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Leadership among Directors of Social Services at Rehabilitative Healthcare Chains

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Walden University
2017

Abstract

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John Paul T. Abenojar

MSW, University of Michigan, 2005

BS, San Diego State University, 2003

Dissertation Submitted in Partial Fulfillment

of the Requirements for the Degree of

Doctor of Philosophy

Healthcare Administration

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Abstract

Rehabilitation and healthcare centers (RHCs) provide ongoing care to the elderly and chronically ill. To maximize the quality of this care, RHC staff must be properly trained to respond to patient care crises and communicate across departments. Although researchers have studied the leadership styles, strategies, and interactions of facility administrators and nursing directors, there is a substantial gap in the literature on the leadership styles and strategies employed by directors of social services (DSSs). The aim of this phenomenological study was to address this gap in the research by exploring how DSSs influenced leadership policies, prepared subordinates for crisis intervention and management, perceived that social workers influenced decision-making in patient care, and believed that communication amongst RHC staff about patient care could be improved. The conceptual framework for this study was based on 3 leadership model constructs: the multilevel leadership model construct, the situational leadership model construct, and the complex adaptive leadership model construct. Participants included a purposive sample of 10 DSSs working in large, corporate RHCs in Virginia. Data were collected via in-person, semistructured interviews consisting of open-ended questions. Data were analyzed via Hycner's phenomenological approach. Findings from this investigation helped clarify roles and responsibilities of DSSs, thereby improving the leadership they provide to subordinate social workers. Findings may be used to improve communication across professionals within RHCs and emphasize the important role that social workers should play in patient care decisions.

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Dedication

I dedicate my dissertation to all the social workers around the country who work with elderly populations, as well as all the seniors I have met and who taught me valuable life lessons.

I also dedicate this work to the People of Barrio Napo.

A special feeling of gratitude to my late and loving grandparents, Tomas and Pilar, for watching and guiding me from above throughout this journey. I also dedicate this dissertation work to my greatest mentors, the late Dr. Riz Oades, who served as my first mentor. To Dr. Isidro Ortiz for believing in me and for always being there to guide me and encourage me along the way. To Veronica Bejar, who introduced me to the McNair Scholars program, which helped convince me to pursue my doctoral degree, no matter what it took. And lastly, to the love of my life, Eugene S. Bebis, for always being there for me and for inspiring me.

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Lastly, to God be the Glory

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Chapter 1: Introduction

Introduction

Rehabilitation and healthcare centers (RHCs), also known as nursing homes, are facilities that provide ongoing or transitional care to the elderly and chronically ill. To maximize the quality of care, it is essential that RHCs are properly led, trained to respond to patient care crises, and able to communicate across departments within the RHC. Social workers play an important role in patient care at RHCs, but these facilities have a difficult time retaining social workers. The problem in this study involves the leadership provided by directors of social services (DSS) and turnover among RHC social workers. Because research indicates that employee turnover often correlates with the support and direction provided by leaders, it is possible that turnover among RHC social workers is associated with the leadership in large RHC settings. Although researchers have studied the leadership styles, strategies, and interactions of facility administrators and directors of nursing (DONs), a substantial gap exists in the literature regarding the specific leadership styles and strategies employed by DSSs (Aberdeen & Angus, 2005; Joel & Sibille, 2013).

The aim of this study was to address a gap in the research by exploring how DSSs (a) influenced leadership policies, (b) prepared subordinates for crisis intervention and management, (c) perceived that social workers influenced decision-making in patient care, and (d) believed that communication amongst RHC staff about patient care could be improved. In this chapter, I introduce and contextualize the current research. I cover the

problem, purpose, research questions, framework, and nature. I also discuss key terms, assumptions, delimitations, and limitations and implications for social change.

Background

RHCs have live-in residents and a staff of professional caregivers overseen by facility administrators (FAs), (DONs), and (DSSs). RHC staff typically manage the constant healthcare routines of the physically disabled, psychologically unstable, and trauma-prone elderly (AHCA, 2012; Becker, Boaz, Demuth, & Andel, 2011). The daily schedules of RHC staff often include deadening hours of ennui interspersed with brief, all-consuming periods of intense stress related to crisis resolution (Hancock & Kreuger, 2010). This pattern is not unlike the periods of high stress in other performance-demanding environments, such as intensive care units, mental hospitals, or wartime military operations (Hancock & Kreuger, 2010). During crises that require measured, precise, and resourceful action and team coordination, performance is measure in fractions of a second, while preparation time may be drawn out over a period of years (Anderson, Toles, Corazzini, McDaniel, & Colón-Emeric, 2014). Thus, the preparation for crisis prevention and management that leaders provide to RHC staff is critical to the well-being of residents.

Crisis preparation can be challenging for social workers due to a number of factors typical of large RHCs, such as heavy caseloads, administrative duties, difficult clients, and inadequate staff (Bonifas, 2011a; Center for Workforce Studies, 2006). In addition, research indicates inadequate autonomy and poor levels of administrative support can increase stress levels among them in RHCs (Kim & Stoner, 2008; Simons &

Jankowski, 2008). For example, burnout and turnover among RHC social workers related to stress, conflict, ambiguity, and overload can create substantial challenges for DSSs (Kim & Stoner, 2008; Lambert, Cluse-Tolar, Pasupuleti, Prior, & Allen, 2012; Rai, 2013). According to the American Health Care Association (AHCA, 2011), DSS turnover rates in the United States are as high as 74%, which is nearly three times higher than the 27.3% nationwide average turnover rate for all social service professionals (AHCA, 2011).

While several researchers have studied the leadership styles and strategies of facility administrators, DONs, and their interactions (Anderson et al, 2014; Castle, 2008; Donoghue & Castle, 2009; Kruzich, 2005; Molinari, Hedgecock, Branch, Brown, & Hyer, 2009), there is a substantial gap in the literature on the roles and practices of DSSs within an RHC. Little is known about how DSSs (a) influenced leadership policies, (b) prepared subordinates for crisis intervention and management, (c) perceived that social workers influenced decision-making in patient care, and (d) believed that communication amongst RHC staff about patient care could be improved.

Problem Statement

The care for RHC patients is complex and requires the collaboration of a multidisciplinary team of healthcare professionals due to multimorbid, chronic conditions (Tenetti, Fried, & Boyd, 2012). RHC staff, including doctors, nurses, and social workers, must collaborate to provide patient care, prepare for crisis, and act during a crisis. A significant hurdle in the efficient orchestration of communication and care among RHC staff is fragmentation within RHCs and the larger healthcare system due to bureaucracy,

organizational hierarchies, and emphasis on patients' discrete health conditions over their holistic health. Such fragmentation can stifle staff communication, interdependence, relational coordination, decision-making, and care outcomes (Toles & Anderson, 2011).

Communication between RHC staff is also necessary to holistically address patients' physical, psychological, and social needs. Typically, doctors and nurses at RHCs focus on patients' physical health; however, neglected social and psychological factors can lead to deterioration in patients' mental and emotional health. Thus, it is important that RHC patients receive holistic treatment, including the services provided by social work professionals. Interdisciplinary communication between RHC healthcare professionals should integrate the input and recommendations of social work professionals.

Social workers play an important role in patient care, but RHCs have a difficult time retaining them. The problem of the current study is associated with DSS leadership and the turnover of RHC social workers. These elevated turnover rates correlate with a variety of factors, including excessive workloads, high levels of professional stress due to patient crises, and lack of recognition. Because research indicated that turnover often relates to the support and direction provided by leaders, it is possible that turnover among RHC social workers relates to the leadership in large RHC settings. The complex care environments of RHCs requires leaders, including DSSs, to lead and prepare subordinates to work as part of an interdisciplinary team, and thus prepare them for the prevention and management of patient crises. Although previous researchers examined the leadership styles, strategies, and interactions of facility administrators and DONs (Anderson et al.,

2014; Castle, 2008; Donoghue & Castle, 2009; Molinari et al., 2009; Kruzich, 2005), a substantial gap existed in the literature on the specific leadership styles and strategies employed by DSSs (Aberdeen & Angus, 2005; Joel & Sibille, 2013).

Purpose of the Study

The purpose of this phenomenology was to explore DSS leadership at large, corporate RHCs in Virginia. Specifically, I examined how DSSs (a) influenced leadership policies, (a) influenced leadership policies, (b) prepared subordinates for crisis intervention and management, (c) perceived that social workers influenced decision-making in patient care, and (d) believed that communication amongst RHC staff about patient care could be improved. Results from this investigation provide insights to improve DSS leadership and reduce social worker turnover in RHCs.

Guiding Questions

RQ1. How do directors of social work at large corporate RHCs influence leadership policies at corporate, facility, and social service staff levels?

RQ2. How do directors of social work at large corporate RHCs prepare subordinate social workers for crises prevention and management using multilevel, situational, and complex adaptive leadership?

RQ3. Based on the experiences of directors of social work at large corporate RHCs, how do social work professionals influence decisions made regarding patient care and well-being?

RQ4. How do directors of social work at large corporate RHCs believe communication among all staff regarding patient care and well-being could be improved?

Conceptual Framework

The conceptual framework for this study was based on the following three leadership model constructs: (a) the multilevel leadership model construct (Hunt, 1991), (b) the situational leadership model construct (Hersey & Blanchard, 2007), and the complex adaptive leadership model construct (Uhl-bien & Marion, 2008). I chose these three because examples of each are found within large, corporate RHCs. In addition to these leadership models, each RHC organization executes three major leadership functions associated with these leadership models: (a) multilevel leadership (corporate governance, strategic planning, and human resources management), (b) situational leadership (caregiving, prevention, and management of anticipated crises), and (c) complex adaptive leadership (crisis management associated with patient injury and disease emergencies).

The multilevel leadership model (Hunt, 1991) is applicable to large hierarchical organizations with several levels of simultaneously operating leadership. This model covers a longer period, as leaders project different levels of leadership at different times. The model also covers many issues simultaneously – a feature referred to as a pluralist approach (Jacques & Clement, 1995). The focus of this study was the direct leadership level in which DSSs lead subordinate social workers influenced by the effects of the entire organization's leadership and decision-making complexity.

In the original model, situational leadership was depicted as a supervisory format between a leader and a subordinate, which varied according to subordinates' education

and experience. The highest degree of structuring was necessary for the lowest level of subordinates in a "telling" style of supervision; one rung up from that would be a "selling" style; another rung up would be a "participating" style; and finally one rung up from that would be a "delegation" style (Thompson & Vecchio, 2009, p. 837). Supervisors who demonstrate delegation styles exert greater control over subordinates who are less mature in terms of commitment, competence, and self-direction. As subordinates mature, they require less control of supervisors until reaching the point of self-direction and autonomy.

The third component of the conceptual framework for this study was the complex adaptive leadership model. This approach conceives of leadership as an emergent phenomenon of a dynamic system of agents that interact with each other in complex feedback networks. While traditional leadership theory focuses on the single charismatic leader, the complex adaptive leadership model focuses on the entire complex and adaptive system of an organization as the unit of analysis. Within the context of a bureaucratic organization, complexity theory includes three types of leadership roles: (a) adaptive, (b) administrative, and (c) enabling (Uhl-Bien & Marion, 2008). A complex-adaptive leader engages followers to work together toward creative solutions and strategies (Anderson et al., 2014).

Nature of the Study

While quantitative methods are appropriate for the collection, statistical analysis, and hypothesis testing of numerical data (Campbell, 2014; Hoe & Hoare, 2012), qualitative research allows for the in-depth exploration of a phenomenon. This study's

phenomenological design allowed me to identify, understand, and interpret data acquired from participant interviews (Anderson, 2010). Thus I explored DSSs' lived experiences relative to the research questions.

The goal of this research was to understand leadership, staff communication, crisis training, and social workers' roles in patient care decisions—all from the perspectives of DSSs who worked in large, corporate RHCs. When the research goal is to explore a phenomenon from participants' perspectives—focusing on their subjective experiences and interpretations of the world (Moustakas, 1994)—phenomenological designs are useful (Lapan, Quartaroli, & Riemer, 2012),

I selected a qualitative method for this research because I did not aim to test hypotheses or perform statistical tests on numerical data. Instead, I sought to perform an in-depth exploration of the lived experiences of DSSs employed by large, corporate RHCs. Because an understanding of DSSs' lived experiences was central to this study, phenomenology was the most appropriate design.

Phenomenological interviews give participants the chance to describe the phenomena of interest according to their unique perspectives (Converse, 2012). I collected data via in-person, semistructured interviews, consisting of open-ended questions. Participants included 10 DSSs who worked in large, corporate RHCs in Virginia. I recruited participants through the National Association of Social Workers (NASW). After obtaining the e-mail addresses of prospects, I e-mailed invitations to all members in Virginia (Appendix A). The e-mail contained study-related information, as well as my contact information in the event of questions. The following inclusion criteria

were stated in the invitation. Each candidate had to (a) be currently employed, full-time, as a DSS at a state-licensed RHC that qualifies for Medicare and Medicaid, and which has consistently had more than 120 beds for at least 5 years; (b) have at least a bachelor's degree in social work from an accredited school; (c) be licensed in the Virginia; (c) have at least 2 years of full-time experience at their current facility; and (d) be responsible for at least two full-time subordinate social workers. I invited eligible individuals to contact me to schedule in-person interviews, which were predicted to last no longer than 60 minutes. I conducted interviews in quiet, private locations convenient to participants, such as local public libraries. Interviews were not conducted at participants' places of employment.

Prior to the interviews, I reviewed the study purpose, obtained informed consent, and allowed participants to ask any study-related questions. Interviews were audio-recorded and transcribed. I used NVivo 11 to help organize the data and then followed Hycner's (1999) approach to phenomenological analysis.

Definitions

Complex adaptive systems. Complex adaptive systems are non-linear systems with diverse interactive agents (people) who are capable of mutually adjusting to changing internal and external influences in order to produce different outcomes (Anderson et al., 2014; Anderson, Issel, & McDaniel, 2003).

Context-specific leadership. This type of leadership functions in specific organizational environments with unique characteristics, such as skilled nursing home facilities in the United States (Blair & Hunt, 1986).

Crises intervention leadership. Crisis intervention leadership is a situational construct consisting of leadership styles initiated by DSSs, social workers, or groups of social workers to inspire or direct interventions by other social workers individually or in teams to remedy, mitigate and/or stabilize nursing home residents who experience cognitive and/or behavior psychosocial, physical, or psychosocial/physical emergency crises or trauma while living in skilled nursing home facilities (Anderson et al., 2014).

Developing crises leadership. Similar to crises intervention leadership, developing crises leadership is a situational construct consisting of leadership styles initiated to inspire or direct interventions by social workers individually or in teams to observe, track, or monitor psychosocial, physical, cognitive, behavioral, or chronic disease developments among nursing home residents prior to a psychosocial or physical emergency crises or trauma, to prevent or develop staff readiness for its imminent occurrence (Anderson et al., 2014).

Local interaction strategies. Local interaction strategies refers to interaction strategies between staff and leaders. Strategies may be positive, such as offering enthusiasm or praise, or negative, such as passing the blame or refusing to collaborate (Anderson, et al., 2014).

Multilevel leadership. Multilevel leadership describes that exerted in large bureaucratic organizations such as the U. S. military, large government departments, large corporations, large hospitals, and large RHCs. In such organizations, a stratum of leadership exists, each connected to a unique organizational culture (Wong, Bliese, & McGurk, 2003). Hunt (1991) developed a context-specific, multilevel leadership model

for large organizations, such as the military or healthcare organizations, in which many subordinates of a hierarchical organization operate simultaneously.

Psychosocial care services. Psychosocial care services describe the tasks in which social services practitioners engage, such as care planning, individual assessment, or individual and group counseling (Bonifas, 2011a).

Routine management leadership. Routine management leadership is a situational construct consisting of a leadership style or styles initiated to inspire or direct the routine completion of normal functional rounds tending to the needs of a nursing home resident or residents by individual social workers or those organized in teams (Kelly et al., 2010).

Situational leadership. Situational leadership is operationally defined as supervision styles prescribed for varying levels of subordinate readiness, flexibility, and competence with regard to the amount of task structuring required (Blanchard, Zigami, & Nelson, 1993). This kind of leadership has been overlaid upon the uncertain circumstances and outcomes found in RHCs set off by psychosocial behaviors, physical conditions, or cognitive phenomena of RHC residents (Kelly et al., 2010).

Relational coordination. Relational coordination describes actions taken by those who manage the interdependence between tasks and people, or the relational dynamics of coordinating work to facilitate task integration (Gittell, Weinberg, Pffferle, & Bishop, 2008).

Shared governance leadership. This type of leadership is exerted at the point-of-service (Porter-O'Grady, 1991, 1997) and found in the work-based-learning approaches

of action research, but considered an alternative to "entrenched hierarchical management structures" (Williamson, 2005, p. 491).

Assumptions

In this study, I first assumed that all participants met the study's inclusion criteria. Because I did not validate their employment or experience, I relied on their self-reported credentials. I also assumed the interview questions I asked were appropriate for gathering the data needed to answer the research questions. To ensure this, I had the interview protocol validated by a panel of two subject matter experts. Finally, I assumed that all participants had the mental capacity to answer interview questions and to respond openly and honestly. To encourage forthcoming responses, I protected the identities of all participants.

Scope and Delimitations

I targeted the study sample of DSSs using inclusion criteria. It is unlikely to find DSSs with subordinates in RHC facilities with fewer than 120 beds because smaller facilities require fewer social workers. Thus, the largest facilities would have the most variation in DSS leadership functions and challenges. Also, I purposively selected participants from the population of DSSs located near my home in Virginia, which has 187 for-profit RHC facilities (Nursing Home Compendium, 2013). The conceptual framework was confined to my selection of leadership constructs.

Limitations

The current study had a couple of limitations. First, the geography was limited. Although the goal of qualitative research is not generalizability, results from this study

are not applicable to any other populations of DSSs. The small sample size was also a limitation. Because the majority of RHCs have less than 120 beds, and DSSs are rarely employed full time in facilities with fewer than 120 beds, the population of DSSs in the geographic range of this investigation was small. Finally, due to the heavy workloads of full-time DSSs, it was difficult for prospective participants to find time to participate. To limit inconvenience, I conducted interviews on the weekends, when participants were free of work-related responsibilities.

Significance of the Study

The current study has significant, positive implications. First, the results are expected to help clarify the roles and responsibilities of DSSs, and thus improve the leadership they provide to subordinate social workers; ultimately, this would increase the quality of care provided to patients. By improving the leadership and direction provided to social workers, the high turnover rates among them may be reduced in RHCs. Because turnover can disrupt the quality and continuity of patient care, reducing social worker turnover is important for providing the best care to RHC residents. Results from this investigation may also improve communication among RHC professionals and provide recognition for the important role that social workers should play in patient care decisions.

Summary

RHCs provide critical care to individuals who need ongoing, managed healthcare. Workers in these facilities provide care and supervision to the elderly, as well as those with chronic health conditions. In order to maximize the quality of care, it is essential that

RHC staff are properly led, trained to respond to patient care crises, and can communicate across departments. Because the turnover rate among RHC social workers is particularly high, research into the leadership strategies and behaviors among DSSs is needed. Although researchers have extensively studied the leadership styles, strategies, and interactions of facility administrators and DONs, there is a substantial gap in the literature on the leadership styles and strategies employed by DSSs. I address this gap in the literature by exploring how DSSs (a) influenced leadership policies, (b) prepared subordinates for crisis intervention and management, (c) perceived that social workers influenced decision-making in patient care, and (d) believed that communication amongst RHC staff about patient care could be improved. Results from this investigation are expected to provide insights to improve DSS leadership and reduce social worker turnover in RHCs.

Chapter 2 presents a detailed investigation and synthesis of the existing body of research on social workers, DSSs, RHCs, and leadership. Chapter 3 provides a discussion of the methodology; the results are presented in Chapter 4. Chapter 5 includes a discussion of study results, implications, and recommendations.

