Nurse Preparation and Organizational Support for Supervision of Unlicensed Assistive Personnel in Nursing Homes: A Qualitative Exploration

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Purpose: Nursing supervision of the routine daily care (e.g., grooming, feeding, and toileting) that is delegated to unlicensed assistive personnel (UAP) is critical to nursing home service delivery. The conditions under which the supervisory role is organized and operationalized at the work-unit level, taking into account workloads, registered nurse/licensed practical nurse staffing, and role expectations, are not well understood. The purpose of this paper is to describe the organizational, managerial, and nurse-level factors associated with the nurse’s role as supervisor of UAP in nursing homes. Design and Methods: An ethnographic approach to data collection included 31 interviews, 170 hr of observation, and organizational document review at three nursing homes. Analysis included micro-coding and content analysis. Results: Findings revealed (a) considerable variation in organizational resources, systems, and processes to support organization and operationalization of the supervisory role; and (b) limited evidence of nurses’ estimation of the potential benefits of training and organizational systems to support supervisory practice and the complexity of the supervisory role. Implications: Delivery of high-quality nursing home care is a matter of national importance, and these findings offer a call to action for nursing home leaders in policy, academia, and ownership and management positions. Nurses must be equipped with competencies and skills that reflect the complex organizational environments in which they work. Additionally, nursing home administrators and managers must be equipped with the competencies and skills needed to effectively and efficiently organize and operationalize care delivery practices to support nurses’ role enactment.

Key Words: Long-term care, Nursing, Roles, Systems

Nursing supervision of the routine daily care (e.g., grooming, feeding, and toileting) that is delegated to unlicensed assistive personnel (UAP) is critical to nursing home service delivery. Supervisory practices in long-term care are associated with implementation of care practices for continence (Lekan-Rutledge, Palmer, & Belyea, 1998), nutrition (Crogan & Shultz, 2000), hydration (Kayser-Jones, Schell, Porter, Barbaccia, & Shaw, 1999), and end of life (Kayser-Jones et al., 2003); client outcomes and events (Anthony, Standing, & Hertz, 2000); and UAP outcomes, including job satisfaction, turnover, and retention (Bowers, Esmond, & Jacobson, 2003; Parsons, Simmons, Penn, & Furlough, 2003).

Registered nurses (RNs) are required to supervise the performance of the nursing tasks delegated to UAP, with the scope of delegation determined by state boards of nursing. State jurisdictions also set the scope of delegation authority and supervisory...
responsibility for licensed practical nurses (LPNs), although RNs retain ultimate accountability for supervising UAP. Limited evidence suggests inconsistent differentiation between RN and LPN delegation authority and/or supervisory practices in nursing homes (Mueller, 2005). Research is needed to explore how regulatory guidelines for delegation and supervision are operationalized in these settings, where more LPNs than RNs are employed.

Few studies have explored the nurse’s supervisory role as a primary focus of inquiry; however, limited evidence suggests lack of adequate preparation (regardless of RN or LPN licensure) and inadequate resources for this supervisory responsibility (Eaton, 2001; Iowa CareGivers Association, 2000; Schirm, Albanese, Garland, Gipson, & Blackmon, 2000). Furthermore, inconsistent, less effective, or deficient supervisory practices are implicated in substandard care practices and negative events (Anthony et al., 2000; Kayser-Jones et al., 2003). Eaton’s (2000) study of 14 nursing homes identified a lack of supervision in the majority of sites, including little task instruction or feedback. Bowers, Esmond, and Jacobson (2000) identified gaps in supervision during heavy workloads, with UAP describing completion of tasks most noticeable to supervisors (i.e., picking up soiled laundry) and elimination of time-consuming tasks (i.e., toileting, mouth care, range of motion, and walking). There is a paucity of research exploring the underlying organization-level factors associated with supervisory practices. Further study is needed to elucidate the conditions under which the supervisory role is organized and operationalized at the work-unit level, taking into account workloads, RN/LPN staffing, and role expectations. The purpose of this paper is to describe the organizational, managerial, and nurse-level factors associated with the nurse’s role as supervisor of UAP in nursing homes.

