The Effect of Coaching on Nurse Manager Leadership of Unit Based Performance Improvement: Exploratory Case Studies

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Final DNP Project Report
The Effect of Coaching on Nurse Manager Leadership of Unit Based Performance Improvement: Exploratory Case Studies

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University of Kentucky
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December 2013

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Dedication

I dedicate this doctoral capstone project to my husband Marty who has taken on extra "house husband duties" for the last three years and my children Justin and Katie.
Acknowledgement

I acknowledge my committee for their support during my progression during my doctoral study and the wonderful nurse managers who participated in the case studies.
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Introduction to Final DNP Capstone Report

Cynthia Baxter

University of Kentucky
The nurse manager role has experienced an explosion of responsibilities and expectations over the last decade. As a result, competency and skill acquisition for the successful nurse manager has become the focus of many nurse managers, nurse executives, researchers and organizations. The three manuscripts contained in this final capstone report will explore the acquisition of nurse manager competency, propose coaching as a methodology for acceleration and improvement of nurse manager skill acquisition and describe the results of three case studies using coaching as an intervention to improve the performance improvement skill acquisition of nurse managers.
Manuscript 1

Exploring the Acquisition of Nurse Manager Competence
Title: Exploring the Acquisition of Nurse Manager Competence

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This manuscript is written using AMA reference style and is in press for Nurse Leader publication.
Abstract

In the increasingly complex environment of healthcare, the nurse manager provides vital leadership for healthy work environments, positive patient outcomes and achievement of organizational goals. However, the development of skills critical for success is often overlooked and new nurse managers struggle during their role transition from a clinical provider to nursing leadership. This article presents the results from two institutions using the Nurse Manager Skills Inventory Tool© that accompanies the Nurse Manager Leadership Partnership Learning Domain Framework© to explore the acquisition of nurse manager competence.
**Background**

In the increasingly complex environment of healthcare, the nurse manager provides vital leadership for healthy work environments, positive patient outcomes and achievement of organizational goals. However, the development of skills critical for success is often overlooked and new nurse managers struggle during their role transition from a clinical provider to nursing leadership. The Nurse Manager Leadership Partnership Learning Domain Framework© (Learning Domain Framework©) was developed through collaboration between the American Organization of Nurse Executives and the American Association of Critical Care Nurses.¹² (Figure 1) The evidence based framework consists of three domains: the development of the *leader within*, the *science of managing the business* and the *art of leading people*.³⁻¹¹ “Leadership skills begin with knowing one’s self” and skills required for success in the *leader within* domain include personal mastery of emotional intelligence, accountability and responsibility for one’s communication and actions, developing authentic leadership skills of self discovery and improvement, and developing enough self confidence to empower others.¹¹ The science of *managing the business* spans a collection of skills that enable the nurse manager to plan strategically for quality care and financial stability of their area of responsibility. Using foundational thinking, clinical knowledge, performance improvement methodologies and technology skills, the nurse manager manages financial and human resources to efficiently improve quality care. To *manage the business*, the nurse manager must be able to *lead the people* by “managing relationships and influencing others” toward common goals by fostering teamwork, “developing trust and managing conflict.”¹¹ The three competency domains reflect the explosion of responsibility and expectations of the current nurse manager role.
Based on a review of the literature, nurse managers and nursing staff perceive competencies that revolve around management of the unit at a higher priority than nurse executives. Those competencies include staffing and scheduling, empowering and development of staff, unit operations, teamwork, communication, and conflict resolution. Nurse executives ranked competencies focused on organizational strategic planning, finance and analytical thinking higher than unit based competencies. Anthony also found that nurse managers prioritized competence differently based on their level of formal education. Nurse managers holding an Associate Degree were more focused on tasks or operations, those with a Bachelor’s Degree were more focused on professional development and those with a Master’s Degree were more organizationally focused. Kleinman found differences between nurse managers and nurse executives in the importance placed on formal educational. Nurse executives desired master’s level education for nurse managers much more strongly than did nurse managers. Formal graduate education promotes broader system thinking skills needed for success in both current nurse manager and future nurse executive roles.

While the review of the literature emphasized defining the necessary competencies and skills demonstrated by successful nurse managers and less on the acquisition and development of these important skills, nurse managers and executives alike agreed that significant challenges existed for the new nurse manager. Those challenges were the vast responsibilities of the nurse manager role, the lack of knowledge and skills of new nurse managers to achieve success, and the constant competing priorities and demands on the nurse manager’s time. These challenges can be overwhelming and nurse managers have difficulty balancing the responsibilities of their new role. Much like the journey for new graduate nurses described by Benner, new nurse managers, or experienced managers with new responsibilities, acquire new
skills by following the “journey” of novice to expert requiring orientation and development to be successful in their new role.\textsuperscript{11, 12} The Nurse Manager Skills Inventory Tool© accompanying the Learning Domain Framework© is designed to assess the learning and development needs of nurse managers and is based on Benner’s Novice to Expert theory of skill acquisition.\textsuperscript{1, 2, 12}

Nursing leaders at the Veteran’s Administration Medical Center (VAMC) and the University of Kentucky Health Care Enterprise (UKHC) in Lexington, Kentucky wanted to develop a competency based orientation and development program for their nurse managers. The Nurse Manager Skills Inventory Tool© is designed to assess strengths and weaknesses and identify areas of development for nurse managers based on the Learning Domain Framework©. Both organizations independently utilized the Nurse Manager Skills Inventory Tool© to perform baseline assessments of their nurse managers’ perceived competency. This article will present a comparison of the self assessed competency of the nurse managers employed by the two organizations and how the information guided program development.

**Methods**

A voluntary, electronic survey design was administered to all nurse managers working at the VAMC and UKHC. Institutional Review Board approval was obtained from the VAMC and the University of Kentucky. Thirty-seven nurse managers completed the on line assessments. The distribution by organization and years of experience are presented in Table 1. The return rate was 89\% for VAMC (n=16, N=18) and 44\% for UKHC (n=21, N=48).

The Nurse Manager Skills Inventory Tool© was used to assess the 15 competencies in the three domains of the Learning Domain Framework©. Nurse
managers were asked to rate themselves according to their perceived level of
competence using Benner’s scale of 1 = Novice, 2 = Advanced Beginner, 3 =
Competent, 4 = Proficient, and 5 = Expert as directed by the Nurse Manager Skills
Inventory Tool©. (Table 2)

Analysis

At the VAMC, detailed descriptions of the skills included in each competency
category were provided and nurse managers were asked to rate each category. The
category skills were averaged to create mean scores for each competency. At the
UKHC, organizational specific items related to each of the competency categories were
developed and nurse managers were asked to rate each item. Items scores were
averaged by individual and then averaged to create mean scores for each competency
category. The data were analyzed using Statistical Package for the Social Sciences. Mean scores for each competency were determined by years of experience and for each organization.

Results

The domains of managing the business (science) and leading the people (art) are presented in Figures 2 through 5. The leader within is not represented in the figures because it was only collected at VAMC. For both organizations, nurse managers’ perceived competence increased with years of nurse manager experience and with the exception of clinical practice, it took 6 years for most competencies to reach “proficient” (4) level. It also took 6 years for the science of managing the business to reach the same perceived level of competence as the art of leading the people. In both organizations the only competency that nurse managers rated as “expert” or near
“expert” (5) level was clinical practice once nurse managers achieved 6 to 10 years of experience.

For nurse managers with less than 2 years of experience, clinical practice (in the science domain) was the highest perceived competency (VAMC m = 3.67 and UKHC m = 3.64). The lowest perceived competencies were all within the science domain and reached below or at advanced beginner scale (2): financial management (VAMC m = 1.33 and UKHC m = 1.67), performance improvement (VAMC m = 1.88 and UKHC m = 2.00), foundational thinking (VAMC m = 2.00 and UKHC m = 1.93) and strategic management (VAMC m = 2.00 and UKHC m = 1.96). The two other competencies within the science domain (human resource management and technology) ranged from just above advanced beginner (2) to barely approaching competent (3). Scores in the art of managing the people domain (human resource leadership, relationship management, diversity and shared decision making) were higher than the science domain with most being perceived at competent (3) or slightly below.

Nurse managers with 3 to 5 years of experience rated themselves only slightly higher. Again, the range of perceived competency for those skills in the art category (means of 2.75 to 3.5) ranged higher than those in the science (means of 1.28 to 3) category. The highest perceived competency was clinical practice (VAMC m = 3.75 and UKHC m = 2.75), the lowest were financial management (VAMC m = 2.00 and UKHC m = 1.89), performance improvement (VAMC m = 3.25 and UKHC m = 1.93), technology (VAMC m = 2.75 and UKHC m = 2.17) and strategic management (VAMC m = 2.75 and UKHC m = 1.38). Performance improvement showed slightly better perceived competence when compared with nurse managers with less than 2 years of experience with a mean range of 1.93 to 3.25.
At 6 to 9 years of nurse manager experience, there was notable increase in all competency categories and again, the highest perceived competency was clinical practice (VAMC m = 5.00 and UKHC m = 4.75). Consistent with the findings of the perceived competency of nurse managers with less than 2 years and 3 to 5 years experience, the perceived competency of those with 6 to 9 years of experience was higher in the art domain (mean scores ranged from 3.35 to 4.41) than in the science domain (excluding clinical practice) with mean scores ranging from 2.57 to 3.80. The lowest rated competencies were technology (VAMC m = 3.50 and UKHC m = 2.57), financial management (VAMC m = 3.00 and UKHC m = 3.19), and strategic management (VAMC m = 3.00 and UKHC m = 3.33). Although foundational thinking approached the proficient level (4) with mean scores of 3.50 (VAMC) and 3.80 (UKHC), none of the science domain competencies (excluding clinical practice) reached proficient (4) levels.

Nurse managers with 10 or more years of experience again scored their clinical practice (VAMC m = 4.50 and UKHC m = 5.00) competence highest, reaching expert (5) or just slightly below expert levels. There was minimal change in the perceived competence in the art (mean scores ranged from 3.30 to 4.17) and science domains (excluding clinical practice, means range of 2.50 to 4.05) over the perceived competence of nurse managers with 3 to 5 years of experience. The lowest rated perceived competencies in this group were financial management (VAMC m = 2.5 and UKHC m = 3.67) and strategic management (VAMC m = 3.17 and UKHC m = 3.26). The perceived competence in the art domain ranged from slightly above competent (3) to slightly over proficient (4) with mean scores ranging from 3.33 to 4.17 with most competencies approaching the proficient level.
Discussion

This data illustrates that while many clinically strong nurses are promoted to nurse manager roles, clinical expertise does not prepare the new nurse manager for the wide range of competencies required for success. Competencies identified in the Learning Domain Framework© and the Nurse Manager Skills Inventory Tool© may be beneficial for interview and selection of candidates for nurse manager positions.

It was remarkable that the nurse managers in two different institutions had similar perceptions of their management competence. The VAMC is a mid-sized referral center for smaller Veterans Administration facilities with two divisions located approximately 5 miles apart providing services ranging from outpatient to long term care, including intensive and inpatient care. The operating inpatient bed capacity is less than 200 with a large outpatient function. UKHC is an enterprise consisting of three acute care locations and specialty hospitals for cancer, pediatric and cardiac care as well as a large outpatient service. It is a tertiary medical center for Kentucky and contiguous states with an operating bed capacity over 700+. The only notable differences in perceived competence, defined by a difference in means between facilities of 1 or more, were an increase in perceived competence of strategic management (VAMC m = 2.75, UKHC m = 1.38) and clinical practice (VAMC m = 3.75, UKHC m = 2.75) at 3 to 5 years. However, means were equal between the two facilities by 6 to 9 years of experience.

While there were some slight organizational differences, overall the trends confirmed an increase in competence over time taking approximately 6 years to reach “competent” levels for most competencies. Over time, the lowest rated competencies were finance, performance improvement, foundational thinking and strategic management. These competencies reflect the broader vision required for succession
planning to nurse executive positions from the ranks of nurse managers. Competencies identified in the literature as those higher in priority for nurse managers and staff, human resources management and relationship management reached competent and proficient levels sooner.\textsuperscript{3,4,6,8} Even so, nurse managers never reached perceived competence of expert (5) for any competence other than clinical practice and may reflect the dynamic nature of healthcare and thus, the nurse manager role.