Chapter 2: Literature Review

Introduction

Healthcare leadership in large corporate nursing homes (NHs), also known as rehabilitation and healthcare centers (RHCs), is often suboptimal due to poor staff communication, lack of staff interdependence, ineffective leadership practices, and organizational structure (Swagerty, Lee, Smith, & Taunton, 2005; Toles & Anderson 2011). For chronically ill patients whose conditions require coordinated management and treatment, leadership practices that are fragmented, uncoordinated, and bureaucratic can inhibit the quality of care they receive (Colón-Emeric et al., 2006; Kontos, Miller, & Mitchell, 2010; McDaniel & Driebe, 2001). Poor RHC leadership can also lead to poor healthcare outcomes (White-Chu, Graves, Godfrey, Bonner, & Sloane, 2009).

Although substantial literature exists on RHC leadership, it is disproportionately focused on nursing home administrators and staff (Anderson et al., 2014; Castle, 2008; Donoghue & Castle, 2009; Molinari et al., 2009; Kruzich, 2005), which is likely due to the small number of RHCs that employ social workers. Typically, DSS leadership only exists in large RHCs because of Federal law 42 CFR 483.15. Also known as the Nursing Home Reform Act of 1987, this law requires RHCs to staff at least one social worker for every 120 facility beds in order to provide social services that optimize residents' well-being (Bonifas, 2009; CMS, 2013; DHHS, 2013; Fort Cowles, 2003; SWPI, 2010). Only 25% of RHCs in the United States have more than 100 beds, and only 15% of social workers in all RHC facilities nationwide receive clinical supervision by a DSS (Harris-Kojetin, Sengupta, Park-Lee, & Valverde, 2013; SWPI, 2010; Zhang, Gammonley, Paek,

& Frahm, 2009). Because social workers comprise less than 5% of all RHC staff, RHC administrators and nurses in leadership positions supervise most social workers, rather than dedicated DSSs (Bonifas, 2009; Harris-Kojetin et al., 2013; SWPI, 2010).

Researchers have studied the leadership styles and strategies of RHC facility administrators and directors of nursing (DONs), as well as interactions between these two types of leaders (Anderson et al., 2014; Castle, 2008; Donoghue & Castle, 2009; Kruzich, 2005; Molinari et al., 2009). However, a substantial gap exists in the literature regarding the specific leadership styles and strategies of DSSs (Aberdeen & Angus, 2005; Joel & Sibill, 2013). The DSS occupies a leadership role that fulfills multilevel leadership requirements of the corporation and facility, including management of the facility's social services staff. Thus, the aim of this phenomenological study was to explore the leadership strategies employed by DSSs in large, corporate RHCs in the United States. Specifically, I explored how DSSs (a) influenced leadership policies, (b) prepared subordinates for crisis intervention and management, (c) perceived that social workers influenced decision-making in patient care, and (d) believed that communication amongst RHC staff about patient care could be improved. In the context of the RHC, I explored three situational constructs of DSSs: (a) multilevel leadership of routine management, (b) situational leadership of developing crises, and (c) complex adaptive leadership of psychosocial crises intervention.

The aim of this chapter is to provide a comprehensive analysis and synthesis of the existing body of literature on leadership and social workers in RHCs. It begins with a description of the literature search strategy, followed by a discussion of the study's

conceptual framework. I then review relevant studies on RHC leadership and social work. Non-traditional, non-generic, and context-specific leadership models are distinguished from context-free leadership theories that are described more generally. I provide detailed descriptions of the roles, missions, and medical models of RHCs, including (a) the organizational models of privately owned chain RHCs and resident growth trends, (b) staff functions and functional models within RHCs, (c) conceptual background of leadership styles, (d) alternative leadership styles within RHCs, and (e) supervisor–subordinate relationships and staff turnover trends.

Literature Search Strategy

To begin the literature search, I developed a list of key words for relevant search topics (Table 1), which generated 165 peer-reviewed articles. Several databases were accessed to mine articles: PsychINFO, PsychARTICLES, Business Source Complete (), (CINAHL), Digital Commons Network (DCN), (ERIC), MEDLINE, Google Scholar (), Science Direct (), Social Sciences Citation Index (SCSI), and Sociology Research Database (). The initial search resulted in very little on the lived experiences of DSSs, and no articles on the following three categorical situations within corporate RHCs: (a) multilevel leadership of routine management, (b) situational leadership of developing crises, and (c) complex adaptive leadership of psychosocial crises intervention. Thus, I expanded the scope of my search terms, as depicted in Table 1.

The leadership of DSSs in the context of RHCs is a multi- and interdisciplinary activity affecting a wide range of disciplines and professions, such as leadership in business administration, public administration, public health, healthcare, medicine,

nursing, gerontology, science, social work, psychology, sociology, and education. I located relevant articles in specialized databases and organized an annotated bibliography by subcategory to develop the chapter. Themes and connections became apparent as I placed more articles into this structure.

Leadership Studies

In general, two broad categories of leadership studies emerged from the search: context-free and context-specific. *Context-free* leadership is a hypothetical and generic category that includes a wide variety of leadership styles free of specific situations, objectives, and organizational contexts (Blair & Hunt, 1986). Typically, the objective of researchers who study this type of leadership is to understand motivational incentives, command and control leadership, and implement broad, strategic planning. Leadership styles in this category include laissez-faire, transactional, transformational, authentic, and servant. A description of these well-known, context-free leadership styles are described in the following section.

Table 1

Search Topic Categories and Key Words

Search Topics	Keywords
Leadership	
Context-specific	leadership, military, strategic leadership, Army, transformational, joint
Complex relationships	interdisciplinary teams; intervention research, nursing home residents; management, nursing research, staffing, environmental change, manager tenure; nursing homes, management, staff interactions, complexity science, case study, resident outcomes; social work, palliative care, interprofessional collaboration, healthcare teamwork; coordinating mechanisms, boundary spanners, routines, relational coordination, input uncertainty, performance; nursing homes, nursing management, complexity, outcomes, staff relationships.
Distributed	empowering action research, evaluation, leadership development, shared governance, work-based learning
DSS	directors of social work, nursing homes; long-term care, psychosocial, social services, social work, staffing ratios; quantitative, elder abuse and neglect, long-term care, social services; hospital, managed care, models of supervision, organizational restructuring; social environment, administration, human resources, social work, nursing facility; history, inter-professional teamwork, leadership, sociology, ream collaboration; nursing homes; professional qualifications, professionalism, social service directors
Situational	situational leadership, nursing homes
Nursing home issues	
Environment	nursing home care, work organization, regulation, quality, violence, epistemology; culture change, resident-centered care, person-centered care, long-term care, nursing home, medical model, certified medical director
Organization	nursing homes, closures, newspaper
Operations	long term care nursing home, elderly, emergency, transitional care, collaboration, transfers; nursing homes, survey, administrators, mental health services; nursing homes, nurses, geriatric nursing, nursing personnel, nursing staff, homes for the aged, health knowledge, attitudes, practice, hospital emergency service, preventable hospitalizations, transfers, hospital avoidance
Staffing	for profit organizations, job attitudes, nonprofit organizations, nursing homes, sectoral differences, value congruence
Social workers	conflict, social workers, nursing homes
Nursing home residents	
Characteristics	nursing home, end-of-life, length of stay, palliative care, advance care planning; social construction, nursing home, long-term care, dying, end-of-life, hospice, secondary analysis, qualitative research
Quality of care	long-term care, work organization, front line workers, health care; nursing homes, elderly, quality of life; end-of-life care, long-term care, structure/process/outcome model, nursing homes, assisted living/residential care; nursing leadership, patient outcomes, systematic review; dementia, structures, processes; nursing homes; residential care/assisted living; systematic review; nursing homes, elderly, quality of life

Context-Free Leadership

Following Taylor's (1911) empirical studies of scientific management in the late 19th and early 20th centuries, early leadership research distinguished between laissez-faire and transactional styles of leadership (Lewin & Lippit, 1938; Lewin, Lippit, & White, 1939). Scholars later developed new lines of investigation by proposing transformational leadership as a more effective style of multi-factor leadership in innovative enterprises that benefitted from creative engagement with followers (Avolio, Bass, & Jung, 1995; Bass, 1985, 1990; Bass & Avolio, 1993; Bass & Steidlmeier, 1999; Bennis & Nanus, 1985; Burns, 1978, 1993; Howell & Shamir, 2005; Nahavandi, 1997; Stacey, 1996; Yukl, 1989, 1999, 2006; Yukl & Van Fleet, 1992). Other scholars developed theoretical offshoots of transformational leadership, such as servant leadership (Greenleaf, 1991).

More recently, researchers investigated qualities related to effective leadership, such as authenticity (Avolio & Chan, 2008; Avolio, Walumba, & Weber, 2009; Bass and Steidlmeier, 1999; Luthans & Avolio, 2003; Swann, Chang-Schneider, & McClarty, 2007; Walumba, Avolio, Gardner, Wernsing, & Peterson. 2008) and emotional intelligence (Goleman, 1995, 1998, 2013; Goleman, Boyantis, & McKee, 2013) as critical to understanding the making of transformational leaders. A description of each of the major leadership styles follows.

Laissez-faire leadership. Laissez-faire leadership is a passive leadership style, known as leading without leading (Hinkin & Schriesheim, 2008). These leaders are often avoidant and non-confrontational, and the style of laissez-faire leadership is often

considered detrimental to organizations (Judge & Piccolo, 2004). Lewin and associates (Lewin & Lippit, 1938; Lewin et al., 1939) were the first behavioral psychologists to label a particular style of leadership as laissez-faire. The researchers contrasted laissez-faire leadership with democratic and autocratic styles. Even in this early stage of leadership research, laissez-faire leadership was associated with suboptimal outcomes. Lewin and colleagues claimed that democratic leaders inspired cohesiveness, while autocrats produced overly submissive followers. Consequently, the scholars disparaged laissez-faire leadership for providing little guidance or feedback to followers in the form of evaluation. Lewin and Lippit (1938) claimed that the absence of active, hands-on leadership led to disorganization and lack of group direction.

Transactional leadership. Later leadership theorists contrasted laissez-faire leadership with transactional leadership, which uses a carrot-and-stick approach to organizing and directing followers (Bass, 1985). The transactional leadership model includes the following four elements, considered the cornerstones of effective management: (a) clearly stated goals and objectives, (b) clearly specified behaviors that followers can use to achieve these goals, (c) active monitoring of the group, and (d) positive and negative feedback to enforce compliance (Nahavandi, 1997). The basis of transactional leadership is the concept of contingent rewards for successful completion of tasks assigned by management (Bass, Avolio, Jung, & Berson, 2003). Transactional leaders provide followers with clear instructions on what they must do to achieve organizational objectives. The leader then takes steps to reward followers when tasks are effectively accomplished (Bass et al., 2003).

Transformational leadership. Burns (1978) and Bass (1985) developed the model of transformational leadership as an improvement to transactional leadership. Transformational leaders are charismatic, visionary, and inspirational leaders who appeal to followers' ideals and higher-order values, such as self-actualization or community service, rather than simple exchanges of benefits for performance (Bass, 1985). Burns (1978) contrasted transactional and transformational leadership by asserting that transactional analysis focuses on the relationship between leaders and followers, and the methods leaders deploy to motivate followers; whereas transformational leaders engage with followers on a more inspirational level, emphasizing higher, mutually held ideals.

Burns (1978, 1993) was the first to shift the focus of leadership studies from the habits and strategies that managers use to motivate others to the personal qualities of remarkable, transformational individuals. Burns (1978) also broadened the scope of leadership studies to consider new types of interactions between leaders and followers. Burns conceptualized the transformational leader as a visionary who raises a group to a higher level of achievement by inspiring followers to innovate, think outside the box, and go beyond the merely efficient accomplishment of tasks assigned to them. Some scholars criticized the theory for being overly idealistic and failing to consider how transformational leaders might function in the context of conservative organizations with teams of more pragmatic, less enlightened leaders (Bennis, 1959; Gronn, 1996, 2002; Lee, 2014; Leithwood & Jantzi, 2000).

Bass (1985) expanded upon Burns' transformational leadership theory and developed the Multifactor Leadership Questionnaire (MLQ), an instrument for assessing

transformative leadership factors. Bass attempted to define the psychological traits that enable transformational leaders to alter the values and aspirations of followers. The MLQ measures passive and active characteristics of leaders who inspire followers to emulate them. The MLQ has been widely adopted by other researchers (Bass et al., 2003).

Authentic leadership. Bass and Steidlmeier (1999) opened a new line of research within the study of transformational leadership when they made a distinction between the *pseudo* and the *authentic* transformational leaders. Authentic transformational leaders are those who use their influence to empower followers, while pseudo transformational leaders use their influence for self-gain. Luthans and Avolio (2003) further developed the theory of authentic leadership, contrasting the deficit-reduction model that dominated leadership studies with the broaden-and-build model, adapted from Fredrickson's (2001) work in positive psychology. The deficit-reduction approach to management sought to discover what a leader was doing wrong and make corrections, while the broaden-and-build strategy sought to nurture existing competencies and to develop new ones (Luthans & Avolio, 2003).

Swann et al. (2007) investigated whether someone described by followers as an authentic leader had a different working self-concept as transformational or transactional. Building on this research, Avolio and Chan (2008) showed that a leader's self-concept was not necessarily fixed or stable, but could be influenced by events and experiences. Other psychological studies indicated that training exercises and self-reflection can manipulate trigger events that promote positive self-image (Roberts, Dutton, Spreitzer, Heaphy, & Quinn, 2005). Along these lines, Luthans and Avolio (2003) made the case

that the goal of research into authentic leadership should be to foster “positive self-development” that resulted “in both greater self-awareness and self-regulated positive behaviors” (p. 243) in leaders and their associates. Walumbwa et al. (2008) operationally defined four critical components of authentic leadership scales found to be statistically reliable, including balanced processing, internalized moral perspective, relational transparency, and self-awareness. Walumbwa et al. asserted that self-awareness entailed a realistic assessment of one's personal strengths and weaknesses.

Servant leadership. Greenleaf (1991) proposed a model of empathetic and emotionally attuned leaders, which he referred to as *servant leaders*. The servant leader embodies such virtues as listening, empathy, trustworthiness, service orientation, and community building (Spears, 2004). In an overview and critique of Greenleaf's research, Smith (2005) concluded that servant style leadership was particularly well suited to the information services arena. Russell and Stone (2002) surveyed the literature on servant leadership and found that empathetic and emotionally intelligent leadership was positively correlated with job satisfaction, caring for others, and organizational commitment. Subsequent research into the characteristics and effectiveness of transformational leaders must recognize the importance of emotional competencies (Yukl, 1999). However, leadership strategies that emphasize empathy and human connections over toughness and authoritarian rule may challenge common stereotypes of effective leadership.

Context-Specific Leadership Styles

In contrast to context-free leadership styles described above, which can be

generally applied to a variety of situations and individuals, context-specific leadership styles are applicable to the unique objectives and characteristics of specialized situations and organizations (Blair & Hunt, 1986). These kinds of organizations, such as those that manage healthcare, safety, and public sector subcategories, are among many unique sectors that practice context-specific leadership styles. Specific organizations in this subcategory include the U.S. military, State National Guard, DHS, FBI, CIA, ATF, CDC, DHHS, SAMHSA, FEMA, FAA, RHCs, local police, local fire departments, the VA, and all other hospitals.

The three types of context-specific leadership styles are multilevel, situational, and complex adaptive. Context-specific leadership situations include those that are uncertain, time pressured, and high stakes. The objectives of context-specific leadership include routine and crisis-ready management, the development of crisis management plans, and management during crisis (Hadley, Pittinsky, Sommer, & Zhu, 2011).

The scope of the current study was limited to context-specific leadership in large, corporate RHCs. Because only a small subset of existing research fit all of these descriptors, it was necessary to broaden the scope of this chapter to include other organizations that practice crisis management. In context-free leadership, there has been increased attention on emotional intelligence models of leadership, such as leaders' abilities to focus on themselves, others, and the wider world, while minimizing distractions and preconceptions (Goleman, 2013). In the multilevel, complex context of RHCs, these abilities could be critical.

Conceptual Framework

Traditionally, the focus of leadership research has been context-free leadership in wide array of organizational contexts (Blair & Hunt, 1986). Generic, context-free leadership as a field of study has its theoretical origins in the social sciences, including sociology, anthropology, psychology, the humanities, history, and philosophy. The practical implications of context-free leadership studies are relevant to applied professional fields, such as business management and public administration (Blair & Hunt, 1986).

Nahavandi (1997) discussed context-free leadership as having three basic categories, including interpersonal influence, goal orientation, and hierarchical organization. The *interpersonal* aspect of leadership follows from the complementary status of leaders and followers. That is, for there to be leaders, there must be followers. Since a leader's role is to persuade, inspire, or influence his or her followers, leadership must be *goal oriented* in that leaders direct their followers to achieve certain ends. Finally, the unequal status of leaders and followers defines the structure of any group with leaders as *hierarchical*, rather than communal or egalitarian.

In the burgeoning stages of evidence-based leadership research in the early 20th century, the primary focus was male leaders of large U.S. corporations (Avolio et al., 2009). As the century unfolded, context-free leadership theory developed in many different directions. Today, leadership studies have expanded not only to include a more professionally, ethnically, and culturally diverse set of leaders, but also to consider the characteristics of followers, diverse types of organizations, the interactive dynamics

between leaders and followers, and the cultural contexts in which leadership occurs (Avolio et al., 2009). The current study did not rest on this body of traditional leadership theory. Instead, it focused on the emerging concept of context-specific leadership.

While some context-specific leadership situations could hypothetically utilize generic, context-free leadership styles, RHC leadership requires leadership styles unique to this context. The single facility and department levels are where DSSs provide ongoing leadership. Because no formal leadership theories exist for the context-specific leadership described in this study, I utilized the following three leadership model constructs: the multilevel leadership model construct, the situational leadership model construct, and the complex adaptive leadership model construct. All three models function simultaneously within large corporate RHCs.

The Multilevel Leadership Model Construct

Hunt (1991) developed a context-specific, multilevel leadership model that applies to large organizations, such as military or healthcare organizations, in which there are many subordinates in a hierarchical organization with several forms of leadership operating simultaneously. This context-specific leadership model built upon Jaques' (1989) theory of stratified systems. Context-specific leadership governs the behaviors of many instead of just those in a dyadic relationship. This model covers a longer period, as leaders project different levels of leadership at different times. The model also covers many issues simultaneously – a feature referred to as a pluralist approach that "seeks to avoid the objectivist-subjectivist extremes in dealing with underlying assumptions" (Jacques & Clement, 1995, p. 661). Wong et al. (2003) prepared a diagram of the

multilevel leadership model that illustrated hierarchical leadership within a military organization (Figure 1).

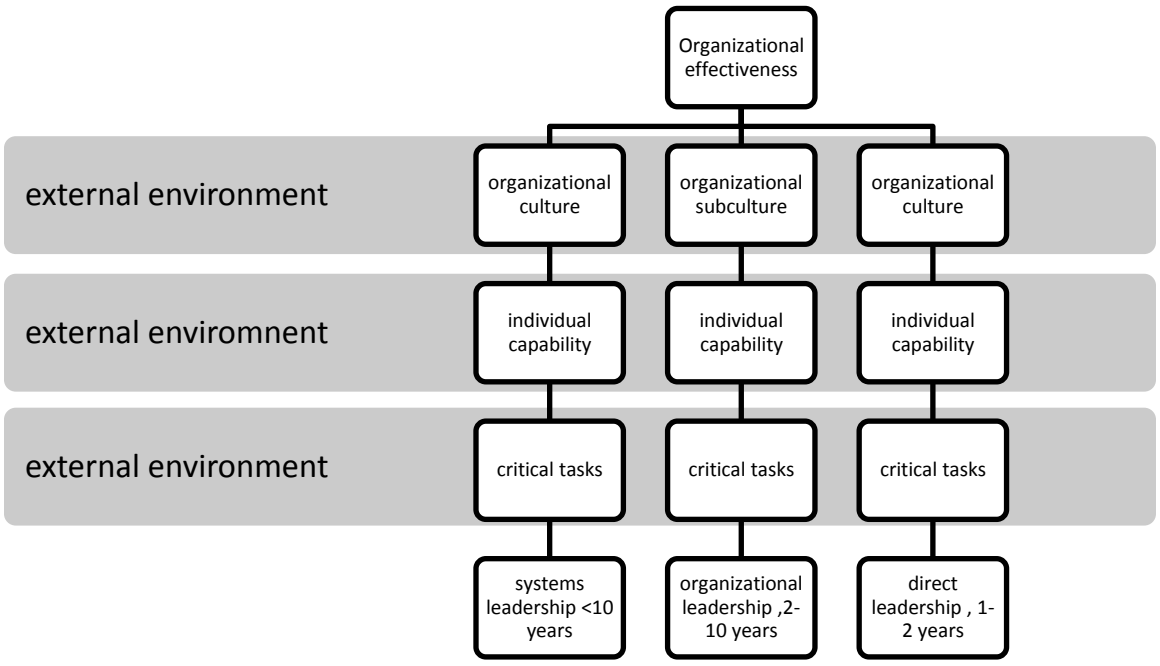

Figure 1. Multilevel leadership model. Adapted from Wong et al. (2003)

The organizational structure illustrated in Figure 1 is distinctly comparable to RHC facilities. There are three leadership levels in the multilevel model. The first level is the systems leadership model, which contains the highest level of leadership applicable to the entire organization. As applied to RHCs, this level includes top managers in the corporate headquarters of private sector RHCs, such as chief executive officers (CEO), chief operating officers (COO), and chief financial officers (CFO). The second level is organizational leadership, which is equivalent to the franchise-level managers of RHCs. Policies developed at this level have shorter periods and involve less complexity. The

third level is direct leadership, which correspond to managerial positions within RHCs, such as nursing managers and DSSs.