Methods

The researcher used a focused, topic-oriented ethnographic approach to understand the organization and operationalization of supervisory practices in nursing homes. In contrast to grand-scale ethnography, this inquiry was a focused, time-limited exploration of an organization (Muecke, 1994) and the topic orientation narrowed data collection (Spradley, 1980) to organizational factors and employee perceptions associated with the supervisory role. This ethnographic approach offered a holistic and contextualized interpretation (Roper & Shapira, 2000) of supervisory practices, using different data sources to understand the systems, processes, and employee perspectives that collectively contribute to supervisory practices. In qualitative inquiries, the researcher is the human instrument for data collection, interpretation, and analysis (Lincoln & Guba, 1985). Triangulation of data collection methods included in-depth interviews, observation, and review of organizational documents to strengthen and validate data interpretation (Lincoln & Guba, 1985; Roper & Shapira, 2000). For example, the researcher used interviews to clarify observations made during fieldwork and to confirm linkages between different observations. Organizational documents (e.g., job descriptions) identified expectations that could be explored further in interviews and observations. Clarification and confirmation promoted the investigator’s ability to understand the supervisory role the way supervisory practices are seen by staff (Spradley, 1979).

Elena O. Siegel, an RN with doctoral preparation in qualitative methods, conducted participant recruitment and data collection. In-depth consultation occurred throughout data collection and analysis with Heather M. Young, an RN and geriatric nurse practitioner with doctoral preparation and extensive experience in qualitative methods. The researcher received approval to conduct this research from each facility and approval of study procedures from the University of Washington Human Subjects Division. Given the small sample of participants from each nursing home and the relatively few participants in the different employment categories (e.g., management, staff nurse, RN/LPN, etc.), participants are at risk for identification and linkage to findings by other participants and employees working at their site. For this reason, the description of the settings is presented in a manner that precludes identification of participants via recognition of the study site.

Sample and Procedure

Site and Participant Sample.—The researcher purposively selected three nursing homes with fewer deficiencies than state and national averages to participate. This inclusion criterion reflected an assumption that, in the least, the sample would share the most basic levels of organizational systems needed to support the minimum care standards set forth by regulatory guidelines. Additionally, the researcher selected sites to maximize the heterogeneity of work environments to gain breadth of perspective for different systems and processes used to support supervisory practices. Selection considered organizational characteristics (size, profit status, and chain affiliation), staffing practices, and care models.

The researcher presented study information at staff meetings, distributed study flyers to employees, and posted flyers at sites prior to data collection. To avoid introducing bias regarding multiple meanings attached to supervision, the investigator broadly described the study purpose for site and participant recruitment:

I want to understand the way nurses and UAP work together to give resident care. . . . the types of things
they tell each other about their work and the residents’ care needs ... how, when, where, and in what situations they tell each other these things ... the types of work they do together to care for residents.

The researcher received oral consent prior to observing activities in nonpublic areas and before informally asking questions and written consent prior to conducting formal interviews. The researcher distributed letters requesting interviews to employees during work hours and set appointments with interested employees to review the consent form and, if consented, to conduct the interview. All appointments with staff nurses and UAP occurred during non-work hours.

**Formal Interviews.**—Audiotaped interviews lasting 30 to 45 min took place with 31 employees to identify perceptions, understandings, and expectations for (a) the supervisory role and (b) the organizational systems and processes that support supervisory practices. The researcher purposively recruited participants to attain breadth of perspective across job classifications: administrators, nurse managers, charge/staff nurses, and UAP. Additional nurse and/or UAP sampling characteristics included tenure, shift, RN/LPN licensure, and observable communication styles. The only inclusion criterion was current employment at the participating facility for at least 1 month. The researcher determined the adequacy of the sample by the “relevance, completeness, and amount of information obtained” (Morse, 1991 p. 135); recruitment by job classification and nurse/UAP characteristics varied across sites and continued until theoretical saturation within each site was achieved (i.e., no substantial gaps in data). Questions explored how nurses and UAP work together, employees’ understanding of expectations for nurse–UAP interactions and supervision, and actual practices. Questions also asked about the participants’ role in the supervision of UAP, aspects of their job that made it easy or challenging to fulfill this role, and their strategies for role performance. The researcher used an interview guide during semistructured interviews (see Appendix). This interview guide was developed from preliminary questions informally pilot-tested with nurse colleagues to verify the appropriateness and clarity of questions. The researcher transcribed, coded, and analyzed the audiotapes shortly after interviews.