**Application to Nurse Manager Development Program Planning**

These results support the use of an organized, incremental and integrative approach to nurse manager orientation and development much like what is already in place for new nursing graduates following the experiential theory of skill acquisition described by Benner.\textsuperscript{12} Typically an interim nurse manager “orients” the new nurse manager over a brief period of time and is then available for consultation to the new nurse manager as issues arise. During the orientation time, both nurse managers are accountable for the unit but only the new nurse manager is accountable during the consultation phase. Some organizations have coaching and mentoring programs designed to support the new nurse manager during the consultation phase or longer. Some organizations provide classroom education to teach leadership skills for nurse managers. However, most of these programs are loosely defined and based on current leadership theories in business and healthcare versus an organized approach specific to the unique needs of nurse managers.

The Learning Domain Framework© provides a model on which to build a nurse manager specific orientation and development program. The Nurse Manager Skills Inventory Tool© assesses the needs of the nurse manager population and identifies the starting point to build an organized, incremental and integrated program to accelerate
new skill acquisition for both the new nurse manager, and for existing nurse managers as their roles and responsibilities change. Using Benner’s theory, nurse managers need opportunities for experiential learning to build their competency to expert (5) levels.\textsuperscript{12} Thinking of nurse manager skill acquisition in this manner, pairing up nurse managers with subject matter experts to complete assignments or projects requiring competencies identified in the framework and inventory tool might accelerate skill acquisition and lay the groundwork for future success for that competency.

**Recommendations for Practice and Future Research**

The Nurse Manager Skills Inventory Tool\textsuperscript{©} was useful in determining gaps when planning, implementing and evaluating programs to strengthen nurse manager competency and to identify the desired qualifications for preceptors and/or coaches for new nurse managers. The purpose of this article was to report on the findings from two evidence-based practice projects and not intended to produce generalizable knowledge. Use of the Nurse Manager Skills Inventory Tool\textsuperscript{©} for self-assessment by nurse managers in organizations to guide professional development programs is recommended. Assessing nurse manager competencies identified in the Learning Domain Framework\textsuperscript{©} and the Nurse Manager Skills Inventory Tool\textsuperscript{©} can focus on-going competency development to broaden the skills of nurse managers to prepare for advancement to the executive level.\textsuperscript{3, 7, 8} Cadmus and Johansen recently proposed a front line nurse manager residency program for new nurse managers with less than 2 years of experience.\textsuperscript{14} While this type of program may pose financial and other challenges for organizations, the lack of self-assessed competence to the competent (3) level for nurse managers with less than 2 years of experience exhibited in this study illustrates the need for this type of out-of-the-box thinking. Academic institutions may find financial benefit in developing a Master’s program or short term certificate program
designed to build successful competencies for the nurse manager role that includes a clinical component designed to accelerate skill development according to Benner’s theory and the Learning Domain Framework©.¹²

Most nurse executives have informally observed what is now supported in the literature: patient care units with competent successful nurse managers have healthier work environments with positive unit outcomes. Further exploration of the relationship of nurse manager competence in relation to unit specific nurse and patient outcomes would strengthen the business case for funding nurse manager development programs by showing strong return on investment for the organization. Future intervention studies to test the effects of orientation, continuing education, development and/or nurse manager coaching programs on nurse manager perceived competency and unit outcomes would focus strategies for strengthening nurse manager competence and the link to organizational success. Programs shown to accelerate the competence level of the nurse manager leader would be beneficial to patients, staff and organizations.
References


Table 1: Sample distribution by years of Nurse Manager Experience

<table>
<thead>
<tr>
<th>Years of Experience</th>
<th>VA (n=15)</th>
<th>UKHC (n=21)</th>
<th>Total (n=36)</th>
</tr>
</thead>
<tbody>
<tr>
<td>0-2</td>
<td>3</td>
<td>8</td>
<td>11</td>
</tr>
<tr>
<td>3-5</td>
<td>4</td>
<td>4</td>
<td>8</td>
</tr>
<tr>
<td>6-9</td>
<td>3</td>
<td>3</td>
<td>6</td>
</tr>
<tr>
<td>10+</td>
<td>6</td>
<td>6</td>
<td>12</td>
</tr>
</tbody>
</table>
Table 2: Perceived level of competence using Benner’s Scale\textsuperscript{12}

<table>
<thead>
<tr>
<th>Scale</th>
<th>Competence</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Novice</td>
</tr>
<tr>
<td>2</td>
<td>Advanced Beginner</td>
</tr>
<tr>
<td>3</td>
<td>Competent</td>
</tr>
<tr>
<td>4</td>
<td>Proficient</td>
</tr>
<tr>
<td>5</td>
<td>Expert</td>
</tr>
</tbody>
</table>
Figure 1: The Nurse Manager Leadership Partnership Learning Domain Framework©, copyright 2006, by the American Organization of Nurse Executives (AONE). All rights reserved.  

Nurse Manager Leadership Partnership Learning Domain Framework

The Science: Managing the Business
- Financial Management
- Human Resource Management
- Performance Improvement
- Foundational Thinking Skills
- Technology
- Strategic Management
- Clinical Practice Knowledge

The Leader Within: Creating the Leader in Yourself
- Personal & Professional Accountability
- Career Planning
- Personal Journey Disciplines
- Optimizing the Leader Within

The Art: Leading the People
- Human Resource Leadership Skills
- Relationship Management & Influencing Behaviors
- Diversity
- Shared Decision Making

THE NURSE MANAGER

© 2006 NMLP
Figure 2: Self-assessed competence for Nurse Managers with < 2 years of experience (UKHC n=8, VAMC n=3)
Figure 3: Self-assessed competence for Nurse Managers with 3-5 years of experience (UKHC n=4, VAMC n=4)
Figure 4: Self-assessed competence for Nurse Managers with 6-9 years of experience (UKHC n=3, VAMC n=3)
Figure 5: Self-assessed competence for Nurse Managers with 10 years or more of experience (UKHC n=6, VAMC n=6)
Manuscript 2

Coaching Nurse Managers for Success
Abstract

While formal education and training set the foundation for new leadership roles, coaching helps the nurse manager gain insight and develop skills that are transferred into practice. This article will examine the benefit, theoretical constructs and model of coaching for improving skill acquisition for nurse managers.
Background

As the leader closest to direct patient care, the nurse manager plays a pivotal role in linking the organization’s mission, vision and goals to the day to day operations (Thompson, Purdy & Summers, 2008). Nurse manager competency is vital to promoting healthy work environments, staff performance and positive patient outcomes (Baston & Yoder, 2012). Unlike the business sector, healthcare hasn’t prioritized leadership development for the middle management level with the same vigor (Ponte, Gross, Galante & Glazer, 2006). New nurse managers experience significant role transitions that cause “self-doubt, identity shifts, boundary realignments, and unrealistic expectations to get it right the first time” (Weinstock, 2011, p 211). Kowalski and Casper (2007) expose the myth that new middle managers of any organization are comfortable and ready to perform within 100 days; it is more realistic to expect that the role transition will take up to one year to understand the system, culture and politics. The expectation that new skills are acquired over time, from novice to expert, and strengthened by experience is supported by Benner’s (1984) theory of skill acquisition for nurses (Table 1). Benner’s theory is applicable to nurse managers in new roles, new institutions or with new responsibilities.

Successful nurse manager competencies are defined in the Nurse Manager Leadership Partnership Learning Domain Framework© (Learning Domain Framework©, Figure 1) that was jointly developed by the American Organization of Nurse Executives and the American Association of Critical Care Nurses (AONE, AACN, 2006). The evidence based framework consists of three domains: the development of the leader within, the science of managing the business and the art of leading people. The Nurse Manager Skills Inventory Tool© accompanying the Learning Domain Framework© is designed to assess the learning and development needs of nurse managers and is
based on Benner’s novice to expert theory of skill acquisition (AONE/AACN, 2006; Sherman & Pross, 2010). Using the Nurse Manager Skills Inventory Tool©, Baxter and Warshawsky (in press) found that even after 10 years of nurse manager experience, most competencies reached proficient but not expert levels. In addition, most competencies took 6 years to reach competent levels. While formal education and training set the foundation for new leadership roles, coaching helps the nurse manager gain insight and develop skills that is transferred into practice (Dubnicki & Sloan, 1991; Kramer, Maquire, Schmalenberg, C., et al., 2007).

Coaching is a formal relationship, much like a partnership, focused on meeting the learning needs of the coachee to improve performance. Coaching differs from mentoring; a mentor serves as a trusted counselor in a relationship that is self-selected, informal and long lasting (Decampli, Kirby & Baldwin, 2010). Coaching is similar to counseling as both are focused on understanding the deeper meaning of behavior but coaching differs from counseling because both participants are mutually focused on goals which may not be the case with counseling alone (Machin, 2010, p 45). During coaching, mutually developed goals are used to map a path for optimal performance during a time limited relationship by maximizing strengths, improving weakness and monitoring progress of the coachee (Weinstock, 2011; Kowalski & Casper, 2007; Decampli, et al., 2010; Davis, Middaugh & Davis, 2008). In the ever changing landscape and increasing complexity of healthcare, all nurse managers, new to the role or not, could benefit from coaching to expose them to new ideas, resources and problem solving techniques (Decampli, et al., 2010). Coaching can unleash a nurse manager’s potential much like a professional athlete uses a coach to maximize performance.
Review of the literature

To gain an understanding of the potential of coaching as a strategy for nurse manager development, a review of the literature was performed using CINAHL, PsycINFO, Cochrane and Google Scholar search engines using the following search terms in order to narrow the focus for the application of coaching for Nurse Managers: coaching and Nurse Managers; coaching and middle managers; coaching and nurse executives; coaching and nursing and management. Articles were limited to English only, full text, primary research between 2002-2012 describing outcomes for the use of coaching as a development strategy for nurse managers or middle managers. Of the 340 articles reviewed, 11 articles were relevant to the inclusion criteria; 6 were specific to nursing and 5 were specific to a variety of business settings (Table 2). The benefits of coaching identified in the literature review can be organized into two themes, the benefit to the individual and the benefit to the organization (Rivers, Pesata, Beasley & Dietrich, 2011; Ciller & Terblance, 2010; Karsten, 2010; Karsten, Baggot, Brown & Cahill, 2010; Simpson, 2010; Wallis, 2010; Argarwal, Angst & Magni, 2009; Meland & Stern, 2009; Moen & Skaalvik, 2009; Bowles, Cunningham, De La Rosa & Picano, 2007; McNally & Lukens, 2006). The benefits are summarized in Table 3 and striated by nursing and business as well as individual and organizational benefits.

The individual benefits derived from coaching align with the three learning domains identified in the Learning Domain Framework©. Coaching improved self-awareness and personal mastery (the leader within), improved the ability to lead others (leading people) and developed a wider view of the business (managing the business) for the coachee. Consistent with Benner's theory of skill acquisition, coaching nurse or middle managers during new or changing roles strengthened individual competencies. Moen and Skaalvik (2009) demonstrated a difference between middle managers that
were coached and those that were not. Middle managers who were coached experienced improved self-efficacy (p<0.05) and understanding of personal factors contributing to success (p<0.01), contrasted with those in the control group (no coaching) who experienced worsening of goal commitment (p<0.01), satisfaction (p<0.05), autonomy (p<0.01) and understanding the relatedness of personal factors on lack of success (p<0.01). Two business sector studies revealed stronger individual outcomes using coaching for front line managers than higher level executives (Argarwal, et al., 2009; Bowles, et al., 2007). Argawal, et al. (2009) reported that coaching for front line managers to improve sales performance was stronger (p<0.001) than for higher management levels (p<0.05) and Bowles, et al. (2007) reported a higher degree of recruitment quotas reached in the coached middle manager group (p<0.05) than for the executive level (no difference). In addition, middle managers who are educated about coaching and experience coaching by their direct supervisor are more likely to use coaching successfully with their staff (Haas, 1992; Argarwal, et al., 2009).