Critical tasks in the model reflect missions, strategies, and organizational design elements at each leadership level. *Individual capability* refers to the individual leader background factors, preferences, capabilities, and skills at each level. External environments (e.g., regional cultures) influence the organizational culture and subcultures of the organization and individual RHC facilities. In particular, the current study focused on the direct leadership level, in which DSSs exert leadership over subordinate social workers, who in turn, are influenced by the effects of the entire organization's leadership and decision-making complexity.

The Situational Leadership Model Construct

Hersey and Blanchard initially proposed a situational leadership theory (SLT) in 1969, which Blanchard revised in 2007 (Thompson & Vecchio, 2009). In the original model, SLT was depicted as a supervisory format between a leader and a subordinate that varied by the educational and experiential maturity of subordinates. The highest degree of structuring was necessary for the lowest level of subordinates in a "telling" style of supervision; one rung up from that would be a "selling" style; another rung up would be a "participating" style; and finally one rung up from that would be a "delegation" style (Thompson & Vecchio, 2009, p. 837). The entire gamut, from bottom to top, illustrates increasing "readiness for self-direction" (Thompson & Vecchio, 2009, p. 837). At the delegation level, the supervisory leader exerts greater control over subordinates who are less mature in terms of commitment, competence, and readiness for self-direction. As the

maturity of subordinates increases, the supervisory leader exerts less control until subordinates are completely self-directed and require minimal supervision.

Complex Adaptive Leadership Model Construct

A recent trend in leadership research incorporates concepts from complexity theory. This approach conceives of leadership as an emergent phenomenon of a dynamic system of agents that interact with each other in complex feedback networks. For example, Uhl-Bien and Marion (2008) relegated the top-down, bureaucratic paradigms of leadership to the last century. New forms of social organization, mediated by electronic communication networks, have enabled more adaptive and creative leader-follower relations, based on an interactive dynamic. Technological disruption of traditional communication systems has thus engendered more dynamic leadership styles, based upon rapid knowledge dissemination and feedback.

While traditional leadership theory focuses on the single charismatic leader, or perhaps the dyadic interaction between leaders and followers, complexity leadership theory focuses on the entire complex and adaptive system of an organization as the unit of analysis. Within the context of a bureaucratic organization, complexity theory includes three types of leadership roles: (a) adaptive, (b) administrative, and (c) enabling (Uhl-Bien & Marion, 2008). A complex-adaptive leader engages followers to work together toward creative solutions and strategies (Anderson et al., 2014). For example, Williamson (2005) described shared governance leadership for nursing leaders in training. Administrative leaders implement formal planning, according to established rules or organizational mandates, while enabling leaders try to minimize the constraints of

bureaucracy.

Rationale for Selection of these Models

The current study focused on the large corporate RHCs principally at the single facility and department levels where DSSs provide ongoing leadership in U.S. RHC facilities. For-profit RHC facilities comprise 69% of all ownership categories in the U.S., with nearly 11,000 facilities (CMS, 2013); facilities with over 100 beds comprise 50% of all 7,780 facilities (CMS, 2013). Most importantly, this facility type contains all three of the leadership models (multilevel, situational, and complex adaptive), which are continuously practiced within the corporate headquarters of an organization and each facility. In addition to these leadership models, each RHC organization executes three major leadership functions associated with these leadership models: (a) multilevel level leadership (corporate governance, strategic planning, and human resources management); (b) situational leadership (caregiving, prevention, and management of anticipated crisis); and (c) complex adaptive leadership (crisis management associated with patient injury and disease emergencies).

The current study was an exploration of context-specific leadership in which the unique functions of the particular organizational context of RHCs drive the kind of leadership that uniquely supports, enhances, and suits those functions. Post-acute health centers have a unique and highly specialized life-sustaining function that involves providing ongoing care to medically and cognitively fragile individuals. Many of these individuals have been discharged from hospitals and referred to RHCs with advanced

dementia and other life threatening chronic diseases, and require substantial medical care. A summary of the conceptual framework is provided in Table 2.

Table 2

Functions of Leadership Types in Rehabilitation Healthcare Centers

Context-specific leadership	Function
Multilevel leadership	Routine management: Caregiving services, medical coordination, and compliance with regulatory requirements, and provision of financial support
Situational leadership	Developing crises management: Medical and psychosocial caregiving, prevention, and management of anticipated crises situations – likely accidents and serious chronic disease symptoms characteristic of this cohort
Complex adaptive leadership	Crisis management: Associated with mitigation and recovery from patient injury and disease emergencies that commonly occur in this population

Key Variables and/or Concepts

This study contained constructs that pertain to the functions typically dealt with by the three context-specific leadership types focused on in this study. Crisis management is the predominant function that requires substantial leadership, given the health of most RHC residents and their high risks of injury or disease-related complications. Research on crises related to these functions tends to be broad and conceptual (Mitroff & Alpasian, 2004; Sweeny, 2008) or based on unique case studies of singular events, such as the results of medicolegal investigations of causes of death among RHC residents (Kennedy, Ibrahim, Bugeja, & Ranson, 2014). A few researchers

studied the type of crises most experienced in RHCs such as falls, cardiovascular problems, gastrointestinal problems, infections, and multimorbidity (Glover et al., 2014; Gudmannsdottir, & Halldorsdorsdottir, 2009; Kihlgren, Wimo, & Mamhidir, 2014; Tenetti et al., 2012). This literature was useful for presenting inclusive frameworks of crises management with emphasis on complex, adaptive, and situational leadership approaches (Anderson et al., 2014; Thompson et al., 2009). However, further research was needed to develop a better understanding of crisis leadership to facilitate the creation of interventions and protocols prior to the occurrence of crisis events. A description of the RHC context is described next.

The Routine Management Construct

Within the context of a bureaucratic organization, an administrative leader implements formal planning according to pre-established rules or the organization's mandate, as is characteristic of transactional leaders (Uhl-Bien & Marion, 2007). However, any of the leadership levels, especially the routine construct variable, may employ several different leadership styles applicable to the complex environments of RHC facilities. Goleman et al. (2004) described such leadership as follows: (a) a visionary leader, (b) a coaching leader, (c) an affiliative leader, (d) a democratic leader, (e) a pace-setting leader, or (f) a commanding leader.

The Developing Crisis Management Construct

Two groups of researchers wrote about the leadership styles applicable to this variable as has been previously described in this chapter: complex adaptive systems, complexity science, and local interaction strategies (Anderson et al., 2014); relational

coordination and task interdependence (Gittel, 2006; Gittel, et al., 2008); adaptive leadership engaging followers to work together toward creative solutions and strategies characteristic of transformational leaders (Anderson et al., 2003; Uhl-Bien & Marion, 2007; Williamson, 2005); situational leadership governing leadership style as a function of the maturity and educational sophistication of the subordinate vs. their direct supervisor (Hersey & Blanchard, 1972; Thompson et al., (2009); and situational leadership during quiet times (Hancock & Kreuger, 2010).

The Crisis Management Leadership Construct

A considerable amount has been written about RHC dynamics and effective leadership styles during crises in a variety of contexts. Here are some examples:

- The intensive care unit (ICU) of a busy hospital during acute care (Gittel, 2002; Young et al., 1998)
- An emergency care trauma unit crisis (Faraj & Xiao, 2006)
- Behind enemy lines during war (Hancock & Kreuger, 2010; Wong, 2003)
- In an unfolding disaster zone (Comfort, 2007; Waugh Jr., & Streib, 2006)
- During an airplane crash landing (Flin, O'Conner, & Mearns, 2002)
- In an orchestra of professionals playing a complex piece with split second "covert" coordination (Mintzberg, 1998)
- During crisis management, crises leadership, or relational coordination, as in the case of public health and safety crises such as infectious disease pandemics or terrorist acts (Gittell, 2006; Gittell et al. 2008; Hadley et al.,

2009)

Methodological Literature

I chose a qualitative empirical phenomenology for this study. This approach was useful for exploring the perceptions and experiences of DSSs in large, corporate RHCs. In addition, this in-depth approach was consistent with the research goal of exploring how DSSs (a) influenced leadership policies, (b) prepared subordinates for crisis intervention and management, (c) believed social workers influenced decision-making regarding patient care, and (d) believed communication amongst RHC staff regarding patient care could be improved. Qualitative phenomenology allows for deep, interactive dialogue through open-ended, semistructured interviews (Moustakas, 1994). This descriptive approach forms the basis of a "reflective structural analysis that portrays the essences of the experience" (Moustakas, 1994, p. 15). Two steps in this descriptive approach were the original descriptions acquired through open-ended questioning and a reflective analysis and interpretation of the underlying structures of the experiences in the context of the participant's description (Giorgi, 1985).

RHC Leadership

The leadership approaches of DSSs can vary significantly based on the staff-to-resident ratio at a particular RHC. In a study on multilevel factors related to psychosocial outcomes in RHC facilities (facility ownership type, ownership turnover, multifacility chain affiliation, facility size, facility location, and the size of social services professional's caseload) that included 121 DSSs, Bonifas (2011a) found that five factors were predictive of resident outcomes. These factors included (a) ownership turnover that

was inherently disruptive, (b) the RHC experiences of social work practitioners, (c) social work practitioner role identity, (d) the priority ascribed to residents' needs for individual care, and (e) balancing the time spent between psychosocial assessments and interventions. In another study on leadership of social workers, Holosko, (2009) found five core attributes of social work leadership, including vision, influence, collaboration, problem-solving skills, and creating positive change.

An increasing number of researchers have considered the context and leadership of RHCs, including its high rates of patients with multimorbidity, the need to redefine leadership to manage functional complexity and stressful periodic crises, and unique organizational functions of RHCs. Researchers have also placed increasing emphasis on relational coordination. Relational coordination describes the mutual understandings of work functions and context, principally determined by the effectiveness of communication between individuals and the "frequency, timeliness, accuracy, and focus on problem solving rather than blaming" of such communication (Gittell et al., 2008, p. 155). In a meta-analysis of 33 peer reviewed journal articles published between 2000 and 2010, Toles and Anderson (2011) found that relationship-oriented practices resulted in improved resident outcomes and employee job satisfaction. Gittell's et al. study of 15 RHC facilities in Massachusetts involved a cross-sectional sample of 252 nursing aides and 105 residents to explore the impact of relational coordination on resident quality of life outcomes. Relational coordination was particularly important in contexts with high levels of task interdependence, uncertainty, and timeliness that could lead to greater employee job satisfaction and resident quality of life. Functional interdependence is high

among RHC caregivers because resident care requires comprehensive skills in a wide variety of areas, and successful completion of any task depends upon the quality of other completed tasks as inputs. Aspects of successful relational coordination among RHC staff include frequent information exchange, problem-solving during crises, and feedback between interdependent staff. High quality relational coordination should increase caregivers' abilities to improvise and coordinate (Gittel et al., 2008).

The focus of the studies discussed in this section were macro or structural challenges faced by social workers, which are helpful for understanding the context and effect of DSS leadership efforts in RHCs. Social work, by its very nature, is best when provided in concert with other services such as nursing, medicine, or psychology. As such, supplemental studies that consider social workers' professional settings and the work they perform in those settings, are important.

Organizational Structure of RHCs

Increasingly, RHCs are privately-owned and operated with offsite, centralized management. Such remote management removes many of the middle management supervisory and leadership functions that can improve resident care. Despite criticism, most RHCs in the United States follow a hierarchical structure. The basis of this criticism is that top-down leadership produces inferior resident outcomes, fosters poor communication between staff, excludes staff from leadership participation, and increases staff turnover. In a case study of 19 staff members in a single RHC facility, Anderson et al. (2005) found that poor staff-to-staff connections limited management of care problems. In another case study of two RHC facilities, including seven medical staff and

119 nurses, Colón-Emeric et al. (2006) found open communication and leadership were related to greater information flow and creativity in problem solving, as compared with top-down leadership. Bakour (2006) found that top-down management styles in an RHC were associated with inferior resident care. Swagerty et al. (2005) found that passive communication among RHC staff related to poor collaboration and less detailed care planning. In a study of two RHC facilities, including nine managers and 26 nursing assistants, Kontos et al. (2010) found that the exclusion of nursing assistants from healthcare planning of residents correlated with generic care plans and poor resident care.

Researchers have also explored RHC leadership strategies for improving staff job satisfaction and resident outcomes. For example, in a study of staff members from 164 RHC facilities, Anderson et al. (2003) found that relationship-oriented leadership related to better resident outcomes in both developing crises and crises situations. In a study of 3,449 RHC staff members, Anderson et al. (2004) found a correlation between reward-focused leadership styles, open communication, and lower turnover among nurses and nursing assistants. In a study of three RHC facilities, 67 staff members, and 14 families, Scalzi, Evans, Barstow, and Hostvedt (2006) found that relationship-management styles and staff empowerment related to culture change in RHC facilities. Gittell et al. (2008) found that stronger relational coordination among RHC staff was associated with better staff satisfaction and resident quality of life.

Operations in RHC facilities are complex due to the end-of-life status and major multimorbidity among many patients (Bern-Klug et al., 2010; Glover, et al., 2014; Gudmannsdottir, & Halldorsdorsdottir, 2009; Kennedy et al., 2014; Tinetti et al., 2012;

Toles & Anderson, 2011). The inherent nature of this situation in multilevel RHCs demands unique leadership from RHC facility managers, including DSSs. RHC leadership requires nearly continuous monitoring and awareness of the status of fragile residents who require care from multidisciplinary teams. This type of leadership must also transcend traditional, context-free leadership, due to residents' specialized and life-threatening situations.

Among RHC leaders, DSSs have multilevel responsibilities that include routine administrative responsibilities, situational leadership in anticipation of crisis, and leadership during medical crises. Moreover, this leadership is relatively new and uncharted, gaining momentum from earlier research in only the past decade and a half. Many researchers (Anderson et al., 2003, 2004, 2005, 2014; Gittell, 2001, 2002; Gittel et al., 2006, 2007, 2008; Hancock & Kreuger, 2010; Toles et al., 2011; Wong, et al., 2003) contributed new key concepts to the literature, such as context-specific relational communication leadership, relational coordination leadership, complex-adaptive leadership, and multilevel leadership. Findings challenged those from previous researchers, such as Wong and Cummings (2007), who argued for the application of context-free traditional leadership formats such as transformational leadership to RHC leadership, and others (Goleman, 1995, 1998, 2013; Goleman et al., 2013) who argued for the use of multiple traditional leadership styles driven by the leadership concept of emotional intelligence.

Operational Characteristics of RHCs

Approximately 8 million individuals were served by 58,500 long-term RHCs in

2012 (see Table 3). These different types of facilities include skilled nursing homes, adult day service providers, home health agencies, hospices, and assisted living facilities. These various RHC facilities, run by voluntary religious, professional, civic, or proprietary private organizations, provide a variety of care levels. Private RHCs require large lump-sum payments, monthly rates, and provide guaranteed lifetime care. While most RHCs provide private care, they do so with public funding (Eaton, 2000). In 2009, $2.3 trillion was spent on personal healthcare in the United States (US Census, 2012). The percentage breakdown of these costs appears in Table 4.

Table 3

RHC Facility Type and Population Served

Facility type	Number of facilities	Percentage of total RHCs	Number of RHC residents served	Percentage of total RHC residents
Skilled nursing homes	15,795	27.0	1,383,700	17.0
Adult day service providers	4,680	8.0	273,000	3.0
Home health agencies	12,285	21.0	4,742,500	59.0
Hospice	3,510	6.0	1,244,500	16.0
Assisted living	12,285	21.0	713,300	9.0

Note. Adapted from "Long-term care services in the United States: 2013 overview," by Harris Kojetin, Sengupta, Park-Lee, and Valverde, 2013.

Table 4

Nursing Home Costs by Payment Source, 2009

Source of payment	Cost (%)
Medicaid	32.8
Out of pocket	29.1
Medicare	20.0
Other government	10.0
Private insurance	7.7

Source: U.S. Census (2012)

RHCS provide full-time medical and psychological support to many individuals during their senior retirement years. The majority of nursing home residents are female (70%), white, widowed, significantly advanced in age (83.2 years median age), and have multiple health issues (Salari & Chan, 2010; U.S. Census, 2014). RHCs provide practical care settings for those who have serious disabilities and chronic diseases, histories of developmental delays, and other serious medical and psychological conditions (Fort Cowles, 2003). RHCs provide residence to those who require constant nursing care due to physical and psychological impairments. Residents may need assistance with personal care activities of daily living (ADL), such as bathing, dressing, toileting, food preparation, and eating (Salari & Chan, 2013). Even without significant impairments, many elderly residents in their 80s and 90s are no longer be able to care for themselves. Some may not have family, friends, or volunteers to care for them. Additionally, they may not qualify for residency in RHCs or be unable to afford the costs of care (Fort Cowles, 2003).

Some RHCs have specialized populations, such as veteran's homes

disproportionately populated by males. Demands for such facilities are expected to grow as the population of aging veterans with long-term disabilities increases (Salari & Chan, 2013). Some RHCs only provide skilled nursing, while others are part of larger Continuing Café Retirement Communities (CCRC) also called Life Care Communities (LCC), which accommodate a variety of resident needs, including rehabilitation, respite, and hospice care (Salari & Chan, 2013). Population turnover in RHCs is high due to elevated mortality, discharge, and re-admission rates (Salari & Chan, 2013).

RHCs provide long-term care, and lengths of residents stays can range from a few months to permanent. In a study of 1,817 RHC residents, Kelly et al. (2010) reported that the median resident stay was 13.7 months. Among residents in the study, 53% died within 6 months of admission at a median age of 83.3 years.

As the aging sector of the U.S. population increases, demands for RHCs may increase. In 2010, the U.S. population included of 40.3 million seniors over 65 years of age, or approximately 13% of the U. S. population. This number is projected to increase by over 100% by 2050, to 83.7 million, or 20.9% of the U. S. population. In 2010, 21.7 million or 7% of the U.S. population was 65 to 74 years old; 13.1 million or 4.2% of the U.S. population was 75 to 84 years old; and 5.5 million or 1.8% of the population was 85 years or older (U.S. Census Bureau, 2014).

The number of RHCs by bed size categories is shown in Table 5. This means more than 50% of RHCs have no legal obligation to include any social workers on their full-time staff because federal rules only require the facilities to employ one full-time social worker for every 120 beds.

Table 5

Number of RHCs by Bed Size Category in the United States: 2012

Facility size by bed size category	Number of facilities	Percentage of all RHC facilities (%)
<50	2,042	13.0
50 – 99	5,740	37.0
100 – 199	6,912	44.0
>199	958	6.0
Total	15,562	100.0

Source: CMS (2013)

Table 6 shows the number of RHCs by ownership type. For-profit RHCs dominate in the marketplace. Many researchers have described for-profit RHCs as having lower quality service than public and non-profit facilities, due to focus on profits over care quality (Eaton, 2000; Fort Cowles, 2003; Harrington, Zimmerman, Karon, Robinson, & Beutel, 2000; Rantz et al., 1999; Robinson & Reeser, 2002). For example, Eaton (2000) found that a greater percentage of non-profit homes had high-quality services (89.6%, $p < .001$) while for-profit homes had a greater percentage of low-quality services (18.3%, $p < .001$).

