the selection ideas from multiple sources and a structured format to pursue (Doody & Doody, 2011). Within the organization, the Department of Nursing Science within the Army Nurse Corps currently endorsed the IOWA model as the evidence-based practice model for the HRP. Consistent with proprietary work ethics, this author has received permission from the University of Iowa to use the EBP practice model for this project.

Literature Review Strategy

The search strategies employed in the literature review include searching electronic databases, including Academic Search Complete database, Business Source Complete database, Cochrane Database of Systematic Reviews, CINAHL Plus with Full Text, Ovid Nursing Journals Full Text database, and PsycARTICLES. In addition, resources from research and professional organizations include American Association of Critical-Care Nurses resources, The Joanna Briggs Institute (Web), and the Journal of Leadership and Organizational Studies-SAGE Journals. Expert consultations from senior leaders within the MHS and academia were consulted. Several printed texts, including books and handbooks, were part of the literature search.

The search strings identified by Powers (2011) were used in the literature search. The search terms and criteria included: *change management, communication, healthcare competencies, evidence-based practice, succession planning, handoff, handover, nurse leader, nurse manager, transition, transformational leadership, nursing leadership, leadership transition,* and *frontline leaders*. Article inclusion criteria included systematic reviews, peer-reviewed journals, full-text articles and sources that were published within the last 10 years unless they were considered classic or landmark research. Exclusion criteria included commentaries and editorials. The Boolean search terms used included (NOT, OR, parentheses, and quotation marks) were used to retrieve a comprehensive selection of literature (Barker, n.d.; Powers, 2011). Determination of the levels of evidence for the selected articles was based on the defining criteria of the American Association of Critical Care Nurses explicated in Peterson et al. (2014). The levels of evidence described by Peterson et al. (2014) included alphanumeric descriptors to categorize research studies based on the consensus of the types of research design to determine the level of evidence from strongest to weakest evidence. According to Peterson et al., (2014):

> "Levels A and B are for studies with an experimental design. Levels A, B, and C are all based on research (either experimental or non-experimental designs) and are considered evidence. Levels D, E, and M are considered recommendations are drawn from articles, theory, or manufacturers' recommendations" (p. 61).

Transformational Leadership

The identified practice challenge proposed for this project is focused on frontline nurse leaders and middle-level managers within transformational leadership theoretical framework.

There are multiple research-based pieces of literature supporting the application of a transformational leadership framework to address the identified practice problem. Transformational leadership theory postulates that transformational leaders are inspirational and can align their values and attributes with the organization's vision and mission, thus positively influencing the people that they lead (Watts, 2013). The transformational leadership framework has been used to study other human characteristics deemed essential to mission success and leadership staff interactions (Watts, 2013). Caillier (2014) noted four significant characteristics of transformational leadership that include the leader's emphasis on the collective vision, inspirational motivation, individual consideration, and intellectual stimulation. Many researchers pursued studies to explicate the fluidity of transformational leadership as opposed to the most traditional form, transactional leadership.

In a longitudinal design study, Munir and Nielsen (2009) used the transformational leadership framework to study whether self-efficacy mediated the relationship between transformational leadership behaviors and healthcare workers' sleep quality over two-time intervals (T1 and T2). The study population at T1 in 2005 was (n = 447) and 18 months later at T2 in 2007 (n = 274). Transformational leadership was measured using the Global Transformational Leadership Scale. Internal consistency and reliability were 0.90 at T1 and 0.91 at T2. The study found statistical significant correlation with sleep quality at T1 (r = 0.21, p <0.01). Similarly, transformational leadership was correlated with sleep quality at T2 (r =0.14, p < 0.05). The results of the stability model indicated strong relationships between transformational leadership at time 1 and time 2 (r = 0.48 p < 0.001), self-efficacy at T1 and T2 (r = 0.65 p< 0.001), and sleep quality at T1 and T 2.

In another study using the transformational leadership framework, Cramm, Strating, and Nieboer (2013) used a cross-sectional survey method, descriptive, and multiple regression analysis, to analyze the influence of organizational characteristics on employee solidarity in the long-term care sector. The study identified that stable employee solidarity as reported by managers and other professionals (t = 1.2; P = 0.218) was statistically significant. All organizational characteristics were significantly correlated with solidarity in the study sample (all at $P < 0.001$), while hierarchical culture and centralization appears to be negatively associated with employee solidarity at (b - 0.143; $P < 0.01$) and (b - 0.158; $P < 0.01$) respectively. The analysis demonstrated that transformational leadership appeared to be important for solidarity (b 0.162; $P < 0.05$), but not transactional and passive leadership styles. The strength of the study included the sample size (n=313) and the study population 26.2% nurses, 73.8% of the respondents were medical professionals in 23 organizations.

In two studies using the transformational leadership framework, Kovjanic, Schuh, Jonas, Quaquebeke, and Dick (2012) found positive outcomes. In study 1, transformational leadership was positively related to job satisfaction (r = .47, p <.001), occupational self-efficacy beliefs (r = .11, p <.05), and effective commitment to the leader (r = .74, p <.001). In study 2, transformational leadership was found to be positively related to job satisfaction (r = .53, p <.001), occupational self-efficacy beliefs (r = .21, p <.05), and effective commitment to the leader (r = .67, p<.001). Strengths of this study included the use of the Multifactor Leadership Questionnaire (MLQ5 X Short) and the use of a conceptual model.

Salanova, Lorente, Chambel, and Martínez (2011), in their study using the transformation leadership framework, suggested training immediate supervisors to become more

transformational would provide hospitals with significant competitive advantages. Salanova et al., (2012) utilized a cross-sectional study design and structural equation modeling (SEM) for data analysis and convenience sampling of the population (n = 280) and supervisors (n = 15). The goodness-of-fit of the model was evaluated using absolute and relative indices. The findings were poor fit of the single-factor model (Delta x^2 = 15.99, $p < 0.05$) compared with the model with four latent factors (i.e., transformational leadership, efficacy beliefs, work engagement and extra-role performance) [x^2 (71, n = 280) =153.70; *RMSEA* = 0.06; *GFI* = 0.93; *AGFI* = 0.89; *CFI* =0.97; *IFI* = 0.97]. The findings were that transformational leadership helped to explain self–efficacy and levels of engagement, which were consistent with the findings from the Kovjanic et al. (2012) study.

Kvist et al. (2013) conducted a longitudinal study with a cross-sectional, descriptive, and quantitative design using the transformational leadership framework. The study found awareness of the work of nursing leaders was low while nurses reported a high level of job satisfaction (*M* = 3.59, *SD* =0.62). The levels of total job satisfaction (*M* = 3.59, *SD* =0.62), transformational leadership (*M* = 3.47, *SD* =0.81) and patient safety culture (*M* = 3.30, *SD* = 0.47) were all moderate (*M* = 4.18, *SD* = 0.69) and was the only Magnet model component that exceeded target level in all of the study hospitals. The strengths of the study included large sample size, multiple research sites, wide cross section of participants, patients (n = 2566), nursing staff (n = 1151), job satisfaction (n = 2707), and patient safety culture (n = 925).

Duygulu and Kublay (2011) used the transformational leadership framework in the implementation of a leadership program. The study noted improvement in the leadership skills within the practice setting (p = 0.001). The study utilized an evaluative design and multi-year

data collection strategy. The sample (n = 30) included Unit Charge Nurses with a Bachelor of Science in Nursing (BSN) degree. The data collection involved (n =151) observers at two university hospitals in Turkey. The survey tool-Leadership Practices Inventory (LPI), which is a validated and reliable instrument, was used for self-assessment. The observers also used the LPI instrument to conduct their assessments.

MacPhee, Skelton-Green, Bouthillette, and Suryaprakash (2012) applied a qualitative descriptive methodological approach in their study to investigate the sustainment of a leadership development program for frontline leaders. Findings from this study suggested that sustainable and positive outcomes for nurse leaders and their nursing staff could be achieved through a program structured in a theoretical framework. The study used multiple cohort groups. However, the sample size (n = 27) was small. Another bias to the study is that it only presented the leadership perspective of their effectiveness.

Weichun, Sosik, Riggio, and Baiyin (2012) utilized transformational leadership theory (Bass, 1985), psychological empowerment theory (Spreitzer, 1995) and organizational identification theory (Ashforth et al., 2008) to study the relationship between leaders and followers. The study design was an Internet-based survey. Descriptive statistic and correlations were used in the analysis. The outcome of the study noted that transformational leadership had significant positive relationships with follower psychological empowerment (r = .50, p < .01) and organizational identification (r = .62, p < .01). Active transactional leadership had significant positive relationships with followers' psychological empowerment (r = .33, p < .01) and organizational identification (r = .69, p < .01). In addition, follower psychological empowerment was positively related to organizational identification (r = .43, p < .01). The

strength of the study included the sample size (n = 375), men (n =297), women (n = 78), and the use of theoretical models linking relationship between variables MLQ. Weaknesses to the study included a response rate of 30.55% compared to 38.9% from the previous study that is not significantly different. Pearson et al. (2007) conducted a systematic review of multiple leadership studies and drew the conclusion that leadership styles and characteristics are both contributors to the development and sustainability of a healthy work environment. Transformational leadership according to Pearson et al. (2007) was associated with staff job satisfaction, patient satisfaction, patient quality of life, unit effectiveness, extra effort, and organizational culture.

Transactional Leadership

Transformational leadership is not the only leadership style that can motivate employees. However, scholars characterize transactional leadership as less motivating to followers because followers are not inspired to rise above their self-interest and the reward that exists with the transaction (Caillier, 2014). Transactional leadership poses comparative differences with transformational leadership. When transactional leadership takes place, leaders and followers are engaged in the exchange relationship to meet their self-benefits, Burns (as cited in Ali, Jan, Ali, & Tariq, 2014). In contrast to transformational leadership, transactional leadership, Schermerhorn et al., (as cited in Ali et al., 2014) postulated four characteristics, contingent rewards, active management by exception, passive management by exception, and laissez-faire. The quid pro quo nature of transactional leadership diminishes the ownership of the organization by the employee. However, in a correlational study (n = 224) of public sector employees, Ali et al., (2014) found strong correlations between transactional leadership and job satisfaction (r =

0.265, $p < .01$), organizational citizenship behavior ($r = 0.426$, $p <. 01$), organizational commitment ($r = 0.527$, $p < .01$), and perceived performance ($r = 0.383$, $p < .01$). However, negative relationships were found between transactional leadership and turnover intention ($r = -0.326$, $p < .01$).

The choice of transformational leadership as the framework for this project over transactional leadership is a thoughtful decision. The decision not to emphasize transactional leadership rests in part on the negative connotations of the quid pro quo adverse outcomes between service members and the military's efforts to eliminate hostile work environments.

Succession Planning

The rapid workforce turnover within the leadership and management positions of the HRP are primarily related to the demanding missions of soldiers who function in a multiplicity of roles. The high frequency of turnover within the leadership positions signals a strong need for active succession planning within the nursing units and the HRP. Succession planning is connected to talent management and the organization's decision to promote its longevity (Knudson, 2014). "Succession planning and talent management should be viewed as essential parts of every leader 's responsibility to address the gap in leadership within each health care organization and across the industry as a whole"(Knudson, 2014, p. 9). Knudson (2014) described the chasm as a lack of succession planning and stated that organizations faced with gaps in managerial positions are forced to hire unskilled fillers who they then supplement with additional training.

The transformational leadership process described by Knudson (2014) requisite succession planning and talent management across the enterprise and specifically at the frontline

where patient care occurs. Currie (2010) addressing succession planning urges nurse leaders to transition from a contingency and reactive approach and foster to leadership succession through strategic planning. According to the Office of Personnel Management (n.d.d), to fill mission critical occupations, succession planning must be part of strategic planning, and the development of a formal mentoring program can provide opportunities for employees to develop into leaders thus reducing turnover.

Handoff or Handover

The process of handoff or handover has been recognized as a patient safety concern at the bedside between oncoming and off going shifts (Wakefield, Ragan, Brandt, & Tregnago, 2012). According to Gordon and Findley (2011), the process ensured accurate and reliable communication transfer between the involved parties. However, the same emphasis is not given to frontline leaders and middle-level managers. Dewey (2012) noted, "People are naturally anxious about transition and what it means for their particular job or role. Transitional environments are rife with questions, uncertainty, and fear of the unknown" (p. 136). Similarly, the staff bears some of the anxiety, as they too wants to know how the leadership change will affect them (Dewey 2012). Dragoni, Park, Soltis, and Forte-Trammell (2014) identified several elements critical to frontline leader development to include role knowledge, figuring out boundaries, and the need for a supervisor to model effective leadership behaviors.

According to The Joint Commission (2012, p.1), "Ineffective hand-off communication is recognized as a critical patient safety problem in health care; in fact, an estimated 80% of serious medical errors involve miscommunication between caregivers during the transfer of patients." An effective handoff is deliberate in its intent and purpose to communicate information between

sender and receiver (TJC, 2012). A plethora of literature is accessible that addresses nurse handoff between caregivers. However, the literature is less robust in respect to the handoff at the nurse manager level.

The role of leadership in patient safety extends beyond their HRM duties to encompass the guardian of the culture of safety (Sammer & James, 2011). Without proper handoff between incumbents and successors, these nurse leaders are faced with the difficult task of leading with uncertainty through trial and error. Bridging the transition gap through the deliberate transfer of responsibility using a standardized handoff process is an initial step towards building and sustaining high-reliability within the organization (Chassin & Loeb, 2014).

Handoff Tools and Strategies

In a systematic review of the literature on handoff mnemonics, Riesenberg, Leitzsch, and Little (2009) reviewed 46 articles and identified 24 mnemonic addressing handoffs. The most frequently used mnemonic (69.6%) published over a three years period was the SBAR (Situation, Background, Assessment, and Recommendation) tool (Riesenberg et al., 2009). The use of SBAR as a handoff tool is clearly documented in the literature and has been used to pass patient care information from nurse to nurse, physician to physician, and among interdisciplinary teams (Boaro et al., 2010; Cornell, Townsend, Gervis, Yates, & Vardaman, 2014).

According to the Institute for Health Improvement (2015), SBAR was developed by Michael Leonard, MD, and colleagues at Kaiser Permanente in Colorado. Following the landmark IOM (1999) report "*To Err is Human,"* "The Agency for Healthcare Research and Quality (AHRQ) in conjunction with the Department of Defense released Teams Tools and Strategies to Enhance Performance and Patent Safety (TeamSTEPPS) as the national standard for

team training in healthcare" (King et al., n.d., p. 4). The SBAR handoff tool was published as one of the communication instruments in the TeamSTEPPS training. The SBAR tool is now the standard handoff tool within the HRP. Formulating leadership handoff within the SBAR structure (see Appendix A) will maintain consistency with the established communication strategy of the HRP.

Literature Analysis

Transformational leadership theory has been applied across multiple spectrums-business, government, healthcare, private, and public sector, and across multiple disciplines. Based on the examination of the literature, transformational leadership theory has formed the framework for many studies in nursing and other industry and has received positive reviews. Weichun, Sosik, Riggio, and Baiyin (2012) utilized transformational leadership theory in combination with two other theories to develop a research framework and studied the phenomena of the followers' psychological empowerment, and organizational identity.

Transformational leadership has been successfully studied using multiple research methodologies to include qualitative and descriptive studies, correlational studies, integrative reviews, systematic reviews, and quasi-experimental studies. Consistent across several studies was the use of the (MLQ) as the primary data collection instrument. The MLQ has been tested for validity and reliability by multiple researchers using Cronbach alpha calculations. The use of the MLQ in various studies revealed similar results of positive leadership traits (Yukl, 1999).

The research studies on transformational leadership identified the positive contribution to what is already known and indicated areas need further exploration. The majority of the studies were qualitative studies, descriptive or correlational studies, integrative reviews, systematic

reviews, or randomized controlled trials with inconsistent results, which are classified as Level C (Peterson et al., 2014). The sample sizes for most of the studies were small coupled with the low response rate from the use of the survey methodology, thus limiting the possible generalization of individual studies. Gaps in the current literature include sparse recommendations for the implementation or immersion of transformational leadership into existing leadership structures.

Furthermore, the absence of follow-up studies to implement programs that were developed creates a gap in assessing the success of those programs. The studies identified were not revisited to give any idea of sustainability. Multiple references were made to the need for training managers and only one study implemented and evaluated a training program (Duygulu & Kublay, 2011). However, the Duygulu and Kublay (2011) study only included staff nurses and only included BSN nurses. According to Cadmus and Johansen (2012), the timing is right for the development of transition leadership programs for frontline nurse managers but stopped short of identifying a framework for the program or identifying core contents.

Background of the Military Healthcare System

The MHS is a worldwide enterprise operation consisting of multiple HRPs. Data available as of 2013 reflected that the HRPs are subdivided into 56 hospitals, 361 ambulatory care clinics, and 249 dental clinics. Over 60,000 civilian employees and 86,000 military personnel service the MHS (Health.mil, 2014). The size of the MHS and diversity of functions within the system creates multiple opportunities for leadership development. Inherent in those opportunities is the frequency of change that occurs at all levels of the enterprise. When anticipated change is unplanned, the resultant effect has a direct influence on leadership success, staff morale, patient's outcome, and the transition of frontline leaders and middle-level managers

that are transitioning into new practice roles. These frontline leaders and middle-level managers customarily do not receive the handoff from their predecessors. On instances, when handoffs occur, it is limited based on time constraints, and lack of a systematic approach or process. Historically, the outgoing leader would have an opportunity to pass the baton to the incoming leader in what is traditionally referred to as the right seat left seat.

The challenge within the HRP is that, more often than not, the incoming leader arrives after the outgoing leader has transitioned. This gap creates a steep learning curve for the new replacement and a chasm for the transitioning individual. Creating a leadership buffer through a designated handoff process/tool would allow the newly transitioned personnel to gain perspective of their role and quickly transition into their practice rather than starting from scratch. In those instances, a streamlined handoff process would prevent abrupt and unnecessary changes to the already fragile practice environment allowing transitioning personnel to have a clear understanding of the evidence that is driving the practice. One factor that compounds the situation beyond the 18-24 months turnover is the fact that the individuals who are expected to assume the new positions usually come from other organizations. Though the organizationa mignt be from within the MHS, some are returning from deployment or a non-clinical role, and are not aware of current practices. The issue of turnover is not unique to the MHS. However, the frequency of role change might be unmatched.

Summary

The prospect of maintaining a cycle of continuous process improvements within the clinical setting hinges on frontline leaders and middle-level managers, who are prepared to execute the mission, motivate, supervise, coach, and mentor the staff. Transformational

leadership theory supports the concepts that leaders guide their organizations through change (Dudley-Brown, 2012). The literature review identified many supporting evidence for the application of the selected leadership theoretical framework to the practice problem. The studies reviewed for this project elucidated strengths and weaknesses that were not unique to the chosen framework. Strengths identified in the literature review included the use of instruments such as the MLQ and LPI, which were analyzed for validity and reliability across multiple studies. Weaknesses identified in the literature review included the low survey response rates. However, studies have demonstrated positive outcomes using the transformational leadership framework (Kovjanic et al., 2012). The level of evidence yielded from the literature review is acceptable and supports the project.

Transactional leadership was discussed to provide supporting evidence of the fluidity of leadership styles that leaders use in the execution of their roles and functions. A review of literature related to handoff, succession planning, TeamSTEPPS, and the use of SBAR as a communication tool was presented in this section. The literature synthesis indicates strong support for the use of transformational leadership framework to address the practice issue and a good fit for the military environment. Finally, the IOWA model of evidence-based practice was selected as the evidence-based translation model. The IOWA Model provides a path for the development of evidence-based practice in a clinical setting (Grove et al., 2013).

Section 3 will introduce the approach and method to be used in developing the proposed program module. The conceptual framework is introduced identifying the data collection and sampling strategy. Section 3 will also provide information on the IRB information, the approach to data analysis, and program evaluation.

Section 3: Methodology

Introduction

The purpose of this project was to develop an evidence-based TLIP module to bridge the transition gaps for frontline and middle-level managers. The project also aimed to offer tools and strategies to facilitate successful leadership handoff and transition for frontline leaders and middle-level nurse managers transitioning to their new practice role. These individuals, when assigned, rarely have meaningful contact with their outgoing counterparts. The prospect of maintaining a continuous process improvement cycle within the clinical setting hinges on frontline leaders and middle-level managers, who are prepared to execute the mission, as well as motivate, supervise, coach, and mentor the staff. The clinical leadership challenge that currently exists is one in which frontline leaders and middle managers frequently transition in and out of leadership and management positions without receiving a handoff. These nursing professionals are required to assume leadership roles at a moment's notice, and the replacement manager received either inadequate handoff or no orientation to their roles and duties, causing them to rely on trial and error.