**Observation.**—The purpose of observation was to describe the nurse’s role as supervisor of UAP in the natural (work) setting (Morse, 1991). Participant observation is central to ethnographic approaches to inquiry (Roper & Shapira, 2000). The researcher conducted observations as a passive participant, limiting interactions to that of a bystander (Spradley, 1980); site visits solely involved observing and recording specific activities of interest for this study. Observations totaling 170 hr occurred across shifts and units, with the majority during morning and afternoon shift changes because these times were determined to offer the most opportunities to observe nurse–UAP interactions. Observation activities rotated through units to minimize staff reactions to the researcher’s presence (Schnelle, Osterweil, & Simmons, 2005). The researcher recorded field notes during or shortly after observations. Data collection from observation continued until data saturation within each site was achieved (Morse, 1991; Roper & Shapira, 2000).

**Document Review.**—The researcher reviewed organizational documents to identify management’s expectations for the supervisory role that were deemed worthy of formalization. Document review was limited to standard documents relating to formal administrative and employee policies, including job descriptions, policies and procedures, employee handbooks, orientation materials, and performance appraisal templates.

**Trustworthiness**

Consistent with Lincoln and Guba’s (1985) criteria for establishing credibility, data collection involved (a) prolonged field inquiry and copious data collection over a period of 4 to 6 months per site until data saturation was achieved across sites (Morse, 1991; Roper & Shapira, 2000) and (b) persistent observation to explore the breadth of organizational and employee factors associated with supervisory practices. Additionally, the researcher triangulated the data, using observation, interviews, and document review to confirm information and verify the researcher’s interpretations across different data sources. Detailed methodological field notes and a dictionary of coding definitions provided documentation of coding decisions. Debriefing; discussion of investigator bias; and review of coding practices, discrepancies, decisions, and analytical methods occurred with members of the research team throughout all phases of data collection and analysis.

**Data Analysis**

This ethnographic approach to data analysis used an inductive process (Roper & Shapira, 2000) involving ongoing analysis and coding of the data as they were collected to identify emerging themes for further exploration during subsequent interviews and observations (Spradley, 1980). For example, data revealing concern regarding UAP compliance with resident bathing schedules prompted specific questions during subsequent interviews and focused observation to understand the systems and processes...
fragments into general themes (e.g., definition of supervision, supervisory training, manager support), resulting in more than 500 initial codes. The researcher continually and systematically reviewed, revised, and consolidated micro-codes for consistency, duplication, and relevance, resulting in descriptive themes (e.g., organizational systems/processes, role expectations). They used content analysis to code expectations for the nurse’s supervisory role and nurse–UAP interactions identified in organizational documents. Similarities and trends are summarized and described.

**Results**

**Description of Settings**

The sample of nursing homes in the Pacific Northwest \( (n = 3) \) varied in organizational characteristics, including urban/rural, for profit/not for profit, chain affiliate/independent ownership, size (fewer than 100 beds/more than 150 beds), hierarchical/decentralized structure, traditional medical–nursing/nontraditional care delivery models, functional/team nursing, and staffing ratios (14–32 residents/nurse and 5–12 residents/UAP).

Staffing and job designs for nursing care and medication administration were categorized in one of two ways: (a) a team composed of a charge nurse and a medication nurse (generally an RN and LPN, respectively) or (b) one nurse carrying responsibility for both nursing care and medication administration (either an RN or LPN). UAP job designs also reflected two alternatives: (a) workloads that required UAP to perform routine, task-focused resident care throughout the shift (e.g., grooming, feeding) or (b) workloads that afforded time for UAP to sit and socialize with residents or to congregate in lounges during the last 30 min of the shift for charting and call light response. UAP shifts and change of shift report protocols were organized in one of two ways: (a) nonoverlapping UAP shifts, with impromptu nurse–UAP reports; or (b) 30-min UAP shift overlaps, with formal nurse–UAP reports.

**Description of Interview Participant Sample**

The sample of interview participants \( (n = 31) \) represented variability in job description, age, tenure, and education (see Table 1) and was not necessarily representative of national averages. In all, 63% of staff nurses interviewed were RNs. This percentage is higher than national nursing home averages, as is the percentage with BSN preparation (55%). Only (25%) reported formal supervisory training in their nursing programs.