Table 6

Number of RHCs by Ownership Type in the United States: 2012

Ownership type	Number of facilities	Percentage of all RHC facilities (%)
Government	915	6.0
Non-profit	3,912	25.0
For profit	10,825	69.0
Total	15,562	100.0

Note: Adapted from "Nursing Home Compendium, 2013 Edition," by Centers for Medicare and Medicaid Services, 2013, p. 13.

According to Eaton (2000), the distinguishing factors between service quality provided by for- and non-profit RHCs was not actually profit status, but management philosophy and work organization systems. Low service quality is often found in understaffed facilities, which also tend to have lower resident activity levels, less social engagement by residents, more quality deficiencies, less teamwork, less continuity of care, less information sharing, less gerontology training for all staff, lower pay, fewer benefits, and non-union conditions (Eaton, 2000). Other researchers disagreed with Eaton, associating for-profit status with poor care quality (Fort Cowles, 2003; Grabowski & Town, 2011; Grant, 2008; Kruzich, 2005; Pesis-Katz et al., 2013; Rantz et al., 1999; Werner, Stuart, & Polsky, 2010). Table 7 shows that most RHC facilities are currently certified for both Medicaid and Medicare, which are the two principal government programs for nursing home funding.

Table 7

Number of RHCs by Certification Type in the United States: 2012

Certification type	Number of facilities	Percentage of facilities (%)
Medicaid only	536,000	3.0
Medicare only	84,000	5.0
Dually Certified	14,332,000	92.0
Total	15,562,000	100.0

Note: Adapted from "Nursing Home Compendium, 2013 Edition," by Centers for Medicare and Medicaid Services, 2013, p. 14.

Table 8 shows the occupancy rate of the number of Medicare- and/or Medicaid certified beds. Occupancy rates of 80% or better on an annual basis are generally considered well occupied with allowances given for seasonally normal fluctuations. Total, or 100% occupancy, would show that no space is available for anyone new.

Table 8

Number of Medicare/Medicaid-Certified Beds in the United States: 2012

Certification type	Number of beds	Occupancy rate (%)
Not occupied	283	17.0
Occupied	1,383	83.0
Total	1,666	100.0

Note: Adapted from "Nursing Home Compendium, 2013 Edition," by Centers for Medicare and Medicaid Services, 2013, p. 15.

RHC Treatment Models

The principal treatment approach found in most RHCs has been termed the *medical model,* which describes emphasis on acute medical care, safety, uniformity, and hierarchal leadership (White-Chu et al., 2009). Fort Cowles (2003) described the medical

model setting as a hospital-like atmosphere that is "not homey," or "conducive to social interaction or personal empowerment" … or the kind of "whole person focus" implementing a biopsychosocial, interdisciplinary teamwork focus required by Medicare (p. 241). From an organizational perspective, many RHCs are substantially bureaucratic despite their small sizes. This bureaucratic effect on residents includes heavily mandated routines, schedules, rules, and chains of authority. The bureaucracy may be fostered by protocols and standards mandated by Medicare and Medicaid (Fort Cowles, 2003).

Fort Cowles (2003) wondered why the mental, emotional, and spiritual needs of people who reside in medical model facilities are often ignored. In recent years, many others questioned this and whether high levels of prescription drug use and shortened life expectancies were related to the unfriendly atmospheres or medical model facilities. In *A Life Worth Living*, physician William Thomas described an experiment he performed as medical director of Chase Memorial Nursing Home in upstate New York in 1991. The study included 80 significantly disabled elderly residents. Thomas changed the facility environment into one that was resident-centric, as distinguished from a classic medical model facility. The changes emphasized patient care and comfort through new policies that allowed plants and pets into the facility, eliminated severe regimentation, introduced freedom from eating and other living schedules based on nurses' convenience, and reorganized the facility to maximize patient convenience, privacy, entertainment, self-governance, and socialization. Thomas asserted that residents should be treated as consumers who deserve a meaningful quality of life and activities of their choice, so as to avoid boredom, helplessness, and loneliness, despite suffering from chronic disabilities.

This research led to a new approach called *the culture change model*.

Medicare, Medicaid, and RHCs

Medicaid is a form of long-term government medical welfare funded by both federal and state governments. A means test must be passed to qualify for Medicaid. Medicare is short- term government health insurance for all eligible U.S. citizens above the age of 65. Individuals must spend a minimum of 3 days in the hospital and must have a skilled nursing need to qualify for RHC/nursing home coverage.

Medicare and Medicaid, which were initiated by the Johnson Administration in 1965, have evolved over the years (Harris-Kojetin et al., 2013). In order for patients to receive continued Medicare support for RHC stays, they must have physician-validated rehabilitative potential (Harris-Kojetin et al., 2013). Medicare often covers short-term rehabilitation and hospital services. Patients may receive Medicare coverage for up to 100 days of rehabilitation stays at RHC facilities. During the first 20 days, Medicare covers 100% of their healthcare expenses, and from days 21 to 100, Medicare covers 80%. The remaining 20%, also known as the co-pay, is billed to the patient's supplemental insurance. If the patient's supplemental insurance will not cover the remaining costs, the patient is responsible for the co-pay, which amounts to $161 per day (U.S. Department of Health and Human Services, 2016). A Medicare initiative called the Bundled Payments for Care Improvement program covers short-term, inpatient rehabilitation for up to three overnight hospital stays, with the goal of safely discharging patients from RHC facilities within the first 20 days.

Approximately 25% of all Medicare beneficiaries discharged from hospitals to

RHCs are readmitted back to hospitals within 30 days (Jencks, Williams, & Coleman, 2009). This is such a common occurrence at RHCs that the facilities have been referred to as a *revolving door to rehospitalization* (Mor, Intrator, Feng, & Grabowski, 2010). This revolving door is so active because care in RHCs is very costly for those who do not qualify for Medicare support (Kelly et al., 2010). In addition, RHC residents who require hospitalization because of disease symptoms or injuries sustained while in RHCs are also transferred to hospitals for treatment. Per diem hospital costs are substantially higher than RHC costs, which necessitates the return of patients to RHCs as soon as hospital treatment recovery allows. Demonstrably, transfers between RHCs and hospitals increase the chances of further patient injury due to medical errors because payment incentives in the Medicare system do not encourage coordination of beneficiary care (Mor et al., 2010).

Medicaid covers long-term care stays for qualified low-income persons. Many financially challenged seniors who do not qualify for Medicaid because they exceed financial thresholds and have end-stage chronic diseases and/or are clearly on an end-of-life trajectory cannot receive financial support. If a patient is at end-of-life with a chronic illness such as CHF or COPD or Cancer, he or she may qualify for Hospice. Hospice care can be either inpatient or at home care. If a patient stays in the facility, room and board is not covered under the hospice benefit unless the hospice medical team determines that short-term inpatient stays for pain and symptom management cannot be addressed at home (U.S. Department of Health and Human Services, 2016).

Staff Functions

According to Eaton's (2000) research, there are three types of RHC facilities: (a) traditional facilities characterized by low-service quality and medical custodial objectives; (b) facilities characterized by high service quality and medical rehabilitative objectives; and (c) facilities characterized by regenerative communities similar to the culture change model previously described. Eaton reported substantial differences between each type of facility. The differences between RHCs with low and high service quality were largely defined by the economics of financing nursing home residency (Eaton, 2000).

Administrator Roles

Although the three different types of RHCs function quite differently, the overall organizational structure of many RHCs resembles the model portrayed in Figure 2. In this respect, the facility administrator of the RHC is the executive in charge of managing the facility's day-to-day activities and making many key decisions. The level of autonomy possessed by administrators of each type of RHC depends on their organizations' ownership objectives. For example, Kruzich (2005) described substantial proprietary trends that have taken place as well as changes in the scale of ownership from autonomous, single, freestanding facilities toward complex multi-facility, multi-institutional systems. Such structural changes have led to changes in facility sizes, objectives, management, staffing, culture, resource allocation, systemic makeup, and leadership. Kruzich pointed out that owners of for-profit agencies often focus on increasing facility efficiency and lowering costs; whereas non-profits focus more on

service quality. The scholar also asserted that administrators of freestanding and non-profit enterprises provide administrators with greater individual autonomy, which does not typically exist in larger corporate environments. Importantly, Kruzich explained that chain-affiliation and unionization often create more restrictions to administrator autonomy than ownership does.

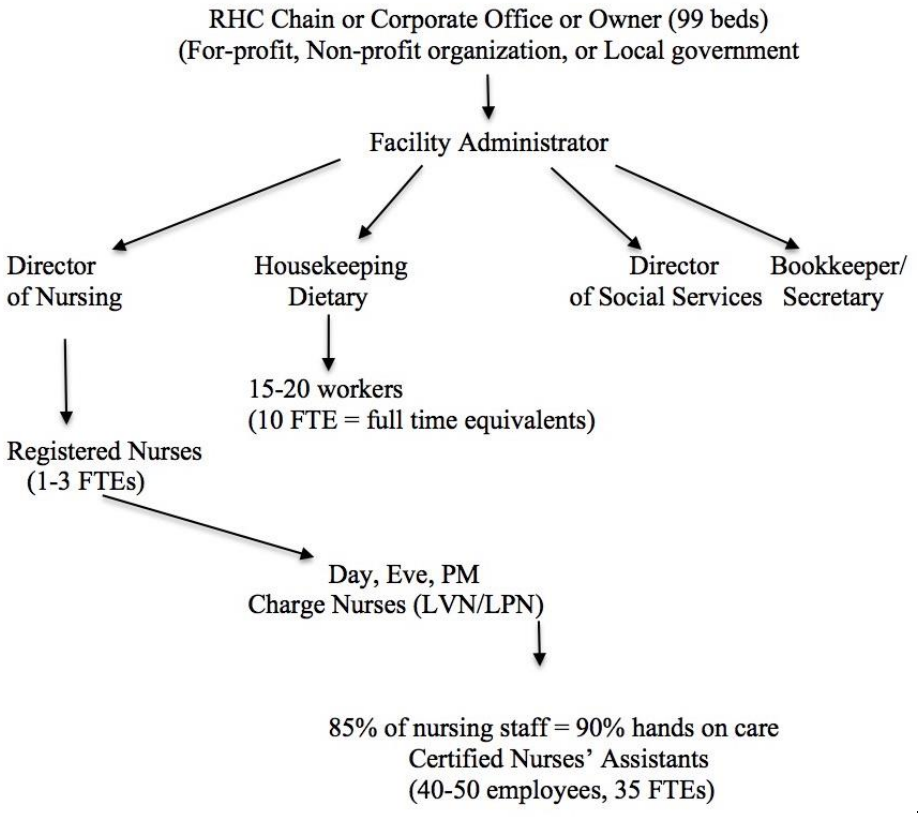

Figure 2. Typical low service quality RHC organization chart (adapted from Eaton, 2000)

Management Roles

Below the facility administrator are at least two levels of management, as shown on the left side of Figure 2. Also referred to as the directorship level, this may include

directors of admissions, nursing, medicine, and social services, depending upon the facility's size and ownership. The facility administrator may also be the director of administration of a particular facility, especially if the facility is part of a large chain. For example, the director of nursing in a nursing home is in charge of the professional nursing staff, just as the DSS is in charge of the social worker staff. This general description must be scrutinized, however, given recent changes in the multi-facility ownership of nursing facilities. Patrick and Laschinger (2006) described the major changes in large bureaucratic structures that have removed significant leadership from directors of nursing and other middle managers. The scholars asserted that the restructuring of U.S. healthcare in the past decade has negatively affected organizations' capacities to provide effective nurse leadership.

Nursing Roles

Much of the daily work with residents is in the hands of certified nursing aides; and parallels the work of social workers because of their limited numbers, as can be seen in Figure 2. Although this increases the span of control of their remaining leaders (not lost through layoffs or turnover), the reduction in power held by their leaders due to reorganization described by Patrick and Laschinger (2006) could have enabled more subordinates to be managed given fewer responsibilities to be managed.

In addition, there has been another trend in RHC management towards positive local interaction patterns and strategies between all staff in opposition to traditional hierarchal strategies (Anderson et al., 2014; Gittell et al., 2008). This is a scheme in which staff in some RHCs all the way down the chain of command and management take

more opportunities to engage with each other formally or informally exchanging new information within the RHC environment– a scheme that has been "guided by complexity science" (p. 1) and which views nursing home organizations as "complex adaptive systems" because of the disruptive nature of RHCs in which "diverse workers interact with each other to meet their work demands" (pp. 1-2).

Anderson et al. (2014) recently reported on their multiple cross section case analysis study of four RHCs. Two of the facilities were high quality and two were low quality, and all four had social workers on staff. Two of the RHCs were identified in State of North Carolina regulatory surveys as low quality with common local interaction patterns. The other two were identified in the State of North Carolina regulatory surveys as high quality with a *positive pattern of local interaction patterns.* Participants in the study reported on two different relationships and management practices that might also be called leadership, as the managers were responsible for encouraging or discouraging local interaction strategies between the staff.

Social Workers

Social workers in RHCs ideally provide support for medically challenged RHC residents in their senior years. Social workers in this context are educated medical caregivers who principally function as direct counselors to residents. These professionals may also act as liaisons to residents' families, RHC administration, RHC staff, RHC regulators, external emergency medical and hospital support systems, local clergy, and local funerary systems. In these roles, social workers may coordinate admissions and provide other administrative support, facilitate resident councils, develop care plans,

work out financial resources, arrange for transportation, purchase personal items, resolve conflicts (family members, staff, and residents) and problem solve to improve pain management and eliminate environmental stressors.

In an RHC setting, the functions of social workers are primarily in supportive roles – a professional fiduciary position in which social workers act in the best interests of the RHC resident in a global sense, apart from their own self-interests, and sometimes even ethically apart from the interests of the RHC (Robison & Reeser, 2002). During a typical day, social workers may serve in a variety of the aforementioned roles while tending to the personal needs and requests of residents. In effect, the social worker plays one of the most important roles in the RHC's residents' support system. This is a role with high potential for misunderstanding, frustration, conflict, and emotional stress that can exact a heavy toll on social workers unprepared, unsuited and lacking sufficient fortitude for such a demanding responsibility. The demands of the social workers' role in RHCs might partially explain the high turnover rates among social workers at these facilities.

Leadership exerted by the social worker in guiding the RHC resident is of paramount importance, providing guidance, objective judgment, recommendations, as well as execution of many of the residents' requests. While social workers are fiduciaries of nursing home residents, they are also subordinates to the RHC as an institutional organization, the RHC administrator, the medical director, the nursing director, and the DSS, as applicable. In such a complex role, understanding the provision of DSS leadership over social worker subordinates in RHC facilities first requires an appreciation

of the context that surrounds, governs, and provides organizational structure for RHCs, the RHC staff, and social workers within the RHC.

Director of Social Services Role

DSSs are usually part-time leaders of other social workers and staff. Their leadership styles may vary, dependent upon the organization of the facility, the ownership of the RHC, the size and complexity of the facility functions, and the resident census. Thus, they may provide situational, transformational, adaptive, decentralized, opportunistic, shared governance in a complex adaptive system of self-management, shareholder leadership, crises intervention, and developing crises leadership.

Job Satisfaction Among Social Workers

Many researchers have approached the research problem of providing effective leadership in RHCs from a limited, disparate set of directions. For example, in a national survey of over 1,000 DSSs, Bern-Klug et al. (2010) found that the maximum number of multimorbid residents that RHC social services staff could reasonably serve was approximately 50–75% less than the average number of residents for which they were responsible. Such heavy workloads may leave social workers feeling overwhelmed.

Researchers have conducted a variety of studies on the job satisfaction of social workers in RHCs. For example, Dye (2013) found that social workers employed in culture change RHCs had greater job satisfaction than those in RHCs that followed approaches that were traditional or combined culture change and traditional approaches. Gleason-Wynn and Mindel (2008) found that supervisor support, satisfaction with clients, autonomy, and coworker support correlated with job satisfaction and turnover intent

among a sample of 326 RHC social workers in Texas. Elpers and Westhuis (2008) found that organizational leadership impacted job satisfaction, while Gittell et al. (2008) reported that relational coordination among RHC employees (including social workers) was positively associated with resident quality outcomes and job satisfaction.

Social worker job dissatisfaction within RHC facilities may be indicated by high turnover rates, which averaged 27% in 2011 and cost organizations an average of half a billion dollars, annually (AHCA, 2012; Seavey, 2004). These large impacts parallel the much higher turnover rates and associated costs of all nursing and direct care staff in RHC facilities, which exceeded 50% in 2011 (AHCA, 2012). As high as these rates are, they are not unusually high for RHCs that have been "persistently high for decades, ranging upwards of 100%" (Mukamel et al., 2009, p. 1039) at times. However, they are very high relative to the annual turnover rates of the U.S. healthcare industry, which was just of 15% in 2011 (BLS, 2014).

Many researchers have investigated causal factors of elevated turnover rates among RHC staff (Kim & Stoner, 2008; Lambert et al., 2012; Mukamel et al., 2009). For example, in a study of Midwestern social workers, Lambert et al. (2012) found that age, tenure, supervisory status, organizational commitment, and pay/benefit satisfaction directly related to turnover intent. Kim and Stoner (2008) reported that the interactive effects of role stress, lack of job autonomy, and inadequate social support predicted burnout (emotional exhaustion, depersonalization, and lack of personal accomplishment) and turnover intentions among California social workers. Additionally, Simons and Jankowski (2008) found that changes in job design (increased autonomy, greater equity

in pay and benefits, more promotional opportunities) and greater support from coworkers and supervisors could improve job retention among RHC staff. Turnover appears to have an unequivocally large effect upon RHC residents that may correlate with increased drug use, morbidity, and mortality among residents (Gawande, 2014; Lambert et al., 2012; Thomas, 1996).

Farmer (2011) took a broader view on social service staff turnover by considering how the social work profession could take a leadership role in increasing job satisfaction for all roles that social workers fill, both inside and outside of RHCs. One concern brought up by a number of researchers was the key association of supportive supervision in increasing the levels of job satisfaction (Cole, Panchanadeswaran, & Daining, 2004; Davis-Sacks, Jayaratne, & Chess, 1985; Siefert, Jayaratne, & Chess, 1991). The point made was that this kind of supervision not only allows support that is psychologically important for social workers but it also gives them a better perspective on what they add to the practice, both of which can give them a greater sense of job satisfaction with their work.

Organizations that make social worker job satisfaction a priority can enhance the role of social workers, reduce absenteeism, decrease turnover, and increase quality of services (Farmer, 2011). Researchers reported that a variety of factors can contribute to job satisfaction among social workers, including the work itself, a sense of achievement, responsibility, job security, relationships with supervisors, relationships with co-workers, salary, job autonomy, promotion opportunities, working conditions, co-worker support, clarity of job role, recognition, participation in decision making, and adequate resources

(Barber, 1986; Cole et al., 2004; Elpers & Westhuis, 2008). When these factors are not present, burnout and job dissatisfaction can occur (Gleason-Wynn & Mindel, 1999; Jayaratne & Chess, 1986).

Leadership also has a significant effect on employee job satisfaction (Elpers & Westhuis, 2008; Farmer, 2011; Fisher, 2009). Leaders can foster job satisfaction by understanding what motivates employees (Fisher, 2009); however, few models emphasize obtaining social workers' views and opinions to improve their job satisfaction. Use of the 360-degree feedback model might change that, according to Richardson (2010). The 360-degree model incorporates feedback from social workers that might enable leaders to become more aware of the influence of their leadership roles on subordinates' job satisfaction. Fisher (2009) also highlighted Herzberg's (1962) two-factor or motivation hygiene theory, which includes job enrichment and job enlargement, which are often job satisfaction factors. Job enrichment policies may help social workers complete tasks from start to finish, rather than fragmenting tasks. Job enlargement would expand the scope of a social worker's role to join a team working on a larger issue for a time.