Also evident in the literature was a correlation between individual nurse manager, or middle manager, competency on positive outcomes that contribute to organizational success. Managers that were coached experienced increased staff satisfaction, higher achievement of performance goals, increased retention and recruitment of staff and reduced manager turnover. As mentioned above, Aragawal, et al. (2009) and Bowles, et al. (2007) reported better sales performance and recruiting quotas for middle managers who were coached in comparison with those that were not (p<0.001 and p<0.01 respectively). Following a two year individual coaching program for senior leadership in an acute care hospital, voluntary nurse turnover was cut in half, patient satisfaction rose from the 50th percentile to the 75th percentile and employee satisfaction rose from the 50th percentile to the 65th percentile (Karsten, 2010). Medland and Stern (2009)
reported higher employee engagement surveys at one year following coaching for new
nurse managers in comparison to their counterparts who did not receive coaching.
Using coaching in a convenience sample of senior managers in a large Fortune 500
banking company, Wallis (2010) demonstrated a return on investment of 317% as a
result of improved and sustained performance of participants. McNally and Lukens
(2006) calculated that the budget neutral, or breakeven cost for their coaching program
to support nurse managers during role transition would be retention of one nurse
manager. They retained 4 nurse managers who indicated that without coaching, they
would have left the institution resulting in a strong positive return on investment.

Managers and employees are motivated when coaching is used as a
management philosophy to develop employee’s performance instead of only to resolve
issues (Misiukonis, 2011). While formal education and training set the foundation for
new leadership roles, coaching helps the nurse manager put this training into practice.
The true deliverable of coaching is the insight and competence gained by the coachee
that can be transferred into practice (Ponte, et al., 2006). Consistent with Benner’s
(1984) novice to expert theory and the goals of coaching, new nurse managers benefit
from coaching to meet expected competencies for individual and organizational
performance.

**Theoretical Frameworks of Coaching**

Coaching is theoretically grounded in the realm of developmental psychology and
the domain of “interpersonal skills” (Locke, 2008). Three relevant theories are
described: Behavioral Control Theory (Gregory, Beck, & Carr, 2011; Bandura, 1997),
Self-Efficacy Theory (Bandura, 1997) and Benner’s Novice to Expert Theory of Skill
Acquisition for Nursing (Benner, 1984). Coaching borrows from all three of these
theories in order to change behavior and gain desired outcomes. The inter-relatedness of these theories as a construct for coaching is illustrated in Figure 2.

One of the primary purposes of coaching is to help the coachee learn to regulate their own behavior in order to achieve success in the workplace (Gregory, et al., 2011). The methodology of coaching should lead to a deeper understanding of self, improve critical thinking and promote transformational leadership (Locke, 2008). The coach needs to be able to ask “thought provoking questions and authentically share observations without generating defensiveness” while “fostering collaboration and trust” (Kowalski & Casper, 2007; Locke, 2008, p 104). Behavioral Control Theory (Gregory, et al., 2011; Bandura, 1997) is the foundation for the two action components of coaching: goals and feedback. The premise of this theory is a simple feedback control loop. In order to change an undesired outcome to a desired outcome (goal), the individual is assisted to see a change in behavior by the coach that may result in achieving the desired outcome (feedback). As a result of this insight, the individual controls or changes their behavior in order to close the gap between what is desired (goal) and the undesired outcome currently occurring (Gregory, et al., 2011; Bandura, 1997). Coaching provides the feedback portion of the loop by mirroring or reflecting back to the coachee what is observed, or prompting the coachee to self reflect, in order to understand why the gap exists. Mirroring is when the coach presents a true picture of the situation to the coachee and reflecting back is paraphrasing back to the coachee what was said. The true situation may not be congruent with the perception of what the coachee believes is occurring. These two techniques will assist the coachee in gaining a full understanding of why the gap exists and to identify actions and goals to close the gap. Feedback and questioning that lead the coachee to self-reflecting on the behavior that led to an undesired outcome will provide more specific and useful information to change behavior.
and prevent defensive or self-defeating emotions that could hamper success (Gregory, et al., 2011).

Effective coaching leads to improved self-efficacy, empowerment and ultimately performance that contribute positively to organizational success (Bastin & Yoder, 2012). Bandura’s Self Efficacy Theory (1984) expands the feedback control loop to include a triad of variables self-efficacy: behavior, internal personal factors and the external environment. Self-efficacy, or control of behavior, is affected by all of these variables; changes in one variable will cause a change in the other (Bandura, 1997). Because humans function in a societal group, choices of action within this triad can be facilitated by the reflective thought that coaching provides. Bandura emphasizes that the internal personal factors of self-efficacy and self-esteem affect performance and behavior within the external environment (in this case the work group). Self-efficacy is how a person views their ability to carry out an action; self-esteem is a judgment of self-worth. These internal beliefs can work independently of each other. More than high self-esteem is required to succeed and persons with high self-efficacy can hold such high standards for themselves that their self-esteem suffers, or conversely, persons with low standards can have high self-esteem (Bandura, 1997). Coaching can provide the coachee a safe venue to balance self-efficacy and self-esteem.

Nurse Manager leadership skill development is a journey following the skill acquisition model of Benner’s Novice to Expert Theory (1984). In Benner’s theory, she emphasizes that knowing how is different that knowing that. Knowing how is learning a skill, but experience is required to know that. Knowing that includes the linkage of the bits and pieces of experience that connects the current situation’s need to what you have learned in the past. This “perceptual grasp is connoisseurship” which allows the “practitioner to see the situation as a whole and provide expert action in a way that might
not be consciously apparent to the practitioner” (Benner, 1984, p 5). Coaching is a method to support and facilitate the type of self-reflection and introspection required to gain self-awareness, critical thinking and form alternatives for future action. Furthermore, coaching provides a safe environment to gain experience and thus accelerate movement from novice to expert.

**The Model of Coaching**

All coaching models have the following stages or steps in common: preplanning and assessment phase, active coaching phase and a follow up phase (Baston & Yoder, 2012; Ponte, et al., 2006; Kowalski & Casper, 2007; Decampli, et al., 2010; Davis, et al., 2008; Locke, 2008; Gregory, et al., 2011; Whitmore, 2009). In the preplanning and assessment phase an initial self-assessment alone or in combination with assessments from others (ie, 360 degree evaluation) is completed. The Nurse Manager Skills Inventory Tool© has been used to assess competencies specific to nurse managers for practice development (Baxter & Warshawsky, in press; Decampli, et al., 2010). While an initial assessment is needed in the preplanning stage and is usually accomplished using some sort of formal tool, informal assessment occurs throughout the coaching intervention and is used to guide actions of both the coach and coachee during the process. The initial meeting occurs within the preplanning assessment phase. During this meeting the coach and coachee begin to form a relationship and agree on a desired course.

During the active coaching phase, the coach’s role is to use techniques designed to generate self-feedback and insight from the coachee. This holds the coachee responsible and accountable for their progress and promotes self-efficacy, self-esteem and critical thinking. The coach must do this in a manner that is empathetic and
nonjudgmental to foster the trust and mutual respect required for success. The primary skills required of the coach are active listening and effective questioning. Active listening is exhibited by open body posture, maintaining eye contact and observation of coachee non verbal behavior. As a result of active listening the coach is able to formulate themes and perceive relationships in the context of the discussion (Whitmore, 2009; Wesson, 2010). Effective questioning (Kowalski & Casper, 2007; Whitmore, 2009) includes mirroring (presenting the true situation), reflecting back (paraphrasing what the coachee has said) and summarizing (reducing the conversation to prevailing themes). Questions should prompt the coachee to self reflect on the sequence of events that led to a positive or negative outcome so that the coachee can understand what behaviors lead to that outcome. Once this understanding is achieved, the coach can support the coachee in determining what alternative actions or behaviors could be used in the future to achieve or strengthen the desired outcome. These actions or behaviors lead to goals.

Whitmore (2009) suggests starting with open ended questions to allow the coachee to lead the conversation to their area of concern. Once a concern is identified, starting broad and moving to more specific questions, avoiding leading questions and following the interest of the coachee will lead to the root cause of the concern. These techniques are designed to allow the coachee to gain their own insight and generate solutions for the issues that arise. Kowalski and Casper (2007, p 175) suggest a mnemonic (A, E, I, O, U) for asking questions in this manner:

A=awareness of what has been noticed
E=experience of thoughts and feelings associated with whatever happened
I=intention in the situation including the purpose and gain
O=ownership of the coachee’s part in the outcome
U=understanding of the situation and the outcomes by the coachee
As a result, issues will be identified around which goals for resolution will need to be mutually established. Gregory, et al. (2011) suggests developing actions that progressively lead to accomplishment of a more complicated goal and achieving the lower rung or easier to achieve actions first. This allows the coachee to develop self-efficacy and build progress as well as provides a framework for the coachee to follow after the coaching engagement (ie, break it down to more manageable parts). They also suggest reminding the coachee that set backs are normal and expected, thus goals may remain flexible and adjusted along the way. Goals should be aligned with the organization’s goals in order to be supported. Using a model for goal setting can ensure that all elements for success have been considered and included. The Whitmore (2009) method for goal setting uses the GROW and SMART models and should be stated in the positive (Table 4). These models are designed to assist in defining goals that are clear, achievable and time bound.

As the coachee gains insight, achieves goals and builds self-efficacy, the coaching relationship winds down with less frequent sessions. The duration of the coaching relationship can range from a few months to a year or more depending on the focus of the coaching engagement. During the follow up and close out phase of the coaching engagement, the activity shifts to monitoring progress, providing follow up and defining an end to the engagement. It may also include a report to the coachee’s supervisor describing the outcomes of the engagement.

**Attributes of the Coach and the Coachee**

Attributes of both the coach and coachee, consistent with Bandura’s Theory of Self Efficacy (1984) affect success and include internal personal factors of both the coach and the coachee and the relationship between them. The coach should be
approachable, demonstrate caring, support and encouragement, have strong communication skills, be objective and utilize a balance of active listening and reflective questioning (Baston & Yoder, 2012; Ponte, et al., 2006; DeCampli, et al., 2010; Locke, 2008). While the coach for a nurse manager would need to be knowledgeable about the healthcare industry, it was not felt by Ponte, et al. (2006) that the coach has to be a nurse or a nursing leader. Regardless of whether an internal or external coach is selected, the ability to discuss critical and politically sensitive topics with a neutral party while receiving objective feedback is identified as essential (DeCampli, et al., 2010). An internal coach would know the organization, its culture and politics; the external coach would be unbiased. Different variables specific to the coach or coachee may drive the selection of a coach such as culture, sex, age, etc (DeCampli, et al., 2010). The coach should avoid being too authoritative, unclear, emotional or fail to assess the situation from the clients perspective (Baston & Yoder, 2012).

The coachee should be motivated and receptive to coaching demonstrated by accepting responsibility for the sessions, actively participating, ensuring clarity of feedback, working toward goals and providing follow up during the sessions (Baston & Yoder, 2012). In comparison to other leaders, Ponte, et al. (2006) report that nursing leaders are described by coaches as having a broader worldview and approach to their life and work, passion and caring for people, high collaboration and coordination skills, are good practice managers, and are more sensitive and courageous. Nursing leaders were also described as less assertive than business leaders, are poor general managers and “at the most senior level, do not provide enterprise-wide leadership through a nursing lens but limit themselves to advocating for their discipline or profession” and lack confidence even when successful and accomplished (Ponte, et al., 2006, p 323).
Comparisons such as these allow both the coach and coachee to approach the engagement with a wider vision for their goals and performance.

**Implications for Practice and Future Research**

While coaching is often used to address problems, it should be more widely used to develop employees. If the organization values coaching, employees are likely to view coaching as important (Misiukonis, 2011). The use of coaching is an effective strategy to support nurse managers in a variety of situations: orientation as a new nurse manager, support during role transitions and during new initiatives and during changing responsibilities as well as for ongoing development and succession planning. A formal, structured coaching program for nurse managers will enhance, facilitate and accelerate skill acquisition and promote individual and organizational benefits faster than orientation and education alone. The Nurse Manager Skills Inventory Tool© identifies strengths and weaknesses of the nurse manager. As a result of this assessment, an individually tailored coaching plan for the nurse manager using subject matter experts to accelerate and refine skill development can be developed.