Findings associated with RN and LPN responses are presented collectively as findings from nurses. Data analysis of RN–LPN respondent comments did
not generate differences in themes, possibly due to site selection bias. Respondent references to the term *nurse*, rather than references to RN or LPN, reflect the generic manner in which participants referred to these positions.

**Organization-Level Factors and the Supervisory Role**

**Systems for Role Development.**—Organizational support for development of the supervisory role varied across sites from noninteractive self-study materials to sponsored classes, workshops, in-services, and interactive role modeling, role playing, and coaching. Managers expressed varying levels of organization-level responsibility for development of nurses’ supervisory skills; they either made no reference to responsibility or readily claimed accountability for this aspect of nurses’ professional development:

> While ... [the nurse] could be an excellent caregiver ... they might not have the ability to supervise and that presents another task [for us]. We help the licensed person with a way of effectively supervising and training the [UAP] who provide the hands-on care ... Part of our managers’ tasks are to help in mentoring the nurses ... meeting on an ongoing basis with the licensed person and helping them see what the person under their supervision is doing and not doing.

**Staffing Systems.**—Staffing, in general, represented a challenge for supervision of UAP, including workload, need for overtime, and competing role demands:

> Time, patient load ... I would say that’s the biggest thing right now is patient load, just because [the nurse is] so busy. It’s hard to be always there kind of supervising, kind of overseeing ... when [the nurse is] down here, [they] have no clue what’s happening [over there] and so that would be, I think, the biggest barrier is the time and the patient load.

Participants identified medication administration as one competing role demand: “Nurses don’t [guide, direct the care of the resident] because they are so tied up with pushing the pill and that seems to be the primary [role].”

**Other Systems to Support Supervisory Practices.**—Across sites, the format and timing for change of shift reports as a means to support nurse–UAP communication varied from formal and routine group shift reports to impromptu nurse-to-UAP exchanges. Across sites, the frequency and timing of performance evaluations as a means to reinforce expectations for the supervisory role varied from routine to limited and annual to sporadic. Although the supervisory role is generally considered a component of nurses’ performance evaluation, written expectations for evaluating this aspect of the nurse’s role varied per performance appraisal forms and job descriptions.

**System-Level Recommendations to Support Supervisory Practices.**—Discussions of challenges associated with enacting the supervisory role emphasized “industry” or “funding” constraints rather than organization-level system influences. Nurses revealed little discontent with the systems and resources available in their work settings:

> ... [I’m] overloaded. Definitely, and so are they—[UAP are] stressed. It may be my interpretation of business but ... the facility is a good facility—I could have worked anywhere, but I picked this one. We’re just understaffed immensely—it’s a sweat factory.

Suggestions for improved communication practices included instituting formal shift reports, and changing nurse and UAP shift times to coincide instead of staggering start times by one-half hour. Participants mentioned heavy workloads as a barrier to implementing formal shift reports. Other recommendations included increased staffing, greater nurse involvement in the UAP training process, and institution of routine performance appraisals. Recommendations for changes to existing formal performance evaluation processes included less frequent evaluations for long-tenured staff, standardized forms with fewer individualized comments, and greater involvement of management in conducting UAP appraisals.

**Management-Level Factors and the Supervisory Role**

**Role Expectations.**—Interviews with managers revealed an extensive and complex job description for the supervisory role, including oversight and monitoring of resident care, communication, support, training/guidance, problem solving, assessment/evaluation of UAP skills and performance, scheduling, leadership, and teamwork (see Table 2). In terms of compatibility with job designs, one manager suggested “in an ideal world” 50% of the nurse’s time should be spent in a supervisory capacity, in comparison to actual time of about 10%. RN and LPN job descriptions included general statements of nurses’ supervisory responsibilities, with few specific role elements noted. Nurses generally described their supervisory role simplistically as “oversight and monitoring” or “making sure things get done.” When questioned about what they actually do with UAP, without using the label *supervision*, nurses revealed an extensive and
complex job description similar to that represented by management.