Approach and Methods

The approach to address the project issue included constructing a conceptual diagram as a guide to laying out the assessment, structure, process, and outcomes of the elements that are required knowledge of the transitioning leader (see Appendix A). The conceptual diagram in Appendix A is an extended version of the evidence-based TLIP module intended to explicate a more detailed view of what the TLIP will address. The TeamSTEPPS framework approach was selected as it represents the organization's commitment to clarity in communications. The AHRQ (2014) noted that TeamSTEPPS is a teamwork system to enhance communication and

collaboration. The SBAR (Situation, Background Assessment, and Recommendation) tool within TeamSTEPPS is the communication tool that is used within the organization to communicate with the interdisciplinary team to enhance patient safety.

The handoff process represents the transfer of responsibility and accountability from one person to the next in a clear format while allowing the receiver to acknowledge the information and ask questions for clarity (AHRQ, 2014). Status, Team, Environment, and Progress (STEP) is another tool in the TeamSTEPPS training that is present in the conceptual diagram. Within the diagram, STEP represents an assessment of the background information the transitioning leader needs to know. The guiding philosophy to frame the assessment in TeamSTEPPS is to reduce the stress of introducing new tools to the nurse leaders that might cause confusion. The first structural element includes the clinical decision support systems (CDSS) within the organizations. The care delivery systems are the PCTS and the patient-centered medical home (PCMH). These patient-care models represent the framework for patient care delivery within the Army Nurse Corps and the HRP. The second structural element is the EOC. The EOC is composed of The Joint Commission standards and other regulatory requirements. The third fundamental component involves human resources. The human resources component covers the employee and other personnel requirements to include military and civilian evaluation systems, employee union, evaluations, equal employment opportunity (EEO), and equal opportunity (EO).

The handoff process includes (a) induction and orientation to the role requirements, (b) organization policies, (c) strategic management resources, (d) personnel leadership tools and strategies, (e) leadership coaching, (f) understanding management dashboards, (g) aligning personal philosophy, and (h) unit mission with organizational mission and vision to achieve

success. The outcome measures to be addressed involve staffing matrix, schedules, nursing outcome measures, patient, and staff feedback, and the initiation of a handoff mechanism.

Project and Design

The aim of the project was to develop an evidence-based TLIP module based on the best available evidence and the organizational structure. To develop the proposed targeted induction-training module to effect the needed change, stakeholder's and senior leader's buy-in is vital. For this strategy to close the gap in the current leader transition process, it was necessary to perform a gap analysis. The gap analysis encompassed literature resources, review of the frontline leaders and middle-level managers' competency checklist, and review of existing organizational policies. The nurse executive council will need to sanction the project. The project was approved by the organization's Institutional Review Board (IRB), as well as Walden University's IRB (IRB number 09-15-15-0050572). The design for this project was a descriptive design using the survey method. The survey method was appropriate for this project based on the potential study population and the aim of the project. The project outcome was to facilitate the development of a handoff process and an orientation program for front-line and middle-level leaders and managers transitioning to their role at the HRP level within the MHS. With this in mind, a heterogeneous population was necessary to ensure that the product is generalizable (Grove, Burns, & Gray, 2013). Keough and Tanabe (2011) noted the flexibility of using the survey and its ability to reach a large population of respondents through several means such as the World Wide Web, postal service, and in person. To adjust to the critique of survey methods being vulnerable to the tendency of respondents portraying themselves in the best light, Keough and Tanabe (2011) suggested the use of a reliable and valid tool. Dolnicar and Grün (2014)

noted the survey design to be a factor to consider and suggested consideration is given to the length, formatting, and the manner in which the questions are asked.

The purpose of a study was an important factor in the design of the study. Groves et al. (2013) stated that a descriptive design has the potential to lead to theory development and practice problem identification. Additionally, there was no intent to manipulate any variables or provide treatment or intervention during the project development. Using a descriptive study design, Eastwood, Roberts, Williams, and Rickard (2013) employed an anonymous, structured, multiple-choice survey questionnaire to collect data for their study. Eastwood et al. (2013) described partitioning the survey subheadings to focus on the peculiarities that the research intends to elicit from the respondents. The concepts postulated by Eastwood et al. (2013) were employed in the design of a needs assessment survey (see Appendix C). Conducting a short, anonymous needs assessment survey of current frontline leaders and middle-level managers was necessary for the development of the project platform.

Sample Population and Setting

The population of focus was frontline and middle-level nurse managers of one HRP of the MHS. Purposive sampling of the incumbents within the organization helped identify the strengths and barriers within their roles. Purposive sampling was sought because of the uniqueness of the organization and the specific characteristics of the study population (Terry, 2015). A needs assessment questionnaire was used to gather supporting information and to identify gaps in practice on which to base the induction training module. Gathering information from incumbents encouraged buy-in and fostered the development of an induction training module tailored to the current roles and functions (see Appendix D).

The participants included active duty ANC commissioned officers in the ranks of First Lieutenant (1LT), Captain (CPT), Major (MAJ), and Lieutenant Colonel (LTC). The population of commissioned officers at the selected ranks are all prepared at the BSN level as an entry requirement for the U.S. Army Nurse Corps (Army Nurse Corps, 2012). Though the experience levels and duty assignments vary across the ranks, these officers can assume the nurse manager's role at a moment's notice. The nurse manager has full responsibilities for the daily functioning of the nursing unit to include personnel management.

Frontline leaders also include Non-Commissioned Officers (NCO) who are in leadership positions. The population of NCOs includes ranks of Sergeant (SGT), Staff Sergeant (SSG), and Sergeant First Class (SFC). The education entry level of the NCO ranges from high school diploma to higher degree levels based on the individual NCO. Common factors between the NCO and the ANC officer include specific educational and developmental career tracks. The NCO has responsibilities that include personnel management and supervision, acquisition and maintenance of equipment, supplies, and other responsibilities that mirror the middle-level managers' responsibilities. The middle-level manager's and their assistant positions are occupied by both military and civilian staff. The civilian nurse counterparts to the ANC officers are also highly specialized individuals, some of whom share dual roles as Army Reserve officer and Department of the Army civilians.

The civilian nurse manager within the HRP shares the same responsibilities as their military counterparts. Individuals who occupy the middle-level positions handle the daily operations of the nursing units. Their responsibilities cover the gamete of the American Association of Nurse Executive [AONE] (2008) "Nurse manager skill inventory". Surveying the

identified participant population informed the development of the TLIP module for current frontline leaders and their replacements. The support of the Chief Nursing Executive and other senior leaders was necessary to initiate the data collection and to develop a comprehensive program that would benefit the organization.

Setting: The Health Readiness Platform

The HRP is a 120-bed Medical Center with of multiple specialties, both inpatient and ambulatory care specialties. Services offered by the HRP include graduate medical training programs, nursing and allied health training programs, and residency programs for specialties such as psychology (Dwight David Eisenhower Army Medical Center [DDEAMC], 2011). The medical center serves a population of approximately 40,000 beneficiaries both active duty soldiers, retirees, and their families. The average workforce is over 2,600 staff members both active duty soldiers and civilians (DDEAMC, 2011). The nursing systems are progressive and embrace employee involvement in clinical decision–making fostered through Nurse Practice Councils. The councils represent staff members from the Unit Practice Councils to the ANC Council. Nursing care delivery is supported by the implementation of the PCTS and the Patient-Centered Medical Home. The systems of care are augmented by the implementation of TeamSTEPPS (AHRQ, 2014) and the concepts of high-reliability organizations such as leadership commitment and commitment to resilience (Chassin & Loeb, 2013).

Data Collection

The data collection was focused on gathering baseline information from the frontline leaders and middle-level managers within the hospital and subsidiary clinics. A consent form explaining the project aim and goals was sent to all potential participants via email. Participants

were offered the opportunity to complete the needs assessment survey by following a link to the survey housed on a SharPoint page. Those participants who preferred to complete a paper copy were given the option to request a copy to be emailed to them with instructions on how to return the survey without disclosing their identity. At the close of the survey, there was no request for paper copies of the survey. The interested participants were selected from the list of frontline leaders, managers, and nursing staff in a supervisory position. The survey was designed with the information and instructions presented in the needs assessment and demographic survey (see Appendix C). The participants were provided access to the survey and were asked to review and comment on the agenda items on the survey. Following receipt of the participants feedback, a thank you email was sent to the participants. The information gathered was aggregated and incorporated into a final draft of the TLIP module (see Appendix D).

Data Analysis

The data were limited to the information needed to inform the training module development. Descriptive statistics will be used to analyze the quantitative data from the demographic survey as well as the pre- and post-test from the Nurse Manager Skill Inventory instrument. The type of data analysis that is anticipated included mean, mode, and standard deviations. The data will be presented in tables, graphs, and charts where appropriate. Data analysis included the application of statistical standards package such as IBM SPSS current version. Technical assistance in analyzing the data was sought from the nurse informaticist. Descriptive statistics was appropriate for use in this project to describe the data and to present clear and concise information (Polit, 2010).

Instrument

The data collection strategy was to use the Nurse Manager Leadership Partnership (NMLP) Nurse Manager Skills Inventory (NMSI) instrument. The instrument was used to conduct pre-training assessment and post training assessment of the participants' knowledge base. Permission to use the instrument was sought and received (see Appendix C). The NMSI instrument was the result NLMP collaborative work between the AACN and the AONE. The NMSI is part of a larger framework developed to build leadership training for nurse managers (AACN, n.d.). The framework consists of three domains addressing the science of managing the business, the art of leading people, and the leader's personal and professional development. The composition of the three domains within the framework includes 15 categories of skills (see Table 1) that are assessed using the NMSI instrument. The instrument is a self-administered tool, which was designed to capture the skills and leadership behaviors that the NMLP warranted necessary for the nurse manager's success (AACN, n.d.d). The methodology recommended for the use of the tool includes four components: (a) the nurse manager uses the tool to review and rate himself/herself in each of the content areas, along a scale from minimal skill/experience to expert, (b) the nurse manager's supervisor does the same, rating the nurse manager in his/her specific role, and (c) the nurse manager and supervisor meet to review the two assessments. For areas where assessments differ they can: (1) discuss why the perceptions differ (2) discuss and develop plans for improvement/professional development. The tool can become the basis for career pathway planning and delineating professional targets (AACN, n.d.).

Table 1.

Nurse Manager Skills Inventory

Domains	Categories
The Science: Managing the business	1. Financial management 2. Human resources management 3. Performance management 4. Foundational thinking skills 5. Technology 6. Strategic management 7. Clinical practice knowledge
The Art: Leading people	1. Human resource leadership skills 2. Relationship management and influencing behaviors 3. Diversity 4. Shared decision-making
The leader within: Creating the leader in yourself	1. Personal and professional accountability 2. Career planning 3. Personal journey disciplines 4. Optimizing the leader within

Source: Nurse Manager Leadership Partnership. (2006). *Nurse Manager Skills Inventory.* Retrieved from http://www.aacn.org/wd/practice/docs/nurse-manager-inventory-tool.pdf. Reprinted with permission.

The Nurse Manager Competency Instrument (NMCI) has evolved over time. The instrument title noted progressive titling from the NMCI to the NMSI. Foundational to the development of the tool is Katz (1955) framework (Chase 2010; DeOnna, 2006). According to Katz (1955), " Performance depends on fundamental skills rather than personality traits"(p. 33). From this fundamental premise, Katz (1955) identified three skills necessary for administrators to possess. These abilities include the development of technical, human, and conceptual skills. Katz (1955) described technical skills to include knowledge and the ability to analyze activities within specialized work settings. Human skills encompass the manager's ability to communicate and build consensus within a non-threatening environment that enable followers to act without fear of retribution (Katz, 1955). The third element, conceptual skill, is described as the

manager's ability to conceptualize the organization as a unit of interrelated systems working harmoniously through interconnections, both inside and outside of the organization (Katz, 1955).

DeOnna (2006) conducted a three-phased descriptive research study, the result of which established reliability and content validity index of the NMCI. The first phase of the study involved a literature review in identifying domains that were associated with the actual work of nurse managers. In phase 2 of the study, content validity index was established noting inter-rater agreement for the instrument as 0.8166 on a content validity scale index of 1.0. During phase 2, DeOnna (2006) pointed out that the "Results produced a 58-item measure of human capital management with acceptable content validity"(p. 44). In the third phase of the study, 251 questionnaires yielded a return rate of 45% (DeOnna, 2006). Based on the analysis of the survey results, the reliability of the NMCI instrument was established based on a series of diagnostic measures including test/retest, Cronbach's alpha (α=.9530; n=88), and exploratory factor analysis (DeOnna, 2006).

The first generation instrument consisted of 93 items and took approximately 15 minutes to complete (DeOnna, 2006). The current NMSI consists of 81 items grouped under 11 competency domains and is estimated to take approximately 15 minutes. Permission to use the survey is restricted to paper copies. The participants will be asked to complete the pretest before attending the training and to complete the post survey immediately following the training. The scoring options on the instrument are novice experience/skill, competent experience/skill, and expert practice. The instrument also includes space for comments from the person conducting the self-assessment and for the supervisors. The intent of the instrument was for the nurse manager's supervisor to score the nurse manager using the same instrument, make comments

then discuss the results and collaboratively develop necessary training. For the purpose of this project, the instrument was only used as a self-assessment tool. The surveyor scored the participants' response by correlating numerical values to the participants' selection choices, for example, novice =1, competent =2, and expert =3. The results were then entered into an Excel spreadsheet for analysis. The participants' scoring option on the instrument was based on Dreyfus and Dreyfus novice to expert rating.

The Dreyfus and Dreyfus model of skill acquisition consist of five stages. Stage one is the novice stage in which the student is task oriented and follows rules (Dreyfus, 2004). The second stage that is not included on the instrument is the advanced beginner (Dreyfus, 2004). At the advanced beginner stage, the student can apply prior learning about the task (Dreyfus, 2004). At stage four, the competent performer was also not included as an option for the participant. At the final stage, the proficient performer was considered skilled and possessed their world view of what needs to be done (Dreyfus, 2004).

Protection of Human Subjects

The initiation of the project will follow Walden University's Institutional Review Board (IRB) approval as well as the hospital IRB approval. The collection of demographic data and personally identifiable information was not required for this project. All inadvertent personally identifiable data was removed and discarded before analyzing the data to ensure that the data remained anonymous,. Senior leadership sponsoring was another strategy to ensure the protection of the human subject. The project planner completed the human protection training administered by the National Institute of Health and complied with all institutional training requirements.

Project Evaluation Plan

According to Hodges and Videto (2011), program evaluation is a non-linear process conducted for multiple reasons to determine if the program plans and efforts are meeting the intended goals and objectives for which the program was designed. The project evaluation will include a pre and post knowledge assessment of the training using the AONE instrument. A broader evaluation of the project would focus on critical analysis of how the project was implemented and how effective the program was in meeting the identified objectives (Centers for Disease Control and Prevention, 2012; Hodges & Videto, 2011). One evaluation framework that would be suitable for assessing the program is the CDC evaluation for public health programs (see Appendix B).

Summary

The approach to addressing the identified project issue included constructing a conceptual diagram as an assessment guide for laying out the structure, process, and outcomes of the element that are requisite to the knowledge of the transitioning leader. The handoff process represented the transfer of responsibility and accountability from one person to the next in a clear format while allowing the receiver to acknowledge the information and ask questions for clarity (AHRQ, 2014). Closing the gap in the current leader transition process, it was necessary to perform a gap analysis. The gap analysis encompassed literature resources and review of the frontline leaders and middle-level feedback from the survey and the TLIP model. The design for this project was a descriptive design using the survey method. The survey method was appropriate for this project based on the potential study population and the aim of the project. Purposive sampling of incumbents and prospective leadership candidates within the organization

helped to identify strengths and barriers and inform the project development. The IOWA model of evidence-based practice to promote quality of care was the selected conceptual framework for the practice project. Data collection and analysis was in context with IRB approval and the compliance with the protection of human subjects. Finally, the evaluation plan included pre and post knowledge assessment of the training material as well as formative evaluation utilizing the CDC program evaluation framework and standards. Section 4 will describe the evaluation and findings of the project regarding the goals and outcome addressed. The implications for practice and policy development will also be discussed in this section, followed by discussions on the strength and limitations of the project, and self-development of the author.

Section 4: Findings, Discussion, and Implications

Introduction

The evidence-based TLIP module was developed to address leadership handoff between frontline leaders and middle-level managers during role transition. The development of the training module required input and feedback from the current leaders within the organization who currently occupy those positions. The incumbents have firsthand knowledge of the gaps, challenges, and opportunities that would create a tangible solution to mitigate unforeseen challenges for their predecessor. The findings from the needs assessment gathered from the incumbent leaders and managers consists of the quantitative and qualitative information presented in this section.

Summary of Findings

The data collection for the development of the TLIP module was consistent with the process outlined in Section 3. The participants were asked to review the proposed agenda items that included activities that were common to the incumbent's position, and to provide additional comments. The survey was sent to 30 incumbents of which 57% (17) responded. The overall response to the survey (see Figure 2) was positive with 82% (14) of the respondents either agreeing or strongly agreeing with the items that they reviewed. The remaining 18% (3) respondents were uncertain. Among the respondents, 82% (14) had 10 years or more in the healthcare setting, 12% (2) had 7 to 10 years, and 6% (1) had 4 to 6 years. However, 35% (6) had less than 1 year in their positions, and 35% (6) had 1 to 3 years (see Figure 3). The majority of the participants, 94% (16) held a bachelorette degree or higher, with 60% (9) reported as having graduate degrees, and only one participant held a diploma.

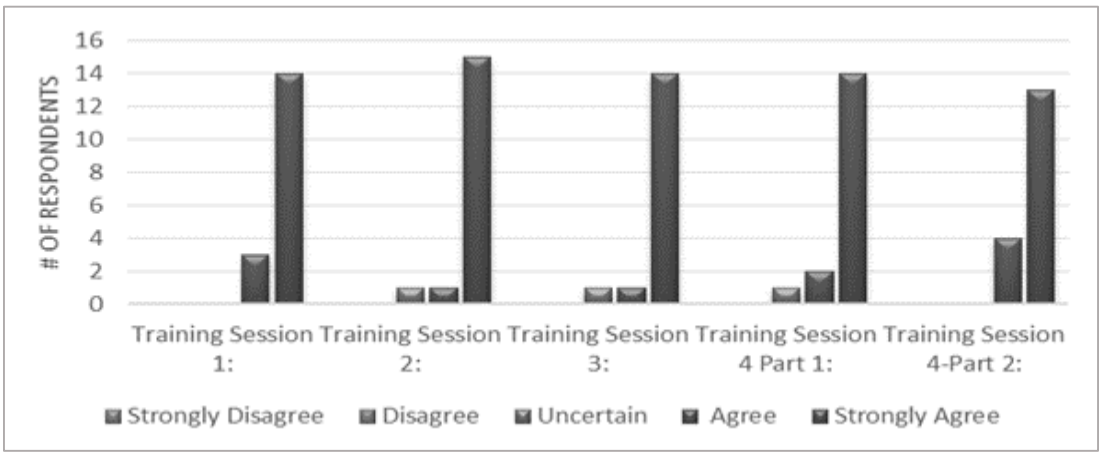

Figure 2. Levels of agreement with proposed training.

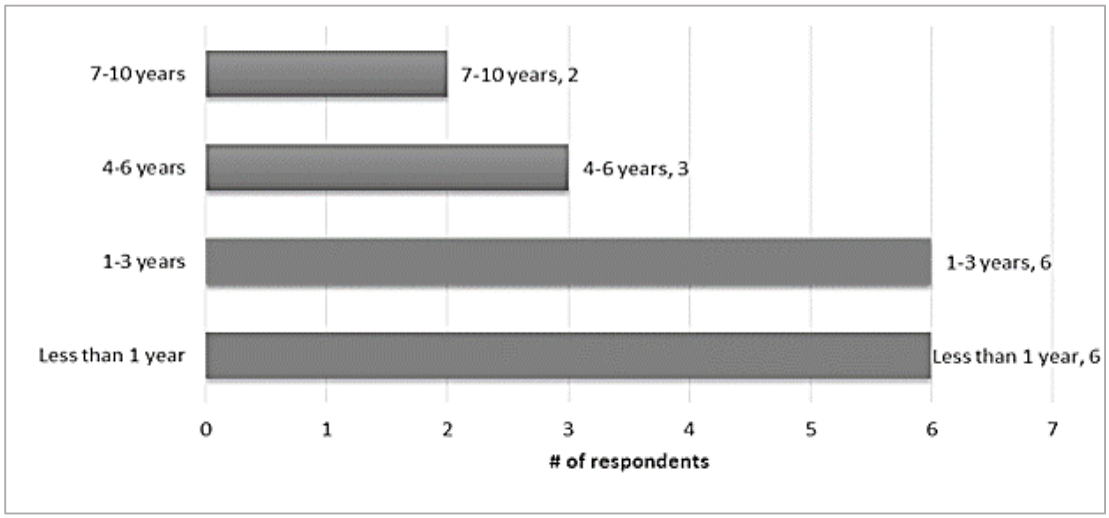

Figure 3. Number of years in current position.