Further research into the value of coaching as a strategy to improve nurse manager competency and the links to individual and organizational benefits would strengthen the themes found in the literature review. The suggestion that the nurse manager who has been successfully coached, will in turn be able to successfully coach staff, warrants further investigation and if proved, would increase the return on investment of a formal, structured coaching program. Pairing subject matter experts with nurse managers to facilitate skills that individual nurse managers assess themselves as less than competent deserves further scrutiny due to the short term
nature of such a relationship and the high impact possibilities in terms of low cost and high benefit.
References


<table>
<thead>
<tr>
<th>Competency Level</th>
<th>Description</th>
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<tbody>
<tr>
<td>Novice</td>
<td>No background understanding of the situation, no experience</td>
</tr>
<tr>
<td>Advanced Beginner</td>
<td>Demonstrates marginally acceptable performance, can recognize aspects or</td>
</tr>
<tr>
<td></td>
<td>pieces of a situation</td>
</tr>
<tr>
<td>Competent</td>
<td>Perceives situations as a whole and can prioritize appropriate actions</td>
</tr>
<tr>
<td>Proficient</td>
<td>Perceives the situation as a whole and recognizes expected outcomes and</td>
</tr>
<tr>
<td></td>
<td>deviations and makes advanced decisions</td>
</tr>
<tr>
<td>Expert</td>
<td>No longer relies on analytical thinking and has enough experience to</td>
</tr>
<tr>
<td></td>
<td>intuitively make connections and pair with appropriate actions</td>
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</table>
Table 2: Research Summary of Coaching Literature Review

(2002 through 2012, CINAHL, PsycINFO, Cochrane and Google Scholar databases using the following search terms: coaching & nurse managers, coaching and middle managers, coaching and nurse executives, coaching and nursing and management)

<table>
<thead>
<tr>
<th>Reference</th>
<th>Design/Sample</th>
<th>Purpose/Findings</th>
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<tbody>
<tr>
<td>Rivers, R, Pesata, V, Beasley, M &amp; Dietrich, M. (2011) Transformational leadership: creating a prosperity-planning coaching model for RN retention. <em>Nurse Leader</em>, 9(5), 4-51.</td>
<td>Qualitative and quantitative pre test and post test design Convenience sample of 18 nurses &amp; nurse managers of an academic medical center</td>
<td>To determine the effects of a life coach on compassion fatigue and cumulative stress. After 3 face to face meetings and weekly telephone calls with a life coach, the participants felt less vulnerable to stress ( (p&lt;0.001) ), more satisfied with life ( (\text{overall } p=0.002, \text{family } p=0.001, \text{emotions } p=0.011, \text{social } p=0.010) ) and experienced less burnout ( (p=0.001) ). There was an overall theme of self awareness.</td>
</tr>
<tr>
<td>Cillers, F &amp; Terblance, L. (2010) The systems psychodynamic leadership coaching experiences of nursing managers. <em>Health SA Gesondheid</em>, 15(1), doi:10.4102/hsag.v15i1.457. Qualitative and descriptive Voluntary convenient sample of 6 Nurse Managers in different hospitals</td>
<td>To describe the learning experiences of nursing managers during leadership coaching using the systems psychodynamic learning model. After 10 hours of individual coaching over 10 weeks, participants experienced reduced role anxiety, improved their interpersonal skills, systems thinking, ability to leverage power within their position and manage boundaries, and self care.</td>
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<tr>
<td>Karsten, M. (2010) Coaching: an effective leadership intervention. <em>Nursing Clinics of North American</em>, 45, 39-48. doi:10.1016/J.cnr.2009.11.001 Descriptive case study Convenience sample of 150 senior leaders in a hospital</td>
<td>To illustrate the cultural effect of a 2 year program of individual coaching for senior leadership in one hospital that experienced significant leadership transition Post coaching intervention, voluntary nurse turnover decreased from 16-8% with 30% turnover for nurses in their first year of hire to 10-12%, patient satisfaction rose from the 50\textsuperscript{th} percentile to the 75\textsuperscript{th} percentile and employee satisfaction rose from the 50\textsuperscript{th} percentile to the 65\textsuperscript{th} percentile.</td>
<td></td>
</tr>
<tr>
<td>Karsten, M, Baggot, D, Brown, A &amp; Cahill, M. (2010) Professional coaching as an effective strategy to retaining frontline managers. <em>Journal of Nursing Administration</em>, 40(3), 140-44. Descriptive pilot study 20 nursing directors, 12 of who completed surveys</td>
<td>To measure the effectiveness of coaching as a leadership strategy during a significant number of nursing leadership changes. After individualized coaching the nursing directors experienced improved job satisfaction ( (9/12 \text{ strongly agreed}, 2/12 \text{ agreed and } 1/12 \text{ neutral}) ), experienced improved relationships with their direct reports ( (5/12 \text{ strongly agreed}, 4/12 \text{ agreed}, 2/12 \text{ neutral and } 1/12 \text{ not applicable}) ) and mixed results for stronger relationship with their supervisor ( (5/12 \text{ strongly agreed}, 3/12 \text{ agreed}, 4/12 \text{ neutral}) ).</td>
<td></td>
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<tr>
<td>Simpson, J. (2010) In what ways does coaching contribute to</td>
<td>Qualitative interpretative epistemological embedded</td>
<td>To explore the attributes of coaching for this company.</td>
</tr>
<tr>
<td>Reference</td>
<td>Design/Sample</td>
<td>Purpose/Findings</td>
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| **effective leadership development?**  
*International Journal of Evidence Based Coaching and Mentoring, special issue 4, 114-* | case study | Using a semi structured interview approach, the positive benefits of coaching for individuals and the organization were organized into common themes. Positive benefits for individuals were improved confidence, interpersonal skills, self awareness, work life balance, career planning and decision making. Positive benefits for the organization were improved recruitment, retention of good staff, more flexibility leading to better performance, management of risk and perceived good value for coaching program costs. |
| **Wallis, G. (2010) Does a “blended” programme of developmental and coaching, produce sustainable change?**  
*International Journal of Evidence Based Coaching and Mentoring, special issue 4, 105-13.* | Descriptive case study | To explore whether a “leadership development program that includes coaching generates” (p 105) changes in performance, a method to measure that change and if change occurs, does it last. Following an educational session and one on one coaching sessions utilizing an external coach, the coaching sessions were found to be more positively received and the participants general perceptions were that they had gained skills leading to a “wider stakeholder management,” more positive personal development and their affect on leading their team for better performance. |
*The international journal of human resources management, 20(10), 2110-34.* | Post implementation quantitative & qualitative descriptive survey analysis | To determine the effects of coaching on sales performance and job satisfaction at three months following intensive coaching training. There was a strongly positive relationship between job satisfaction and sales performance (p<0.001) and between sales performance and DM coaching intensity after controlling for job satisfaction (p<0.001). The positive relationship extended to higher managerial levels in this sample but slightly weaker; job satisfaction and DM performance (p<0.05) and executive coaching intensity on the DM performance after controlling for job satisfaction (p<0.05). |
*Journal for nurses in staff development, 25(3), 141-7.* | Descriptive case study | To use coaching as a additional resource to develop new nurse managers as compared with their traditional five day non consecutive leadership training program. Use of an internal coach approximately every other week for 6 months along with periodic sessions as needed lead to all 7 new nurse managers remaining in their position and with higher employee engagement scores at one year as compared to their counterparts (most coaching sessions revolved around conflict management). |
<p>| <strong>Moen, F &amp; Skaalvik, E. (2009) The effect from executive coaching on performance psychology.</strong> | Qualitative pre-test post-test control group design | To explore the effects of an external executive coaching program and a middle manager coaching leadership program on psychological variables. |</p>
<table>
<thead>
<tr>
<th>Reference</th>
<th>Design/Sample</th>
<th>Purpose/Findings</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>International Journal of Evidence Based Coaching and Mentoring, 7(2), 31-49.</strong></td>
<td>19 executives and 108 middle managers in a fortune 500 company were assigned to experimental and control groups</td>
<td>The executives in the experimental group experienced improved self-efficacy (p&lt;0.01), goal setting (clarity, feedback and strategy p&lt;0.05), satisfaction (p&lt;0.05), autonomy (p&lt;0.01), relatedness (p&lt;0.05) and causality variables (strategy p&lt;0.05, success and failure accountability p&lt;0.01). The executives in the control group experienced no statistically significant changes. Middle managers experienced improved self-efficacy (p&lt;0.05) and success causality (p&lt;0.01). The control group experienced worsening of goal commitment (p&lt;0.01), satisfaction (p&lt;0.05), autonomy (p&lt;0.01) and relatedness (p&lt;0.01).</td>
</tr>
<tr>
<td>Bowles, S, Cunninham, C, De La Rosa, G &amp; Picano, J. (2007) Coaching leaders in middle and executive management: goals, performance, buy in. <em>Leadership and organizational development journal,</em> 28(3), 388-408.</td>
<td>Qualitative case study design</td>
<td>To “test the effectiveness of coaching for middle and executive level managers within a large recruiting organization” (p 388) Using individual coaching focusing on individual goals, approximately 50% of goals set were reached, 80% of middle managers and all but one executive manager exhibited “buy in” for the coaching program, and a there was a positive correlation between “buy in” and specific competencies measured. In terms of the outcome of quotas reached, coached participants performed better than non coached participants (p&lt;0.01) with a higher degree of quotas reached in the middle manager group (p&lt;0.05) than in the executive level group which was statistically non significant.</td>
</tr>
<tr>
<td>McNally, K &amp; Lukens, R. (2006) Leadership development, an external-internal coaching partnership. <em>Journal of Nursing Administration,</em> 36(3), 155-61.</td>
<td>Descriptive case study following a successful pilot program</td>
<td>Following a successful pilot 6 month program using an external coach supported internal coaching program (coach/leader individual sessions and group sessions) for 12 new clinical directors to implement a new nursing practice model (relationship centered, outcome focused) and facilitate leadership development, the facility implemented a hospital wide coaching program aimed at increasing leader self awareness and to meet professional and personal goals. Using monthly face to face and additional telephone coaching sessions for 6 months and some group coaching sessions survey results of 67% of the participants were: 100% felt more confident and competent in their roles, &gt;50% indicated they were more likely to stay in their positions and participants perceived more value from on-one coaching sessions than from the group sessions. 4 leaders stated they would have left their positions without the support of coaching; using $90,000 as the average salary for these 4 leaders &amp; the cost of the program at $85,000, the hospital calculated the return on investment as “budget neutral if only one director was retained as a result of coaching” (p 160).</td>
</tr>
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Table 3: Summary Table of Benefits of Coaching for Individuals and Organizations

<table>
<thead>
<tr>
<th></th>
<th>Individual Benefits</th>
<th>Organizational Benefits</th>
</tr>
</thead>
</table>
| **Nursing Specific** | *Improved*  
Job Satisfaction  
Interpersonal skills  
System thinking  
Ability to leverage power within the organization  
Manage boundaries  
Relationship with direct reports  
Self-awareness  
Work life balance  
Self-care  
*Decreased*  
Stress  
Burnout  
Role anxiety | *Improved*  
Employee satisfaction scores  
Employee engagement scores  
Patient satisfaction scores  
Staff nurse retention  
Nurse manager retention  
*Decreased*  
Staff turnover  
Nurse manager turnover |
| **Business Specific** | *Improved*  
Job satisfaction and performance  
Leadership skills  
Interpersonal skills  
Ability to lead team for performance  
Self-awareness  
Work life balance  
Career planning  
Decision making  
Self-efficacy  
Goal setting  
Autonomy  
Accountability  
*Decreased*  
Stress | *Improved*  
Recruitment and retention of staff and managers  
Flexibility leading to improved performance  
Management of risk  
Stakeholder management (wider management leading to improved performance)  
Leadership of teams to better performance  
Job satisfaction  
Achievement of goals  
Return on investment for the cost of coaching program |
Table 4: GROW and SMART Models for Goal Development (Whitmore, 2009)