**Nurse–UAP Communication as a Primary Element of the Supervisory Role.**—Managers reported expectations for ongoing, informal nurse–UAP communication and formal shift reports. RN/LPN job descriptions identified general expectations for nurse reports to UAP; however, observed practices suggested inconsistencies between job descriptions and actual employee practices.

**Communication of Expectations.**—Nurses’ autonomy to determine their supervisory style was a common theme. However, there were differences in management’s explicit expectations for role style, ranging from “captain of the team” to “parenting.” Managers’ communication of role expectations varied. One approach supported nurses’ independence:

> I do not spend time with the new nurse other than in hiring, discussing my expectations when I hire, and even sometimes probably that’s not clear...I believe the nurses have an autonomy so this is why I haven’t said, “This is what you have to say to [UAP] each day.” [Nurses] are professional and they’re supposed to do what they’re supposed to do.

Nurses acknowledged management’s vague communication of expectations with little expression of concern: “They never say how they want us to interact...basically, you need to get your point across of what needs to be done, but there’s never been any guidelines of how to go about doing that.” Another approach for communicating management expectations reflected continual reinforcement: “I really go over the [nurse’s] job descriptions and really focus on the importance of the ongoing communication with [UAP], and I hold monthly meetings with nurses and that’s an opportunity for me to reinforce [my expectations].”

**Nurse-Level Factors Associated With the Supervisory Role**

**Supervisory Training.**—Participants commonly reported on-the-job training and life experiences as means for learning the supervisory role, with little discussion of formal supervisory training in nursing programs. Other sources for skill development included prior experience working as a UAP; observation; and on-the-job support from nurses, mentors, and management. They also reported previous work experiences (i.e., non-nursing administrative positions, restaurant/retail services) and personal experiences (i.e., parenting) as experiences that developed supervisory skills.

Managers expressed the need for nurses to have greater training for their supervisory role:

> ...one thing that is not usually taught consistently in all the different nursing schools is the leadership aspect of a charge nurse. How do I coordinate 4 or 5 people now giving care to my residents under me? How do I pass my pills and still supervise these people?

Managers reported that RNs were generally more prepared than LPNs for the role of charge nurse: “The RN has more skill in supervision, much more than an LPN does and the critical-thinking pieces—clinical things, but supervisory too.” Another explained:

> I think it would depend upon if they are a [RN] versus a LPN...I think the [RN] would tell you that they are more responsible...they are responsible for what the [UAP] do...depending on the LPN, you’d probably have a little more difficulty gleaning that information. They don’t like to be in charge of—they don’t like to be the supervisor of [UAP].

Reflecting on LPNs’ supervisory role, a nurse explained:

> ...I think it’s because it was early on and [LPNs]...were reporting to the RNs, the [UAP] were reporting to the RNs...[LPNs and UAP] were all under the RNs as far as riding on their licensure or whatever, and so it is very strange for [LPNs] to have [UAP] riding on [them]—it’s brand new.

In contrast to management, there was little discussion by nurses of dissatisfaction or concern with the lack of formal supervisory training they received prior to entering the workforce. One
nurse shared rationale for seeking additional role development:

... there was a resident complaint ... and that’s when I kind of got the idea ... the buck stops here ... I didn’t want my [UAP] to ... be written up and called into the office. I wanted to be able to be a better supervisor, watch them closer if I felt they had a weak point ...

**Individual Approaches to Supervision.**—Nurses stressed the importance of respect, value, and trust to encourage positive UAP work practices. Individual approaches to supervision ranged from deliberate, purposeful, proactive, and confident, to inconsistent, reactive, or hesitant. Hesitation related to an uneasiness with “being in charge,” conducting performance appraisals, or being involved with disciplinary and corrective activities:

There are some people who are very uncomfortable supervising. They’re wonderful clinical nurses—they just are not comfortable with confrontations ... not comfortable being assertive, saying “No ... you need to do this.”

[Nurses] tend to not want to guide, direct, manage, use the nursing process to lead their staff ... [why?] Fear of reprisal from the [UAP]. They hate to discipline. “If I do this with the [UAP] and then the [UAP] is not going to do what I want ... If I do this with the [UAP] then she’ll run to the [management] and she’ll complain about me.”

[If I say] “good job,” fine. But if you say [the UAP] is not doing a good job, they get mad at you. So you’re in the middle. Your purpose is to correct the situation, but they think this is offensive. They don’t really think you are trying to help them out.