The distribution of respondents was an important factor in the needs assessment. The majority of the respondents, 41% (7), were middle-level managers currently serving as incumbents. The second highest responses were from frontline leaders represented as charge nurse, 35% (5). The remaining five respondents included two frontline leaders serving as assistants, one nurse; a Chief Nursing Office and an Informatics' Specialist (see Figure 4).

The response rate from the noncommissioned officers who serve as primary frontline leaders was not adequatly represented in the feedback (see Figure 4). The findings included a critical comparison of the employment status of the respondents. The majority of the respondents were military 65% (11) and civilians 35% (6) (see Figure 5). The Military Captains represent the largest group of military respondents. The significance of the respondent identified as Captains relates to the group of mid-career leaders who are either transitioning to assistant middle manager positions or have recently assumed the position (see Figure 5). The variation in the respondents work setting, and the number of staffs they supervised significantly added to the diversity of response and the significance of the existing information gap in the transition and handoff process within the work setting. While the majority of the respondents indicated they did not hold a certification, 41% (7), the majority who did were certified in Medical /Surgical Nursing: 23% (4). Among the remaining respondents, one indicated possessing three certifications (see Figure 8).

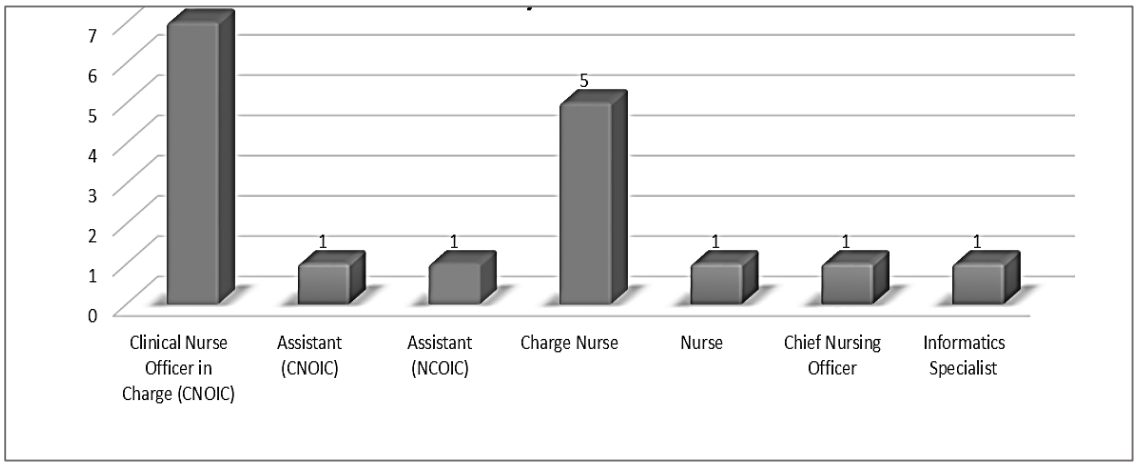

Figure 4. Duty positions.

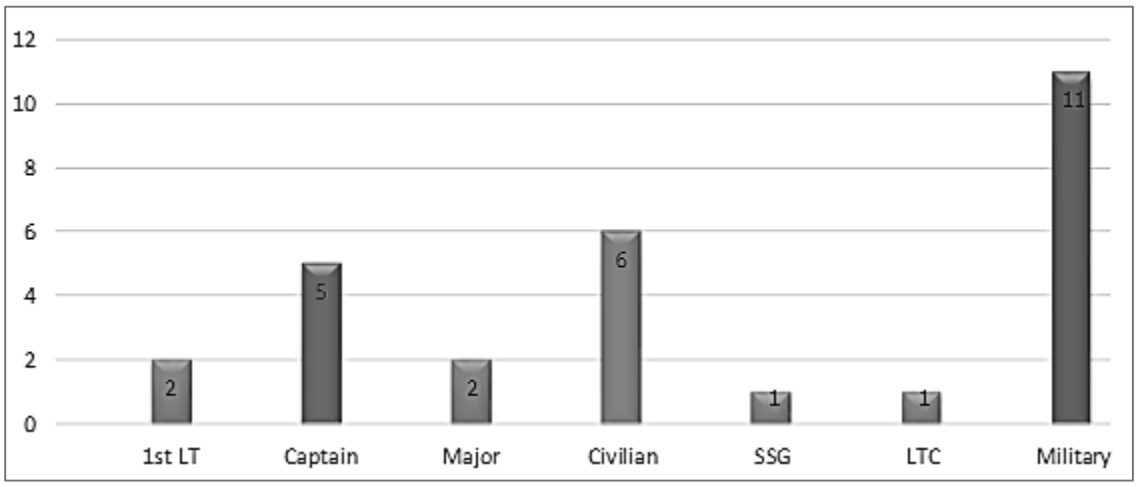

Figure 5. Categories of respondents and related employment status.

The majority of the respondents, 47% (8), work in the inpatient setting while 29% (5) work in the outpatient setting (see Figure 6). The other respondents were identified as nonclinical areas to include Hospital Education and administrative roles (see Figure 6). The credibility of the response to the TLIP module is illustrated by the fact that 82% (14) of the respondents supervised one to sixty or more employees (see Figure 7). This finding is of interest as some respondents indicated that they have never received mentoring, 29% (5), and 18% (3) only received annual mentoring.

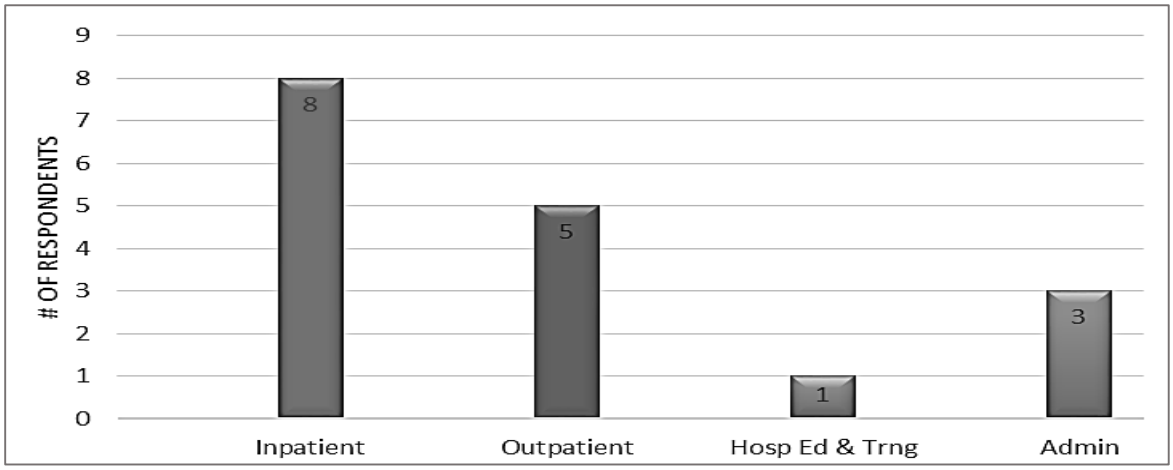

Figure 6. Respondents work setting.

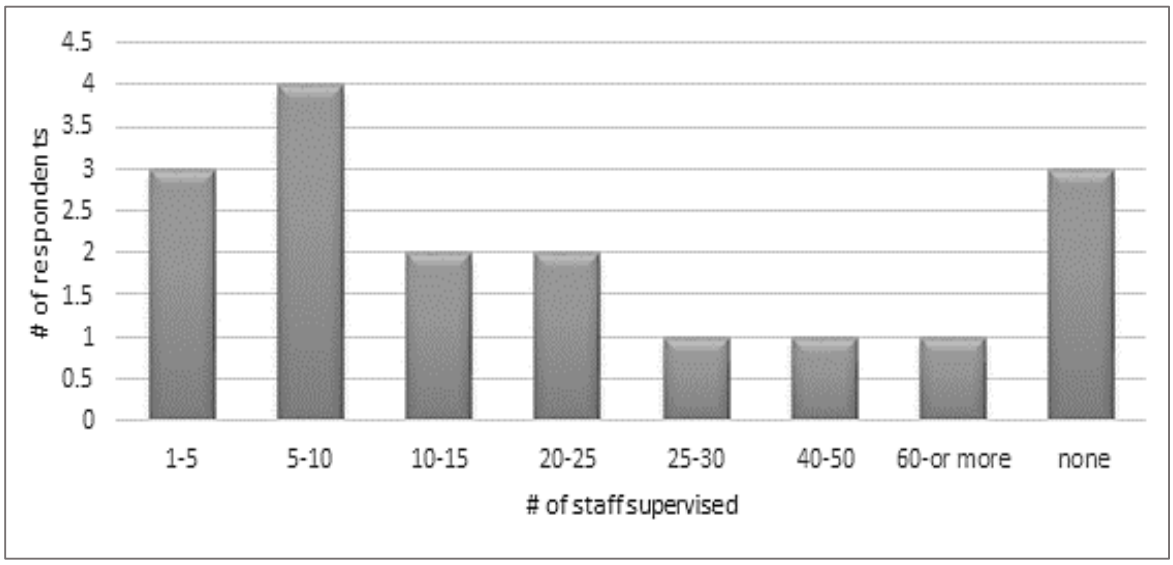

Figure 7. Respondents that provided staff supervision.

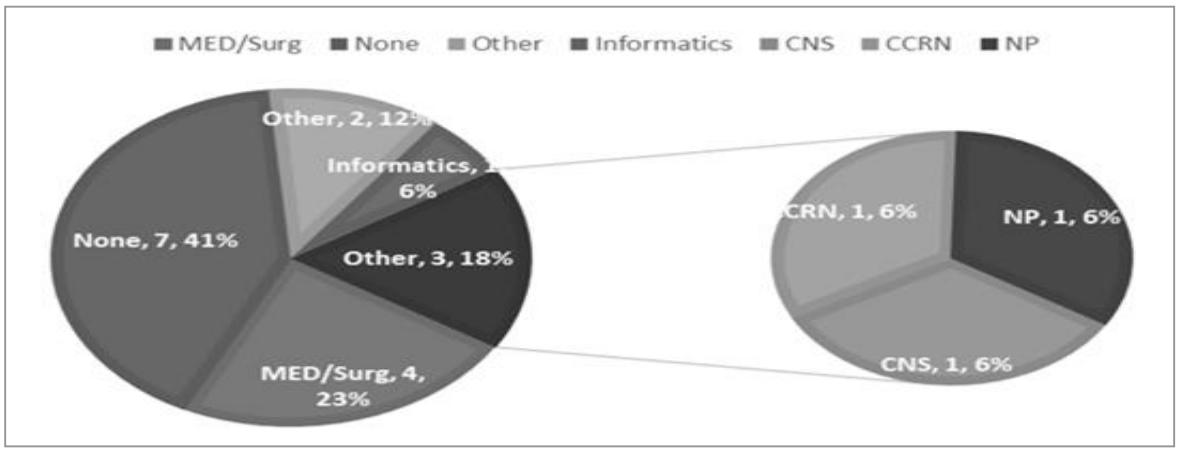

Figure 8. Certification status.

While a majority of the respondents, 41% (7), indicated that they received mentoring on a quarterly basis, the remaining 12% (2) reported receiving monthly mentoring (see Figure 9). The gap identified in mentoring helps to explain the apparent knowledge deficit related to succession planning. Based on the respondents' feedback, 41% (7) indicated that they were not aware of succession planning.

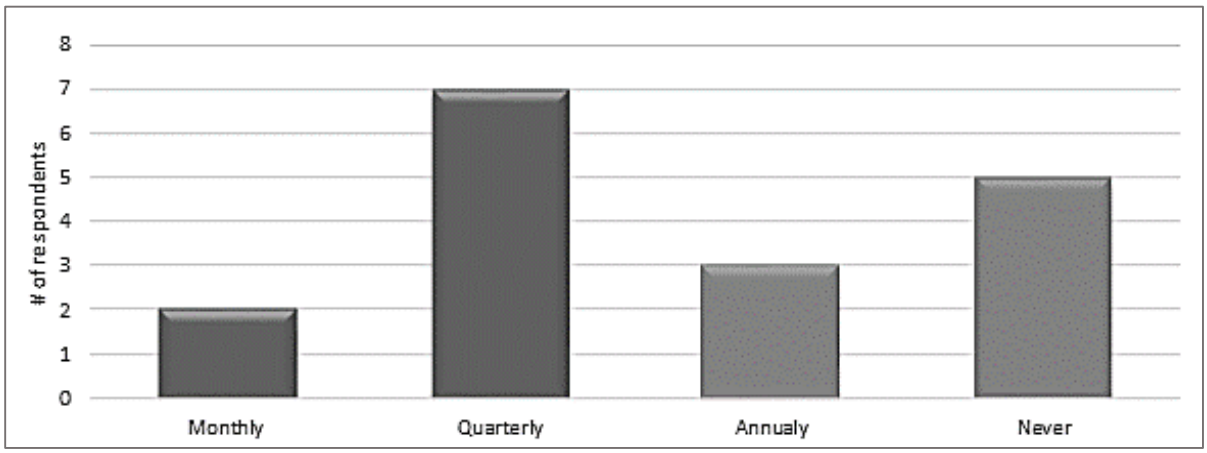

Figure 9. The frequency of receiving mentoring**.**

While 59% (10) of the remaining respondents reported some level of awareness of succession planning, only 24% (4) noted they were extremely aware of succession planning (see Figure 10). Gauging the intent that the TLIP module would potentially help in closing the communication gap in the leadership handoff, induction, and transition, the respondents were asked to indicate the likelihood that they would attend the training. Overwhelmingly, 94% (16) of the respondents indicated that it is likely and highly likely that they would attend the training (see Figure 11).

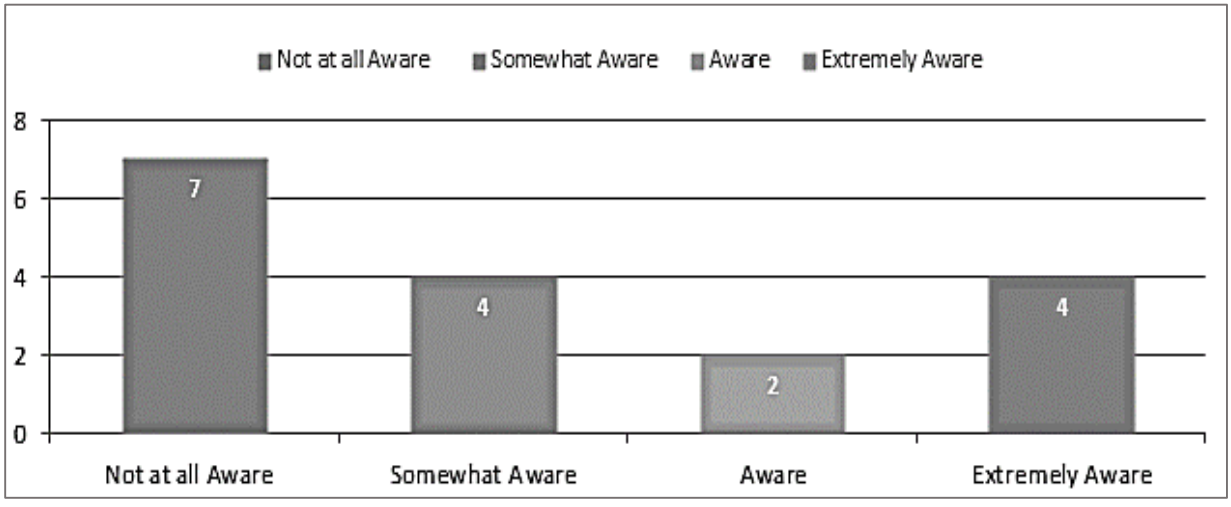

Figure 10. The level of awareness of succession planning.

The qualitative feedback from the needs assessment provided rich data that enlightened the quantitative responses (see Table 2). The qualitative responses from the needs assessment survey were transcribed verbatim to maintain the meaning and reasoning of the respondents. The information was grouped based on the training session in which they the responses were provided. While the comments were overwhelmingly supportive of the quantitative responses, a few of the comments warrant further review. These comments indicate an underlying misconception that all leaders have the same capability and received training before assuming their position is likely a contributing factor that helped to propagate leadership deception.

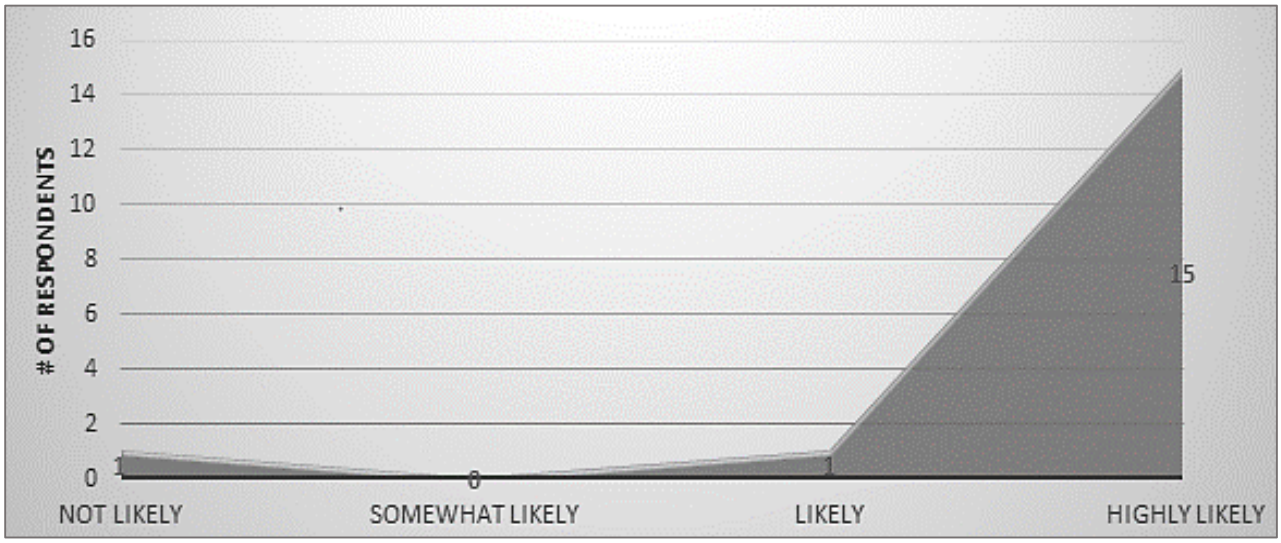

Figure 11. Likelihood of the respondents attending leadership induction and handoff training.

Table 2.