Farmer (2011) posited that social worker leaders should be proactive, demonstrate values, ethics, vision, and effective communication. Holosko (2009) stated that important qualities for social workers included the ability to influence others to act, collaborate, problem-solve, and enact positive change. Barber (1986) thought leaders should also share their policy formulation duties with social workers to allow them to become a part of the process so they might be able to reduce their case load assignments.

A different kind of leadership could be a feasible alternative given the increasingly centralized corporatization of nursing homes, which may be stripping leadership away from individual nursing homes without reducing turnover or improving the quality of RHC services. Yeatts and Seward (2000) suggested that shifting leadership to autonomous work teams of 3–15 people delegated with technical and managerial responsibilities, as has been done in a midsize non-profit RHC in Wisconsin, may reduce turnover and improve healthcare quality in RHCs.

Turnover is a significant problem in RHCs. According to the American Health Care Association (AHCA, 2011), RHC employee turnover and burnout rates have surpassed 27% for decades. Five states, according to the AHCA report, have an annual turnover rate as high as 100%. Specifically, these statistics reflect the unstable and disruptive work environments for RHC social workers, characterized by absenteeism, job dissatisfaction, and high levels of turnover intention (Gawande, 2014; Lambert et al. 2012).

Needs of RHC Residents

Social work researchers Munn and Zimmerman (2006) surveyed 437 family members of RHC residents in 31 nursing homes and 19 residential care/assisted living facilities in a stratified, random sample to determine what family members valued as the most important factors for their loved ones in the end of days care in these facilities. Survey questions were oriented around three categories (structure, process, and outcome), based upon the Donabedian's (1966) healthcare quality model. Structure refers to the

healthcare setting. Process describes what is done to provide care, and outcome describes how patients are ultimately affected. The model was modified to allow for outcomes associated with dying, such as the option of being pain-free as it was originally conceived of as addressing the kind of end of life care in long-term settings that focus on rehabilitation, recovery, and survival that are not consistent with the idea of good death (IOM, 1990). The idea of a good death in a RHC centers about an old population likely to suffer from dementia and chronic illness for a long period prior to death. Results of the study suggested that what residents' families wanted most during the last month of their loved ones' lives was "more staff" or "more educated staff" (p. 52). Frequency responses to coded responses are shown in Table 9. Note that numbers in parenthesis show the frequency of responses from coding in which all frequencies above 20 are listed.

Table 9

Substance and Frequency of Codes Associated with "What Was Done That Most Helped" and "What Could Have Been Done to Make Things Better"

Structure	Quality of Care at the End of Life Process	Outcome
Staff Adequacy (67)	"Being there" (379)	"Home"
Staff Training (42)	Staff Attitude/Empathy (126)	Comfortable
Staff Consistency (40)	Staff Direct Care (102)	Clean (23)
Facility Environment (39)	Resident Preference (49)	
Facility Size (31)	Resident Preference (49)	
Family Emotional Support (39)		
	Staff-Resident Relationship (35)	
	Family Care Monitoring (29)	
	Physical Symptom Management (24)	
	Private Caregiver (21)	
	Individualized Care (20)	
	Social Work Support (13)	

Note. Adapted from "A good death for residents of long-term care: Family members speak," by J.C. Munn and S. Zimmerman, 2006, *Journal of Social Work in End-of-Life & Palliative Care, 2*(3), 45-59.

Perhaps the ultimate test of the quality of social work and leadership of social workers in RHCs is the outcome of long-term care. Munn and Zimmerman (2006) asserted that quality of care evolved rapidly in American society over the past 35 years. That evolution moved concern from the purely medical perspective of relieving physical distress, to one in which the principal concerns are pain and symptom management (Ersek & Wilson, 2003), as well as patient and family care satisfaction (World Health

Organization, 2004).

McKinley and Adler (2005) researched the perceptions of elderly residents on the quality of life in RHCs using focus groups. Twenty-one residents of RHCs ranging in age from 80 to 101 years old who lived in the facilities from 6 months to 14 years took part in four focus groups. Participants included 14 women and 7 men. Findings clustered about four themes: (a) generativity or demonstrating concern for others who are dying and their families, (b) spiritual well-being or finding ways to discover the meaning in life and to express those beliefs (c) homelike environment or asking for the nursing home to be more like their own homes, and (d) privacy so that residents can put their own things where they want. Social workers can play an important role in these activities, such as demonstrating concern for families.

Directors of Social Work

Kadushin, Berger, Gilbert, and Aubin (2009) conducted a qualitative study of 17 DSSs in a hospital setting where the sustainability of supervision was "threatened by the elimination of middle management and supervisory positions" (p. 181) under recent managed care policies aimed at reducing costs. Such cost-reduction strategies have increased job stress for social workers (Center for Health Workforce Studies, 2006). Supervision in hospitals is the organization of the work of supervisees to fulfill hospital objectives. This would be a resource-intensive, non-revenue generating function that might be assigned a low priority under managed care. A semistructured telephone focus group interview format was conducted by four researchers on six topics: (a) access to individual educational/clinical supervision; (b) access to different models of supervision,

e.g., group, peer; (c) supervisors' professional discipline; (d) administrative supervision and accountability for job performance; (e) use of outside supervisors; and (f) organizational changes affecting supervision. Findings were that supervision in large hospital corporate structures "set the tone for the types of supervisory models apparent within the organization" (p. 191). So even for social work supervision, it was obvious that the corporate "system-driven nature of individual social work supervision was also reflected in workers' statements about the emphasis of their work on discharge planning, length of stay, cost control and how this emphasis shaped their supervision" (p. 191). This was reflected in other ways as well. For example, participants noted that when they had social workers as managers, supervisors, or particularly department directors, "some reported that their ability to obtain supervision was eroded by the increased administrative demands of their supervisor" (p. 191). Overall, those who were supervised by social workers or others felt that "their supervisors' primary commitment was to the corporation or the hospital bureaucracy and that the supervision they received was not systematically matched to their needs" (p. 197). In other words, obtaining access to supervision was thought be subordinated to hospital or corporate policies to control costs "through length of stay and discharge planning" (p. 197). Thus, peer consultation was relied upon more frequently for clinical and supervisory support by default.

Summary

The purposed of the current empirical phenomenology was to explore DSS leadership at large, corporate RHCs in Virginia. Specifically, I explored how DSSs (a) influenced leadership policies, (b) prepared subordinates for crisis intervention and

management, (c) perceived that social workers influenced decision-making in patient care, and (d) believed that communication amongst RHC staff about patient care could be improved. In this chapter, context-specific leadership styles were described as options available to help DSSs lead social worker subordinates in RHC facilities. Additionally, other key literature related to this leadership was described, such as services provided for geriatric care, the role, mission and treatment models of skilled nursing homes in the United States, the staff functions within skilled nursing homes, studies related to social work job satisfaction and methodology, the ways previous researchers have approached the problem, the rationale for selection of the variables or concepts, and the review and synthesis of studies related to the research questions.

This study filled is expected to fill important gaps in the literature and extended knowledge in the discipline. The leadership styles and performance of RHC DSSs during routine situations, developing crises situations, and crises situations were evaluated by DSSs. Prior to the current investigation, a dearth of research existed on this topic. In the next chapter, I describe the study methodology, based on the conceptual model, and research questions previously described in chapter one.

Chapter 3: Methodology

Introduction

Social workers are vital to comprehensive RHC care; however, high rates of turnover make it difficult for RHCs to retain these needed professionals. Because turnover is often linked to leadership, it is important to explore leadership among RHC DSSs. The purpose of the current empirical phenomenology was to explore DSS leadership at large, corporate RHCs in Virginia. Specifically, I explored how DSSs (a) influenced leadership policies, (b) prepared subordinates for crisis intervention and management, (c) perceived that social workers influenced decision-making in patient care, and (d) believed that communication amongst RHC staff about patient care could be improved.

In this chapter, I provide details of the study's methodology. The chapter begins with a description of the research design and rationale for the selected methodology. I also disclose my role as the researcher. Details of the study's methodology, including participant selection, instrumentation, and procedures for recruitment, participation, and data collection are presented. Details of the data analysis plan are followed by a detailed discussion of how I ensured the trustworthiness of my data. Finally, I outline the ethical assurances I implemented. The chapter concludes with a brief summary.

Research Design and Rationale

The following questions guided the study:

RQ1. How do directors of social work at large corporate RHCs influence leadership policies at corporate, facility, and social service staff levels?

RQ2. How do directors of social work at large corporate RHCs prepare subordinate social workers for crises prevention and management using multilevel, situational, and complex adaptive leadership?

RQ3. Based on the experiences of directors of social work at large corporate RHCs, how do social work professionals influence decisions made regarding patient care and well-being?

RQ4. How do directors of social work at large corporate RHCs believe communication among all staff regarding patient care and well-being could be improved?

Qualitative researchers examine and interpret data to extract meaning and establish empirical knowledge (Denzin, 1998). The key processes of qualitative analysis include the (a) collection and interpretation of data, (b) creation of concepts, and (c) characterization of context (Corbin & Strauss, 2014). Qualitative research allows for the exploration of participants' lived experiences and understandings of the world around them (Stevenson, Britten, Barry, Barber, & Bradley, 2000). Researchers can obtain in-depth information through qualitative investigation, which they can use to explore participants' beliefs, motivations, or actions through methods such as interviews, observations, and questionnaires (Lakshman, Sinha, Biswas, & Arora, 2000).

In contrast to qualitative research, quantitative methods involve the collection and analysis of numerical data that do not require interpretation or judgement from researchers. Rather, quantitative researchers draw conclusion directly from the results of statistical analysis (Abusabha & Woelfel, 2003). The focus of quantitative investigation is to gather numerical data to test theories and hypothesis. Although quantitative methods

can provide broad, reliable, and statistically significant data, they do not align with investigations of participants' lived experiences (Penner & McClement, 2008).

Qualitative analysis is valuable when predominantly subjective, difficult to quantify social science knowledge of intangibles, such as leadership quality phenomena, are available and few participants have direct personal experience with the phenomena. While longitudinal studies about RHCs have been performed, a substantial gap in the literature existed on the leadership practices of DSSs in large RHCs, which control more than 69% of all RHC organizations in the United States (CMS, 2013). Although several academic studies exist on RHC nursing activities, nursing staff comprise 65% of RHC employees, whereas social workers comprise less than 4% (AHCA, 2011). Moreover, an extensive search revealed no existing studies on the leadership experiences of DSSs employed at large, corporate RHCs.

Because this study focused on participants' perceptions and experiences, a qualitative methodology was most appropriate. In addition, my goal was not to produce generalizable results, but in-depth, detailed data relative to the phenomenon under investigation. Statistical analysis would not provide me with the deep and rich data needed to adequately address each of the research questions.

The specific design of this study was phenomenological. The research tradition of phenomenology follows a course of studying the first-hand and original experiences of those with direct experience of various phenomenon (van Kamm, 1966). Researchers obtain descriptions of participants' experiences by asking open-ended and follow-up questions. Following that, researchers analyze, reflect upon, and interpret the structure of

these experiences (Giorgi, 1985). Through this entire exercise, the researcher develops an understanding of how participants think about the structure of phenomena in the context of specific situations and how they interpret the essence of those phenomena (Moustakas, 1994).

In the absence of current literature, knowledge, and insight, I sought to explore, interpret, and analyze firsthand knowledge. I accomplished this by collecting data via open-ended and probative questioning of DSSs employed in the complex and specialized context of RHC facilities. Thus, in order to understand participants' lived experiences relative to DSS leadership, I used a phenomenological design that consisted of one-on-one interviews, with both semistructured and open-ended questions (Seidman, 2013).

Role of the Researcher

As opposed to quantitative investigations in which the researcher and the instrument are separate, qualitative research requires researchers to become the instrument through which data flows (Tracy, 2013). Thus, it is important for qualitative researchers to be aware of their personal goals, interests, and thoughts in order to prevent personal perceptions from coloring results of data analysis (Tracy, 2013). In the current study, I acted as observer and interpreter of knowledge and information provided by participants. I am a trained and experienced professional social worker with current and past experience as a DSS employed by a small, corporate RHC. I am also active in professional social work organizations.

In order to prevent my educational training and work experiences from creating bias during data collection and analysis, I practiced bracketing and epoché, which involve

an awareness and suspension of the researcher's opinions and biases in order to clearly view the phenomenon of study (Moustakas, 1994). The practice of bracketing and epoché allowed me to approach each participant interview with the open mindedness required to understand the essence of participants' experiences (Hycner, 1999).

To avoid any potential conflicts of interest, participants with whom I had past or current professional relationships were not included in this investigation. I also excluded participants with whom I may have had conflicting power relationships in professional or business organizations. In addition, I did not include any current or former employees of my employing organization. To further reduce the potential for any conflicts, I informed participants that participation was completely voluntary and they could withdraw at any point. Interviews took place in mutually agreed upon and neutral locations outside of participants' places of employment. Finally, I provided no incentives for participation. There were no other ethical issues, such as conflicts of interest or power differentials, which could potentially bias research outcomes. I was impartial about the outcome of this exploratory study and earnestly desired to explore the research questions as objectively as possible, within the realms of qualitative investigation

Methodology

Participant Selection

Qualitative researchers generally use non-probability sampling because the research goals are not to generate statistically representative samples (Wilmot, 2005). The sample consisted of 10 RSSs employed at large, corporate RHCs in Virginia. The study population included DSSs from the largest segment of the RHC market, which

consisted of large, corporate facilities. I chose this population for three reasons: (a) most of the DSSs and social workers employed by RHCs are found in large facilities due to federal staffing regulations; (b) few studies existed on large, corporate RHCs; and (c) large RHCs provide care for a greater number of rehabilitation patients with short-term stays and more acute care requirements.

I employed a criterion-based purposive sampling strategy. This technique is appropriate for seeking out a specific population with experiences relevant to the research questions (Coyne, 1997). Purposive sampling allows researchers to select participants who can provide in-depth information regarding experiences with a phenomenon (Tuckett, 2004). To qualify to participate in the study, individuals had to meet the following inclusion criteria: (a) be currently employed full time as a DSS at a state licensed RHC that qualified for Medicare and Medicaid, and which consistently had more than 120 beds for at least 5 years; (b) possess at least a bachelor's degree in social work from an accredited school and work in the Virginia; (c) have at least 2 years of full time experience at their current facility; and (d) have at least one full time subordinate social worker for which they were responsible.

Required sample sizes in qualitative research are based on the concept of saturation, which describes the point at which adding more participants does not generate any new information (Tracy, 2013). Researchers recommend a variety of sample sizes for qualitative studies (e.g., Francis et al., 2010; Morse, 1994; Tracy, 2013). For phenomenological investigations, Morse (1994) recommended a minimum sample of six participants, while Francis et al. (2010) suggested 10 to 13 participants. Based on these

recommendations, I selected a sample of 10 participants. Because I reached saturation with 10 participants, it was not necessary to increase my sample size.

I recruited prospective participants through the NASW. I used my professional contact at the association to obtain study permission and to acquire the e-mail addresses of members in Virginia. I then sent out a study invitation, via e-mail, to all prospects (Appendix A). The invitation e-mail included details regarding the study's purpose, participation requirements, and inclusion criteria. I also provided my contact information for individuals who may have any study related questions. Interested individuals who met the inclusion criteria were asked to contact me via e-mail. After interested individuals contacted me, I scheduled interviews with eligible participants at mutually agreed upon times and locations. I e-mailed them the study consent form (Appendix A) prior to the interviews. When I met with participants, I reviewed the consent forms and answered any questions they had. Before interviews began, I collected signed consent forms.

Instrumentation

I collected data for the current research via one-on-one, semistructured interviews consisting of open-ended questions. I developed interview questions with the goal of eliciting in-depth, detailed responses. According to Chapman-Novakofski (2011), open-ended interview questions allow researchers to develop deep understandings of participants' perspectives. A panel of three subject matter experts, including two professors of social work and one leadership expert, reviewed the protocol to ensure the interview questions aligned with the goals of the research. I revised the protocol based on feedback from the expert panel.

I required participants to return the consent form and demographic survey to me so I could ensure their study eligibility. Interviews took no longer than 1 hour and were audio-recorded to ensure accuracy for transcription. As few as 10 interviews may produce credible, meaningful interviews from those who have deeply experienced the study phenomenon (McCraken, 1988). I reached saturation with 10 interviews, so I recruited no additional participants.

Procedures for Recruitment, Participation, and Data Collection

I recruited full-time DSSs employed by the largest skilled nursing home facilities in the United States from the (NASW), an organization with 132,000 current members (NASW, 2015). I contacted an association leader for study permission. After obtaining approval from the NASW and Walden's IRB, I requested the e-mail addresses of NASW members in Virginia. I then sent out a study invitation, via e-mail, to all prospects (Appendix A). The invitation e-mail included details of the study's purpose, participation requirements, and inclusion criteria. I also provided my contact information for individuals who may have any study related questions. Interested individuals who met the inclusion criteria were asked to contact me via e-mail. After interested individuals contacted me, I scheduled interviews with eligible participants at mutually agreed upon times and locations. I then sent the study's consent form (see Appendix A) prior to the interviews. When I met with participants, I reviewed the consent forms and answered any questions they had. Before interviews began, I collected signed consent forms.

I audio-recorded all interviews using a digital recording device. During the interviews, I also took written notes as part of a process of preparing a self-memo of the

interview. At the conclusion of each interview, I thanked participants for their time and explained that a copy of the results would be available to them once data analysis was complete. I stored all recordings and transcriptions in a safety deposit box to which only I had access. I personally transcribed all recorded interviews for analysis. I completed all interviews within a 2-week period.

Data Analysis Plan

I began data analysis after completing all participant interviews. First, I personally transcribed all audio-recorded interviews. I assigned a numeric identifier to each participant to protect participants' identities, which I used during data analysis. After transcriptions were complete, I employed Hycner's (1999) approach to phenomenological data analysis. First, I read the transcriptions to develop categories and themes as they emerged from the data. This stage of analysis involved open coding, which describes going through data line by line in order to examine, compare, and categorize data (Corbin & Strauss, 2014). I identified words, groups of words, sentences, and paragraphs as they related across participants to develop codes. I then labeled codes and assign meaning to them.

After completing open coding, I performed axial coding. During this stage, I pieced the data back together. According to Corbin and Strauss (2014), axial coding involves the examination of situations that led to participants' specific experiences with a phenomenon. Finally, I employed selective coding, which involved developing a central category around which all other categories existed. Selective coding also involves explaining relationships between themes or categories, and refining themes or categories

as needed. In addition, I utilized NVivo 11 to assist with data organization and to help uncover any themes or categories I may have not considered.

Issues of Trustworthiness

I ensured the trustworthiness of study data by implementing measures to ensure credibility, transferability, dependability, and confirmability. According to Lincoln and Guba (1985), the trustworthiness of data refers to its accurate reflection of participants' actual perceptions. Credibility refers the accurate depiction of participants' experiences. To ensure credibility, I performed bracketing to prevent any personal biases from coloring data collection or analysis (Moustakas, 1994). In addition, I performed member checking by having participants review my analysis to ensure I accurately reflected their experiences and perceptions. Member checking empowers participants by involving them in the research process. I ensured the study's dependability, or replicability, by documenting all phases of data collection and analysis in detail. Although transferability, or generalizability, is not the goal of qualitative study, I improved the transferability of this study through thick description, which contextualized study findings. The implementation of each of these trustworthiness procedures improved the study's overall confirmability.

Ethical Procedures

I took care to ensure the ethical treatment of all study participants. Before I conducted any interviews, I obtained study approval from Walden's IRB (approval number 11-29-16-0288232). In addition, I complied with the Belmont Report's (1979) basic ethical principles, including respect, justice, and beneficence. In order to ensure

beneficence, study participation involved minimal risk. I protected participants' identities via numeric identifiers. No identifying information, including the names of participants' employing facilities, were included in any part of the data analysis.

Participation was completely voluntary and participants were free to drop out of the study at any time. I gave no incentives for participation and excluded individuals with whom I had current or past personal or professional relationships. Prior to interviews, participants had opportunities to ask study-related questions. I obtained written consent (Appendix A) before beginning any data collection. Interview data, including audio recordings, transcripts, and field notes were only accessible to me. I stored these items in my personal safety deposit box, to which only I had access. All data analysis occurred on my personal, password-protected computer, to which only I had access. After a period of 5 years, I will have all study-related data destroyed by a professional data disposal company.