Culturally diverse settings revealed supervisory approaches that account for language differences and sociocultural norms:

... miscommunication is the number one thing that really affects the supervisor ... How do I handle it? Well, sometimes I demonstrate—I do a hands-on demonstration ... I like to show it to them ... those are the difficulties being with a diverse setting.

... in that cultural group, there is a respect for the elderly—your elders. And sometimes, a nurse could be much younger than the UAP on the floor ... and how do you deal, culturally, where you cannot really come down too heavy on a person who is older than you are?

Nurses at all levels of supervisory expertise and training referred to management’s ongoing intervening measures to support nurses with their supervisory role in general and in challenging situations: “Usually the charge nurses don’t feel as comfortable giving [UAP] negative feedback, so then they’ll come to [management] and then that’s when [management gets] involved.”

Nurses used personal resources in response to systems-level challenges. For example, questions about how nurses juggle clinical responsibilities and the supervisory role in light of heavy workloads included the responses “I pray a lot” and “I love my job.” Nurses also used personal resources to remedy organization-level constraints associated with UAP work. For example, in situations of recurrent UAP understaffing, nurses reported personally helping with UAP tasks, emphasizing the benefits of these actions to demonstrate nurses’ respect and value for UAP; there was little indication of advocating for UAP or management’s responsibility to ensure adequate UAP staffing.

**Tenure.**—Nurses’ tenure was related to supervisory expertise, with greater confidence in this aspect of the role among more experienced nurses: “[I’ve worked] with my UAP for [a long time]. I pretty much know their behavior ... [his/her] level of understanding ... how [he/she] reacts to certain cases.” Also:

New nurses do seem to have a problem because it’s a lot expected of them—to also to supervise the UAP ... sometimes it’s a struggle ... they’ll go to [management] or ... [seasoned nurses] will step in and say, “You know, this is how you can do it” ... if it still continues to be a problem, usually the licensed nurse leaves ... it takes a real seasoned nurse and someone who is really organized to handle [this job].

**Discussion**

This study provides a breadth of information to better understand how expectations for the supervisory role are organized and operationalized across a small, heterogeneous sample of nursing homes. Major findings revealed (a) considerable variation in organizational resources, systems, and processes to support organization and operationalization of the supervisory role; and (b) limited evidence of nurses’ estimation of the potential benefits of training and organizational systems to support supervisory practice and role complexity.

**Organization-Level Factors and the Supervisory Role**

Management readily acknowledged nurses’ needs for enhanced supervisory training, however professional development opportunities and the structure and process systems to support supervisory practices varied. Van de Ven and Drazin’s (1985) patterned systems contingency theory suggests that work units with lower levels of personnel expertise
require the highest levels of supervisory discretion, structured processes, and formalized systems to attain the best performance. Themes across this sample revealed consistency in systems/resource relationships that were contrary to this systems contingency theory. For example, the least formalized systems, processes, and supervisory discretion were identified where there was greatest turnover and lowest staffing levels (presumably resulting in less expertise). In contrast, greater opportunities for development of supervisory skills and structure and process systems to support supervisory practices were identified where staffing levels were higher, there were greater numbers of RNs as charge nurses, and there was longer nurse/UAP tenure.

Although the patterns across this small sample are not generalizable, it is likely that mainstream industry nursing homes have fewer structure and process systems. Zinn, Brannon, Mor, and Barry’s (2003) work supports this claim, concluding that most units in a 308 nursing home sample did not “appear to be well-organized, accountable bureaucratic systems” (p. 302). This may reflect organizational systems that are functioning at subsistence levels inconsistent with nurses’ role requirements. Discussions regarding subsistence functioning often turn to the adequacy of Medicare/Medicaid reimbursements to support staffing and quality nursing home practices. Although continuation of these discussions is important, the focus must also attend to organizational, managerial, and leadership strategies that support the development of organizational infrastructures, systems, and processes to support effective and efficient utilization of current resources and organization of care delivery practices, given the constraints of existing reimbursement rate structures.