Respondents Qualitative Feedback

Respondents Qualitative Feedback and Comments
Comments on Training Session 1
1. This is a great start, I'm sure there may be things that can be added or subtracted based on the area the incoming leader will be working.
2. Getting to know me...working from the inside out leadership style conflict management style personality style inventory learning style inventory.
3. Not all leadership training is consolidated. Some we take through courses, some the hospital provides and other training is online via the CPAC Website.
4. Didn't know where else to put this, but perhaps adding something to the effect of mentorship to new leaders. Assigning a more seasoned nurse leader within the organization as a resource person/mentor to foster the new leader along, to answer questions and provide guidance. I don't see this within the organization now.
5. How much should new leaders be changing the vision of their assigned unit when they (theoretically) haven't had a chance to evaluate how well the current vision is working (They are new right?)
Comments on Training Session 2
1. When can we implement this, not just for those in transition, but as sustainment and readiness for those currently in the role?
2. Apply the organization's process improvement model to a current problem or issue noted.
3. CNTP training is necessary and fantastic.
4. We use the PCTS Model of care PSRs as a means of reporting Patient Safety events.
5. We have the PI FMT that meets every month, but we do not do a great job of identifying what the organizational PI projects are going to be or what we should be monitoring.
6. Adding KPIs, command metrics, PCTS metrics developing transparency within the organization for sharing this information with all
Comments Training Session 3
1. Need to add the contract staff, how it differs from your civilian staff rating scheme
2. This is awesome! Really need to understand the LMA and TAPES which in my opinion is extremely outdated
3. Discuss the steps to discipline a civilian in regards to ensuring HR is involved to answer any questions. Also, discuss the role of the Union within this facility.
4. Awards could be more frequent. I don't know civilian leave policies.
5. Although I have access to the material and know how to access it, many leaders do not know where to go. Online CPAC training is not an effective way of training. Face-to-face so that the student can ask questions and come up with scenarios is a more valuable way to train.
6. For the proposed audience, this information is covered at nauseam in the CNOIC course, Supervisor development courses, etc. I suggest limiting this information found elsewhere
Comments on Training Session 4 Part 2
1. Relevant content and practical application
2. We have room to improve this with this part
LMA-Labor-Management Agreement**. CPAC-** Civilian Personnel Action Center. **FMT-**Functional Management Team**. TAPES-**Total Army Personnel Evaluation System**. CNTP-** Clinical Nurse Transition Program. **KPI-**Key Performance Index. **PCTS –** Patient CaringTouch System. **PI-**Performance Improvement. **PSR-**Patient Safety Report. **CNOIC-**Clinical Nurse Officer in Charge

Discussion of Findings

The findings from the needs assessment survey indicated overwhelming support for the development of the TLIP module. The data suggested that the postulated gap in leadership transition does exist and that closing the gap would have valued implications for leadership practice and the enhancement of the identified project outcomes. Following the aggregation of the data, a group of middle managers was briefed on the survey results. The group included seven members of the leadership practice council and represented a diverse mix of civilians and military as reflected in the survey results. They were offered the opportunity to review and discuss their thoughts related to the results. The discussion and feedback were no different from the findings noted in Table 2. One of the nurse managers voiced concerns that the changes in the hospital might affect the program while a junior nurse manager echoed that delaying the program would further hamper the transition of new leaders.

The senior nurse leader in the organization was presented with the findings of the survey and the proposed, training module, and the handoff tool. The discussion generated ideas to use the program as a foundation for the leadership training for new nurse managers and those who are 12 months or less in their positions. Based on the Chief Nursing Officers feedback, 35% of the current nurse managers would attend the training, not including those who did not respond to the survey.

Implications

Policy Impact

Leadership training limited to intellectual classroom endeavors while necessary is limited in achieving sustainable nursing outcomes. Stevens (2013), argued that a better application of

the new knowledge be a reflection of meaningful results integrated into the systems and processes that are implemented across care platforms. However, transformational leaders in healthcare are charged with the responsibilities of ensuring that the application of evidence-based practice is integrated into the practice setting. Policy decisions informed by evidence posits a reliable medium through which evidence-based practice is integrated into the clinical setting. According to Stevens (2013), the aim of evidence-based practice is the facilitation and embedding of knowledge into the decision-making processes. However, embedding evidence into practice requires informed leaders and practical tools to facilitate the leader's transition to practice supported through mentoring and regular well-aimed feedback**.**

The TLIP module suggested a transformational onboarding platform for leadership induction and a gateway to shared accountability for practice outcomes. The integration of the evidence-based TLIP module into the onboarding process for frontline leaders and nurse managers is an initial step that helps nurses to be fully prepared to practice to the full extent of their education (IOM, 2010). The imperative for nurses to become full partners with other health care professionals in redesigning health care in the United States (IOM, 2010) is an appeal for nurse leaders to use evidence-based practices in the development of the new blueprint for health care delivery. McSherry et al. (2012) noted that the distinction between nursing excellence and achieving the IOM's domains of health care (AHRQ, n.d.) quality, safe, effective, patient-centered, efficient and equitable care, has become indistinguishable with leadership and management. While McSherry et al., (2012) argued that excellence is "Nebulous" (p. 11), they advocated for the entrenchment of practice frameworks and systematic process as encapsulating agents for the embodiment of evidence-based practice. Practice policy then becomes the

sustainable medium that will inform practitioners across multiple settings and organizational tiers of the standards of care and the reduction of variances in care delivery (Stevens, 2013).

Evidence-Based Practice

The findings from the needs assessment provided specific triggers to address the identified practice gap of leadership handoff and the need for orientation and induction of frontline leaders and middle-level managers. The project was developed based on the IOWA model of evidence-based practice to promote quality care. Following the pathway of the model, the current findings in the literature and the stakeholders' feedback, the next step in the evidenced-based practice is to pilot the project. Changing the paradigm of the organizational culture requires deliberate and conscientious efforts. Evidence-based practice is one such vehicle that brings the best research findings together with the values of the stakeholders and the expertise of the practitioners to address issues at all levels of the organization that influences patient safety and care delivery outcomes (Grove, Burns & Gray, 2013). The embedding of the present knowledge of handoff communication into the decision–making matrix is a step forward to achieve positive patient outcomes (Stevens, 2013).

Research

Evidence-based practice frameworks provided the opportunity for petitioners to systematically apply research findings to the practice setting (Tabak, 2012). Furthermore, the relationship between evidence-based practice and research is undeniably intricate. Thus, the perspective of applying evidence to practice is a trigger for further research. The TLIP module was designed primarily for a military HRP setting, which limits the generalization of the module. The limitations imposed by the focused application of the TLIP module present an opportunity

for researchers to investigate its application to other settings within the MHS and the civilian healthcare system. Embedding the TLIP module and handoff mechanism in the TeamSTEPPS framework that primarily focused on patient handoff is another opportunity for research to investigate further and expand patient safety and communications in a more robust and encompassing framework. According to the *Future of Nursing: Leading Change, Advancing Health report:*

> Health care experts repeatedly encourage health professionals to understand the system's dynamics so they can be more effective in their individual jobs and help shape the larger system's ability to adapt successfully to changes and improve outcomes. In a field as intensively knowledge driven as health care, however, no one individual, group, or discipline can have all the answers, (IOM, 2011, p. 1-11).

Social Change

This project is an integral component in the leadership knowledge and management system cycle aimed at codifying succession planning. The future of nursing campaign calls for expanded opportunities in which nurses are leaders in collaborative improvement efforts and are leaders in advancing health (IOM, 2010). Standardizing the leadership transition process is a first step to ensuring continuity in nursing leadership. Nurse leaders will need to embrace the transition to adaptive staffing systems in which nursing schedules and shift managements are flexible to accommodate non-traditional staffing patterns. The return on investment of human capital management and the cost of training new nurses who leave the job shortly after or during orientation has implications for the future of the profession. Ultimately, this project is vital to leadership stability that will strengthen talent management by fully optimizing staff support to

achieve patient safety and a healthy work environment. According to Tillott and Walsh (2013) "Creating healthcare environments that are conducive to providing and promoting optimal patient and staff outcomes requires a change in the systems and structures that govern the existing culture, with an emphasis on cultural change" (p. 29).

Project Strengths and Limitations

Strengths

The strengths of this project are explicated in the essence of evidence-based practice. The project aimed was to address a real world issue that has a direct influence on patient outcomes. According to The Joint Commission (2012), "Ineffective hand-off communication is recognized as a critical patient safety problem in health care; in fact, an estimated 80% of serious medical errors involve miscommunication between caregivers during the transfer of patients" (para 2). Additional strengths of the project include the use of practice frameworks that were developed and deployed across multiple healthcare settings and supported by research such as the IOWA model of Evidence-based Practice (Grove et al., 2013), Transformational Leadership (Bass, 1985) and TeamSTEPPS (AHRQ, 2015). The alignment of the project objectives with the organization's vision of building a high-reliability organization and the delivery of patient-centered care helped to create stakeholders buy-in. Concomitantly, the project has the tenets and tools to influence action-oriented practice through policy development and to affect the onboarding of new leaders as a foundational element of leadership handoff communication.

Limitations

Limitations to the project primarily revolved around the fact that though the project presented practical tools, the tools have not been piloted. The translation of the project beyond

the identified health care setting will require further modifications, and research to enhance generalization and uptake. The changing nature of the organization is an opportunity that exists for developing new projects and for extending current projects into new dimensions.

Recommendations for Remediation of Limitations in Future Work

The primary recommendation is to pilot the project across different settings and publish the findings for the future development of the TLIP module. A second recommendation is the proposal of research on the correlation between leadership handoff and patient handoff in the clinical setting. Longitudinal research is also possible to understand the transition between leaders who receive the handoff and those who do not. Such knowledge would add to the education and training of novice leaders, influence mentors, and guide leadership training programs. The limitations of the project also provoke opportunities for improvement with future plans to include incorporating new staff into project teams to include sustainability, support, and ownership.

Analysis of Self

Scholar

During the DNP studies, the primary emphasis and learning outcomes focused on scholarship and the precise knowledge necessary for DNP practitioner to earn the scholastics of a terminal degree in nursing practice (AACN, 2006). The scholarship and knowledge gained throughout the program have enhanced the author's academic and practiced skills as a change agent and DNP prepared nurse. The new competencies that have been developed and honed will influence the application scientific principles to practice problems, systems management, and advanced leadership skills (AACN, 2006). The scholar now has the advanced and sound

knowledge of informatics competencies to lead collaborative efforts, and demonstrate professional nursing competencies (AACN, 2006).

As a nurse scholar, it is imperative to have a clear understanding of the difference in practice roles and the delineation of the difference between research, EBP, and performance improvement. This knowledge is necessary for the DNP practitioner to exert professional accountability in project development and systems improvement practices. The scholar-practitioner understands the relevance selecting the appropriate research, reviewing and grading the literature and, the application of the scientific framework for a selected change project.

The possibilities that lay awaiting are reflective of an open range. The open range concept emphasizes the number of possibilities that the DNP prepared nurse can pursue. One such possibility is to travel and incorporate leisure activities to improve mental and physical health. However, success depends on continuous learning and having an acute awareness of the political, social, and economic environments that exist. The scholars knowledge is inclusive of the dynamic, rapidity of change, and the shifting culture of the healthcare delivery systems in the United States and the various sub-cultures that exist in the community and at the organizational level. A reflection on the DiSC profile of the practitioner suggests paying particular attention to the areas of opportunity identified in the profile for future development. The DiSC profile highest dimension is an influencer, and the classical pattern is a persuader. Integrating the DiSC profile suggestions into the pursuit of personal and professional development will help to create balance within the open range of possibilities that exist in healthcare. While earning a DNP will increase access to resources and other opportunities, it also realistically realigned the trajectory towards professional nursing practice, collegiality, and balance.

Practitioner

Staying in orbit with the increasing complexities of the healthcare system changes is a professional goal of the practitioner. It is also evident that to survive the future, it is necessary to develop professional goals that are reflective of success and outward looking while maintaining a professional identity (Hoeve, Jansen, & Roodbol, 2014). The completion of the DNP is a symbol that the future needs nurses willing to build bridges between other professions and lead the charge to inspire new nurses and motivate mature nurses to pursue their passion. The future of nursing requires leaders at multiple levels of the spectrum of care from the classroom to the boardroom (Chard, 2013). To respond to future demands for health care, nurses must exhibit flexibility, creativity, independence, critical thinking, leadership, and collaboration (Lacasse, 2013).

The spectrum of clinical and organizational leadership challenges must be answered with the application of scientific, business, and cost effective strategies. In this arena, the practitioner is prepared with the skills necessary to harness the resources and evidence to initiate, guide the implementation, and evaluate the outcomes of practice decisions. During the DNP studies, the practicum experiences have enhanced the practitioners involvement in addressing organizational challenges ranging from the development of strategies and projects that addressed nursing sensitive indicators such as patient fall prevention, reduction of medication errors, the initiation of policies to address alarm fatigue, and acuity-based staffing.

Project Developer

The process of building relationships within the practicum setting and developing a product that has the potential to improve leadership effectiveness is fundamental to the scholar-

practitioner and nurse leader development. The opportunities to coach, teach, and mentor leaders using evidence-based practice is a lifetime achievement. A myriad of change activities is currently influencing the climate within the organization. According to Manion (2011), "The intentional development of people in the organization is a strategic focus, a future-oriented strategy that exemplifies hope and optimism" (p. 284). These activities include full integration of TeamSTEPPS) (AHRQ, 2015). Other developing activities within the organization involve the journey to transform the organization into an exceptional care facility by integrating the principle of high-reliability organizations (Chassin & Loeb, 2013).

The key to success as a project developer is to align the project with the organization's leadership vision. The developer has to be abreast of changes in the organization's mission and has a working knowledge of the resources available. Knowledge of the theoretical and practice models associated with team building, conflict management, and change management are necessary attributes of the project developer. It is necessary to identify areas that can be improved and appropriate strategies to address the improvements. These strategies include those that yielded success as well as those that need to be secured during project development. During the practicum experience to further the scholarship process the following goals were instrumental in the success of the EBP project development, implementation, evaluation, and dissemination:

1. Building a positive relationship with the core leadership team where the power and influence to change practice with thin the setting resides.
2. Secure leadership buy-in and support at each step of the process.
3. Align the project with the organization mission and values.
4. Use theories and framework that are consistent with the philosophy of the

organization.

5. Integrate the project ideas into the current practice.
6. Actively support activities within the practicum setting while building support for the project.

Future Professional Development

This project marks the entry into professional scholarly practice. The project opened the opportunity for the practitioner to receive objective feedback from the scholar and academic communities. Feedback is a necessary part of the growth and development of the practitioner to prepare for collegial relationships and more challenging leadership assignments (DeRue & Wellman, 2009). The opportunity to disseminate the project outcomes to the practice and research communities are realistic projections for the project. Dissemination will include, face to face engagements, professional seminars, and poster presentations. Publications of the project and the findings from its implementation will add to the body of knowledge of nursing and leadership practice. Finally, the influence of communication on patient safety and outcomes cannot be overemphasized, and leadership handoff will serve as one of the vehicles that integrate shared accountability at the entry level of the leadership ladder.

Summary and Conclusions

The findings from the needs assessment survey indicated overwhelming support for the development of the TLIP module. The data suggested that the postulated gap in leadership transition does exist and that closing the gap would have valued implications for leadership practice and the enhancement of the identified project outcomes. The project strengths are embedded in the comprehensive literature support and the use of scientific tools and practice

strategies to address the clinical challenge. The scholars new competencies that have been developed and honed will influence the application scientific principles to practice problems, systems management, and advanced leadership skills (AACN, 2006). However, staying in orbit with the increasing complexities of the healthcare system changes is a professional goal of the practitioner. Similarly, the project developer needs to align the project with the organization's leadership vision for the success of the project.

The spectrum of clinical and organizational leadership challenges must be answered with the application of scientific, business, and cost effective strategies. Developing a leadership handoff process that incorporates the organizational philosophy has the potential of closing the communication gap and loss of information and strategic vision from one leader to the other while maintaining consistency and stability in the communication process. The success of the project will depend on the practitioners continued growth and development and the dissemination of the project and updated outcomes to the broader academic and practice communities.

Section 5 presents the proposed manuscript for publication and dissemination of the project. There are multiple ways and forums that the project can be shared. However, for the purpose of publication, the forum selected is the United States Army Medical Department Journal. The reason for choosing this forum relates to the nature of the project and the intended audience. The project is about leadership handoff in the MHS as it related to frontline leaders and middle-level managers at the HRP level facilities. The strengths of this approach include the fact that the journal has clear directions and information about the contents and purpose. The guidelines for manuscript submission to the journal are clear and succinct. Another forum

considered was the Nurse Leader- the official journal of the American Organization of Nurses Executives. The benefit of selecting this forum is the audience to which the journal caters and the open source feather that would allow for a wider dissemination of the product.

Section 5: Scholarly Product

Manuscript for Publication

Abstract

Healthcare delivery within the military requires a multifaceted approach to achieve the desired outcomes of safe, effective, patient-centered, timely, efficient, and equitable health care. The prospect of maintaining a cycle of continuous process improvements within military clinical settings hinge on frontline leaders and middle-level managers who must be prepared to execute the mission and motivate, supervise, coach, and mentor the staff. This project showcases a review of current literature translated into the development of an evidence-based Transformational Leadership Induction Program (TLIP) module that consisted of 4 subsections: the environment of care, clinical decision support systems, human resources management, and change management as well as resources for successful leadership within the organization. The training is designed to bridge the transition gap, facilitate role orientation and induction, and socialize frontline and middle-level managers during their role transition. The results of a need assessment survey, approved by the organization, were completed by 30 incumbents and resulted in 57% (17) providing feedback and role-specific contents that were integrated into the development of the TLIP module. The overall response to the survey was positive with 82% (14) of the respondents either agreeing or strongly agreeing with the items that they reviewed. The TLIP module provides a medium that translates current evidence into a succinct training platform capable of enhancing leadership transition and handoff. The TLIP module enables a culture of trust, enhances staff satisfaction, and fosters change management and succession planning within the military healthcare system.

The landscape of healthcare delivery is changing rapidly. It requires a multifaceted approach to achieving the desired outcomes of a safe, effective, patient-centered, timely, efficient, and equitable health care (Institute of Medicine [IOM], 2001). There are no programs or handoff processes within the organization to assist the newly assigned frontline leaders and middle-level managers in the transition to their roles and functions. These individuals when appointed to their new positions rarely have meaningful contact with their outgoing counterparts. The prospect of maintaining a cycle of continuous process improvements within the clinical setting hinges on frontline leaders and middle-level managers, who are prepared to execute the mission, motivate, supervise, coach, and mentor the staff. The clinical leadership challenge that currently exists is a revolving door where frontline leaders and middle managers frequently transition in and out of leadership and management positions without receiving a handoff.

Background of the Military Healthcare System

The MHS is a worldwide enterprise operation consisting of multiple HRPs. Data available as of 2013 reflected that the HRPs are subdivided into 56 hospitals, 361 ambulatory care clinics, and 249 dental clinics. Over 60,000 civilian employees and 86,000 military personnel service the MHS (Health.mil, 2014). The size of the MHS and diversity of functions within the system creates multiple opportunities for leadership development. Inherent in those opportunities is the frequency of change that occurs at all levels of the enterprise. When anticipated change unplanned, the resultant effect has a direct influence on leadership success, staff morale, patient's outcome, and the transition of frontline leaders and middle-level managers who are transitioning into new practice roles. These frontline leaders and middle-level managers customarily do not receive a handoff from their predecessors. When handoffs do occur, they are

limited based on time constraints and lack of a systematic approach or process. Historically, the outgoing leader would have an opportunity to educate and train the incoming leader.

The challenge within the HRP is that, more often than not, the incoming leader arrives after the outgoing leader has transitioned. The gap in the transition creates a steep learning curve for the replacement leader and a chasm for the transitioning individual. Creating a leadership buffer through a designated handoff process/tool would allow newly transitioned personnel to gain perspective of their role and quickly transition into their practice. Implementing a leadership handoff process, will reduce abrupt and unnecessary changes to the already fragile practice environment until transitioning personnel have a clear understanding of the evidence that is driving the practice. One factor that compounds the situation is the fact that the individuals who are assuming the new positions frequently come from other organizations within the MHS, returning from deployment or a nonclinical role, and are not aware of current practices.

Purpose

The prevailing environment of care requires nurse leaders who are prepared to lead collaborative efforts, and develop meaningful partnerships, strategies, and policies that are evidence-based to reduce errors and aid in complex decision making (Porter-O'Grady, 2011). Compounding factors, such as the lack of proper handoff mechanism, role orientation, and constant mission changes, leave the newly assigned frontline leaders and middle-level managers unprepared to meet the clinical, administrative, and human resources demands of the position. The resultant effect challenges staff morale, creates gaps in the standards of care, and reduces staff trust in leadership (Knudson, 2014).

Frontline and middle-level managers execute their roles and functions in complex environments (Baker et al., 2012). The multiplicity of roles includes managing clinical systems, human capital, the environment of care processes, and ensuring that the environment of care supports positive patient outcomes. According to Baker et al. (2012), nurse managers spend a quarter of their time performing their actual duties. The other three-quarters of the nurse manager's time is spent on activities that are difficult to quantify (Baker et al., 2012). For the frontline leaders and managers who do not have the privilege of receiving a handoff during their transition, the situation is even more daunting. The majority of the frontline leaders and clinical nurse managers within the MHS are active duty registered nurses and noncommissioned officers. These nursing professionals are required to assume leadership roles at a moment's notice.