Summary

The goal of the current study was to explore DSS leadership at large, corporate RHCs located in Virginia. In order to capture participants' lived experiences relative to the research questions, I conducted phenomenological interviews with 10 DSSs. I recruited a purposive sample of participants, via e-mail, through my professional contact at the NASW. To qualify to participate in the study, individuals had to meet the following inclusion criteria: (a) be currently employed full time as a DSS at a state licensed RHC that qualified for Medicare and Medicaid, and which consistently had more than 120 beds for at least 5 years; (b) possess at least a bachelor's degree in social work from an

accredited school and work in the Virginia; (c) have at least 2 years of full time experience at their current facility; and (d) have at least one full time subordinate social worker for which they were responsible. I transcribed interviews and then analyzed them using Hycner's (1999) procedures for phenomenological analysis. I employed open, axial, and selective coding to develop and refine themes and categories. I ensured the trustworthiness of study data by implementing measures to ensure credibility, transferability, dependability, and confirmability. I followed ethical assurances, including IRB approval and compliance with principles in the Belmont Report (1979).

This chapter included a discussion of the methodology, including participant selection, instrumentation, and procedures for recruitment. I also discussed my data collection and analysis procedures. I addressed issues of trustworthiness and ethical procedures. The following chapters includes a presentation of the study's results.

Chapter 4: Results

Introduction

The problem of this phenomenological study was the relationship between directors of social services (DSSs) and turnover among rehabilitation and healthcare centers (RHCs) social workers. Social workers are critical to patient care, but retention rates of these professionals are low in RHCs, which may be due to excessive workloads, higher levels of professional stress, and low recognition for their work. While knowledge exists regarding leadership styles, strategies, and interactions of facility administrators and directors of nursing (DONs) (Anderson et al., 2014; Castle, 2008; Donoghue & Castle, 2009; Molinari et al., 2009; Kruzich, 2005), this study addressed the substantial gap in the literature regarding the specific leadership styles and strategies employed by DSSs (Aberdeen & Angus, 2005; Joel & Sibille, 2013). The purpose of this qualitative phenomenology was to explore DSS leadership at large, corporate RHCs in Virginia. Specifically, I explored how DSSs (a) influenced leadership policies, (b) prepared subordinates for crisis intervention and management, (c) perceived that social workers influenced decision-making in patient care, and (d) believed that communication amongst RHC staff about patient care could be improved.

I examined these issues using four research questions. Research Question 1 asked how DSSs at large corporate RHCs influenced leadership policies at corporate, facility, and social service staff levels. Research question 2 examined how DSSs at large corporate RHCs prepared subordinate social workers for crises prevention and management using multilevel, situational, and complex adaptive leadership. Research

question 3 explored how DSSs at large corporate RHCs influenced decisions regarding patient care and well-being. Finally, Research question 4 explored how DSSs at large corporate RHCs believed communication among all staff regarding patient care and well-being could be improved. I collected demographic data for participants, including birth year, race, gender, education level, number of years employed at current RHC, years employed as a DSS, total number of social workers managed, total number of staff in the RHC, the number of rehabilitation beds in the facility, and the total number of beds in the facility.

This chapter outlines the data collection and analysis methods used to answer the guiding questions. The section includes detailed demographic information for the selected sample and the results of the qualitative interviews. The chapter closes with a summary and transition to Chapter 5.

Data Collection

I chose a phenomenological design for this study. This was an appropriate design, as it provided the necessary framework for gathering information from first-hand accounts of the participants who provided the necessary information for exploring the relationship between DSS leadership and turnover among RHC social workers. I obtained descriptions of participants' experiences by asking a range of questions about their experiences. I followed these interviews with a detailed analysis and reflection of their responses in order to interpret their experiences. Throughout the data collection and analysis process, I developed knowledge and understanding about how the participants understood the issues that contributed to low retention rates and the existing relationships

between leadership and social workers. The experience provided missing data and insight into the phenomenon. Because I was the main instrument for data collection, I retained constant awareness about my personal biases, thoughts, and perceptions during all phases of data collection and analysis. This practice was necessary to help me refrain from influencing the results and interpretation of the data. I remained an active but aware observer when interacting with participants. I also practiced bracketing and epoché, which involved the maintenance of active awareness and suspension of my opinions and biases to gain a clear view of the problem of study (Moustakas, 1994). These practices allowed me to interact with each participant with an open mind. As an experienced professional social worker, I also ensured that I had no previous or current professional relationships with any of the volunteer participants during the investigation.

Sampling Strategy and Recruitment

I conducted nonprobability sampling, as the goal of this study was not to generate a statistically representative sample (Wilmot, 2005). The sample consisted of 10 RSSs employed at large, corporate RHCs in Virginia. The study population included DSSs from the largest segment of the RHC market, which consists of large, corporate facilities. I chose this population for three reasons: (a) most of the DSSs and social workers employed by RHCs are found in large facilities due to federal staffing regulations; (b) few studies existed on large, corporate RHCs; and (c) large RHCs provide care for a greater number of rehabilitation patients with short-term stays and more acute care requirements.

The sampling strategy I used was a criterion-based purposive sample. This technique was appropriate for seeking out this specific population, as they have experiences relevant to the research questions (Coyne, 1997). Purposive sampling allowed me to select participants who provided in-depth information regarding their experiences with the phenomenon in question (Tuckett, 2004). To qualify for study participation, individuals had to meet the following inclusion criteria: (a) be currently employed full-time as a DSS at Virginia state licensed RHC that qualified for Medicare and Medicaid, and which consistently had more than 120 beds for at least 5 years; (b) possess at least a bachelor's degree in social work from an accredited school and work in Virginia; (c) have at least 2 years of full time experience at their current facility; and (d) have at least one full-time subordinate social worker for which they were responsible.

Required sample sizes in qualitative research are based on the concept of saturation, which describes the point at which adding more participants does not generate any new information (Tracy, 2013). Researchers recommended a variety of sample sizes for qualitative studies (e.g., Francis et al., 2010; Morse, 1994; Tracy, 2013). For phenomenological investigations, Morse (1994) recommended a minimum sample of six participants, while Francis et al. (2010) suggested 10 to 13 participants. Based on these recommendations, I chose a sample of 10 participants, and this provided the requisite number of participants to reach saturation.

I recruited participants through the NASW, using my professional contact at the association to obtain study permission and to acquire the e-mail addresses of members in Virginia. I sent out the study invitation (Appendix A), via e-mail, to all prospects. The

invitation e-mail included details regarding the study's purpose, participation requirements, and inclusion criteria. I provided my contact information for anyone who had study related questions. Interested individuals who met the inclusion criteria were asked to contact me via e-mail. After the interested individuals contacted me, I scheduled interviews with them at mutually agreed upon times and locations. I also sent them the study's consent form (Appendix A) prior to the interviews. When I met with participants, I reviewed the consent forms and answered any questions they had. Before interviews began, I collected signed consent forms.

Data Collection Process

I collected data via one-on-one, semistructured interviews consisting of open-ended questions. The questions were structured to elicit in-depth, detailed responses. These questions followed Chapman-Novakofski's (2011) logic that open-ended interview questions allow researchers to develop deep understandings of participants' perspectives. The interview protocol received approval prior to the study from a panel of three subject matter experts, which included two professors of social work and expert in leadership. The panel review ensured interview questions aligned with the goals of the research. I revised the protocol based on feedback from the expert panel. Table 10 contains the final set of questions used during the interviews.

Table 10

Topics Covered by Interview Questions

Topics examined	Questions
Interview questions of DSSs about interaction with other facility directors in managing routine corporate leadership policy at the corporate, facility, and the DSS staff levels:	1. What is it like to exert DSS leadership in this facility? 2. What things about your work do you do well? 3. What do you see as most important in your role? 4. What does good leadership mean to you? 5. How do decisions get made here about resident care, schedules, etc.? a. Probe for formal (e.g. care planning meetings) b. e.g. , nurse, social worker, administrator, comes to me to ask my opinion, or nurse, social worker, administrator, asks me about things if they happen to run into me in the hall.
Interview questions of DSSs about the role DSSs play in leading subordinate social workers in preparing for, dealing with, and preventing developing crises at the facility and DSS staff levels at corporate owned facility:	1. What is teamwork like in this facility? 2. Who has asked you for information about the residents you are responsible for? 3. Sometimes you may have information about your resident or residents that you think others on staff need to know. How have you gone about sharing info about your residents with others if they haven't asked? 4. What leadership have you provided social workers on your staff in preparing for, dealing with, and preventing what appear to be inevitable developing crises at your rehabilitation healthcare facility? 5. How much time and effort has your staff spent informally sharing information with others of your staff and other staff in your rehabilitation healthcare facility? 6. What has been the best way you rely upon in discovering what is going on with residents and other staff in your rehabilitation healthcare facility?

Topics examined	Questions
Interview questions about leadership strategies are exerted by DSSs in leading subordinate social workers in managing unfolding crises intervention at the facility and staff levels at corporate owned rehabilitation and healthcare.	1. What has been the very first thing that members of the social worker staff have done when witnessing a serious resident accident, medical or psychological crisis first hand? What was the outcome? How effective has that been? 2. What was the very first thing you did recently when you witnessed a serious resident accident, medical or psychological crisis first hand? What do you do after this? 3. What staff did you rely upon most in an unfolding resident crisis intervention?

The participants returned the consent form with the demographic survey showing their eligibility based upon the inclusion criteria. Interviews lasted about 1 hour and were audio-recorded using a digital recording device to ensure accuracy of the transcriptions I completed. During the interview, I jotted down written notes as part of the transcription process for preparing self-memos for the interviews. After the completion of each interview, I thanked participants for their time and explained that a copy of the results would be made available to them once data analysis was complete. All recordings and transcriptions were stored in a safety deposit box to which only I had access. I personally transcribed all recorded interviews for analysis. The 10 completed interviews produced credible and meaningful results for analysis.

Data Analysis Plan

Data analysis began after I completed all of the participant interviews and transcriptions. First, I personally transcribed all audio-recorded interviews. I assigned a numerical numeric identifier to each participant to protect the participants' identities, which I used during data analysis. After I completed the transcriptions, I used Hycner's

(1999) approach to phenomenological data analysis. First, I read the transcriptions to develop categories and themes as they emerged from the data. This stage of analysis involved open coding, which describes going through data line by line in order to examine, compare, and categorize data (Corbin & Strauss, 2014). I identified words, groups of words, sentences, and paragraphs as they related across participants to develop codes. I then labeled codes and assigned meaning to them.

After I completed open coding, I performed axial coding. This is the stage during where I pieced the data back together. According to Corbin and Strauss (2014), axial coding involves the examination of situations that led to participants' specific experiences with a phenomenon. Finally, I employed selective coding, which involved developing a central category around which all of the other categories existed. Selective coding also involved explaining relationships between themes or categories, and refining themes or categories as needed. In addition, I used NVivo 11 to assist with data organization and to help uncover all of the potential themes and categories presented by the data.

Issues of Trustworthiness

I ensured the trustworthiness of study data by implementing the measures I proposed to ensure credibility, transferability, dependability, and confirmability. According to Lincoln and Guba (1985), the trustworthiness of data refers to its accurate reflection of participants' actual perceptions. Credibility refers to the accurate depiction of participants' experiences. To ensure this, I performed bracketing to prevent any personal bias from coloring the data collection or the analysis (Moustakas, 1994). In

addition, I performed member checking by having participants review my analysis to ensure I accurately reflected their experiences and perceptions. Member checking empowered participants by involving them in the research process. I ensured the study was dependable, or replicable, by documenting all phases of data collection and analysis in detail. My audit trail included any changes made from the methodology presented in this chapter. Although transferability, or generalizability, is not the goal of qualitative study, I improved the transferability of this study through thick description, which provided a context for the study findings. Lastly, the implementation of each of these trustworthiness procedures improved the study's overall confirmability.

Ethical Procedures

I ensured the ethical treatment of all study participants. Before I conducted any interviews, I obtained research approval from Walden's IRB. In addition, I complied with the Belmont Report's (1979) basic ethical principles, including respect, justice, and beneficence. In order to ensure beneficence, study participation involved minimal risk. I protected participants' identities with numeric identifiers and no identifying information, including the name of participants' employing facilities, was included in any part of the data analysis. Participation was completely voluntary and participants were notified of their right to drop out of the study at any time. No incentives were given for participation, and I did not include any participants with whom I had current or past personal or professional relationships. Prior to interviews, participants had opportunities to ask any study-related questions. I obtained written consent (Appendix A) before beginning any data collection. Interview data, including audio recordings, transcripts, and field notes,

were only accessible to me. I stored these items in my personal safety deposit box, to which only I had access. All data analysis occurred on my personal, password-protected computer, to which only I had access. After a period of 5 years, I will have all study-related data destroyed by a professional data disposal company.

Results

In this section, I outline the results of the qualitative data analyses. Table 9 provides information regarding the participants' demographic characteristics. Each participant received an assigned participant number in order to protect his or her identity. Participants provided their birth year, race, gender, and education level. All participants were born between 1978 and 1992. Racially, participants identified as Black, White, or Asian. Five of the participants identified as White, three participants identified as Black, and two identified as Asian. All participants possessed at least a Bachelor's Degree, and six had a Master's Degree.

Table 11

Participant Demographics

Participant number	Year born	Race	Gender	Education
1	1986	Black	Male	Master's
2	1978	Asian	Male	Master's
3	1983	White	Female	Bachelor's
4	1990	White	Female	Master's
5	1985	White	Female	Master's
6	1992	Black	Male	Bachelor's
7	1990	Black	Male	Master's
8	1988	Asian	Female	Bachelor's
9	1980	White	Female	Master's
10	1992	White	Female	Bachelor's

Table 11 displays participant employment information, which provides information regarding the number of years employed at current RHC, years employed as a DSS, the total number of social workers they managed, the total number of staff in their nursing home facility, the number of rehabilitation beds in their facility, and the total number of beds in their facility.

Table 12

Participant Employment Information

Participant Number	Years employed at current nursing home	Years employed as a Director of Social Services	Total number of social workers you manage	Total number of staff in your nursing home facility	Number of Rehabilitation beds in your facility	Total number of beds in your facility
1	5 years	3 years	3	200	60	215
2	3 years	3 years	2	250	30	180
3	2 years	4 years	2	200	40	185
4	6 years	6 years	2	200	40	180
5	2 years	2 years	2	200	50	150
6	3 years	3 years	3	250	50	150
7	4 years	4 years	2	200	40	185
8	5 years	3 years	2	200	35	180
9	7 years	5 years	4	200	65	300
10	3 years	2 years	1	200	30	150

All participants were employed at their current facility for at least 2 years. Two employees were employed 2 years, 3 for 3 years, 1 for 4 years, 2 for 5 years, 1 for 6 years, and 1 for 7 years. All participants served as DSSs at their respective facilities for at

least 2 years. Two participants served for 2 years, 4 for 3 years, 2 for 4 years, 1 for 5 years, and 1 for 6 years. The number of staff employed at participant's RHC ranged from 200 to 250 employees. The number of rehabilitation beds in each facility ranged from 30 to 60 beds. The total number of beds in each facility ranged from 150 to 300 beds.

Qualitative Interview Results

The interview results developed from the interview transcriptions showed the themes that emerged to provide answers to the research questions. This first stage of analysis involved open coding, in which I reviewed the transcripts line by line after importing the data into NVivo 11. At this stage, I created individual nodes for each interview question to organize the initial open coding. During this initial phase, I identified words, groups of words, sentences, and paragraphs as they related across participants' responses. I assigned labeled codes and meaning, as each code reflected information from the previous literature. After I completed the open coding, I performed axial coding, in which I pieced the data back together in order to answer the research questions. Axial coding involved the examining the situations that led to participants' experiences of different aspects of the phenomenon under study. Lastly, I employed selective coding, which involved developing categories that centered on each separate research question. The selective coding stage involved explaining the relationships between each category, and refining the categories to reflect the most relevant information for each question. The results section is organized according to each research question and the relevant categories that emerged for each.

RQ1: Analysis and Results

The analysis and results of research question one pertained to how DSSs at large corporate RHCs influenced leadership policies at corporate, facility, and social service staff levels. The results for research question one included two categories regarding information-sharing and teamwork, and leadership style.

Information sharing and teamwork. Respondents emphasized the importance of teamwork and communication in the development of leadership policies. They discussed strong teamwork in their facilities. As noted by Respondent 1: "teamwork in this facility is good. Since we all get along together." Respondent 5 used almost the exact same wording to describe teamwork, stating "I would say that the teamwork in this facility is good. Since we all get along together." Other respondents provided similar statements, such as Respondent 10: "I would say that teamwork at this facility is good for the most part. We try to communicate effectively." Respondent 7 explained, "I would say that the team work at this facility is good for the most part." Respondent 8 shared, "I would say that teamwork is good but at times it's a bit crazy because some staff have [an] attitude problem." These responses supported the importance of teamwork, but indicated underlying issues that could inhibit it. Other participants noted that teamwork was important in their facilities, but room for improvement existed. For example, Respondent 3 stated, "I would say that the teamwork is good but sometimes a bit crazy because other people have attitude towards each other." Respondent 4 shared a similar mentality, stating that "teamwork at the facility where I work at is good, although we do have challenges but we try to have teamwork spirit." Respondent 2 noted that teamwork was

sometimes challenging “because of lack of communication.” These statements indicate DSSs’ acknowledgement of teamwork and communication as necessary aspects of leadership development. Their knowledge of the issue demonstrated the potential for developing better teamwork and communication to promote more productive work environments.

These observations and acknowledgments shared by participants extended to the methods by which directors influenced policy development at each level of the organization. All 10 participants stated that they promoted the importance of team work and communication through verbal communication and 24-hour nursing reports. The repeated statement pointed to influencing policies at the corporate, facility, and social service staff levels. Directors communicated these observations at the corporate level through the stand-up meetings. Observations could influence policy development at the facility level via communications in 24-hour nursing reports. Directors influenced policies at every level by communicating observations and concerns whenever and with whomever necessary, using direct verbal communication when an observation occurred. Participants’ answers reflected their support of effective communication policies and judgment regarding how they shared patient information. All 10 participants explained that they followed information sharing procedures and HIPPA, depending on the nature of the information shared. These statements highlighted DSSs’ influence on policy at each level, as their statements supported and demonstrated respect for adherence to organizational policies and practices. Such adherence also provides a leadership example

behavior for staff to follow, which may influence supporting leadership policies and development.

Leadership style. Participants used leadership styles to influence leadership policies at corporate, facility, and social service staff levels. Leadership styles influenced policies both in their development and practice, as DSSs' behaviors and actions impacted different levels of the organization. Participants revealed three leadership styles reflected in their responses, including servant, transactional, and transformational.

Servant leadership. Servant leadership embodies such virtues as listening, empathy, trustworthiness, service orientation, and community building (Spears, 2004). Servant leadership styles were reflected in responses by Respondents 7 and 8. For example, Respondent 7 discussed characteristics of listening and empathy stating,

> The most important [part] about my roles is being [an] advocate and at the same time I am a good communicator and I am a type of person that I want to make sure that everyone is on the same page so that staff can provide the best care for residents as possible.

Respondent 7 also noted that "good leadership for me is being there for my staff and set as a good example on how to address any crisis at any given time." Respondent 8 discussed service orientation and community-building, pointing out that "good leadership is you willing to do some self-sacrifices at times so that you are there for your staff especially in a crisis." Respondent 8 also stated "the most important [part] I can see is that being [an] advocate for my patient and making a difference," which was indicative of service orientation and community-building within the care facility.

Transactional leadership. The transactional leadership model includes the following: (a) clearly stated goals and objectives, (b) clearly specified behaviors that followers can use to achieve these goals, (c) active monitoring of the group, and (d) positive and negative feedback to enforce compliance (Nahavandi, 1997). Respondents 1, 3, and 4 reported transactional leadership styles. Responses reflected the necessity of clearly stated goals and objectives.