Management-Level Factors and the Supervisory Role

Nurses across sites readily spoke of management’s intervening measures to support nurses’ supervisory interactions with UAP. The accounts of some study participants suggest that management picks up where nurses leave off, depending on the supervisory skill and comfort level of individual nurses. From a human resources perspective, this supportive management behavior mediates role challenges that might otherwise seem insurmountable to nurses struggling with role demands. However, from a practical standpoint, nurses, not managers, are in the best position to enact immediate and appropriate supervisory practices. A study of the relationship between supervision and nursing home quality care suggested better outcomes when supervisory practices occur during the provision of care (Corazzini, Utley-Smith, Ammarell, & Bailey, 2005). Furthermore, extensive management involvement raises questions regarding practice efficiencies in terms of job designs; allocation of management resources; and opportunity costs to the organization, ownership, employees, and residents. In any organization, responsibility and accountability for establishing effective and efficient systems and resources to support the expected performance of roles falls within the scope of administration and management teams. Few studies have explored nursing home administrator and manager practices in terms of this level of responsibility and accountability.

Nurse-Level Factors and the Supervisory Role

Although nurses identified limited formal training for the supervisory role, they revealed little concern or indication of need for additional training. The literature on nurses’ perceptions of supervisory training needs is limited, and results are mixed. A nationwide survey of 148 nurses rating the adequacy of educational preparation for delegation and supervisory skills from 1 (very poor) to 10 (very well) revealed midpoint ratings (M = 5.0) (Anthony, Standing, & Hertz, 2001). This might suggest that nurses, on average, are neither satisfied nor dissatisfied with the adequacy of their supervisory training. In contrast, nurses responding to an Iowa statewide survey (n = 703) reported the need for more supervisory training (Iowa CareGivers Association, 2000), and nurses participating in a nursing home focus group (n = 36) frequently reported inadequate preparation for the supervisory role (Schirm et al., 2000).

For the current study, there are several possible explanations for nurses’ seemingly passive acceptance of limited formal training opportunities. One explanation points to the mediating effects of management’s involvement, as described in the previous section. Another possible explanation considers team versus primary nursing practice models and the respective education associated with these practices. A National Council of State Boards of Nursing (2005) position paper on nurses working with UAP stated, “Nurses who were educated under a primary [nursing] care model may not realize what they do not know about delegation” (p. 14). The paper cited Zimmerman’s 1995 survey reporting nurses’ overrated delegation competency skills in relation to their actual tested knowledge. A limited or lack of formal nursing education for supervisory practices for RNs or LPNs may bias nurses against recognizing the value of training for this role.

In terms of resources and systems, nurses’ propensity to personally compensate for organization-level challenges is consistent with results from a study of nurses’ approaches to problem solving in hospital settings (Tucker, Edmondson, & Spear, 2002). Nurses in that study generally addressed organization-level problems with direct remedies that supported immediate caregiving demands, revealing little exploration.
of the potential for associated system changes. These problem-solving practices were attributed to time constraints and nurses' relative lower organizational status.

The present study revealed extensive and complex job components for nurses' role as supervisor (see Table 2), suggesting masterful integration of clinical, leadership, and management roles to juggle competing responsibilities and orchestrate functional work teams that promote the delivery of high-quality care. There was little discussion of the multifaceted aspects of the supervisory role, with nurses offering simplistic descriptors of “oversight and monitoring” or “making sure things get done.” Drawing from Buressh and Gordon (2006), the researcher concludes that this finding is not surprising, as nurses are not socialized to speak out and talk about their work. In contrast to few reports of major role challenges by nurses in the current study, nurses participating in the McGillis Hall, McGilton, Krejci, and Pringle (2005) study recognized the vast “scope of the [nurses'] role” as a challenge to enacting supportive supervisory behaviors (p. 186). A possible explanation of the current findings considers, again, the mediating effects of management involvement, as described in the previous section.

**Limitations**

There are several important limitations to these findings. Generalizability may be threatened due to the limited sample size drawn from a single geographical area and possible selection bias associated with site recruitment. However, this study explored a range of site characteristics currently existing in this industry, including typical and innovative organizational structures and approaches to higher quality care. The purposive selection of sites with distinctly different organizational characteristics, staffing, and care models precluded rich description of sites and linkages of findings to sites or participant characteristics to avoid (a) recognition of sites or participants by coparticipants and (b) potential recognition of sites by other readers familiar with the nursing homes in the study region. The topic-oriented ethnographic approach required the researcher to focus data collection on specific content areas, potentially neglecting other rich topics.