Furthermore, the MHS is a multilayered enterprise. The reality of the military registered nurse is that there is a high turnover rate within the organization, and successors can originate from a multitude of locations within the organization as well as from any other HRPs around the country or from around the world. The departing managers and leaders usually do not get the opportunity to handoff to their predecessors. The replacement manager received either inadequate handoff or no orientation to their roles and duties, subjecting them to self-reliance, and trial and error. Hence, the overarching purpose of the project was to create a practical guide to facilitate frontline leaders and middle-level managers in transitioning to their positions in the military HRP facility.

Nature of the Project

The project aim was to develop a Transformational Leadership Induction Program (TLIP) module based on a conceptual framework (see Figure 1). The goal was to bridge the transition

gap, facilitate role orientation, induction, and socialization for frontline and middle-level managers during their role transition. The supporting objective for the project includes the development of a training module that addressed the environment of care, clinical decisions support systems, and human resource management within the organization within the practice setting. The potential outcomes would facilitate leadership handoff and succession planning at the unit level, increased compliance with human resources and human capital management, increased leadership competency alignment, increased communication within the nursing unit, increased the uptake and utilization of evidence-based practice, and improved staff morale and job satisfaction, and decreased staff turnover.

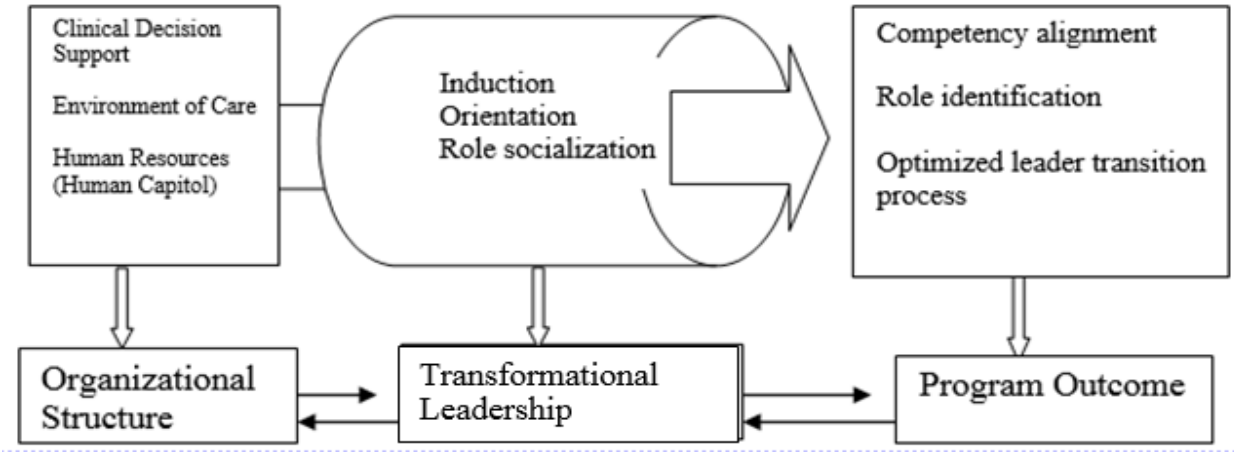

Figure 1. Concept diagram for a Transformational Leadership Program (TLIP) module.

Frontline leaders and middle-level managers are responsible for promoting and establishing practice environments that balance complex demands and perspectives (Laschinger & Wong, 2010). Within the organizational structure, the incumbent leader needs working knowledge of the clinical decision support systems (CDSS). The CDSS comprised the information technology infrastructure that supports evidence-based decision-making through data management. Primarily, the CDSS facilitate the provision of care in complex work environments through the

point of care testing, alerts and reminders, treatment order sets, and real-time information for clinicians to engage in patient-care decisions (HealthIT.gov., 2013).

The CDSS is one component within the organizational structure that is interrelated to the many tenets of the environment of care. The environment of care processes included The Joint Commission's (TJC) standard requirements for safety, security, hazards and material waste, fire safety, and medical equipment, and utilities (Mills, 2013). Orienting the transitioning leader to the roles and responsibilities of the position includes the environment of care systems process, policies, and procedures critical to the unit and organizational outcomes.

The third underlying component of the conceptual TLIP model encompasses human resources management (HRM) and human capital management (HCM). Armstrong (2006) referred to the HRM and HCM components as people management. Frontline leaders and middle-level managers are responsible for pulling together the philosophies, strategies, policies, processes, practices, and programs essential in the daily operations of the organization's human resources assets (Armstrong, 2006). The policies and practices of governing people management include scheduling multiple types of leaves policies, equal opportunity and equal employment opportunity, workers compensation, labor management practices, hiring practices, disciplinary practices, pay and compensation, conflict management, performance evaluation, promotion, and much more. According to the Office of Personnel Management, (n.d.a) a "Results-oriented, high-performance workforce involves a succinct orientation to performance appraisals, communication, awards, pay-for-performance, diversity management, and labor/management relations within the organization" (para. 3).

Implications for Social Change

This project is an integral component in the leadership knowledge and management system cycle aimed at embeding succession planning. The future of nursing campaign calls for expanded opportunities in which nurses are leaders in collaborative improvement efforts and are leaders in advancing health (IOM, 2010). Standardizing the leadership transition process is a first step to ensuring continuity in nursing leadership. Nurse leaders will need to embrace the transition to adaptive staffing systems in which nursing schedules and shift managements are flexible to accommodate non-traditional staffing patterns. The return on investment of human capital management and the cost of training new nurses who leave the job shortly after or during orientation has serious implications for the future of the profession. Ultimately, this project is foundational to leadership stability that will strengthen talent management by fully optimizing staff support to achieve patient safety and a healthy work environment. According to Tillott and Walsh (2013) "Creating healthcare environments that are conducive to providing and promoting optimal patient and staff outcomes requires a change in the systems and structures that govern the existing culture, with an emphasis on cultural change" (p. 29). Social change cannot be realized without authentic leadership commitment.

Approach and Methods

The approach to address the project issue included constructing a conceptual diagram as a guide to laying out the assessment, structure, process, and outcomes that are required knowledge of the transitioning leader (see Figure 2). The conceptual diagram in Figure 2 is an extended version of the TLIP module intended to explicate a more detailed view of what the TLIP will

address. The TeamSTEPPS framework approach was selected as it represents the organization's commitment to clarity in communications.

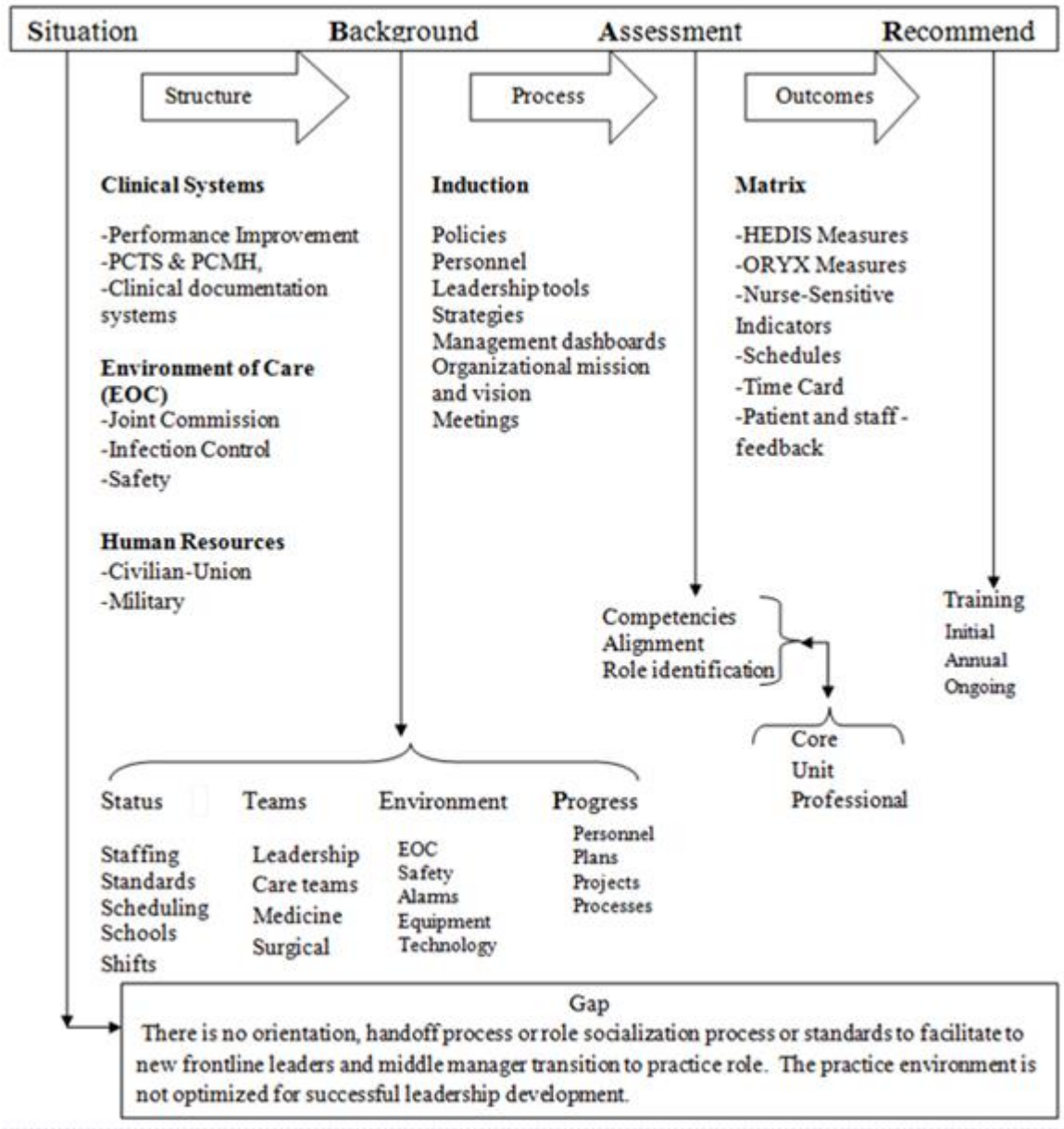

Figure 2. Conceptual diagram of the structure process and outcomes framed in TeamSTEPPS communication (SBAR) format.

The AHRQ (2014) noted that TeamSTEPPS is a teamwork system to enhance communication and collaboration. The SBAR (Situation, Background Assessment, and Recommendation) tool within TeamSTEPPS is the communication tool that is used within the organization to communicate within the interdisciplinary team to enhance patient safety. The handoff process represents the transfer of responsibility and accountability from one person to the next in a clear format while allowing the receiver to acknowledge the information and ask questions for clarity (AHRQ, 2014). Another tool in the TeamSTEPPS training that is present in the conceptual diagram is STEP (Status, Team, Environment, and Progress). Within the diagram, STEP represents an assessment of the background information the transitioning leader needs to know. The guiding philosophy to frame the assessment in TeamSTEPPS is to reduce the stress of introducing new tools that might cause confusion. The structure includes the clinical decision support systems (CDSS) within the organizations. The care delivery systems are the PCTS and the PCMH. These patient-care models represent the framework for patient care delivery within the MHS. Another structural element is the environment of care (EOC). The EOC is composed of The Joint Commission standards and other regulatory requirements. Human resources management is another fundamental component within the structure of the conceptual diagram. The human resources component covers the employee and other personnel requirements to include military and civilian evaluation systems, employee union, evaluations, Equal Employment Opportunity (EEO), and Equal Opportunity (EO).

The handoff process includes induction and orientation to the role requirements, organization policies, strategic management resources, personnel leadership tools and strategies, leadership coaching, understanding management dashboards, aligning personal philosophy, and

unit mission with organizational mission and vision to achieve success. The outcome measures to be addressed involve staffing matrix, schedules, nursing outcome measures, patient, and staff feedback, and the initiation of a handoff mechanism.

Project Design

The aim of the project was to develop a TLIP module based on the best available evidence and the organizational structure. To develop the proposed targeted induction-training module to effect the needed change, stakeholder's and senior leader's buy-in is vital. For the strategy to close the gap in the current leader transition process, it was necessary to perform a gap analysis. The gap analysis encompassed literature resources, review of the frontline leaders and middle-level managers' competency checklist, and review of existing organizational policies. The organizational Nurse Executive Council will need to sanction the project. The organization's Institutional Review Board (IRB), as well as Walden University's IRB, approved the project. The design for this project was a descriptive design using the survey method. The survey method was appropriate for this project based on the potential study population and the aim of the project. The project outcome was to facilitate the development of a handoff process and an orientation program for front-line and middle-level leaders and managers transitioning to their role at the HRP level within the MHS. With this in mind, a heterogeneous population was necessary to ensure that the product is generalizable (Grove, Burns, & Gray, 2013). Keough and Tanabe (2011) noted the flexibility of using the survey and its ability to reach a large population of respondents through multiple means such as the World Wide Web, postal service, and in person. To adjust to the critique of survey methods being vulnerable to the tendency of respondents portraying themselves in the best light, Keough and Tanabe (2011) suggested the

use of a reliable and valid tool. Dolnicar and Grün (2014) noted the survey design to be a factor to consider and suggested consideration is given to the length, formatting, and the manner in which the questions are asked.

The purpose of a study was an important factor in the design of the study. Grove et al. (2013) stated that a descriptive design has the potential to lead to theory development and practice problem identification. Additionally, there was no intent to manipulate any variables or provide treatment or intervention during the project development. Using a descriptive study design, Eastwood, Roberts, Williams, and Rickard (2013) employed an anonymous, structured, multiple-choice survey questionnaire to collect data for their study. Eastwood et al. (2013) described partitioning the survey subheadings to focus on the peculiarities that the research intends to elicit from the respondents. The concepts postulated by Eastwood et al. (2013) were employed in the design of a needs assessment survey. Conducting a short, anonymous needs assessment survey of current frontline leaders and middle-level managers was necessary for the development of the project platform.

Sample Population and Setting

The population of focus was frontline and middle-level nurse managers within one institution within the HRP. Purposive sampling of the incumbents within the organization helped in identifying the strengths and barriers within their roles. Purposive sampling was sought because of the uniqueness of the organization and the specific characteristics of the study population (Terry, 2015). A needs assessment questionnaire was used to gather supporting information and to identify gaps in practice on which to base the induction training module. Gathering information from incumbents encouraged buy-in and fostered the development of an

induction module tailored to the current roles and functions of frontline and middle-level managers.

The participants included active duty ANC commissioned officers in the ranks of First Lieutenant, Captain, Major, and Lieutenant Colonel. The population of commissioned officers at the selected grades is prepared at the BSN level as an entry requirement for the U.S. Army Nurse Corps (U.S. Army, 2012). Though the experience levels and duty assignments vary across the ranks, these officers can assume the nurse manager's role at a moment's notice. The nurse manager has full responsibilities for the daily functioning of the nursing unit to include personnel management.

Frontline leaders also include Non-Commissioned Officers (NCO) who are in leadership positions. The population of NCOs includes ranks of Sergeant, Staff Sergeant and Sergeant First Class. The education entry level of the NCO ranges from high school diploma to higher degree levels based on the individual NCO. Common factors between the NCO and the Army Nurse Corps officer include specific educational and developmental career tracks. The NCO has responsibilities that include personnel management and supervision, acquisition and maintenance of equipment, supplies, and other responsibilities that mirror the middle-level managers' responsibilities. The middle-level manager's and their assistant positions are occupied by both military and civilian staff. The civilian nurse counterpart to the ANC officer is also a highly specialized individuals some of whom shares dual roles as Army Reserve officer and Department of the Army Civilians.

The civilian nurse manager within the HRP shares the same responsibilities as their military counterparts. Individuals who occupy the middle-level positions handle the daily

operations of the nursing units and other departments. Their responsibilities cover the gamete of the American Association of Nurse Executive (2008) "Nurse Manager Skill Inventory". Surveying the identified participant population informed the development of the TLIP module for current frontline leaders and their replacements. The support of the Chief Nursing Executive and other senior leaders was necessary to initiate the data collection and to develop a comprehensive program that would benefit the organization.

Setting: The Health Readiness Platform

The HRP is a 120-bed Medical Center consisting of multiple specialties- both inpatient and ambulatory care specialties. Services offered by the HRP include graduate medical training programs, nursing and allied health training programs, and residency programs for specialties such as psychology (Dwight David Eisenhower Army Medical Center [DDEAMC], 2011). The medical center serves a population of approximately 40,000 beneficiaries both active duty, retirees, and their families. The average workforce is over 2,600 staff members both active duty and civilians (DDEAMC, 2011). The nursing systems are progressive and embrace employee involvement in clinical decision–making fostered through Nurse Practice Councils (NPC). The NPC represents staff from the Unit Council to the ANC council. Nursing care delivery is supported by the implementation of the PCTS and the Patient-Centered Medical Home. The systems of care are augmented by the implementation of TeamSTEPPS (AHRQ, 2014) and the concepts of high-reliability organizations such as reluctance to simplify, sensitivity to operations, resilience and deference to expertise (Chassin & Loeb, 2013).

Data Collection

The data collection was focused on gathering baseline information from the frontline leaders and middle-level managers within the hospital and subsidiary clinics. A consent form explaining the project aim and goals was sent to all potential participants via email. The participant was offered the opportunity to complete the needs assessment survey by following a link to the survey housed on a SharePoint page. Those participants who preferred to complete a paper copy was given the option of request a copy to be emailed to them with instructions on how to return the survey without disclosing their identity. At the close of the survey, there was no request for paper copies of the survey. The interested participants were selected from the list of frontline leaders, managers, and nursing staff in a supervisory position who accepted the invitation. The survey was designed to solicit feedback on agenda items common to leadership roles and functions and demographic survey. The participants received access to the survey and were asked to review and comment on the agenda items. Following receipt of the participants feedback, a thank you email was sent to the participants to the group. The information gathered was aggregated and incorporated into a final draft of the TLIP module.

Results

The participants were asked to review the proposed agenda items that included activities that were common to the incumbent's position and to provide additional comments. The survey was sent to 30 incumbents of which 57% (17) responded. The overall response to the survey (see Figure 3) was positive with 82% (14) of the respondents either agreed or strongly agreed with the items that they reviewed. The remaining 18% (3) respondents were uncertain. Among the respondents, 82% (14) had 10 years or more in the healthcare setting, 12% (2) had 7 to 10

years, and 6% (1) had 4 to 6 years. However, 35% (6) had less that I year in their positions and 35% (6) had 1 to 3 years (see Figure 4). The majority of the participants, 94% (16) held a Bachelors degree of higher, with 60% (9) reported having graduate degrees, and only one participant who held a diploma.

The distribution of respondents was an important factor in the needs assessment. The majority of the respondents 41% (7) were middle-level managers currently serving as incumbents. The second highest responses were from frontline leaders represented as charge nurse 35% (5). The remaining five respondents included two frontline leaders serving as assistants, one nurse, a Chief Nursing Office and an Informatics' Specialist. The response from

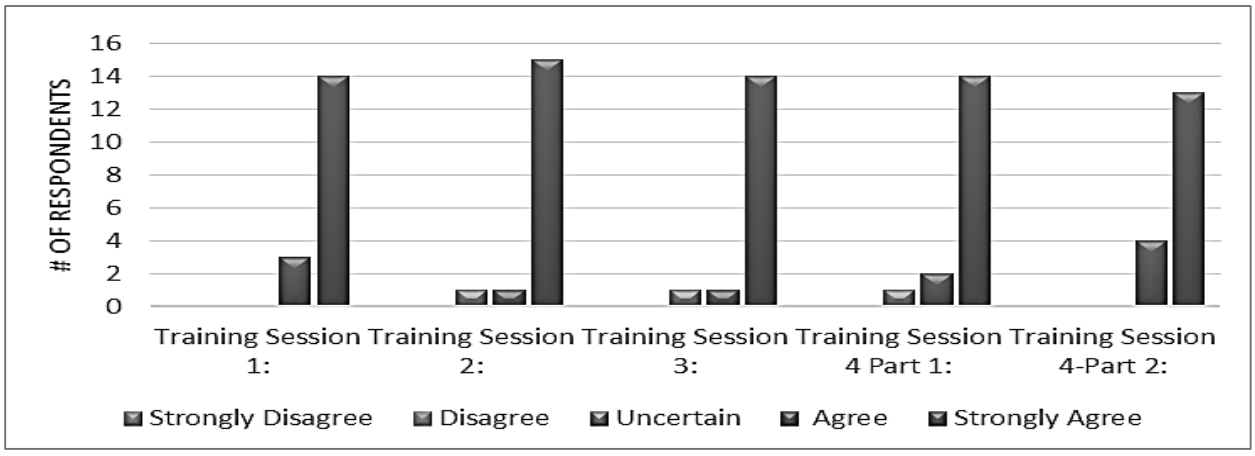

Figure 3. Levels of agreement with proposed training.