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>G</strong></td>
<td>goals- what would you like to talk about, achieve, resolve, decide, solve, accomplish?</td>
</tr>
<tr>
<td><strong>R</strong></td>
<td>reality- what is happening now, what is getting in the way, what have you tried so far?</td>
</tr>
<tr>
<td><strong>O</strong></td>
<td>options- if you had unlimited resources, what might you do, what else?</td>
</tr>
<tr>
<td><strong>W</strong></td>
<td>what’s next- of these options, what are your most powerful steps, what will you do, what is your level of commitment?</td>
</tr>
<tr>
<td><strong>S</strong></td>
<td>specific- what specific results would you like to achieve?</td>
</tr>
<tr>
<td><strong>M</strong></td>
<td>measurable- how will you know you are getting there, what would ultimate success look like, if you completed goal is a 10 (scale of 1-10) where are you now, where would you like to be within _____ time frame?</td>
</tr>
<tr>
<td><strong>A</strong></td>
<td>agreed and accepted- what is our level of willingness to work on this goal, what is your level of commitment?</td>
</tr>
<tr>
<td><strong>R</strong></td>
<td>realistic and reaching- to what degree is this goal a stretch for you, how realistic is it given your current resources?</td>
</tr>
<tr>
<td><strong>T</strong></td>
<td>time bound- what time frame are you willing to commit to?</td>
</tr>
</tbody>
</table>
Figure 1: The Nurse Manager Leadership Partnership Learning Domain Framework©, copyright 2006, by the American Organization of Nurse Executives (AONE). All rights reserved (AONE, 2006)
Figure 2: Theoretical Constructs of Coaching

- Behavioral Control Theory
- Benner's Theory of Skill Acquisition in Nursing
- Self-Efficacy Theory
- Coaching
Manuscript 3

The Effect of Coaching on Nurse Manager Leadership of Unit Based Performance Improvement: Exploratory Case Studies
Abstract

The focus of this exploratory study involving three cases is to examine the effect of coaching on the perceived competence of nurse managers leading performance based improvement teams on their units and on improving unit performance. Coaching was used as a method to accelerate skill acquisition, rather than the usual approach of education alone, based on the idea that when nurses move into the role of a Nurse Manager they begin at the novice level with respect to acquiring new leadership skills. The study was conducted in a moderate sized Veteran Administration Medical Center in the Midwest. A model of coaching is described and evaluated. It appears from the results that coaching improves the perception of competence, is valued by Nurse Managers and teaches Nurse Managers how to coach staff teams.
Background

Nurse Managers have experienced an unprecedented increase in their responsibilities and overall influence for organizational success as a result of healthcare reforms (AONE, AACN 2006; Wiley, 2001; Wong & Cummings, 2007). It is widely recognized that the nurse manager role is “undeniable” in shaping “healthy work environments” and has the most “direct impact” on the care delivered within healthcare systems (AONE, AACN, p 2; Wiley, 2001; Wong & Cummings, 2007; Haas, 1992). However, the development of successful skill acquisition by nurse managers is often over looked and new nurse managers struggle during their first few years of role transition from a clinical provider to a leadership role requiring different skill sets. More realistically, it can take up to one year to be comfortable and competent in a new role (Kowalski & Casper, 2007). Benner’s theory of skill acquisition (1984) for new nurses is applicable to nurse managers new to the leadership role, given new responsibilities or leading in a different institution. Benner’s theory (1984) validates that new skill acquisition moves from novice to expert, is learned over time and strengthened by experience (Table 1).

The evidenced based framework of the Nurse Manager Leadership Partnership Learning Domain Framework© (Learning Domain Framework©) defines the three domains of successful nurse manager competencies: the development of the leader within, the science of managing the business and the art of leading people (ANOE, AACN, 2006). The Nurse Manager Skills Inventory Tool© (AONE, AACN, 2006; Sherman & Pross, 2010) accompanying the Learning Domain Framework© is designed to assess the learning and development needs of nurse managers and is grounded in Benner’s novice to expert theory (Baxter & Warshawsky, in press). Using the Nurse Manager Skills Inventory Tool©, Baxter and Warshawsky (in press) found that nurse
managers’ self-rated competency improved over time but most competencies took 6 years to reach competent levels. Even after 10 years of nurse manager experience, most competencies reached proficient but not expert levels.

Typically, the nurse manager is oriented to their new role or organization by a peer nurse manager over a limited time frame. This orientation may or may not include an educational component designed to strengthen supervisory and leadership skills. Some programs assign a mentor during the period of orientation. A true mentor is a voluntary, long term trusted counselor or guide who engages in a relationship with the mentee rather than an assigned pairing (Decampli, Kirby & Baldwin, 2010). A coach is an experienced leader who assesses, evaluates and works with the coachee to strengthen skills identified as essential for the job (Decampli, et al., 2010; Davis, Middaugh, & Davis, 2008). A coach is not often used to develop nurse manager skill acquisition but is used to develop middle managers in business settings and executives in the healthcare setting. Use of coaching to strengthen and accelerate skill acquisition makes sense.

Evidence suggests that the benefits of coaching can be organized into two themes, the benefit to the individual and the benefit to the organization (Rivers, Pesata, Beasley & Dietrich, 2011; Ciller & Terblance, 2010; Karsten, 2010; Karsten, Baggot, Brown & Cahill, 2010; Simpson, 2010; Wallis, 2010; Argarwal, Angst & Magni, 2009; Meland & Stern, 2009; Moen & Skaalvik, 2009; Bowles, Cunninham, De La Rosa & Picano, 2007; McNally & Lukens, 2006). As reported in the literature, individual benefits from coaching align with the three learning domains identified in the Learning Domain Framework©. Consistent with Benner’s theory of skill acquisition, coaching nurse or middle managers during new or changing roles strengthened individual competencies. Individual benefits to nurse or middle managers who were coached included improved
job satisfaction, interpersonal and leadership skills, self-awareness, autonomy and accountability. Nurse and middle managers who were coached developed improved systems thinking and critical decision making, were able to manage boundaries more effectively resulting in better work life balance and experienced less stress, burnout and role anxiety. As a result of coaching, nurse and middle managers experienced improved relationships with direct reports and were more successful in leading teams. Middle managers who were coached were more likely to successfully use coaching with their staff (Argarwal, et al., 2009).

Organizational benefits from coaching nurse or middle managers include improved employee satisfaction and engagement scores, improved patient satisfaction scores and increased recruitment and retention of staff and managers. Coaching nurse or middle managers increased manager flexibility leading to improved performance both individually and with teams, higher achievement of goals, better management of risk and a positive return on investment for the cost of the coaching program. Coaching provides the insight and motivation required to improve nurse manager competence that can be transferred into practice (Misiukonis, 2011; Ponte, Gross, Galante & Glazer, 2006). While most organizations provide new nurse manager orientation with a peer nurse manager, and some organizations include traditional classroom training for nurse managers that includes both coaching and performance improvement, very few have programs in place to pair the nurse manager with a coach to actively develop leadership skills (Karsten, et al., 2010; & Decampli, et al., 2010).

Lageson (2004) demonstrated a positive effect of nurse manager competence on unit outcomes. Nurse manager competence in quality, or performance improvement, was a significant predictor for positive staff satisfaction (p<0.01). However, Baxter and Warshawsky (in press) found that nurse manager self-rated
competency for performance improvement did not reach proficient or expert levels even after 10 years. While there is some evidence that coaching improves individual competence and has a positive effect on a variety of organizational outcomes, the literature review revealed no study using coaching as an intervention to improve the skill acquisition and competency of the nurse manager in improving unit quality and performance.

**Methods**

**Objectives**

The purpose of this exploratory case study was to examine the effectiveness of a coaching intervention on the performance improvement (quality) competence and skill acquisition of nurse managers leading a unit based performance improvement team of staff and to identify the key attributes of coaching in the setting. The objectives of this feasibility study were to 1. Improve nurse manager perceived competence, 2. Improve unit level performance and 3. Evaluate the proposed model of coaching.

**Study Design**

After Institutional Review Board approval, an intervention study using case methods was used to evaluate the effectiveness of the coaching intervention and its components. The use of this design considers each case study individually and then describes common and contrasting themes found among the participants (Yin, 2009). An encrypted email was sent to recruit four nurse managers who were not in the direct line authority of the principle investigator. Volunteers were further screened to ensure inclusion criteria was met prior to informed consent. Five volunteers responded but only three met all the inclusion criteria. After informed consent, the nurse manager participants self-rated their performance improvement (quality) competence using the
TQManager© assessment tool prior to the coaching intervention and again after the coaching intervention. During the coaching intervention, the nurse managers were responsible for leading their team of staff in a performance improvement (quality) project on their unit. To determine the effectiveness of the coaching intervention, the pre and post intervention self-ratings were compared. Data generated by pre-determined open ended questions designed to determine the key attributes of the coaching intervention were organized into themes and described. Unit based performance improvement data was monitored for three months before, three months during and three months after the coaching intervention.

**Setting**

This study took place in a moderate sized federal Veterans Administration facility in the Midwest. Veterans Administration facilities provide a wide range of services to Veterans including intensive acute care, specialty and primary outpatient care and preventive and rehabilitation care. Almost all supervisors received training in LEAN methodology for efficient process improvement but almost all projects were identified by senior leadership. Shared governance or the consistent use of an evidence based practice model had not been implemented. Unless nurse managers had prior experience elsewhere with process improvement, shared governance or evidenced based practice, these were new skills for them.

**Sample**

Three nurse manager participants participated in the case study. Inclusion criteria were nurse managers with less than 10 years of experience, completion of the facility’s coaching and mentoring education courses, yellow belt LEAN performance improvement training and the inability to meet or sustain a unit based performance
measure as defined by the facility or national benchmark expectations. Inability to meet or sustain was defined as performance measure mean scores worse than expected benchmarks for at least 2 of the last 4, or 4 of the last 8, of the most recent quarters. These inclusion criteria were deemed important in order to evaluate the effect of coaching on nurse manager leadership of unit based performance improvement teams rather than the usual practice of classroom education only. Nurse managers were excluded if they were in the line authority of the principle investigator.

**Tool**

Lageson (2004) measured quality mindedness and focus by using the TQManager© assessment tool (Schmidt & Finnegan, 1993). This tool assesses “5 key managerial competences related to creating work environments where quality management can thrive” (Lageson, 2006, p 2). The participants self-rate how often each statement in the tool is true of themselves; 1- almost never, 2- rarely, 3- sometimes, 4- frequently, and 5- almost never. Scores below 74 indicate significant room for improvement for quality mindedness, scores 75-99 indicate some competence but inconsistent quality mindedness and score 100-125 indicates consistent quality mindedness. Lageson (2004, 2006) reports a Cronbach α of 0.97 and a one dimensional construct validity using the varimax rotation method for the TQManager© assessment tool. Because this tool measures specific competencies for performance improvement that are broadly defined in the Nurse Manager Skills Inventory Tool©, this tool was used for assessment of quality improvement competencies of the nurse managers.
Data Collection and Evaluation

In addition to the pre and post coaching TQManager© self-assessment scores, field notes were made with each coaching interaction and for the final overall evaluation interview. Aggregate data assessing the unit based process improvement efforts was gathered from sources already collected within the facility. Final evaluation of the coaching intervention was conducted using pre-determined questions designed to determine the key attributes of coaching in this setting. (Table 2). Pattern matching logic, identifying common and contrasting results among the participants, was used to formulate descriptive themes that were strikingly similar among the three individual case studies thus lending validity to the overall results despite such a small sample size (Yin, 2009, p 136).

The Coaching Intervention

The coaching intervention followed the models described in the literature consisting of three phases: preplanning and assessment phase, active coaching phase and the final follow up and close out phase (Baston & Yoder, 2012; Ponte, et al., 2006; Kowalski & Kasper, 2007; DeCampli, et al., 2010; Davis, et al., 2008; Locke, 2008; Gregory, Beck & Carr, 2011; Whitmore, 2009). The model of coaching used in this study is summarized in Table 3.

Pre-Planning and Assessment Phase. During the preplanning and assessment phase, the nurse managers self-rated their performance improvement (quality) scores using the TQManager© assessment tool. The nurse manager and coach reviewed the nurse manager’s areas of needs and interests related to their unit’s unmet performance measures, the organization’s performance improvement methodology (LEAN) and The Iowa Model (Titler, et al., 2001) for evidenced based
practice. All nurse managers required at least two individual planning meetings along with two follow up email contacts and one required three of each.