Transactional leadership is characterized by behaviors and expectations that are clearly communicated and demonstrated to staff. Respondent 1 explained, "well it is all good because I get along with everyone and I just do my job" when describing guidance of workflow and carrying out stated responsibilities. Respondent 3 stated that "sometimes [it] is quite stressful because some leaders are not on the same page. But I also do my best, although sometimes it can be frustrating," indicating the need to provide staff with clearly stated directions and action plans. Participants valued order and planning, and demonstrated leadership, as noted by Respondent 4: "I would say it is ok because I have [a] strong personality and we have strong team work." Respondent 1 reiterated the importance of management and direction for staff: "I do manage my social work staff every week. I do departmental meeting every Friday afternoon and discuss any concerns that each of my staff might have and to ensure that everyone is on the same page." These comments indicated leadership which emphasized clearly communicated directions and expectations to staff. Respondent 3 stated "I would say I am a team builder. I always go above and beyond the call of duty regardless of how complex the situation is." Respondent 3's statement further reflected on the importance of working within the group

dynamic, providing examples for staff to follow, and dealing with clearly stated objectives.

Participants believed that providing an example to follow supported the achievement of stated goals and objectives, as noted by Respondent 1: "good leadership for me is to lead by example. You need to be a role model among the team members of the nursing home." Similarly, Respondent 3 stated that "good leadership for me is being there for your subordinates and set as a good example on how to address any crisis at any given time." This leadership style also reflected providing feedback and monitoring for staff alongside providing examples. Further responses supported the notion of supporting staff with the feedback and response mechanism. Respondent 4 noted, "I do manage my staff well and I am always available to support them." Respondent 1 1 stated, "my most important role is to lead by example among staff members here at the facility." Respondent 3 also stated that "the most important [part] in my role as the Director of Social Services in this facility is making a big difference in someone's lives and working effectively with the interdisciplinary team." These statements noted the importance of providing leadership and direction to staff to help them reach their goals.

Transformational leadership. Transformational leaders are charismatic, visionary, and inspirational leaders who appeal to followers' ideals and higher-order values, such as self-actualization or community service, rather than simple exchanges of benefits for performance (Bass, 1985). Respondents 2, 5, 6, 9, and 10 described examples of transformational leadership. Their responses demonstrated aspects of transformational leadership, including the higher order values and sense of duty beyond the job

description, which included patient well-being. Respondent 2 reflected such a style stating,

> Sometimes it is quite challenging because some directors have their own mind set how to address some of the issues that might arise. I learned how to negotiate and compromise because what I want is the best for the resident.

Respondent 2 also noted that "good leadership is getting along with everyone in the organization and at the same time go above and beyond the call of duty." This statement reflected that this style of leadership included acting as a good role model for influencing leadership development in staff, as Respondent 5 noted "good leadership is leading by example. You need to serve as role model among the staff." Other participants shared similar sentiments. For example respondent 6 stated, "good leadership for me is to lead by example. You need to be a role model among the staff at the facility." Similarly, Respondent 10 shared that "Good leadership is getting along with everyone within the organization and at the same time doing above and beyond from what typically you do."

Responses also reflected ideas about higher order service, self-actualization, and performance beyond transactional behavior. Respondent 5 revealed self-actualization, stating, "I am good in what I do and the way I exert DSS leadership in this facility is based on my knowledge and skills to accomplish the task." Respondent 2 shared a similar idea: "I get along with everyone very well because I have [an] open mind and I know how to compromise and negotiate." Other statements pointed to participants' leadership styles for promoting service to their staff and colleagues, demonstrating a commitment to higher order behavior. These respondents cared about their staff's well-

being, as Respondent 5 stated "I manage my social work team very well and I have an open-door policy that they can always see or approach anytime they have a question or concern or if they needed my assistance." Others supplied similar responses. Respondent 6 said, "I manage my staff very well and I have open door policy that they can always see me if they my help to support them." Respondent 9 explained, "I do manage my staff well and I am always available to support my staff in any way possible." Finally, Respondent 10 shared, "I do manage my social work staff every week. I do departmental meeting every Friday morning to check everyone how they are doing as well as to discuss and address any question concern that my staff might have." Each of these statements reflected participants' acknowledgement and understanding of their skills and abilities alongside their commitment to a leadership style that promoted a sense of commitment and dedication from their staff.

In summary, the results for research question 1 provided insight into how DSSs at large corporate RHCs influence leadership policies at corporate, facility, and social service staff levels. Responses reflected ideas regarding information sharing and teamwork, and the ways in which these two areas influenced directors' behaviors with each level of the organization, including treatment of other staff and their subordinates. Responses on participants' leadership styles reflected potential influences on the organizational leadership policies and how directors' observations, opinions, behaviors, and actions might be shared through their interactions with each level of the RHC.

RQ2: Analysis and Results

The analysis and results of RQ2 addressed how DSSs at large corporate RHCs prepared subordinate social workers for crises prevention and management using multilevel, situational, and complex adaptive leadership. Crisis prevention management and management techniques were reflected in responses related to these leadership styles.

Multilevel leadership. Multilevel level leadership refers to corporate governance, strategic planning, and human resources management. Directors prepared their subordinates to handle crisis prevention and management situations by providing them with a thorough understanding of multilevel leadership style. This style includes broad strategic planning and management from each department in the facility. Respondent 1 noted that staff members learn and practice as "decisions get made about resident care, schedules etc. through care planning and care conference meeting. Each interdisciplinary team do provide input on the care plan to ensure that we can provide the appropriate care for the resident." Other respondents, such as Respondent 2, provided similar statements: "the [way] decisions get made about resident care, schedules etc., is through care planning and care conference meeting." Respondent 3 explained, "Decisions get made about resident care, schedules etc. through care planning and care conference meeting." Similarly, Respondent 4 explained, "decisions get made about the resident care, schedules etc. is through care planning and care conference meeting," and Respondents 6, 9, and 10 shared that decisions were made through care planning and conferences. All 10 participants also shared that communication about crises and similar incidents occurred

directly with DONs or administration, indicating multilevel leadership styles across the organizations.

Situational leadership. Situational leadership refers to caregiving, prevention, and management of anticipated crisis. Participants discussed situational leadership by explaining how decisions were made about issues such as resident care and schedules. These responses were also partially reflected in those regarding multilevel leadership, as respondents stated that the different levels of the organization had input regarding the decision-making process. Respondent 2 noted that while

> the decisions get made about resident care…[this occurs] through care planning and care conference meeting. By doing so we develop an appropriate care plan so that we can provide the appropriate care for the resident to meet the resident needs.

Respondents 3 and 9 shared that interdisciplinary teams worked to create care plans that provided each resident with appropriate care. In doing so, Respondents 4, 6, and 10 shared that individualized plans could be developed that met the needs of each resident. Respondent 5 noted:

> We do have [a] stand up meeting in the morning Monday through Friday attended by the interdisciplinary [members] consist[ing] of Director of Nursing, Administrator, Activities, Director of Rehab, Dietitian, Director of Social Services, Admission Director and Resident Assessment Coordinator in which we discuss any patients that had a change in medical conditions and at risks that includes behavioral problems, weight loss, infection and falls.

Participants' responses indicated that situational leadership occurred via input from interdisciplinary teams regarding patient care, crisis prevention, and management of future crises. This style of leadership also sought input from the patients and their family members. The inclusion of each party in the process reflected to a leadership style in which the perspectives of all relevant parties were integrated to develop care, prevention, and management plans.

Complex adaptive leadership. Complex adaptive leadership refers to crisis management associated with patient injury and disease emergencies. Participants 5, 7, and 8 discussed weekly meetings with their interdisciplinary teams that helped handle discussions and assessments regarding residents' infections and falls. Participants who involved subordinate staff on these discussions prepared social workers to report patient injury and disease emergencies. These preparations were important as DSSs described how their social worker staff responded to witnessing serious resident accidents, medical, or psychological crises, firsthand. Respondent 1 described the influence of a complex adaptive leadership style, stating "it is totally depending on the situation and for the most part we report it to the nursing staff then that situation is being address. The outcome was good because the situation was address." Respondent 2 stated echoed Respondent 1's sentiment, explaining "typically, it does involve nursing on the most part but I do provide active role in dealing with psychological crisis, and I do follow our policy procedure. The outcome was good because the situation was addressed." Respondent 3 shared that "it totally depends on the situation and for the most part I report it to the nursing staff, attending physician and or the psychiatrist. The outcome was good because the situation

was addressed with the proper department." These statements also pointed to complex adaptive leadership, as DSSs and their staff worked actively to practice crisis management by quickly relaying information to the appropriate departments and staff members when crises occurred. Respondent 4 pointed out the effectiveness of quickly sharing information with nursing staff, stating they "report it to the Director of Nursing and the nursing administrator immediately to address the situation. The outcome was good and it is always being effective." Respondent 10 reiterated the success of crisis management practices stating that "it usually involved something to do with nursing for most of the time. The outcome is good and it is effective. Because it was addressed accordingly."

Participants' responses reflected the importance of multilevel, situational, and complex adaptive leadership for supporting the management and handling of crisis prevention and management in an RHC. Responses pointed to the importance of DSS's clearly communicating existing levels of leadership in the organization and how to share information through different modes of communication. The responses also indicated the necessity that staff in different departments be willing to communicate at different levels, via different styles, to document patients' needs and incidents. Direct and quick communication of incidents to nursing staff by social work staff supported better outcomes for patients.

RQ3: Analysis and Results

The analysis and results of research question 3 answered the following: based on the experiences of directors of social work at large corporate RHCs, how do social work professionals influence decisions made regarding patient care and well-being?

Relational coordination. Participants' responses reflected relational coordination as the manner in which social work professionals influenced decision-making. The literature described relational coordination as the mutual understandings of work functions and context. Such coordination was understood by how effective communication occurred between departments and individuals. These were previously reflected in responses about the different styles of leadership that supported crisis management and prevention. There was a "frequency, timeliness, accuracy, and focus on problem solving rather than blaming" of such communication (Gittell et al., 2008, p. 155). This type of communication is stated as present during crisis management, as participants noted communicating immediately with the nursing department when an incident occurred. Participants noted interactions were handled quickly, as protocol was followed. For example, Respondent 6 stated, "it usually involved nursing for most of the time. The outcome is good and it is effective. The outcome was good and effective because it was addressed accordingly." Respondent 7 explained that staff "report it to the Director of Nursing and Administrator or the attending physician deemed necessary to address the situation. The outcome was good and it is always being effective." This response indicated that the staff were trained to report incidents to individuals who would know the best course of action to handle patients' needs. Respondent 8 continued this

idea that "it is totally dependent on the situation. For the most part, I report it to the nursing staff, attending physician and or the psychiatrist. The outcome was good because the situation was addressed with the proper department." Responses depicted successful relational coordination among the staff, as this type of interaction was described as successful when characterized by frequent information exchange, problem-solving during crises, and feedback between interdependent staff.

RQ4: Analysis and Results

The analysis and results of research question 4 examined how DSSs at large corporate RHCs believed communication among all staff regarding patient care and well-being could be improved. Respondents discussed this when answering questions about the state of communication in their respective organizations. Responses touched on constantly working toward better communication and remaining aware of any misunderstandings. Teamwork was fundamental to facilitating that communication. Improved communication was needed at each level of the organization and across the social work and nursing departments. Respondent 2 explained,

> I would say that the teamwork is a bit challenging at times because of lack of communication. As the Director of Social Services I always do my very best with regards to effective communication so that everyone is on the same page.

Respondent 6 also pointed this out:

> I would say that the teamwork here is a bit challenging at times because of lack of communication among staff especially nursing staff. As the Director of Social Services I always do my very best to communicate effectively among staff but at

> times is challenging because I have so many task I need to complete at very short period.

Respondent 10 explained that "teamwork at this facility is good for the most part. We try to communicate effectively." This statement demonstrated to the importance of constant communication between staff and departments, as this supported patient care and well-being. All 10 respondents noted that residents, family members, healthcare providers, interdisciplinary teams, and caregivers all asked about patient information. This indicated that communication could be improved by sharing information across these groups when deemed appropriate. All 10 participants also described opportunities to learn about what was occurring with residents and other staff in their rehabilitation facilities through stand up meetings, communication boards, and 24-hour nursing reports. Communication improvements might be facilitated through ongoing information sharing and timely incident reports.

Summary

The analysis and results of research question 1 examined how DSSs at large corporate RHCs influenced leadership policies at corporate, facility, and social service staff levels. The results for RQ1 indicated information sharing, teamwork, and leadership styles as potentially influential of leadership policies, as participants shared their observations, opinions, behaviors, and actions through their interactions within each level of the RHC. The analysis and results of RQ2 addressed how DSSs at large corporate RHCs prepared subordinate social workers for crises prevention and management through multilevel, situational, and complex adaptive leadership styles. Crisis prevention

management and management techniques were reflected in the responses regarding each of these leadership styles, and there was overlap in the styles that contributed to crises prevention and management.

The analysis and results of RQ3 indicated how the participants' employed relational coordination to influence decision-making. The literature described relational coordination as the mutual understandings of work functions and context. Such coordination was demonstrated by how effective communication occurred between departments and individuals. Finally, analysis and results of RQ4 examined how DSSs at large corporate RHCs believed communication among all staff regarding patient care and well-being could be improved. Respondents stated that constantly working towards better communication and remaining aware of any misunderstandings across groups was the key to improving patient care and well-being.

This chapter included a presentation of the methodology used to carry out the study, including participant selection, data collection methods, data analysis procedures, and the results. I also described how I addressed issues of trustworthiness and the ethical procedures that I followed.

Chapter 5 includes a discussion of the results, future research recommendations, study implications, and study conclusions.

Chapter 5: Discussion

Introduction

The purpose of this qualitative phenomenology was to explore DSS leadership at large corporate RHCs in Virginia. Specifically, I explored how DSSs (a) influenced leadership policies, (b) prepared subordinates for crisis intervention and management, (c) perceived that social workers influenced decision-making in patient care, and (d) believed that communication amongst RHC staff about patient care could be improved. This study is considered important because RHCs provide ongoing or transitional care to the elderly and chronically ill, and in order to ensure the best patient care, staff at these facilities require proper training and leadership to respond to patient care crises. This proper training and leadership also requires facilitation of clear and direct communication across departments. In these situations, social workers play a vital role in patient care at these facilities, but RHCs have a difficult time with retaining social workers. This study explored (a) the possibility that employee turnover was related to the support and direction provided by leaders, and (b) whether it is possible that turnover among RHC social workers relates to the leadership they received in large RHC settings. The study also addressed the gap in the research on the specific leadership styles and strategies used by DSSs.

Summary of Findings

I conducted non-probability sampling, because I did not require a statistically representative sample (Wilmot, 2005). I used a criterion-based purposive sample as the technique was appropriate for seeking out this specific population who have experiences

relevant to the research questions (Coyne, 1997). The sample of interest included 10 RSSs employed at large, corporate RHCs in Virginia.

Demographics. All 10 participants provided their year of birth, race, gender, and education level. All participants were born between 1978 and 1992. Participants identified their race as Black, White, or Asian. Five of the participants identified as White, three participants identified as Black, and two identified as Asian. Participants all possessed at least a Bachelor's Degree, and six participants had a Master's Degree. All participants were employed at their current facility for at least 2 years. Two employees were employed 2 years, 3 for 3 years, 1 for 4 years, 2 for 5 years, 1 for 6 years, and 1 for 7 years. All participants served as DSSs at their respective facilities for at least 2 years. Two participants served for 2 years, 4 for 3 years, 2 for 4 years, 1 for 5 years, and 1 for 6 years. The range of staff serving in each participant's respective RHCs ranged from 200 to 250 employees. The number of rehabilitation beds in each facility ranged from 30 to 60 beds. The total number of beds in each facility ranged from 150 to 300 beds.

Results

Research Question 1. The analysis and results of research question 1 answered how DSSs at large corporate RHCs influenced leadership policies at corporate, facility, and social service staff levels. The results for research question 1 included two categories: information sharing and teamwork, and leadership style.

Information sharing and teamwork. Respondents reported the importance of teamwork and communication as fundamental to the development of leadership policies. Many participants discussed strong levels of teamwork in their facilities, while others

noted that teamwork was important in their facilities, but room for improvement existed. The responses demonstrated directors' acknowledgement of the importance of teamwork and communication for promoting productive work environments. Participants also noted that observations and acknowledgments extended to the methods by which directors influenced leadership policy development at each level of the organization. All 10 participants stated that they promoted the importance of team work and communication, which influenced policies at the corporate, facility, and social service staff levels.

Directors communicated these observations at the corporate level through stand-up meetings, while leadership policy development at the facility level was communicated via 24-hour nursing reports. Directors also influenced policies at every level of the organization by communicating observations and concerns whenever and with whomever necessary. Their answers reflected the understanding of supporting leadership through effective communication policies and by using their judgment regarding how they shared patient information. All 10 participants used identical language to state that existing policies and procedures must be followed. Their statements highlighted participants' influence on policy at each level, as their statements supported and demonstrated respect for adherence to organizational policies and practices. Such adherence also provided example behavior for staff to follow, which fostered support for leadership policies and development.

Leadership style. Participating DSSs influenced leadership policies at corporate, facility, and social service staff levels through their leadership styles, as their behaviors and actions impacted different levels of the organization. Three leadership styles

appeared in their responses, including servant, transactional, and transformational leadership.

Servant leadership. Servant leadership responses reflected an emphasis on listening, empathy, trustworthiness, service orientation, and community building. Participants noted the importance of being a good communicator, advocating for staff and patients, providing care and being self-sacrificing. These were all important behaviors for handing crisis.

Transactional leadership. Participants reflected the transactional leadership model which included: (a) clearly stated goals and objectives, (b) clearly specified behaviors that followers can use to achieve these goals, (c) active monitoring of the group, and (d) positive and negative feedback to enforce compliance (Nahavandi, 1997). Respondents 1, 3, and 4 reported a transactional leadership style. Responses reflected the importance of clearly stated goals and objectives, and emphasized the importance of communicating well and providing clear guidance to support workflow. Statements also reflected the importance of working group dynamics and providing good example to subordinates.

Transformational leadership. Responses included discussion of characteristics of transformational leaders, who are charismatic, visionary, and inspirational. They appeal to followers' ideals and higher-order values, such as self-actualization or community service, rather than simple exchanges of benefits for performance (Bass, 1985). The responses demonstrated aspects of this type of leadership, including higher order values and sense of duty beyond job description, which included patient well-being and

empathy. Responses demonstrated the importance of being a good role model for influencing leadership development in staff and reflected points about higher order service, self-actualization, and performance beyond transactional behavior. Some responses promoted service to their staff and colleagues, which also showed a commitment to higher order behavior. The results provided insight into how DSSs at large corporate RHCs influenced leadership policies at corporate, facility, and social service staff levels.

Research Question 2. The analysis and results of research question 2 answered how DSSs at large corporate RHCs prepared subordinate social workers for crises prevention and management using multilevel, situational, and complex adaptive leadership. Crisis prevention management and management techniques were reflected in the responses related to these leadership styles. Participant responses indicated that the leadership styles also overlapped in their influence on how social workers were prepared for their response to crises.

***Multilevel leadership*.** Multilevel leadership referred to corporate governance, strategic planning, and human resources management. Directors prepared their subordinates to handle crisis prevention and management situations by teaching to subordinates of how to identify multilevel leadership style. This style included broad strategic planning and management from each department in the facility. This was reflected by Respondent 1 who noted that staff learned and practiced as “decisions get made about resident care, schedules etc. through care planning and care conference meeting. Each interdisciplinary team do provide input on the care plan to ensure that we

can provide the appropriate care for the resident." The responses also reflected that communication regarding crises and similar incidents occurred directly with Directors of Nursing or administration, further indicating an understanding and practice by staff of a multilevel leadership style across the organization.

Situational leadership. Situational leadership referred to caregiving, prevention, and management of anticipated crisis. Participants discussed situational leadership by explaining to staff how decisions were made about issues such as resident care and schedules. Similar responses were reflected in those answers related to multilevel leadership, as respondents stated that the different levels of the organization had important input regarding the decision-making process for handling and preventing crises. Respondent # 2 noted this stating while "the decisions get made about resident care… [this occurs] through care planning and care conference meeting. By doing so we develop an appropriate care plan so that we can provide the appropriate care for the resident to meet the resident needs." Responses indicated situational leadership by having interdisciplinary teams provide input into how to appropriately provide patients with care, prevention, and management of future crises.