The non-commissioned officers who serve as primary frontline leaders were not adequately represented in the feedback (see Figure 5). The findings included a critical comparison of the employment status of the respondents. The majority of the respondents were military 65% (11) and civilians 35% (6). The Military Captains represent the largest group of military respondents. The significance of the respondent identified as Captains relates to the group of mid-career

leader who are either transitioning to assistant middle manager positions or have recently assumed the position (see Figure 6).

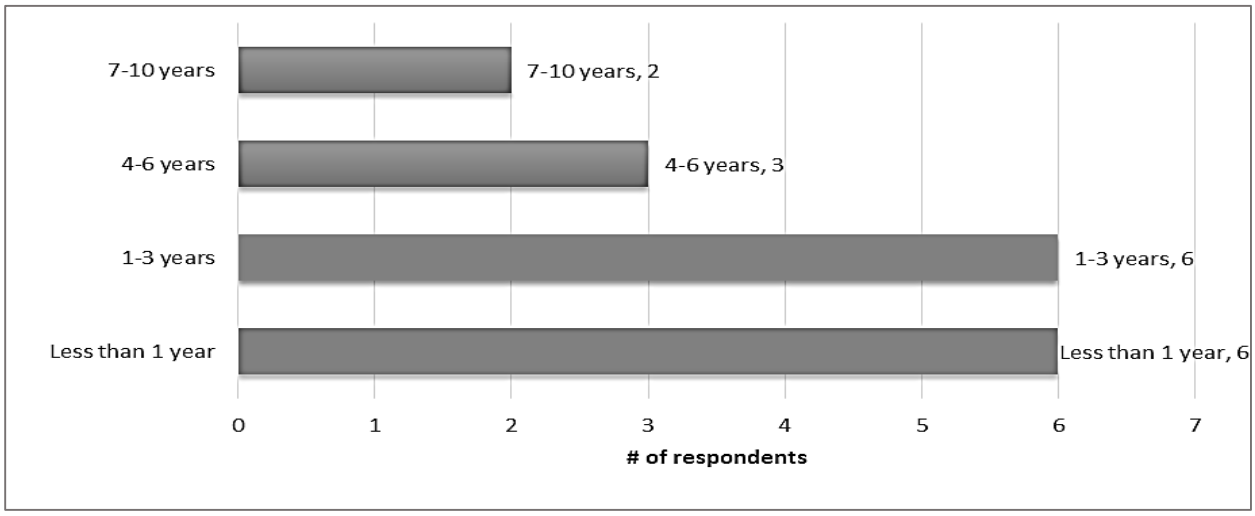

Figure 4. Number of years in current position.

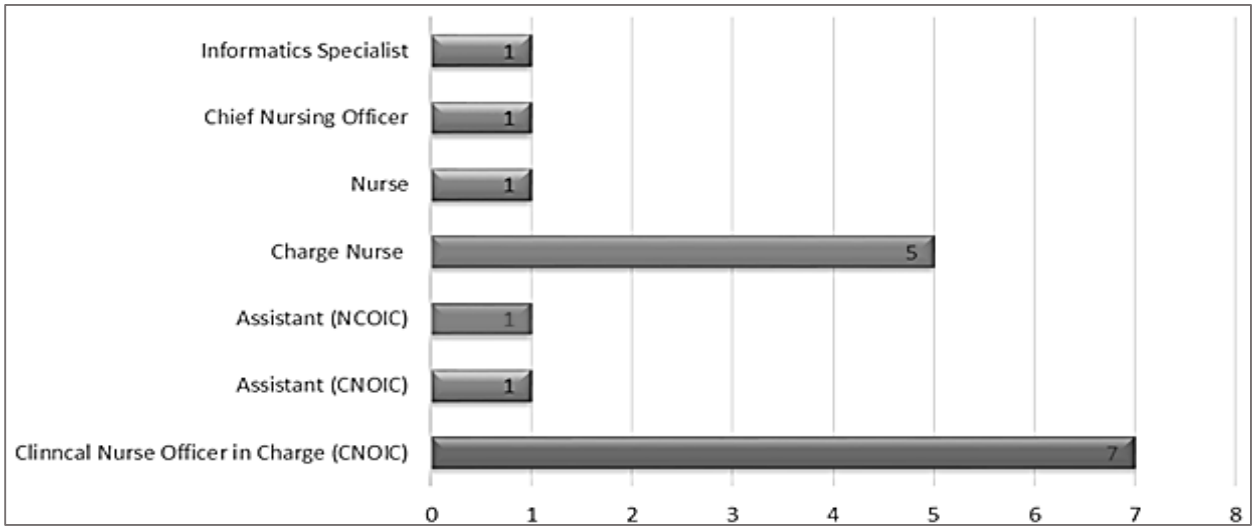

Figure 5. Duty positions.

The variation in the respondents work setting, and the number of staffs they supervised significantly added to the diversity of response and the significant of the existing information gap in the transition, and handoff process within the work setting. The majority of the respondents 47% (8) work in the inpatient setting while 29% (5) work in the inpatient setting. The other respondents were identified as non-clinical areas to include Hospital Education and administrative roles (see Figure 6). Added credibility of the response to the TLIP module is empowered by the fact that 82% (14) of the respondents supervised one to sixty or more employees (see Figure 7). This finding is of interest as some respondents indicated that they have never received mentoring 29% (5), and 18% (3) only received annual mentoring.

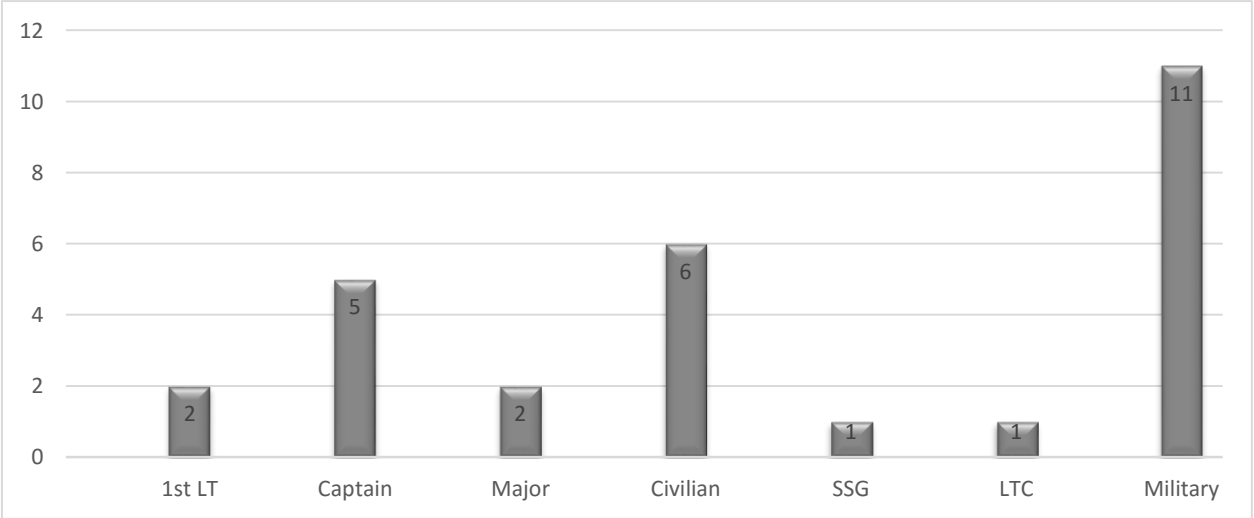

Figure 6. Categories of respondents and related employment status.

While a majority of the respondents 41% (7) indicated that they received mentoring on a quarterly basis, the remaining 12% (2) reported receiving monthly mentoring (see Figure 7). The gap identified in mentoring helps to explain the apparent knowledge deficit related

succession planning. Base on the respondents' feedback 41% (7) is not aware of succession planning.

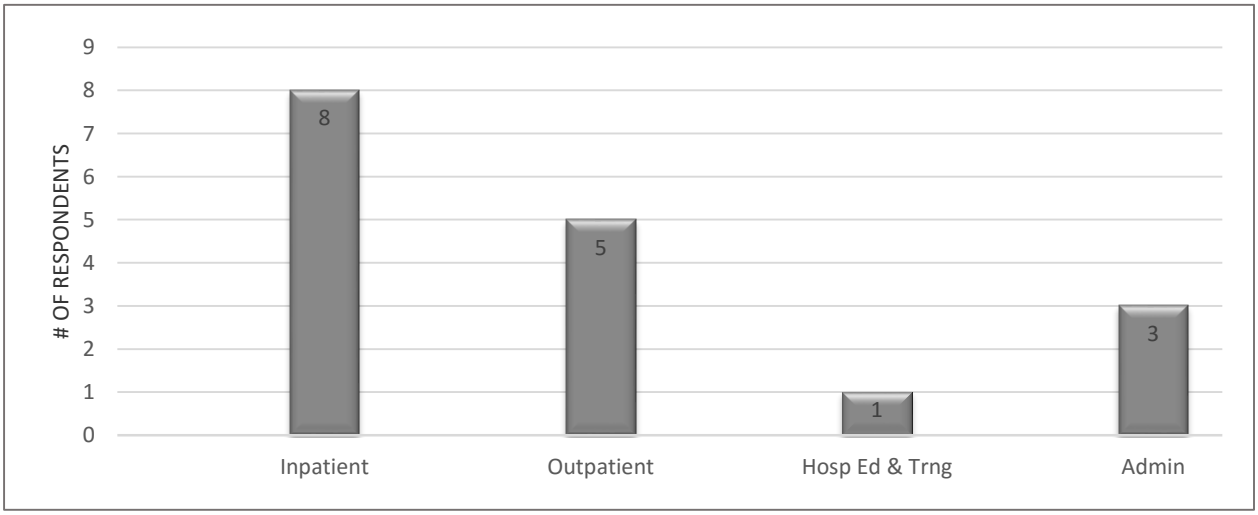

Figure 7. Respondent work setting.

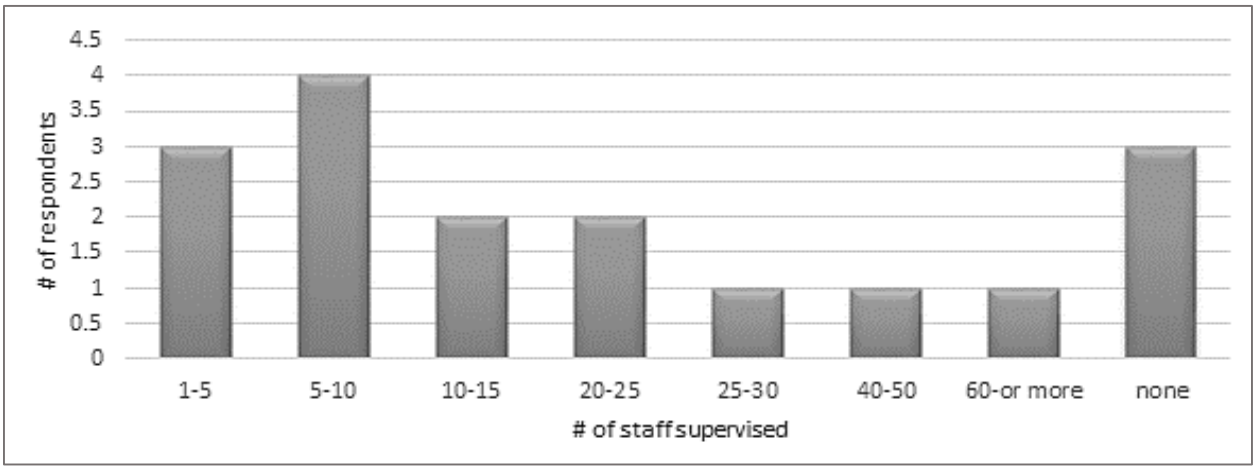

Figure 8. The number of staff supervised by survey respondents.

While 59% (10) of the remaining respondents indicated some level of awareness of succession planning, only 24% (4) noted they were extremely aware of succession planning (see Figure 9). Gauging the intent that the TLIP module would potentially help in closing the communication

gap in the leadership handoff, induction, and transition, the respondents were asked to indicate the likelihood that they would attend the training.

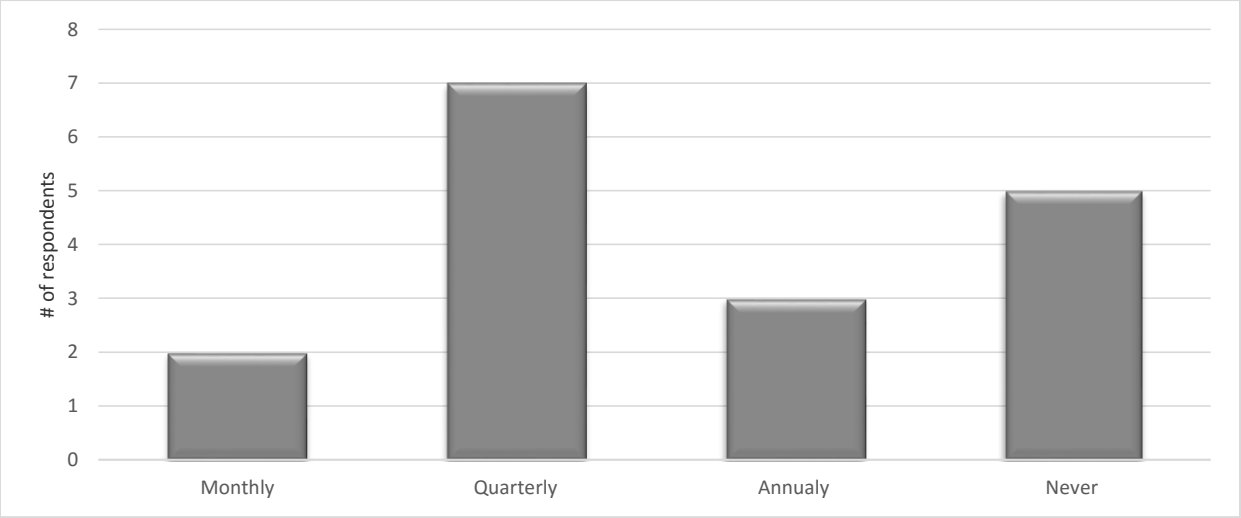

Figure 9. The frequency of receiving mentoring.

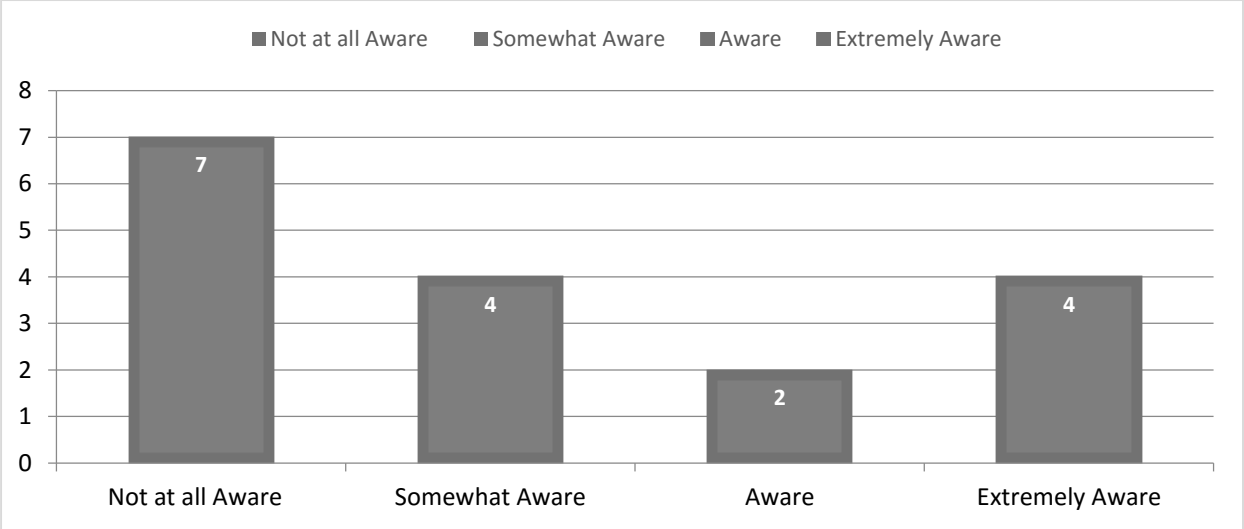

Figure 10. The level of awareness of succession planning.

Overwhelmingly, 94% (16) of the respondents indicated that it is likely and highly likely that they would attend the training (see Figure 10).

The qualitative feedback from the needs assessment provided rich data that enlightened the quantitative responses (see Table 1). The qualitative responses from the needs assessment survey were transcribed verbatim to maintain the meaning and reasoning of the respondents. The information was grouped based on the training session that they were based. While the comments are overwhelmingly supportive of the quantitative responses, a few of the comments warrants further review as they indicate an underlying misconception that are likely contributing factors that helped to propagate leadership deception.

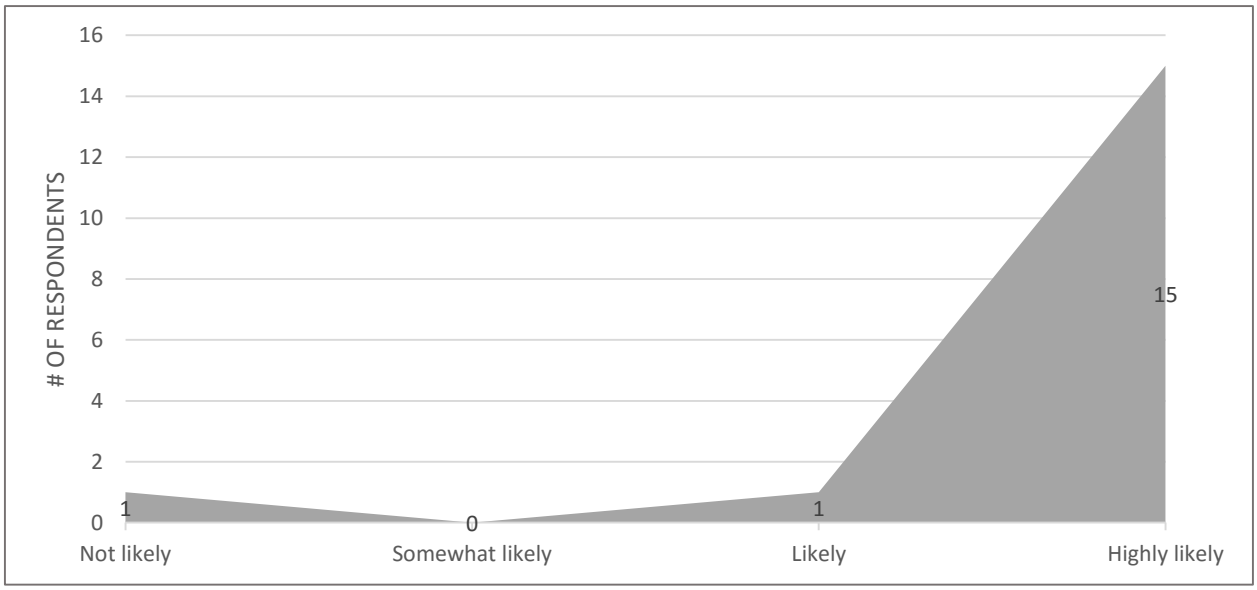

Figure 11. Likelihood of the respondents attending leadership induction and handoff training.

Table 1.
Respondents Qualitative Feedback

Respondents Qualitative Feedback and Comments

Comments on Training Session 1

1. This is a great start, I'm sure there may be things that can be added or subtracted based on the area the incoming leader will be working.
2. Getting to know me...working from the inside out leadership style conflict management style personality style inventory learning style inventory.
3. Not all leadership training is consolidated. Some we take through courses, some the hospital provides and other training is online via the CPAC Website.
4. Didn't know where else to put this, but perhaps adding something to the effect of mentorship to new leaders. Assigning a more seasoned nurse leader within the organization as a resource person/mentor to foster the new leader along, to answer questions and provide guidance. I don't see this within the organization now.
5. How much should new leaders be changing the vision of their assigned unit when they (theoretically) haven't had a chance to evaluate how well the current vision is working (They are new right?)