Basic review of the techniques for LEAN performance improvement and coaching and mentoring were unexpectedly required even though all participants had completed the required education sessions for both. Once the performance measures for the study were chosen, the coach conducted the literature search for evidence based practice for all participants due to the known lack of knowledge and experience with evidenced based practice methodologies. All of the nurse managers chose measures they had previously been unsuccessful in improving because they were interested in finding a methodology that would be successful. There was supervisor and senior leadership support for these projects due to the inability to meet benchmarks, thus the nurse managers felt that the use of coaching was important.

The focus of the literature review was to find actions resulting in successful performance improvements in similar settings, ie improvement of hospital acquired pressure rates in acute and long term rehabilitation units and improvements in surgical suite turnaround times. Additional planning and instruction sessions were required in order to intensively map out the process prior to moving forward to the active coaching phase when the nurse manager led unit based performance improvement teams. The process included how many team meetings, timing of meetings, goals and activities for each meeting, which staff to invite to participate and how to use both the evidence based literature and the LEAN process methodologies.

All nurse manager participants wanted their staff to follow a similar line of planning and instruction that they received from the coach so they assigned individual staff members of their teams evidence to review and present to the group. After
reviewing evidence, all participants chose to use only the current and future state mapping, trialing small cycles of change and posting data portions of LEAN performance improvement methodology rather than employ all the steps of LEAN. (Lexington Veterans Affairs LEAN Yellow Belt Training Manual, 2013). It was felt that strictly following LEAN methodology (additional tools and official A3 development) was cumbersome and non-value added. To sustain improvements, combinations of LEAN and Iowa Model (Titler, et al., 2001) methods were planned as applicable for communication and data reporting to all the staff on the unit (posting process changes and data posters on the unit). All nurse manager participants felt that the best strategy for assembling their staff teams was to choose staff that were positive, previously involved in unit activities and were leaders on their unit. They wanted to build a team most likely to succeed thus setting the stage for successful team projects with other unit staff members in the future.

Active Coaching Phase. The active coaching phase varied depending on the individual nurse manager and team needs but included scheduled team meetings, follow up meetings and activities, and a blend of face to face and/or telephone coaching for the nurse manager leading the teams. The coach attended team meetings at least once and in one case twice. After the projects were underway, the coach and nurse manager contact was at least weekly for the first four weeks and then every other week for the remainder of the time. The contact was either face to face or by phone for varying periods of time and included follow up email contact to ensure that activities or goals went as planned and whether there was a need for an additional verbal face to face or telephone contact from the coach.

During the coaching intervention, the coach used evidence based practice techniques of active listening and effective questioning to generate nurse manager self-
reflection. The nurse manager was held accountable for the team’s progress and in turn held the team accountable for their progress (Whitmore, 2009; Wesson, 2010). The coach used active listening by employing open body posture and eye contact, monitoring of nurse manager verbal and non-verbal communication and organized the discussion into perceived themes and relationships (Whitmore, 2009; Wesson, 2010). Following active listening, effective questioning techniques as described by Whitmore (2009) were used to narrow the focus of the manager’s concerns and provide a safe venue for self-reflection. Initially, questions were open ended and followed the concern of the nurse manager. Once a concern was identified and stated broadly, by avoiding leading questions the concern was narrowed to find the root cause of the issue (Whitmore, 2009). Mirroring, reflecting back and summarizing were other techniques used for self-reflection (Kolwalski & Casper, 2007; Whitmore, 2009). Mirroring presents the true situation which may not be congruent with the nurse manager’s perceptions. Reflecting back paraphrases what the nurse manager said. Summarizing reduces the conversation to the prevailing themes. The nurse manager determined the next subsequent courses of action by evaluating and weighing the possible consequences and outcomes of the planned actions. Goals were then established surrounding identified issues and were reviewed for resolution during the session. Goals, and actions identified to meet them, during the active session were designed to incrementally move toward the overarching objective set during the assessment phase- improve the measure and the skill acquisition of the nurse manager in leading the team to success (Gregory, et al., 2011).

For all of the nurse managers participating in this study, handing off responsibility to the team to define the actions to meet the goal was one of the more difficult things for them to work through. The concept of the nurse manager becoming the coach to the team rather than directing the team’s actions was realized through active listening and
effective questioning techniques. While each worked toward this through different paths, the common fear was failure and their responsibility for the team’s failure. In general the pathway to this self-reflection started with asking the nurse manager to describe how they felt about their team meeting or how the project was going. Based on feedback from the nurse manager, the coach used narrowing questions to help the nurse manager get a better picture of the facts.

Some of the narrowing questions were, “How did each team member respond?” or, if the coach was present for the team meeting, “What are your thoughts about (a particular team member’s) participation?” Further narrowing questions would include something similar to “Why do you think they responded in that manner?” or “How did you feel about those responses?” Once narrowing questions were answered, the coach used mirroring, reflecting back and summarizing techniques to guide the nurse manager to their next goal and plan of action. Examples of mirroring, reflecting back and summarizing were the following: “You felt that the team did not participate, what would happen if you just waited for them to do so?”, “You wrote the plan on the board and no one offered input” and “What I hear you saying is that the team waited for you to tell them what to do. Is that correct?” At some point either the nurse manager noted that she didn’t give the team time to respond or that she felt that they wouldn’t speak up. Further discussion with the coach lead the nurse manager to recognize that she didn’t give the team an opportunity to define the plan of action and the reason was fear of failure. The fear of failure was rooted in lack of experience and competency with the process improvement process or techniques. Once the root cause for concern was identified, goals were set that tested small cycles of change. Failure of a small cycle of change did not jeopardize the entire project and was seen as a test which can be changed until something works rather than a failure.
During the active phase of coaching, the nurse manager also worked with her team. The confidence of the nurse manager participants improved at different and individual rates requiring different approaches and amounts of time from the coach. Although the coach participated in the team meetings that the nurse manager had with their staff initially, this tapered off as the nurse manager participants gained confidence and skill. Goals were set for each team session and mutually agreed upon by the nurse manager and coach. Based on the team session, new goals for the nurse manager and her interactions with the team were formed and the cycle repeated itself. The thought that a nurse manager who is successfully coached may in turn successfully coach their staff was observed in this setting by the coach and the nurse managers. The nurse manager set goals with her team and then reformulated them based on the next session. Terms, phrases and techniques used by the coach were repeated by the nurse manager when leading (and coaching) their staff teams. The staff teams used these same terms, phrases and techniques when leading (and coaching) staff in the unit during the projects. Nurse manager goals were set incrementally for early successes and progressive movement toward the overarching goal of improved performance measures. Again, this same technique for goal setting was used by both the nurse manager leading her team and the team leading the staff.

One of the major obstacles was lack of time away from staffing and work duties for planning and meeting with the nurse manager, teams and staff. The constant competing priorities and demands on the manager’s time is something that is consistently reported in the literature and was true in this study (Anthony, Standing, Glick, et al., 2005; Sherman, Bishop, Egenbeger, & Karden, 2007). In order to work around this potential obstacle, coaching sessions were flexible and convenient to the manager (time, location and method, ie, telephone, during lunch, email). These same
techniques were employed by the nurse managers with their teams and by the teams with the staff. All nurse managers needed coaching regarding time management and inspecting what they expected. Inspecting what they expected was the catch phrase used by the coach to include monitoring progress of the implementation of small cycles of change, providing feedback and holding the team accountable for progress. Again, the nurse manager coached their team to do the same with staff.

All nurse managers required assistance with unit communication and data posting plans but developed a technique that worked for them and their staff by the end of the active coaching phase. Because most process improvement projects were defined by senior management, this skill was at the novice level for the nurse managers. Quick and easy methods were developed to communicate to all staff. Some examples were large handwritten wall posters or white boards with the current small cycle of change process staff should follow and how many days without a HAPU or the current week’s surgical suite turnaround time compared to last week’s. Daily huddles with staff by the team leaders reviewed the current process and answered any questions. The nurse manager huddled with the staff teams to coach them through this process. All of the project teams gradually took over responsibility for the project and the nurse manager, like the coach for the nurse manager, gradually moved to a less active role. Interestingly, all of the managers and unit based teams had similar concerns about leading their staff and peers through the change process: how to deal with negativity and peer pressure, how to incrementally move through the process and how to hold others accountable. The parallel between staff and nurse manager concerns was striking. After addressing these concerns in coaching sessions with the nurse managers, they used coaching techniques to address these issues with their team and their team used these same coaching techniques with staff.
Final Phase. In the close out or follow up stage, nurse managers developed methods to monitor progress and to separate from regular meetings with the coach. The timing of the close out phase was defined mutually by the nurse manager and coach and differed for each nurse manager. The close out phase came naturally and was not forced or artificial despite the time frames set for the study. It was again illustrated that the nurse manager used this same method with their teams, and the teams with staff, so that the process became a unit based culture and expectation and sustainment was achieved.

Results

Effectiveness of a coaching intervention on nurse manager’s perceived competence

The data in Table 4 indicates that all three nurse managers’ self-assessment using the TQManager© tool improved but the degree of improvement varied. TQManager© authors, Schmidt and Finnegan (1993), define scores in a manner very similar to Benner’s novice to expert category progression (Table 5). One nurse manager participant scored twenty or more points higher than the other two nurse manager participants both pre (score 92) and post (score 103) coaching. This nurse manager participant’s higher scores may be attributable to her 6 years of nurse manager experience which is consistent with the findings of Baxter and Warshawsky (in press) that it takes 6 or more years of nurse manager experience to achieve competent levels but 10 or more to reach expert levels for performance improvement competencies (Figure 1). Other contributing factors may be that this nurse manager participant recently transferred from another non VA facility which focused on quality improvement methods, holds a Master’s of Science in Library Science and was familiar with searching
the literature for evidenced based practice. Regardless of these skills, she self-rated herself higher after coaching than she did prior to coaching.

The other two nurse manager participants had less than 6 years of nurse manager experience and did not have prior exposure to organized performance improvement techniques or evidenced based practice methodologies other than the baseline education provided by the facility that was part of the study’s inclusion criteria. While their scores improved post coaching, their TQManager© scores also correlated with the findings of Baxter and Warshawsky (in press) that nurse managers with less than 6 years of nurse manager experience rate themselves less than competent. In all three participants, years of experience as a registered nurse or nursing degree held did not appear to have any impact on TQManager© self-assessment scores (pre, post and improvement differences).

**Improvement of Unit Level Performance**

There was limited evidence that the unit based performance teams led by the nurse managers improved patient outcome scores (Figures 2-4) although the results were not consistent among all nurse managers. Two nurse managers chose to focus their team’s efforts on hospital acquired pressure ulcers (HAPU) and one chose surgical suite turnaround time. Figure 2 illustrates the reduction of HAPU rates to zero post coaching in a progressive care unit whose population consists of intermediate level care between intensive care nursing and nursing on a general medical surgical unit. Figure 3 illustrates the reduction of HAPU rates to below benchmark post coaching in a long term care acute rehabilitation unit. Figure 4 illustrates a reduction of surgical suite turnaround time for the orthopedic service by 50% post coaching. HAPU rates were defined as “the number of discharged patients with HAPU Stage 2 or greater divided by the patient days
(ward day of care for all discharged patients with a length of stay 48 hours or longer) multiplied by 1000” (VA Nursing Outcomes Data Base, 2013). Expected benchmark measures for acute care are defined by the National VA (all VA facilities nationally) and Veterans Integrated Systems Network 9 (VA region for facility) rates. Benchmark rates for acute rehabilitation long term care were defined by internal and evidence based literature rates (VANOD, 2012 & 2013; Vanglides, Lachenbruch, Harrison, Davis & Myers, 2011). Surgical suite turnaround times were defined as the time the last patient leaves the room until the next patient enters. Surgical suite turnaround time benchmark rates were defined by the evidenced based literature and defined for this project as a 50% reduction from baseline time (Friedman, Sokal, Chang & Berger, 2006; Ngu, 2010; Integris, 2011). Because there were efforts under way to improve all these rates before the study was implemented, there are confounding variables limiting the interpretation and strength of these results. However, because the measures were not improved with multiple efforts prior to the study, and because the results of the units and nurse managers participating in this study were significantly better than units or surgical specialty teams not participating in the study, it is reasonable to conclude that coaching had a positive impact. The increase in HAPU rates post coaching for the acute rehabilitation long term care unit (Figure 3) was most likely a result of the facility’s decision to move patients in acute care beds waiting for long term nursing home placement to this unit. This elevated the acuity levels of the population of this unit. The HAPU benchmarks for a long term nursing home care unit are higher than for a rehabilitation unit.
Nurse Manager’s Perception of the Coaching Experience

Pre-determined questions were used to determine how nurse managers perceived the coaching experience (Table 2). Components of the coaching intervention that were unanimously seen as valuable were having a coach who was experienced and expert in performance improvement techniques, using evidence based practice in conjunction with LEAN processes, having a communication and data sharing plan, reducing the LEAN process into something more manageable to use at the unit based level and learning how to lead staff rather than the nurse manager trying to improve processes alone. Managers, teams and staff were excited about the new unit based performance improvement model developed during this study. Infusing evidence based practice into a scaled down LEAN model was viewed as accelerating the improvement process (Table 6). Rather than guessing what actions would improve an outcome, the improvement process was jump started to success by actions already found to be successful in the literature for their setting. Instead of focusing on efficiencies and process alone, evidence for success infused into the model accelerated positive outcomes and generated buy in and support for the change in processes.