Complex adaptive leadership. Complex adaptive leadership referred to crisis management associated with patient injury and disease emergencies. Participants 5, 7, and 8 also stated how an interdisciplinary team helped to handle discussion and assessment of patients who experienced infections and falls. Directors involved staff on these discussions to prepare social workers patient injury reporting and disease emergencies. These preparations were important as directors stated how their social

worker staff responded to witnessing serious resident accidents, medical, or psychological crisis, firsthand**.** Respondent 1 noted "it is totally dependent on the situation and for the most part we report it to the nursing staff then that situation is being address. The outcome was good because the situation was addressed."

Research Question 3. The analysis and results of research question 3 answered the following: based on the experiences of DSSs at large corporate RHCs, how do social work professionals influence decisions made regarding patient care and well-being?

Relational coordination. Participants' responses reflected relational coordination as the manner in which social work professionals influenced decision making. Previous researchers described relational coordination as the mutual understandings of work functions and context (Gittell et al., 2008). This type of communication was stated as present during crisis management, with participants noting that communication occurred immediately with the nursing department when an incident occurred. They noted the interactions were handled quickly, as protocol was followed correctly. Respondent 6 noted this, stating "it usually involved nursing for most of the time. The outcome is good and it is effective. The outcome was good and effective because it was addressed accordingly." Participant responses showed that successful relational coordination occurred among the staff, and this type of interaction was described as effective when showing frequent information exchange, problem-solving during crises, and feedback between interdependent staff.

Research Question 4. The analysis and results of research question 4 answered how DSSs at large corporate RHCs believed communication among all staff regarding

patient care and well-being could be improved. Responses noted that constantly working towards better communication and remaining aware of any misunderstandings ameliorated this problem. Respondent 2 reflected this saying

> I would say that the teamwork is a bit challenging at times because of lack of communication. As the Director of Social Services I always do my very best with regards to effective communication so that everyone is on the same page.

Responses indicated that communication improvements could occur by sharing information across these groups. Communication improvements might be facilitated through continued information sharing among staff in different departments and the reporting of incidents in a timely manner.

Conclusion of Findings

Information sharing, teamwork, and leadership styles influenced leadership policies, as participants shared their observations, opinions, behaviors, and actions through their interactions with each level of the RHC. Leadership policies might be linked to corporate, facility, and social service staff perceptions of the directors' behaviors, which in turn directly or indirectly influence the development and embracing of current or future leadership policies in the organization. The participants' responses also reflected a trend noted in the literature regarding RHC management's movement towards positive local interaction patterns and strategies between all staff in opposition to traditional hierarchal strategies (Anderson et al., 2014; Gittell et al., 2008). The directors' statements and reported behavior patterns reflect the type of leadership policy scheme in which DSSs, organizational staff, and administration in some RHCs engage with each

other to exchange information and interact to develop leadership capacity at each level of the organization. These behaviors allow everyone to meet the demands of the system and patients in a way that improves the environment and chain of command. Such influence on leadership styles also might reduce turnover among social service staff in organizations where such leadership styles or practices are lacking, as supportive supervision correlates with improvements in job satisfaction (Cole et al., 2004; Davis-Sacks, et al. 1985; Farmer, 2011; Siefert et al., 1991). Directors' behaviors demonstrated the potential to support the development or maintenance of further leadership policies that meet the psychological needs of social workers, provide them with a better perspective on their importance in the workplace, and increase their job satisfaction.

DSSs are usually part-time leaders of other social workers and staff. The literature showed that their leadership styles might vary across organizations and be dependent upon facility organization. For example, operations in RHCs can be complex due to the end-of-life status and major multi-morbidity among many patients (Bern-Klug et al., 2010; Glover, et al., 2014; Gudmannsdottir, & Halldorsdorsdottir, 2009; Kennedy et al., 2014; Tinetti et al., 2012; Toles & Anderson, 2011). In addition, the situations in each facility demanded that unique leadership existed within the facility and social work management structures. Leaders were also required to be constantly aware of each situation, as crisis management and prevention were important due to residents' specialized and life-threatening situations. Among RHC leaders, DSSs had multilevel responsibilities that included routine administrative responsibilities, situational leadership

in anticipation of crisis, and leadership during medical crises. Their leadership was noted as relatively new, with research only gaining momentum in the past decade and a half.

As noted previously, Anderson et al. (2003, 2004, 2005, 2014), Gittell (2001, 2002), Gittel et al. (2006, 2007, and 2008), Hancock and Kreuger (2010), Toles et al. (2011), Wong, et al. (2003) and others contributed new key concepts to the literature, especially on the importance of context-specific relational communication leadership, relational coordination leadership, complex-adaptive leadership, and multilevel leadership. Findings also indicated that these researchers challenged previous researchers, such as Wong and Cummings (2007), who argued for the application of context-free traditional leadership formats such as transformational leadership to RHC leadership; and Goleman (1995, 1998, 2013) and Goleman et al., (2013) who argued for the use of multiple traditional leadership styles driven by the leadership concept of emotional intelligence. Different situations provided DSSs with opportunities to exercise a variety of leadership styles, as touched upon in the literature, which ranged from situational, transformational, adaptive, decentralized, opportunistic, shared governance in a complex adaptive system, self-management, shareholder leadership, crises intervention, and developing crises leadership. Participant responses supported the notion that a variety of leadership styles contributed to good outcomes across the organizations. Problems that existed related to poor communication across departments. When staff had support, leadership, and understood what was expected of them, organizational outcomes were positive regardless of the leadership style employed.

Social work professionals have noted influence on the decisions made regarding patient care and well-being through the practice of relational coordination, which was particularly important in contexts with high levels of task interdependence, uncertainty, and timeliness, which could lead to greater employee job satisfaction and resident quality of life. Functional interdependence is high among RHC caregivers because resident care requires comprehensive skills in a wide variety of areas, and successful completion of any task depends upon the quality of other completed tasks as inputs. Successful relational coordination is important in these contexts, and was characterized among RHC staff by frequent information exchange, problem-solving during crises, and feedback between interdependent staff. High quality relational coordination should increase caregivers' abilities to improvise and coordinate complex information (Gittel et al., 2008). These characterizations were all present among the responses provided by the participants.

Previous research indicated that top-down leadership produced inferior resident outcomes, fostered poor communication between staff, excluded staff from leadership participation, and increased staff turnover. Several researchers reported this, such as Anderson et al. (2005), who noted poor staff-to-staff connections limited management of care problems. Similarly, Bakour (2006) found that top-down management styles in an RHC were associated with inferior resident care. Swagerty et al. (2005) found that passive communication among RHC staff related to poor collaboration and less detailed care planning, while Colón-Emeric et al. (2006) found open communication and

leadership related to greater information flow and creativity in problem-solving than did top-down leadership.

Participants in the current study supported the previous literature, believing communication among all staff regarding patient care and well-being could be improved via the development of ongoing communication efforts and relationships at each level of the organization. Improvements in communication occurred when all staff were aware of any misunderstandings and immediately shared incidents with the appropriate department. Communication improvements occur by sharing information across these groups, and might be facilitated through continued information sharing and the reporting of incidents in a timely manner.

Limitations

The purpose of this qualitative phenomenology was to explore DSS leadership at large, corporate RHCs in Virginia. Specifically, I explored how DSSs (a) influenced leadership policies, (b) prepared subordinates for crisis intervention and management, (c) believed social workers influenced decision-making regarding patient care, and (d) believed communication amongst RHC staff regarding patient care could be improved. However, the study had a few limitations. First, the small geographic location served as a limitation. Although the goal of qualitative research is not generalizability, results could not be directly applied to any other populations of DSSs. The small sample size was also a limitation. DSSs are rarely employed full-time in facilities with less than 120 beds, and because the majority of RHCs have less than 120 beds, the population of DSSs within the geographic range of this investigation was small. However, the sample of 10 participants

provided a robust amount of information to explore the research questions. Finally, due to the heavy workloads of full-time DSSs, it might have been difficult for prospective participants to find time to participate. I overcame this limitation by reducing the inconvenience associated with participating by maintaining a flexible schedule that allowed participants to meet with me at times that were convenient for them.

Recommendations for Future Research

The problem addressed by this study related to leadership provided by DSSs and turnover among RHC social workers. Because research indicated that employee turnover was often related to support and direction provided by leaders, it was possible that turnover among RHC social workers relates to the leadership that social workers receive in large RHC settings. This was important to study, because while researchers have studied the leadership styles, strategies, and interactions of facility administrators and DONs, a substantial gap existed in the literature regarding the specific leadership styles and strategies employed by DSSs (Aberdeen & Angus, 2005; Joel & Sibille, 2013). The purpose of this qualitative phenomenology was to explore DSS leadership at large, corporate RHCs in Virginia. Specifically, I explored how DSSs (a) influenced leadership policies, (b) prepared subordinates for crisis intervention and management, (c) perceived that social workers influenced decision-making in patient care, and (d) believed that communication amongst RHC staff about patient care could be improved. The results of the study supported the previous literature, which indicated that to maximize the quality of care provided to patients, RHC staff must be properly led, trained to respond to patient care crises, and communicate across departments.

Social workers continue to play an important role in patient care at RHCs, but these facilities still may have a difficult time retaining social workers due to high turnover rates unless these other issues are addressed. I also noted previously that research in this area remains relatively new, only spanning the last decade and a half. While results from this investigation provided new insights that could be used to improve DSS leadership and reduce social worker turnover in RHCs, given the recent timeframe and the remaining gap in the literature, there are other gaps in this area of study that warrant further research.

The results of this study demonstrated the importance of studying DSS leadership styles in different contexts, as more facilities might expand recruitment and retention of social worker staff. Further research is necessary to understand if different leadership styles are successful in other areas of the United States and internationally. Other DSS's should be interviewed and their answers analyzed to examine any similarities or differences across organizations. The interview protocol developed for this study offers a useful tool that might be replicable across similar studies. Future studies might also expand the sample to include perspectives of other organizational staff and subordinate social workers in order to validate responses provided by DSS leadership.

As indicated by the results, DSS leadership is fundamental to preparing subordinate staff to support patient care and to handle crisis management and prevention for patients. Therefore, it is important that their perceptions and experiences about leadership in the facility are captured clearly and accurately to assess which styles work appropriately. Ongoing research, education, awareness, and professional development are

the ways to improve retention of social work staff in these facilities and improve patient care practices.

Implications for Social Change

The goal of the study was to add to the knowledge base of social workers by providing new insights that could be used to improve DSS leadership and reduce social worker turnover in RHCs. This is an important step in addressing social workers' concerns and helping corporate leaders understand the role they play in managing these problems. Results from this study may contribute to positive social change by increasing the limited knowledge base on DSS leadership in RHCs. In addition, the results of this study have the potential to help new social workers interested in working in RHCs understand how to navigate the complexity of the system and communicate with different leadership styles.

The results of this study also have the potential to promote positive social change by raising awareness of the different levels of leadership within an RHC. Raising awareness at the corporate and facility levels may help to improve communication and understanding about the importance of social workers in improving and facilitating patient care and crisis management. Sharing the results of this study with relevant professional organizations and the RHCs that participated in the study could potentially improve leadership support and understanding of leadership style and social workers' needs.

As previously noted, there remains a gap in the research regarding the study of social workers in the context of RHCs. As this area of research is still new, there are

many research opportunities for future scholars. The main implication for positive social change is that this study could help improve the facilitation of care in RHCs and improve the recruitment and retention of the social workers who are vital to providing for patients' needs and preventing crises in RHCs.

Conclusion

RHCs continue to provide ongoing care to the elderly and chronically ill, and care provided to these patients requires that RHC staff are properly trained and managed to identify and respond to patient crises, especially when communicating across departments. While researchers examined different leadership styles and practices occurring among facility administrators and nursing staff, a gap existed in the literature regarding the specific leadership styles and strategies employed by DSSs with subordinate social worker staff. In order to address that gap, the aim of this phenomenological study was to explore how DSSs (a) influenced leadership policies, (b) prepared subordinates for crisis intervention and management, (c) perceived that social workers influenced decision-making in patient care, and (d) believed that communication amongst RHC staff about patient care could be improved. The conceptual framework of the study was based upon three leadership model constructs: (a) the multilevel leadership model construct, (b) the situational leadership model construct, and the complex adaptive leadership model construct.

Data were collected via in-person, semistructured interviews consisting of open-ended questions from participants from a purposive sample of 10 DSSs working in large, corporate RHCs in the Virginia. Analysis revealed that a variety of leadership styles

supported good management and leadership in RHCs. Results from this investigation provided clarification of DSSs' roles and responsibilities, and offered the opportunity to provide improvements to how DSSs provide leadership to subordinate social workers. Results might also be used to improve communication across professionals within RHCs, and reiterate the important role that social workers should play in patient care decisions.

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Appendix A: Informed Consent Form/Study Invitation

My name is John Paul Abenojar, and I am conducting a doctoral study at Walden University. I obtained your mailing address from National Association of Social Workers (Virginia Chapters).

You are invited to take part in a research study to explore Director of Social Services (DSS) leadership at large, corporate Rehab Healthcare Chains (RHCs) in Virginia. Specifically, I will explore how DSSs (a) influence leadership policies, (b) prepare subordinates for crisis intervention and management, (c) believe social workers influence decision-making regarding patient care, and (d) believe communication amongst RHC staff regarding patient care could be improved. This form is part of a process called "informed consent" to allow you to understand this study before deciding whether to take part.

To qualify to participate in the study, you must meet the following inclusion criteria: (a) be currently employed full time as a DSS at a state licensed RHC that qualifies for Medicare and Medicaid, and which has consistently had more than 120 beds for at least 5 years; (b) possess at least a bachelor's degree in social work from an accredited school of social work; (c) have at least two years of full time experience at their current facility; and (d) have at least one full time subordinate social worker for which they are responsible.

Background Information:
The purpose of this study is to increase the understanding of leadership styles and strategies used by DSSs in large privately held for-profit corporate chain skilled nursing homes found in the United States today.

Procedures:
If you agree to be in this study, you will be asked to participate in an in-person interview that will last no longer than 60 minutes. Interviews will be audio-recorded. I will ask questions about your interaction with other nursing home directors, your role in leading subordinate social workers in preparing for, dealing with, and preventing developing crises at the facility, and what leadership strategies you employ to help subordinate social workers manage unfolding crises. After I have transcribed your audio-recorded interviews, I will send a copy of your interview transcript and ask you to review it for accuracy. This process will help to ensure I have accurately captured your thoughts and ideas during the interview. Your transcript review should take no longer than 30 minutes. Once you have reviewed transcript, I will ask you to contact me to confirm the accuracy of the document, or bring attention to any discrepancies.

Here are some sample questions:

1. How do decisions get made about resident care, schedules, etc. at your facility?
2. What leadership have you provided social workers on your staff in preparing for, dealing with, and preventing what appear to be inevitable developing crises at your nursing home facility?
3. What has been the very first thing that members of the social worker staff have done when witnessing a serious resident accident, medical, or psychological crisis first hand? What was the outcome? How effective has that been?

Voluntary Nature of the Study:
This study is voluntary. Everyone will respect your decision of whether or not you choose to be in the study. No one at the NASW or Walden University will treat you differently if you decide not to be in the study. If you decide to join the study now, you can still change your mind later. You may stop at any time.

Risks and Benefits of Being in the Study:
Being in this type of study involves some risk of the minor discomforts that can be encountered in daily life, such as minor fatigue in this study would not pose risk to your safety or wellbeing.

The study will extend knowledge in social work by filling at least one of the gaps in the research literature about the role of DSSs in large chain privately held nursing facilities. This is knowledge that is expected to benefit the community by revealing what DSSs in the field actually are responsible for and do in the interests of the residents and the community.

Payment:
The will be no payment, gifts or reimbursements for participating in the study.

Privacy:
Any information you provide will be kept confidential. The researcher will not use your personal information for any purposes outside of this research project. Also, the researcher will not include your name or anything else that could identify you in the study reports. Data will be kept secure by being kept under lock and key by the researcher for the duration of the Ph.D. dissertation program, use of number codes in place of real names, storing names in a different location off of any computer from the codes, and discarding the names after the study has been completed. Data will be kept for a period of at least 5 years, as required by the university.

Contacts and Questions:

You may ask any questions you have now. Or if you have questions later, you may contact the researcher via phone – (703)231-4859 and/or e-mail address johnpaul.abenojar@waldenu.edu. If you want to talk privately about your rights as a participant, you can call Dr. Leilani Endicott. She is the Walden University representative who can discuss this with you. Her phone number is 612-312-1210. Walden University's approval number for this study is **11-29-16-0288232** and it expires on **November 28, 2017.**

Please print or save this consent form.

Obtaining Your Consent

If you have read this study invitation, meet the inclusion criteria, and would like to participate, please sign below to indicate your consent. You may print and mail signed forms to John Paul Abenojar.

Alternatively, you may e-mail sign forms to Johnpaul.abenojar@waldenu.edu

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[Participant's Printed Name]

[Signature]

Appendix B: Demographic Questionnaire

Date: _____

Name: _____

Numeric Identifier of Personnel Interviewed and Designation:

_____

Time of interview: _____

Interview Guide

1. What year were you born?

2. What is your race?
White,
Black or African American
American Indian or Alaskan Native
Asian
Native Hawaiian or other Pacific Islander
Multiple races
3. What is your gender?
Female
Male
4. What formal education have you had?
    Less than high school degree
    High school degree or equivalent (e.g. GED)
    Some college but no degree
    Technical College
    College
    Postgraduate or professional degree

5. Years employed with your current nursing home?
0-5
6-10
11-15
16-20
21-25
25+

6. Years employed as a DSS?

0-5
6-10
11-15
16-20
21-25
25+

7. Total number of social workers you manage?

8. Total number of staff in your rehabilitation and healthcare facility?

9. Number of rehabilitation beds in your facility

10. Total number of beds in your facility.

Appendix C: Interview Protocol

DSS Leadership Practices

The following questions deal with first-hand direct experiences you've used dealing with routine or reoccurring situations at your nursing home facility. I would like to now ask you some questions about your leadership experiences at your organization. In formulating your responses to the questions I'm going to ask you, I'd like to ask you to focus upon one or two cases in particular you've experienced that were similar so your responses can be based on specifics.

Interview questions of DSSs about interaction with other facility directors in managing routine corporate leadership policy at the corporate, facility, and the DSS staff levels:

1. What is it like to exert DSS leadership in this facility?

2. What things about your work do you do well?

3. What do you see as most important in your role?

4. What does good leadership mean to you?

5. How do decisions get made here about resident care, schedules, etc.?

    a. Probe for formal (e.g. care planning meetings)

    b. e.g. , nurse, social worker, administrator, comes to me to ask my opinion, or nurse, social worker, administrator, asks me about things if they happen to run into me in the hall.

Interview questions of DSSs about the role DSSs play in leading subordinate social workers in preparing for, dealing with, and preventing developing crises at the facility and DSS staff levels at corporate owned facility

6. What is teamwork like in this facility?

7. Who has asked you for information about the residents you are responsible for?
8. Sometimes you may have information about your resident or residents that you think others on staff need to know. How have you gone about sharing info about your residents with others if they haven't asked?
9. What leadership have you provided social workers on your staff in preparing for, dealing with, and preventing what appear to be inevitable developing crises at your rehabilitation healthcare facility?
10. How much time and effort has your staff spent informally sharing information with others of your staff and other staff in your rehabilitation healthcare facility?
11. What has been the best way you rely upon in discovering what is going on with residents and other staff in your rehabilitation healthcare facility?

Interview questions about leadership strategies are exerted by DSSs in leading subordinate social workers in managing unfolding crises intervention at the facility and staff levels at corporate owned rehabilitation and healthcare.

12. What has been the very first thing that members of the social worker staff have done when witnessing a serious resident accident, medical or psychological crisis first hand? What was the outcome? How effective has that been?

13. What was the very first thing you did recently when you witnessed a serious resident accident, medical or psychological crisis first hand? What do you do after this?
14. What staff did you rely upon most in a unfolding resident crisis intervention?