Comments on Training Session 2

1. When can we implement this, not just for those in transition, but as sustainment and readiness for those currently in the role?
2. Apply the organization's process improvement model to a current problem or issue noted.
3. CNTP training is necessary and fantastic.
4. We use the PCTS Model of care PSRs as a means of reporting Patient Safety events.
5. We have the PI FMT that meets every month, but we do not do a great job of identifying what the organizational PI projects are going to be or what we should be monitoring.
6. Adding KPIs, command metrics, PCTS metrics developing transparency within the organization for sharing this information with all

Comments Training Session 3

1. Need to add the contract staff, how it differs from your civilian staff rating scheme
2. This is awesome! Really need to understand the LMA and TAPES which in my opinion is extremely outdated
3. Discuss the steps to discipline a civilian in regards to ensuring HR is involved to answer any questions. Also,
4. Discuss the role of the Union within this facility.
5. Awards could be more frequent. I don't know civilian leave policies.
6. Although I have access to the material and know how to access it, many leaders do not know where to go.
7. Online CPAC training is not an effective way of training. Face-to- face so that the student can ask questions and come up with scenarios is a more valuable way to train.
8. For the proposed audience, this information is covered at nauseam in the CNOIC course, Supervisor development courses, etc. I suggest limiting this information found elsewhere

Comments on Training Session 4 Part 2

1. Relevant content and practical application
2. We have room to improve this with this part

LMA-Labor-Management Agreement**. CPAC-** Civilian Personnel Action Center.
FMT-Functional Management Team**. TAPES-**Total Army Personnel Evaluation System**. CNTP-** Clinical Nurse Transition Program. **KPI-**Key Performance Index.
PCTS – Patient CaringTouch System. **PI-**Performance Improvement. **PSR-**Patient Safety Report. **CNOIC-**Clinical Nurse Officer in Charge

Interpretation of Findings

The findings from the needs assessment survey indicated overwhelming support for the development of the TLIP module. The data suggested that the postulated gap in leadership transition does exist and that closing the gap would have valued implications for leadership practice and the enhancement of the identified project outcomes. Following the aggregation of the data, a group of middle managers was briefed on the survey results. The group included seven members of the leadership practice council and represented a diverse mix of civilians and military as reflected in the survey results. They were offered the opportunity to review and discuss their thoughts related to the results. The discussion and feedback revealed similar findings (see Table 2). One of the nurse managers voiced concerns that the changes in the hospital might affect the program while a junior nurse manager echoed that delaying the program would further hamper the transition of new leaders.

The senior nurse leader in the organization was presented with the findings of the survey and the proposed, training module, and the handoff tool. The discussion generated ideas to use the program as a foundational to the leadership training for the new and nurse managers and those who are 12 months or less in their positions. Based on the Chief Nursing Officers feedback 35% of the current nurse managers would attend the training, not including those who did not respond to the survey.

Implication for Evidence-based Practice

The findings from the needs assessment provided specific triggers to address the identified practice gap of leadership handoff and the need for orientation and induction of frontline leaders and middle-level managers. The project was developed based on the IOWA

model of evidence-based practice to promote quality care. Following the pathway of the model and the current findings in the literature, and the stakeholders feedback, the next step in the evidenced-based practice is to pilot the project. Changing the paradigm of the organizational culture requires deliberate and conscientious efforts. Evidence-based practice is one such vehicle that brings the best research findings together with the values of the stakeholders and the expertise of the practitioners to address issues at all levels of the organization that influences patient safety and care delivery outcomes (Grove, Burns & Gray, 2013). The inclusion of the current knowledge into the decision–making matrix is a step forward to achieve positive patient outcomes (Stevens, 2013).

Implications for Practice

The practice implications for the TLIP module and Leadership SBAR (LSBAR) tool (see Appendix E) extend beyond handoff at the bedside between oncoming and off going shifts to a shared mental model for leadership practice and patient safety (Wakefeild et al., 2012). Frontline leaders and middle-level managers are responsible for executing a myriad of tasks encompassing clinical and administrative roles and functions that will be facilitated through the TLIP module. According to Gordon and Findley (2011), the process of handoff ensures that accurate and reliable communication transfer between the involved parties. However, the same emphasis is not given to frontline leaders and middle-level managers. Dragoni et al., (2014) identified several elements critical to frontline leader development to include role knowledge, figuring out boundaries, and the need for a supervisor to model effective leadership behaviors. It is within the context of leadership development that the transitioning leader will gain the institutional knowledge necessary to assimilate the meaning and translation of the organization's

mission and vision. Implementation of the TLIP into the induction and orientation of the new leader will provide a platform from which leadership competencies can associate with their roles and functions. Furthermore, measures of efficiency and effectiveness can be assessed and streamlined within the practice setting based on the framework of the TLIP module and LSBAR tool. The opportunity for senior leaders and incumbents to develop succession planning is further enhanced by the fact that the TLIP module includes the AACN 2006 healthy work environment standards. The cumulative effect of the TLIP module and LSBAR tool on practice is the standardization of leadership transition to practice. Laying the foundation for frontline leaders and middle-level managers to focus on inculcating high-reliability concepts and healthy work environment standards during the induction and orientation facilitates the organization's journey to towards a high-reliability organization (Chassin & Loeb, 2013).

Conclusions

Leadership handoff is an imperative to ensuring safe patient care and staff satisfaction within the multidisciplinary care team and the changing environment of patient care delivery. The notion of doing business as usual and doing things the way they were always done (Willis, 2012) is not reflective of the evidence-based practice and patient safety goals. The implications for social change are supported through research on communication and leadership. This project is an integral component in the leadership knowledge and management system cycle aimed at codifying succession planning. The future of nursing campaign calls for expanded opportunities in which nurses are leaders in collaborative improvement efforts and are leaders in advancing health (Institute of Medicine, 2010). Standardizing the leadership transition process is a first step to ensuring continuity in nursing leadership. Furthermore, implementing the TLIP module and

LSBAR tool has the potential of increasing leadership compliance with human resources and human capital management. Senior leaders will have the added opportunity to align and validate the transitioning leader's competencies and chart new processes for leadership growth and development. Finally, the emphasis on increased communication across the health care platform will undoubtedly increase the uptake of EBP engagement, performance improvement, and improved staff morale and job satisfaction.

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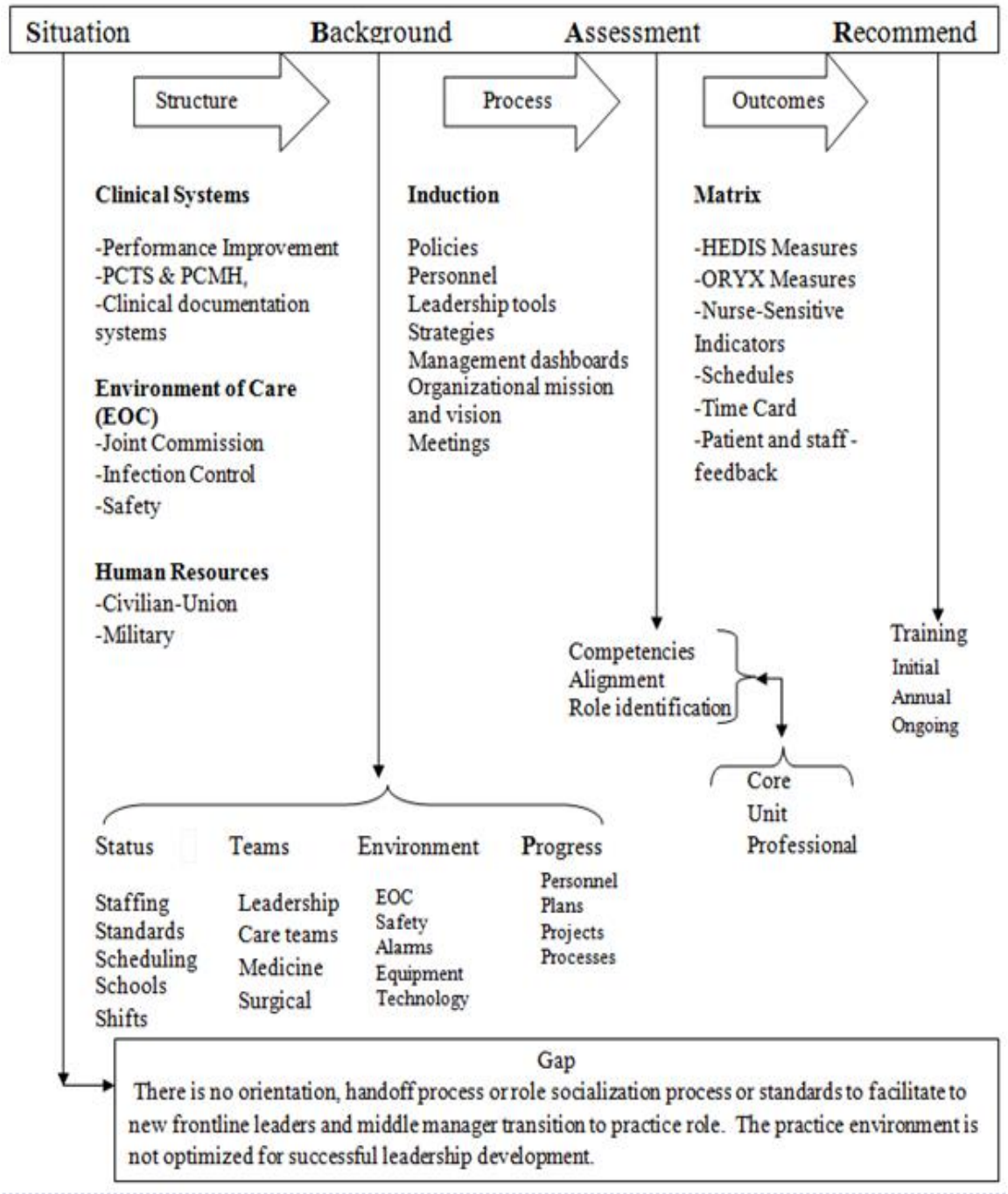
Appendix A: Conceptual Diagram of the structure process and outcomes framed in TeamSTEPPS communication (SBAR) format.



Appendix B. Steps in Evaluation Practice and Standards for Effective Evaluation

Steps in Evaluation Practice	
Engage stakeholders	Those persons involved in or affected by the program and primary users of the evaluation.
Describe the program	Need, expected effects, activities, resources, stage, context, logic model.
Focus the evaluation design	The purpose, users, uses, questions, and methods, agreements.
Gather credible evidence	Indicators, sources, quality, quantity, logistics
Justify conclusions	Standards, analysis/synthesis, interpretation, judgment, recommendations.
Ensure use and share lessons learned.	Design, preparation, feedback, follow-up, dissemination
Standards for Effective Evaluation	
Utility	Serve the information needs of intended users
Feasibility	Be realistic, prudent, diplomatic, and frugal.
Propriety	Behave legally, ethically, and with regard for the welfare of those involved and those affected.
Accuracy	Reveal and convey technically accurate information.

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Appendix C. Needs Assessment and Demographic Survey

Review training sessions 1 through 4 outlined below (content, pre-work, activities, and outcomes), then rate the extent to which you agree or disagree with the contents. Add additional feedback in the comment box provided.

Content of Training Session 1
1. Introduction to leadership competencies
2. Sources of evidence-based practice
3. Competency validation methods and strategies

Pre-work:
Complete self-assessment portion of competency based assessment tool

Activities:
1. Review and crosswalk institution's mission and vision with the assigned unit's mission and vision and contrast with personal vision
2. Review the institutional policies related to competency validation

Outcome Measures:
1. Create new vision or modify existing documents.
2. Initiate a leadership Handoff Portfolio

Training Session 1:
Based on your review of the items in training session 1, to what extent do you agree or disagree with the contents?

*

	Strongly Disagree 1	2	Uncertain 3	4	Strongly Agree 5
Strongly Disagree=1 Disagree=2 Uncertain=3 Agree=4 Strongly Agree=5	◉	○	○	○	○

Comments on training session 1. Please provide any additional feedback/comments/suggestions.

Training Session 2
1. Introduction to Clinical Decision Support Systems

Performance Improvement
Patient Care Practice Model
Clinical Documentation

Pre-work
1. Obtain a list of the institution's priorities/strategic map
2. List of unit's priorities/performance metric

Activities:
1. Immersion of new staff to the unit (orientation to CBO completion)
2. Develop process map/standard operating procedure or adapt or modify existing ones
3. Understanding and tracking mandatory training requirements
4. Understanding the purpose or function of an order of merit roster for the unit

Outcome Measures:
1. Identify and interpret performance improvement & evidenced-based practice models used by the institution
2. Identify outcomes metric-unit & institutional dashboards

Training Session 2:
Based on your review of the items in training session 2, to what extent do you agree or disagree with the contents?
*

	Strongly Disagree		Uncertain		Strongly Agree
	1	2	3	4	5
Strongly Disagree=1 Disagree=2 Uncertain=3 Agree=4 Strongly Agree=5	○	○	○	○	○

Comments on Training Session 2. Please provide any additional feedback/comments/suggestions on the proposed training outline.

Training Session 3
1. Human Resources
-Military
-Civilian

Pre-work
1. Unit roster with employees by type and initial counseling dates
2. Locate HR manual and resources and employee union information

Activities: Building successful teams.
1. Compare military and civilian leave policies
2. Review table of penalties
3. Review timecards and schedules practice
4. Peer reviews vs. Peer feedback
5. Hiring policies, process and procedures
6. Awards and recognition

Outcome Measures
1. Develop counseling metric
2. Develop leave tracking
3. Initiate an individual development plan

Training Session 3
Based on your review of the items in training session 3, to what extent do you agree or disagree with the contents?

	Strongly Disagree 1	2	Uncertain 3	4	Strongly Agree 5
Strongly Disagree=1 Disagree=2 Uncertain=3 Agree=4 Strongly Agree=5	○	○	○	○	○

Comments Training Session 3. Please provide any additional feedback/comments/suggestions on the proposed training outline.

Training Session 4 Part 1
Environment of Care (EOC)

Pre-work
1. Review practice guidelines (TJC, Clinical practice guidelines infection control & safety)

Activities:
High Reliability Organizations.
1. Develop a metric for walking rounds
2. Safety tracking metric
3. Training requirement metric

Outcome Measure:
Initiate a historical unit report metric

Training Session 4 Part 1
Based on your review of the items in training session 4 Part 1, to what extent do you agree or disagree with the contents? *

	Strongly Disagree		Uncertain		Strongly Agree
	1	2	3	4	5
Strongly Disagree=1 Disagree=2 Uncertain=3 Agree=4 Strongly Agree=5	○	○	○	○	○

Comments Training Session 4 Part 1. Please provide any additional feedback/comments/suggestions on the proposed training outline.

Please complete the following demographic information.

1. Type of Certification *

Privacy Act Advisory: No personally identifiable data will be collected, and all data used for reporting and analysis will be in aggregate form only. Participation is voluntary and a failure to participate or respond to any question will not result in any penalty or loss of benefits. Instructions: Check the box next to the item that applies to you. If you are completing this form electronically, double click the box then in the default section, select the checked box. Save or print the completed survey and return it to the person who sent it to you. Please complete the following demographic information. 1. Type of Certification: Choose Option

Specify your own value:

---

2. Highest degree earned *

---

3. What is your current status? *

---

4. Please identify your title. (Please note—if the options below does not EXACTLY match your title, select other and enter your exact title). *

4. Please identify your title. (Please note—if the options below does not EXACTLY match your title, select other and enter your exact title).: Choose Option

Specify your own value:

5. Identify your work setting

- (•) 5. Identify your work setting: Choose Option
- ( ) Specify your own value:

---

6. On average, how many staff do you supervise? *

---

7. How often do you receive role specific mentoring? *

---

8. If you are in a leadership role, did you receive a handoff from the person that you replaced? *

Yes

---

9. How many years have you been in your current position? *

---

10. How long have you worked in the field of health care? *

- (•) 10. How long have you worked in the field of health care? : Choose Option
- ( ) Specify your own value:

---

11. If you were offered the opportunity to attend leadership handoff induction and orientation training, what is the likelihood that you would attend? *

	Not Likely		Likely	Highly Likely
	1	2	3	4
Not likely=1 Somewhat likely=2 Likely=3 Highly likely=4	◉	○	○	○

12. What is your level of awareness of succession planning? *

	Not at all Aware	Somewhat Aware		Extremely Aware
	1	2	3	4
Not at all Aware=1 Somewhat Aware=2 Aware=3 Extremely Aware=4	○	○	○	○

Appendix D. Transformational Leadership Induction Program (TLIP) Module

Unit/Activity's Name: DDEAMC

Title of Presentation: A Practical Approach to Facilitate Frontline and Middle-Level Nursing Leader Transition: Focus on the Military Healthcare System"
Description of Presentation: This presentation is to provide leadership handoff training to assist newly assigned leaders in their role orientation, induction, and socialization. The training will address factors that compound the situation to include the frequent leadership and staff turnover and the fact that frontline leaders and middle-level managers assuming new positions are usually coming from other organizations, returning from deployment or a non-clinical role, and are not aware of current practices. The issue of turnover is not unique to the Military Healthcare System. However, the frequency of role change might be unmatched. The accompanying training will consist of four modules, environment of care, clinical decision support systems, human resources management, and change management as well as resources for successful leadership within the organization. The training is designed to bridge the transition gap that exists when leaders transition to new positions without receiving a handoff or received an inadequate handoff. The challenge within the facility is that, more often than not, the incoming leader arrives after the outgoing leader has transitioned. This gap creates a steep learning curve for the future replacement and a chasm for the transitioning individual. Creating a leadership buffer through a designated handoff training process would allow the newly transitioned leader to gain perspective of their role and quickly transition into their practice rather than starting from scratch. The training is geared at embedding leadership concepts that introduce the leader to the concepts of high-reliability organizations embedded in TeamSTEPPS framework, the culture of trust, change management, succession planning, and building a healthy work environment. The class will consist primarily of lecture with power point visual aids, practical exercises and orientation to a leadership handoff matrix, and the development of a leadership handoff binder.

Total Contact Hour Calculation of Objectives = 260 divided by [60] = 4.5 Contact Hour

OBJECTIVES:	**CONTENT:**	**TIME FRAME:**	**PRESENTER:**	**TEACHING STRATEGIES:**
List the learner-oriented educational objectives in behavioral terms. ***(Must have at least 3 performance objectives)***	**Provide an outline of the content/topic presented and indicate to which objective(s) the content/topic is related.**	**State the time frame for topic/ content area.**	**List the presenter for each topic/ content area.**	**Describe the teaching strategies used by each presenter for each topic/content area.**
The learner will be able to:				

OBJECTIVES:	CONTENT:	TIME FRAME:	PRESENTER:	TEACHING STRATEGIES:
1. Describe the leadership competency validation process and the implications for leadership handoff.	*1. Introduction to leadership competencies* *a) Sources of evidence that support leadership competencies* *b) methods and strategies of competency validation* c) Review and crosswalk institution's mission and vision with the assigned unit's mission and vision. 2. Review institutional policies related to competency validation Complete self-Assessment section of nurse manager skill inventory tool d) Complete self–assessment section of leaderships competency based orientation tool e) Immersion of new staff to the unit (orientation to CBO completion)	60 minutes	Rudolph Newman	Select from the following: Lecture/PowerPoint Discussion Lecture Demonstration Practical exercise
2. Differentiate between multiple clinical systems utilized in the practice setting .	2. Introduction to Clinical Decision Support Systems a) Clinical documentation (Essentris, CHCS, ALTHA) b) Individual Staff development (Army Career Tracker-Civilian and Military) c) Workload Management systems(WMNSI, DMHRSI, ATAPS) d) Human Resource Management systems (TAPES, e) Error reporting system (PSR)	60 minutes	Rudolph Newman,	Select from the following: Lecture/PowerPoint Discussion Demonstration

OBJECTIVES:	CONTENT:	TIME FRAME:	PRESENTER:	TEACHING STRATEGIES:
	f) Feedback systems (TRIST, APLES, ICE)			
3. Articulate the clinical leaders role in Performance Improvement, Patient care practice model and evidence based practice	3. Performance Improvement roles and functions a) Leaders role in within the systems of care (Patient CaringTouch System, PCMH, TeamSTEPPS, Customer service) b) A. Locate process maps/ Standard operating procedure for work setting c) Performance & Evidence-based practice & model used by the institution (FOCUS-PDCA, DMAIC & IOWA Model) d) Outcomes metric-unit & institutional dashboards e) Mandatory training requirements (staff vs. leadership)	60 minutes	Rudolph Newman,	Select from the following: Lecture/PowerPoint Discussion Demonstration
4. Identify the human resource / human capital management requirement within the sphere of the frontline leader and middle level manager	4. Human Resources Military & Civilian a) Compare military and civilian leave policies b) Review table of penalties c) Review timecards and schedules practices d) Peer reviews/ Peer feedback e) Hiring policies, process and procedures f) Awards and recognition g) Order of merit roster for the unit h) Employee Union i) Counseling requirements	40 minutes	Rudolph Newman	Select from the following: Lecture/PowerPoint Discussion Demonstration
5. Assimilate the roles and	5. High Reliability Organizations	40 minutes	Rudolph Newman,	Select from the following:

OBJECTIVES:	CONTENT:	TIME FRAME:	PRESENTER:	TEACHING STRATEGIES:
functions of the leader's influence on the Environment of Care (EOC)	1. Develop a metric for walking rounds 2. Safety tracking metric 3. Training requirement metric 4. Managing Change in Complex Organizations 5. Locate evidence-based resources to facilitate leadership decisions. 6. Develop succession plan for current position			Lecture/PowerPoint Discussion Demonstration Practical Exercise

Appendix E. Leadership SBAR Tool

A PRACTICAL GUIDE TO LEADERSHIP HANDOFF: LSBAR

Frontline & Middle-Level Managers in the Military Health System

CLINICAL DECISION SUPPORT (CDSS)
ENVIRONMENT OF CARE (EOC)
HUMAN RESOURCES MANAGEMENT (HRM)

Leadership
Situation
Background
Assessment
Recommendation

Introduction

The landscape of healthcare delivery is changing rapidly. Thus, requires a multifaceted approach to achieving the desired outcomes of safe, effective, patient-centered, timely, efficient, and equitable health care. The prospect of maintaining a cycle of continuous process improvements within the clinical setting hinges on frontline leaders and middle-level managers, who are prepared to execute the mission, motivate, supervise, coach, and mentor the staff. Compounding factors such as the lack a of proper handoff mechanism, role orientation, and constant mission changes leaves the newly assigned frontline leaders and middle-level managers unprepared to meet the clinical, administrative, and human resources demands of the position.