All components of the coaching intervention were valued although all nurse managers recognized that finding time was an obstacle. However, being flexible with approaches overcame this hurdle. In turn, they recognized that they could do the same in working with their staff teams to resolve this issue. All three nurse managers felt that they could repeat the process and found themselves coaching their staff teams much like they were being coached and have a higher comfort level with this approach than they did prior to their involvement in the study. All planned to use this approach in the future and one had already started to apply the same process to another situation. They
also planned to inspect what they expect and use a communication and data plan to ensure sustainability.

The nurse manager participants described the following as desirable characteristics for a coach: flexibility, being a content expert for the area of concern (in this case performance improvement), having confidence, being trustworthy and calm, steering negatives to positives, being non-judgmental and is a good listener. When asked for any further input or comments all the nurse managers were most pleased with the sense of achievement and empowerment that they, and their staff teams and other unit staff members felt with the project(s) progress. Staff ownership for success and culture change regarding outcomes was illustrated by the following comment, “the culture now is that a pressure ulcer is not acceptable.” All nurse managers felt that it didn’t matter whether their coach was their supervisor or another person as long as they had the attributes identified as valuable in this setting. All the nurse managers described the ideal coach as flexible, empowering, did not micro-manage and viewed mistakes as learning opportunities.

**Discussion**

Despite the limitations of conducting three case studies, which represent three trials of an approach to coaching, the experience suggests that coaching is a viable methodology for improvement and acceleration of skill acquisition for nurse managers. It is interesting that all nurse managers in this study had received the required inclusion criteria of education in LEAN performance improvement and coaching and mentoring methodologies. However, prior to the coaching intervention, none of them were comfortable using what they learned in the practice setting based on this education alone. Consistent with Benner’s theory of skill acquisition for new nurses (1986), and
the findings of Baxter and Warshawsky (in press), it appears that new and / or inexperienced nurse managers developed proficient and expert levels by practicing. It was also interesting that, in this study, nurse managers with less than 6 years of experience rated themselves as less than competent using the TQManager© tool which corresponded with the self-assessment ratings based on years of experience by Baxter and Warshawsky (in press). The development of nurse managers should be given the same or more attention as is being given to staff or executive level employees due to the nurse managers’ close proximity to patient care, the impact of their leadership on healthy work environments (AONE, AACN, p 2; Wiley, 2001; Wong & Cummings, 2007; Haas, 1992) and the reality that in a new role they start over as a novice.

Arganwal, et al.’s (2009) finding that managers who are educated about, and experienced coaching, are more likely to use coaching successfully with their staff was supported in this study. It was remarkable that all nurse managers mirrored the coach’s behavior and techniques with their team and the team mirrored the nurse manager’s behavior and techniques with the unit staff. Coaching the nurse manager accelerated not only the nurse manager’s skill acquisition but the skill acquisition of the team and staff on the unit.

It is estimated that coaching took approximately 40 hours of time for both the coach and the nurse manager, totaling 80 hours of in kind time at a cost of approximately $4,000 including benefits. The incidence of a pressure ulcer extends the length of stay by a median of 4.31 days (Graves, Birrell, & Whitby, 2005). Cost of care is approximately $2,100 / day for this facility in acute care and $1,200 / day in the acute rehabilitation long term care unit. The presence of a pressure ulcer would cost approximately $9,051 extra per Veteran in acute care and approximately $5,172 extra per Veteran in acute rehabilitation long term care. Thus, the breakeven point for
coaching would be one prevented pressure ulcer. Operating room time in this facility costs $52.00 per minute. The mean turnaround time of 20 minutes achieved in this study (during the coaching and post coaching phases) resulted in a reduction of $1,020 dollars per orthopedic case. The breakeven point for coaching in this surgical setting was 4 cases. Spread of this reduction of turnaround time to all surgical specialties in this facility by even 10 minutes would result in an additional 25 hours of surgical suite time a week (usual weekly cases of 75). Given that the average case time is 2 hours, enough surgical time would be available to perform approximately 12 more cases per week. Coaching as described is a cost effective methodology for nurse manager skill acquisition.

Limitations and Future Research

Small sample size is was a limitation in this study. Other limitations were the confounding variables affecting the outcomes. Because the performance measures chosen for improvement in this study were a high priority for the facility, the unit based performance improvement teams were not the only activities aimed at improving the measures. However, the units involved in the study had quicker and more significant improvements than the other units despite all the facility level actions for improvement. Even though the nurse managers who participated in the study were not in the direct line authority of the coach, they may have been biased because the coach held a leadership role in the facility. Based on the nurse managers’ responses to questions, within this limited sample, the position held by the coach seems to be less important than the approach to coaching and the attributes of the coach. Lastly, the results would have been strengthened by longer data monitoring and reporting beyond three months post coaching. Future assessment efforts includes replication on a larger scale including more participants and the use of coaching to improve the acquisition of additional skills.
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Table 1: Benner’s Theory of Skill Acquisition (1984)

<table>
<thead>
<tr>
<th>Competency Level</th>
<th>Description</th>
</tr>
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<tbody>
<tr>
<td>Novice</td>
<td>No background understanding of the situation, no experience</td>
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<tr>
<td>Advanced Beginner</td>
<td>Demonstrates marginally acceptable performance, can recognize aspects or pieces of a situation</td>
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<tr>
<td>Competent</td>
<td>Perceives situations as a whole and can prioritize appropriate actions</td>
</tr>
<tr>
<td>Proficient</td>
<td>Perceives the situation as a whole and recognizes expected outcomes and deviations and makes advanced decisions</td>
</tr>
<tr>
<td>Expert</td>
<td>No longer relies on analytical thinking and has enough experience to intuitively make connections and pair with appropriate actions</td>
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Table 2: Questions to Assess Perceptions of Coaching Experience

<table>
<thead>
<tr>
<th>Question</th>
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<tbody>
<tr>
<td>What components of the coaching intervention were perceived by the nurse managers as valuable?</td>
</tr>
<tr>
<td>What components of the coaching intervention were perceived by the nurse managers as not valuable?</td>
</tr>
<tr>
<td>Of those components of the coaching intervention perceived as not valuable, what alternate components would have been perceived as valuable?</td>
</tr>
<tr>
<td>After the coaching intervention, do the nurse managers perceive their ability to coach their staff improved?</td>
</tr>
<tr>
<td>What actions, if any, will the nurse managers incorporate into their own practice when coaching their staff or peers?</td>
</tr>
<tr>
<td>What characteristics do the nurse managers perceive are desirable for a coach?</td>
</tr>
<tr>
<td>Other comments or input?</td>
</tr>
<tr>
<td>Would you prefer a supervisor as a coach or is another person more desirable to you?</td>
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</table>
Table 3: Coaching Model and Lessons Learned used in this Case Study

<table>
<thead>
<tr>
<th>Coaching Phase</th>
<th>Planned Model</th>
<th>Lessons Learned</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pre-Planning</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Initial Meeting</td>
<td>Get organized</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Overview of feasibility study</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Review TQManager© tool</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Skill assessment</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Communication and team blg</td>
<td></td>
</tr>
<tr>
<td></td>
<td>LEAN skills</td>
<td></td>
</tr>
<tr>
<td></td>
<td>EBP* skills</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Change management theory</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Planning</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Setting timelines</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Setting goals*</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Additional planning meetings</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Team intervention planning</td>
<td></td>
</tr>
<tr>
<td></td>
<td>This stage is as long as the active phase to be successful</td>
<td></td>
</tr>
<tr>
<td></td>
<td>NMs* were not confident implementing something they have learned but not practiced</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Need scaled down version of performance improvement model, current facility model too cumbersome, infused EBP*</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Coach served as instructor and content expert as well as coach</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Formal face to face (F2F) meetings were difficult to accomplish after the initial meeting so alternate communication used to facilitate as appropriate (during lunch, telephone, email)</td>
<td></td>
</tr>
<tr>
<td>Active</td>
<td>NM* team intervention</td>
<td></td>
</tr>
<tr>
<td></td>
<td>NM carries out plan to coach team</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Coach observes and provides feedback at next coach/NM mtg</td>
<td></td>
</tr>
<tr>
<td></td>
<td>new goal setting cycle repeats</td>
<td></td>
</tr>
<tr>
<td></td>
<td>PI feedback &amp; further coaching</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Techniques used by coach:</td>
<td></td>
</tr>
<tr>
<td></td>
<td>active listening</td>
<td></td>
</tr>
<tr>
<td></td>
<td>open body posture, eye contact</td>
<td></td>
</tr>
<tr>
<td></td>
<td>monitor verbal/non verbal</td>
<td></td>
</tr>
<tr>
<td></td>
<td>formulate themes &amp; perceived relationships</td>
<td></td>
</tr>
<tr>
<td></td>
<td>questioning techniques</td>
<td></td>
</tr>
<tr>
<td></td>
<td>broad to specific</td>
<td></td>
</tr>
<tr>
<td></td>
<td>follows concern of NM</td>
<td></td>
</tr>
<tr>
<td></td>
<td>mirroring</td>
<td></td>
</tr>
<tr>
<td></td>
<td>reflecting back</td>
<td></td>
</tr>
<tr>
<td></td>
<td>summarizing</td>
<td></td>
</tr>
<tr>
<td></td>
<td>mutual goal setting</td>
<td></td>
</tr>
<tr>
<td></td>
<td>incremental</td>
<td></td>
</tr>
<tr>
<td></td>
<td>ties back to overarching goal</td>
<td></td>
</tr>
<tr>
<td></td>
<td>examine consequences</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Unexpectedly, coach participated in team meetings in the beginning as needed vs observed</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Formal F2F meetings difficult due to time constraints of both NM* and staff, mirrored alternate communications as described above</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Found that coaching process was implemented &quot;in turn&quot;-NM and staff team members emulated process, phrases and techniques used by coach within their sphere of influence during the project</td>
<td></td>
</tr>
<tr>
<td></td>
<td>As expected, all participants gained confidence at their own individual pace, requiring flexibility in intensity &amp; style of approach</td>
<td></td>
</tr>
<tr>
<td></td>
<td>As expected, incremental goal setting and early success improved comfort level of participants (breakdown overarching goal into manageable parts)</td>
<td></td>
</tr>
<tr>
<td>Follow up &amp; Close Out</td>
<td>Gradually less involvement by coach</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Development of follow up and sustainment plan</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Final evaluation of intervention</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Coaching ends</td>
<td></td>
</tr>
<tr>
<td></td>
<td>As expected, as the NM and teams gained confidence, they gradually pulled away from the coach</td>
<td></td>
</tr>
</tbody>
</table>

*NM= Nurse Manager

*EBP=Evidenced Based Practice (Iowa Model)