Why you need a Handoff

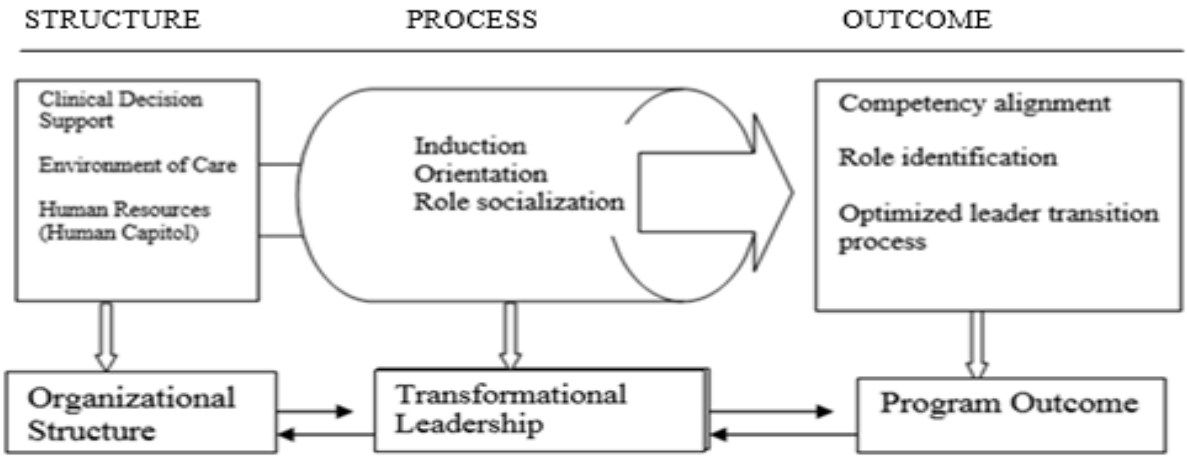
1. You are new to the position
2. You are new to the organization
3. You cannot possibly know everything about the new position
4. The last position you had was nothing like the new one
5. Your staff is awaiting your decision
6. Your leaders are awaiting your reports
10. Patient safety is your number one concern
11. Staff satisfaction depends on your leadership
12. You need a baseline
13. Continuity of care
14. This is your first leadership/manager role
15. Do you know what works and what does not?
16. What do you need to do right now, and what can wait?
17. Where are your support systems?
18. Opportunity to ask questions
19. Opportunity for verification
20. An opportunity to review any relevant data

" Ineffective hand-off communication is recognized as a critical patient safety problem in health care; in fact, an estimated 80% of serious medical errors involve miscommunication between caregivers during the transfer of patients" TJC, 2012).

Simplifying the Complex Relationships within the Practice Setting

Figure 1. Concept Diagram

Transformational Leadership Induction Program (TLIP) module



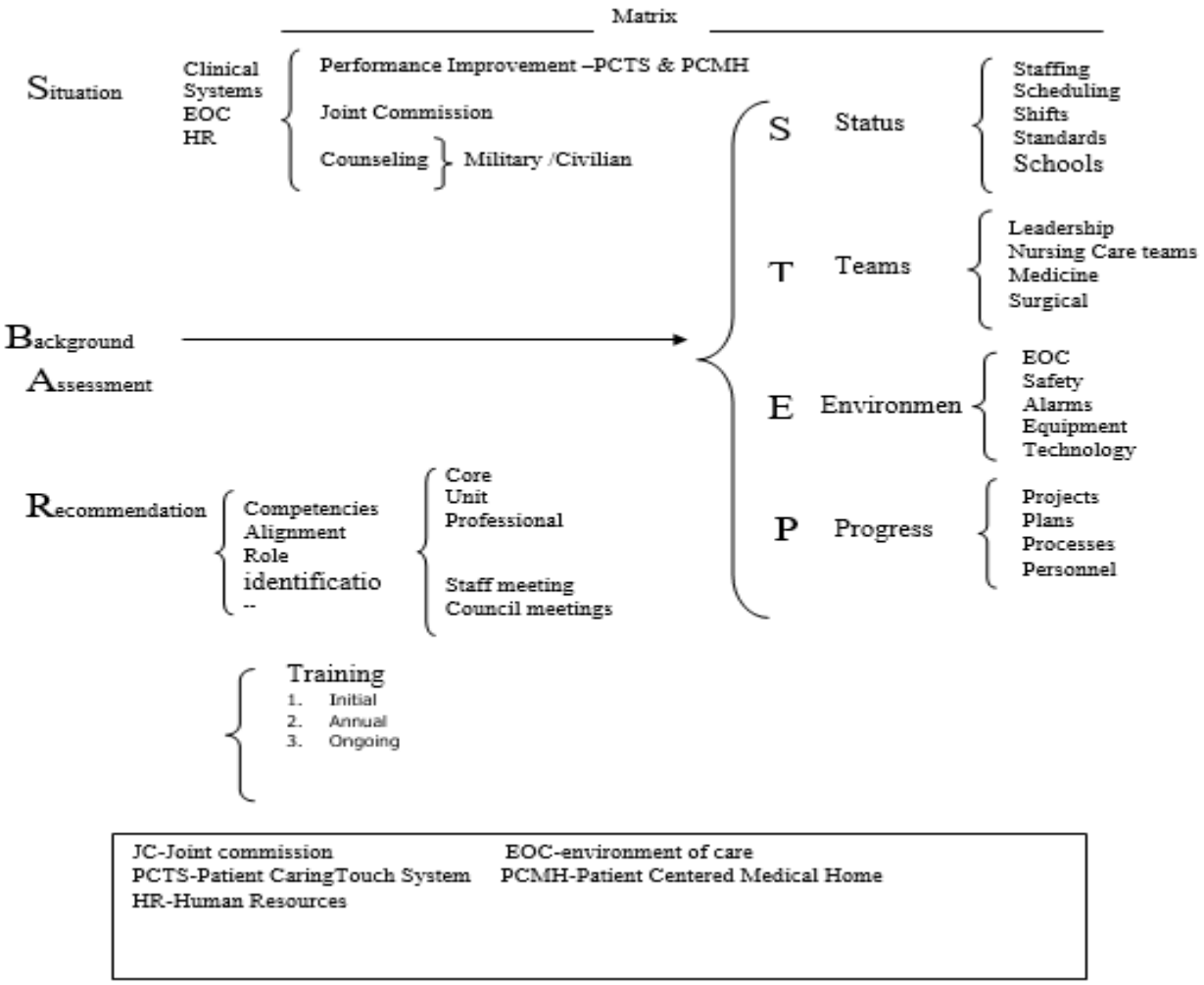
Frontline leaders and middle-level managers are responsible for promoting and establishing practice environments that balance complex demands and perspectives (Laschinger & Wong, 2010). The CDSS comprises the information technology infrastructure that supports evidence-based decision-making through data management. Primarily, the CDSS facilitates the provision of care in complex work environments through point of care testing, alerts and reminders, treatment order set, and real-time information for clinicians to engage in patient care decisions (HealthIT.gov. 2013).

The environment of care processes includes The Joint Commission's (TJC) standard requirements for safety, security, hazards and material waste, fire safety, medical equipment and

utilities (Mills, 2013). Understanding the roles and responsibilities of the position include the environment of care systems process, policies, and procedures critical to the unit/organizational outcomes. The third overarching component of the conceptual TLIP model (Figure 1) encompasses human resources (HRM) and human capital management (HCM). The policies and practices of governing people management include scheduling, multiple types leaves policies, equal opportunity and equal employment opportunity, workers compensation, union rules and practices, hiring practices, disciplinary practices, pay and compensation, conflict management, performance evaluation, and promotion and much more.

Leadership SBAR Matrix in (Figure 2) outlined the handoff process that represents the transfer of responsibility and accountability from one person to the next in a clear format while allowing the receiver to acknowledge the information and ask questions for clarity (AHRQ, 2014). The Status, Team, Environment, and Progress (STEP) are embedded within the diagram to represents an assessment of the background information the transitioning leader needs to know. The guiding philosophy to frame the assessment in TeamSTEPPS is to reduce the stress of introducing new tools that might causes confusion.

Figure 2. Leadership SBAR



JC-Joint commission EOC-environment of care
PCTS-Patient CaringTouch System PCMH-Patient Centered Medical Home
HR-Human Resources

About Your UNIT/CLINIC/SECTION STRUCTURE

Unit Type: select all that applies to your situation

☐ Critical Care ☐ Progressive Care ☐ Telemetry ☐ Med/Surg ☐ Internal Medicine Clinic

☐ Troop Medical Clinic ☐ ER ☐ OR ☐ GI ☐ GU ☐ EENT ☐ Residential Treatment

Facility ☐ PSYCH ☐ Internal Medicine Clinic ☐ Family Medicine Clinic ☐ GYN ☐ ED ☐

☐ Education & Training ☐ Radiology ☐ Other _____

Patient /Client Population:

☐ Adults ☐ Pediatric ☐ Active Duty ☐ Beneficiary ☐ Civilian ☐ Contractors

☐ Other _____

Unit Size:

#of Beds _____ #of Female beds _____ #of Male beds _____ #of Pediatrics_____

Average Daily Census _____N/A_____ Overflow capacity_____

Number of Personnel:

Physician_____PA_____APRN_____RN_____RN_____LPN_____CNA_____TECH_____

MSA _____Secretary _____Other _____

Common Conditions & Diagnoses or Scope of Service (e.g. Education dept.)

_____

_____

_____

NOTES: What other services does your unit /clinic/section provides?

_____

_____

_____

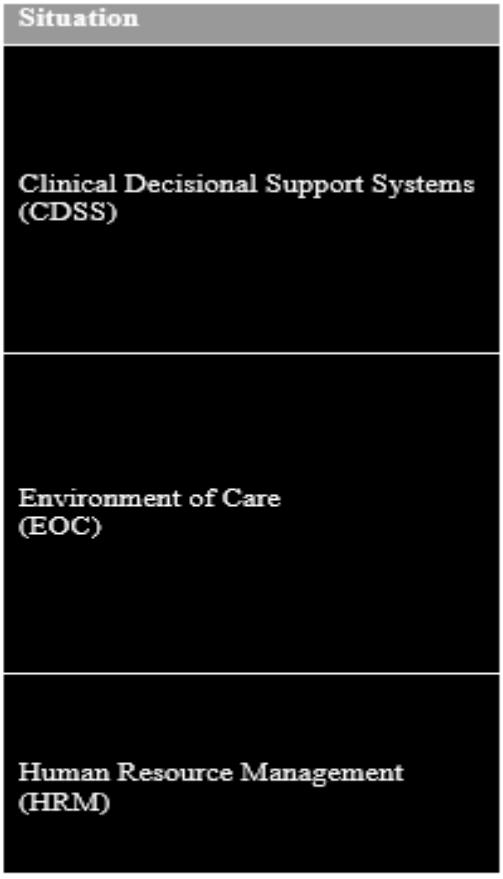
_____

_____

Quick Notes

Quick Notes

Quick Notes



"Management is doing things right; leadership is doing the right things."

(Peter F. Drucker, 2001)

Clinical Decision Support Systems

Enterprise contact #:				
Identify the clinical decision systems within the work setting				
System Name/ Type	Purpose	Local Contacts		
		Name	Phone	Email
ATAPS				
ALTHA				
DTMS				
DMHRSI				
DTS				
CHCS				
WMNSI				
JKO				
ACT				
Omni cell				
Schedule Anywhere				
Mosby's Skills				
Mosby' Consults				

Notes Page: Are there any expected changes or new systems on the horizon?

Environment of Care

If deficiencies are found, document the date that work order was placed and recorded into work order log.				
The Joint Commission	Last visit	Outcomes	Areas needs improvement	Recommendation
Unit Performance Improvement Projects	Title	Start Date	Status	Comments

Care Delivery Models	Patient Caring Touch System (PCTS) Patient Centered Medical Home(PCMH) Other

	Unit Practice Council	Nurse Practice Council	Leadership Practice Council	Nurse Executive Council	
Status					
contacts					

Safety Concerns

Work Orders	
Work order #	Status:
Work order #	Status:
Work order #	Status:

Human Resources Management

Military Personnel		Evaluation Due	Counseling	Records Complete	Disciplinary Action	Promotions
	Officers					
	NCOs					
	Enlisted					
	Reserve					
	Other					
Comments						

Gains and Loss	
Detailed	
Leave	
Medical	
Pass	
Retirement	
Schools	

Notes

_____

_____

_____

_____

Civilian Personnel	Levels (permanent/ temporary/ contract)	Evaluation Due	Counseling	Records Complete	Disciplinary Actions	Awards
Comments						

Gains and Loss	
Detailed	
Leave	
Medical	
Pass	
Retirement	
Transfer	
Schools	

Hiring Actions						
Staff Type	Area of need	#of vacancies	Date action initiated	Target date	Status	HR Contact

Notes Page: Note areas that need immediate attention.

Quick Notes

Background

Status

Teams

Environment

Progress

"Psychology keeps trying to vindicate human nature. History keeps undermining the effort."
(MASON COOLEY, City Aphorisms)

Status

		Notes
Staffing	• Who makes the schedules?	Obtain a copy of the TDA/staffing document
	• What are your responsibilities for scheduling	
	• What is the staffing mix?	What is the staffing methodology?
Scheduling	• Self-scheduling	
	• What are the scheduling rules?	

	• Leave and Pass rule?
	  • Convalescent leave
	  • Sick leave
	  • Annual leave
	  • Leave without pay
	  • Absent without leave
	  • Military leave
		What works/flex scheduling etc.

Shifts	• Rotating shifts • Days • Evenings • Nights • On call • Cross covering • Straight 8's	**Ask about workflow**
Standards	• TeamSTEPPS • Metric and Dashboards • Medical Command Polices • Hospital Policies • Nursing policies • Evidence-based Practice	**Where are the policies located?**
Schools/Training	• Military education • Civilian education • Staff education • Unit education	**Criteria/contracts/status reports**

Teams

		Notes
Leadership		
Nursing Care Teams		
Medicine		
Surgical		
Performance Improvement		
Hazmat		

Notes

Environment

		Notes
Patient Care Environment		
Safety	• Fire/Electrical Safety • Medication Safety • Fall Prevention • Code Blue • Infection Control • Clinical Alarms • Code system	
Equipment	• Beds Management • Key control • Hand Receipt	
Items Turn-in	Status	
Purchase	Status	
Damage Items	Status	
Technology	Wireless devices	
other		

Progress

		Notes		
Projects	• Unit projects			
	• Section projects			
	• Hospital projects			
Plans	Unit Training Plans	Monthly	Quarterly	Annual
	• Mock Code			
	• Evacuation			
	• Preceptor Course			
	• Charge Nurse Course			
	• SHARP			
	• TARP			
	• TeamSTEPPS			
	• Customer Service			

Processes	• Leave and passes	
	• Temporary duty assignment	
	• Patient Safety Reports	
	• Evaluations	
	• Performance Improvement	
	• FOCUS-PDCA	
	• DMAIC	
	• EBP	
	• Research	
Personnel	• Performance improvement	
	Rating Schemes	
	Military	
	Civilian	
	Competency Validation	
	CBO	
	Initial	
	Ongoing	

NOTES

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What do you need to move forward?

Quick notes_____

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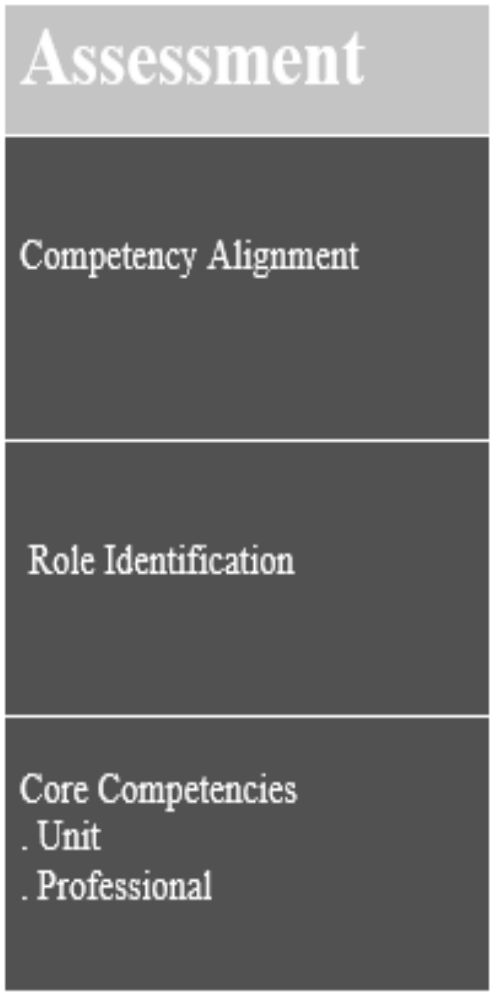

The highs of great men reached and kept were not attained by sudden flight, but they while their companions slept, were toiling upwards through the night

Poet Henry Wadsworth Longfellow

Core Competencies

- Unit
- Professional

Leading the Unit/Section/Clinic:

Change Management
Problems solving and decisions making
Managing politics and influencing others
Risks Management
Setting vision and strategy
Workload management
Budget and finance knowledge and skills
Organizational Knowledge

Leading the self:

Demonstrate core values
Lead by example
Self-management
Emotional intelligence

Leading others:

Communicate effectively
Developed others
Value diversity and difference
Build and maintain relationships
Manage teams and work groups

(Society for Human Resources Management, 2008)

Notes

Competency Alignment

Complete Leadership Initial CBO

Complete Nurse Manager Skills Inventory

Role Identification

	Who	When	Where
Assistant Nurse Manager			
Leadership Practice Council			
Nurse Executive Council			
Committees			
_____			
_____			
_____			
_____			

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Recommendations

What are your recommendations to move forward?

Quick Notes

In the absence of an incumbent, develop an action plan based on your assessment.

Strategies could include:

- Staff survey
- Conduct a SWOT
- Seek out a mentor
- Review regulations
- Do not make any immediate change unless necessary
- Conduct a needs assessment
- Collaborate with colleagues from other departments

Recommendations
Training needs assessment
Initial –Strengths, Weakness Opportunity & Threats
Annual-process reviews and feedback assessments
Ongoing-staff recognition & feedback


Leadership is not about the size of your ego, it about your ability to respect the people you follow and inspire those who follow you.