*Using Whitmore (2009) goals of GROW and SMART (methodology used by facility)
<table>
<thead>
<tr>
<th></th>
<th>NM “A”</th>
<th>NM “B”</th>
<th>NM “C”</th>
</tr>
</thead>
<tbody>
<tr>
<td>TQManager© Pre Coaching Score</td>
<td>92</td>
<td>52</td>
<td>71</td>
</tr>
<tr>
<td>TQManager© Post Coaching Score</td>
<td>103</td>
<td>84</td>
<td>78</td>
</tr>
<tr>
<td>TQManager© Score Increase Pre to Post Coaching</td>
<td>11</td>
<td>32</td>
<td>7</td>
</tr>
<tr>
<td>Degrees Held¹</td>
<td>BSN/MSLS</td>
<td>BSN</td>
<td>MSN</td>
</tr>
<tr>
<td>RN experience</td>
<td>14</td>
<td>20</td>
<td>21</td>
</tr>
<tr>
<td>RN VA² experience</td>
<td>2</td>
<td>20</td>
<td>1</td>
</tr>
<tr>
<td>NM³ experience</td>
<td>8</td>
<td>5</td>
<td>4</td>
</tr>
<tr>
<td>NM VA experience</td>
<td>&lt;1</td>
<td>5</td>
<td>1</td>
</tr>
</tbody>
</table>

Possible range of scores: 25-125

¹BSN= Bachelor’s of Science in Nursing
MSN= Master’s of Science in Nursing
MSLS= Master’s of Science in Library Science
²VA= Veteran’s Administration Medical Center
Table 5: Comparison of TQManager© Scores (p, 143) with Benner’s Novice to Expert Scale

<table>
<thead>
<tr>
<th>Competency Level</th>
<th>Description of Competency</th>
<th>Schmidt and Finnegan’s TQManager© Scores</th>
<th>Description of Competency</th>
</tr>
</thead>
<tbody>
<tr>
<td>Novice</td>
<td>No background understanding of the situation, no experience</td>
<td>&lt;74</td>
<td>Considerable room for Improvement</td>
</tr>
<tr>
<td>Advanced Beginner</td>
<td>Demonstrates marginally acceptable performance, can recognize aspects or pieces of a situation</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Competent</td>
<td>Perceives situations as a whole and can prioritize appropriate actions</td>
<td>75-99</td>
<td>Well on your way</td>
</tr>
<tr>
<td>Proficient</td>
<td>Perceives the situation as a whole and recognizes expected outcomes and deviations and makes advanced decisions</td>
<td>100-125</td>
<td>Consistently demonstrate performance improvement (quality) philosophy</td>
</tr>
<tr>
<td>Expert</td>
<td>No longer relies on analytical thinking and has enough experience to intuitively make connections and pair with appropriate actions</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Table 6: Comparison of Veterans Administration VATAMMCS Performance Improvement Model, LEAN Improvement Model, Iowa Evidenced Based Practice Model and Blended Model Developed in this Case Study

<table>
<thead>
<tr>
<th>VA Performance Improvement Model- VATAMMCS</th>
<th>LEAN Improvement Model</th>
<th>Iowa Model</th>
<th>Blended Model</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Vision / Analysis</strong></td>
<td></td>
<td></td>
<td>Vision / Analysis</td>
</tr>
<tr>
<td>How does it fit with the National, VISN and local visions or the strategic plans? Ensures executive leadership support</td>
<td>Triggers</td>
<td>Is this a priority for the organization?</td>
<td>What is the unit based trigger? Does it fit into the strategic plan and have support?</td>
</tr>
<tr>
<td><strong>Team</strong></td>
<td>Team / Aim</td>
<td></td>
<td><strong>Team / Aim</strong></td>
</tr>
<tr>
<td>Involve the stakeholders of the process, use front line staff</td>
<td>Define the problem Charter &amp; VOC Put the team together</td>
<td>Form a team Assemble relevant research &amp; related literature Critique and synthesize research for use in practice</td>
<td>Form a team Find and critique evidence, literature Are there VA best practices? Form the unit based team Perform any VOC (focus on the people that are the focus of the change, staff or Veterans?) Define the goals/aim using SMART</td>
</tr>
<tr>
<td><strong>Aim</strong></td>
<td></td>
<td>Is there a sufficient research base? No: conduct research Yes: Pilot the change in practice Select outcomes to achieve Collect baseline data Design EBP guidelines</td>
<td></td>
</tr>
<tr>
<td>What are we trying to accomplish? SMART goals (specific, measurable, attainable, realistic, timely)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Map</strong></td>
<td>Map / Measure</td>
<td></td>
<td><strong>Map / Measure</strong></td>
</tr>
<tr>
<td>Drawing a picture of the process</td>
<td>Evaluate current state &amp; operational barriers Tools: process map, observation and timing tools, etc</td>
<td>Evaluate current and future state &amp; operational barriers Tools: process map, observation and timing tools, etc</td>
<td>Evaluate current and future state &amp; operational barriers Tools: process map, observation and timing tools, etc</td>
</tr>
<tr>
<td><strong>Measure</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Change</strong></td>
<td>Change</td>
<td></td>
<td><strong>Change</strong></td>
</tr>
<tr>
<td>Change principles Small tests of change-PDSA</td>
<td>Improve systems Tools: PDCA cycles, LEAN tools (affinity diagram, risk volume grid, prioritization matrix, multi-voting, 5 whys RCA)</td>
<td>Implement EBP on pilot units Evaluate process &amp; outcomes Modify the practice guideline</td>
<td>Infuse EBP and LEAN methods institute small cycles of change based on EBP and process mapping</td>
</tr>
<tr>
<td><strong>Sustain / Spread</strong></td>
<td>Sustain</td>
<td></td>
<td><strong>Sustain / Spread</strong></td>
</tr>
<tr>
<td>Process control strategy for spread Tools: as above</td>
<td>Institute into practice Analyze structure, process and outcomes data Disseminate results</td>
<td></td>
<td>Combine EBP and LEAN tools that make sense for the project (communication, data posting and spread plans)</td>
</tr>
</tbody>
</table>
Figure 1: Comparison of Nurse Manager Pre and Post Coaching TQManager© Self-Assessment Scores with Years of Nurse Manager Experience, n=3

Nurse Manager Pre & Post Coaching TQManager© Scores and Years of Nurse Manager Experience

- NM "A": Pre Coaching: 100, Post Coaching: 80
- NM "B": Pre Coaching: 90, Post Coaching: 60
- NM "C": Pre Coaching: 80, Post Coaching: 70

Legend:
- Pre Coaching
- Post Coaching
- VA NM experience in yrs
- NM experience in yrs

Years of Experience
0 1 2 3 4 5 6 7 8 9
TQManager Score
0 20 40 60 80 100 120
Figure 2: Nurse Manager “B” Acute Care Hospital Acquired Pressure Ulcer (HAPU) Rate Pre, During and Post Coaching Intervention

Nurse Manager "B" Acute Care Unit HAPU Rates Pre, During and Post Coaching

Unit= nursing unit over which the Nurse Manager has responsibility, progressive care
Ntl= National Veterans Administration (VA) Rates
VISN= Veterans Integrated Systems Network Rates (regional grouping of VA facilities)
Figure 3: Nurse Manager “C” Acute Rehabilitation Long Term Care Hospital Acquired Pressure Ulcer (HAPU) Rates Pre, During and Post Coaching

Benchmarks as defined by the International Pressure Ulcer Survey 2011 (Vanglides, Lachenbruch, Harrison, Davis & Myers)
Figure 4: Nurse Manager “A” Orthopedic Surgical Suite Turn Over Times Pre, During and Post Coaching Intervention

Benchmark rates (Friedman, Sokal, Chang & Berger, 2006; Ngu, 2010; Integris, 2011)
Conclusion to Final DNP Capstone Report

Cynthia Baxter

University of Kentucky
The acquisition of nurse manager competence occurs over time and with experience. As described in this report, nurse manager self-rated competency suggests that it takes approximately 6 years for nurse managers to perceive themselves as competent, and up to 9 years to perceive themselves as proficient, for those skills identified as important for nurse manager success. Even clinical practice, the role from which most nurse managers promote, took 6 or more years for nurse managers to self-rate themselves as expert or near expert. With the vast responsibility of the nurse manager role and the impact on patient care, orientation and development of the nurse manager role deserves the same or more attention than the staff nurse or nurse executive role.

This report suggests that coaching is an effective method to further develop and accelerate nurse manager skill acquisition for unit based performance improvement and is more effective than education alone. Exploring the use of coaching with a larger sample of nurse managers and a larger sample of skills could strengthen the reported results. Replication of the model of coaching used in this report would validate this model, or suggest changes for a more effective model, for acceleration and improvement of nurse manager skills. And finally, replication of the blended model for unit based performance improvement with other nurse managers in the setting of this report would validate the model or identify needed changes for success.
Appendix A

**TQManager® Assessment Tool**
*Reproduced with permission from TQManager (Schmidt & Finnegan, 1993, Jossey Bass Publishers)*

1. Circle ONE for timing of survey: PRE-coaching       POST-coaching

2. Please use a 3 letter & 3 number combination as a unique identifier known only to you that you will use each time you self rate this self assessment tool during the study:________________

3. How often is each of these statements true of you?

<table>
<thead>
<tr>
<th>Statement</th>
<th>Almost Never</th>
<th>Rarely</th>
<th>Sometimes</th>
<th>Frequently</th>
<th>Almost Always</th>
</tr>
</thead>
<tbody>
<tr>
<td>I consider that keeping my subordinates and colleagues fully informed as</td>
<td></td>
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<tr>
<td>a top priority.</td>
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<tr>
<td>I have full confidence in my subordinates, and I make a point of</td>
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<tr>
<td>showing it.</td>
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<tr>
<td>I don’t mind taking risks with those around me, knowing that even if</td>
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<tr>
<td>we did fail, we'll learn.</td>
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<tr>
<td>I try to make it comfortable for people to give me their honest</td>
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<tr>
<td>feedback on how they view my actions.</td>
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<tr>
<td>I am a good listener.</td>
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<tr>
<td>I make a special effort to understand people who support positions</td>
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<tr>
<td>with which I disagree.</td>
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<tr>
<td>Teams are always more creative and productive than individuals in</td>
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<tr>
<td>dealing with complexity.</td>
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<tr>
<td>I make every effort to recognize team effort, rather than singling out</td>
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<tr>
<td>individuals.</td>
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<td>-----------------------------------------------------------------</td>
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<td>----------------------------------------------------------------</td>
<td>----------------------------------------------------------------</td>
<td>----------------------------------------------------------------</td>
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<tr>
<td>I take the time to document important work processes.</td>
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<tr>
<td>I try to make certain that we don't just solve problems, but also look for their root causes.</td>
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<tr>
<td>My colleagues and I set goals that are measurable.</td>
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</tr>
<tr>
<td>Solving problems is important, but taking time to find their causes is even more important.</td>
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</tr>
<tr>
<td>I am fair and consistent in giving appropriate recognition and rewards to the people I supervise.</td>
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</tr>
<tr>
<td>I have given people a clear idea of what they have to do to get special recognition or rewards.</td>
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</tr>
<tr>
<td>My colleagues and I regularly review our recognition and reward systems to assess their fairness and impact.</td>
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</tr>
<tr>
<td>I am alert for new opportunities to give appropriate recognition for innovations or work well done.</td>
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<td></td>
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</tr>
<tr>
<td>Employees should be encouraged to take some risks and should be applauded even when those risks do not produce the desired results.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>I consider that training and coaching are one of my key responsibilities as a manager.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
My subordinates and I all know how to use the Plan-Do-Study-Act process.

I use quality-improvement processes to review business performance and results.

I seek and value my team’s input on their workload and priorities.

4. Please answer the following:

<table>
<thead>
<tr>
<th>Question</th>
<th>Response</th>
</tr>
</thead>
<tbody>
<tr>
<td>(use whole numbers only, do not round, i.e., 1 ½ years = 1 year)</td>
<td></td>
</tr>
<tr>
<td>Years of experience as a RN</td>
<td></td>
</tr>
<tr>
<td>Years of experience within the VA as a RN</td>
<td></td>
</tr>
<tr>
<td>Years of experience as a Nurse Manager</td>
<td></td>
</tr>
<tr>
<td>Years of service within the VA as a Nurse Manager</td>
<td></td>
</tr>
<tr>
<td>Nursing Degrees earned &amp; any other degrees earned</td>
<td></td>
</tr>
</tbody>
</table>
References


https://library.hill-rom.com/.../VanGlider.Results%20from%20the%2020...