The findings from this study can be used as a foundation for future research with larger, more diverse samples and broader scopes of inquiry to explore linkages between site and participant characteristics. Studies are needed to understand the implications of RN/LPN staffing practices for supervision of UAP, given staffing practices across this industry that employs greater numbers of LPNs than RNs. Research is also needed to explore relationships between elements of supervisory practices and resident/staff outcomes, identifying supervisory practices that support implementation and sustainability of best practices.

**Implications**

The findings from this study suggest that some staff nurses are ill prepared and/or inadequately supported to promote optimal performance by the direct care workers in their charge. Inadequate preparation and support have vast consequences for nursing home quality care and carry implications for facility owners, management teams, administrators/nursing program educators, and policy makers. How can mandates for efficient high-quality care be achieved if nurses are not adequately prepared and supported to lead and manage the direct caregivers under their supervision? In today’s turbulent health care environments, clinical proficiency is not enough for nurses to orchestrate functional work teams. Concerns regarding RNs’ lack of formal supervisory training are compounded, considering nursing home industry-wide staffing with more LPNs than RNs. Despite underlying assumptions set forth by nurse practice acts and professional expectations that leadership positions are predominantly held by RNs, it is very common for LPNs to take on these roles. State regulations for RN and LPN scopes of practice and RN and LPN licensure education programs must coincide and consider the pragmatic and fiscal aspects of industry-wide staffing patterns and implications for actual supervisory practices.

The current study findings prompt discussion regarding owner-, management-, nurse-, and policy-level responsibility to ensure nurses’ adequate preparation to supervise and manage the work of UAP. Recognition of educational gaps in supervisory skills training is increasing and industry is responding, with numerous opportunities emerging for RNs and LPNs through independent programs including Coaching Supervision, offered by the Paraprofessional Healthcare Institute (2005), and LEAP (Learn, Empower, Achieve, Produce), offered by Mather LifeWays (2006). Notwithstanding the effectiveness of these programs, the voluntary nature of participation requires reliance on facility-level support. Is it appropriate to relegate foundation-level supervisory skills training to employers? Are management teams adequately prepared to take on this training role?

Although managers at all study sites readily acknowledged the need for staff nurses to receive supervisory training, there was little mention of organization-level responsibility at facilities where the training was lacking. This is not surprising, given industry trends placing little emphasis on these basic nonclinical skills at all levels of management and facility administration. Nurses in long-term care often gain access to management positions as a result of demonstrated clinical expertise, with little or no
training or requirements for training to support management role challenges. Federal standards for nursing homes require only that the director of nursing be an RN. In fact, many directors of nursing are educated in diploma or 2-year associate nursing programs. A Centers for Medicare & Medicaid Services report concluded, “Strong leadership among Directors of Nursing (DONs) as well as unit supervisors was critical, but frequently absent, in part because no training was provided for supervisory roles in nursing facilities” (Feuerberg, 2001, p. 13). Moreover, formal education and training for nursing home administrators charged with overall management of the nursing home varies considerably across states. Ongoing high rates of job turnover among all levels of administrative and management staff may, in part, reflect a workforce inadequately prepared to meet industry challenges.

The findings associated with nurses’ seemingly passive acceptance of little or no formal supervisory training are of concern, particularly when coupled with nurses’ apparent acceptance of the status quo for the organizational systems that support enactment of their role. This finding may reflect what Buresh and Gordon (2006) referred to as nurses’ “silence” regarding the complexities of nursing practice. Tucker and colleagues (2002) contended that nurses’ patterns of personally compensating for organization-level problems promote sustenance of the problems, with little opportunity for management remedy.

These findings offer a call to action for nursing home leaders in policy, academic, and ownership and management positions to address the critical gap in nurses’ preparedness for the nonclinical aspects of their roles. Nurses must be equipped with competencies and skill sets requisite to maximizing role enactment, considering the complex organizational environments in which they work. Nursing home administrators and managers must be equipped with the competencies and skills needed to effectively and efficiently organize care delivery practices and systems to support nurses’ role enactment and promote optimal outcomes for residents. Findings suggest the need for (a) enhanced partnerships between academia, industry, and existing supervision education programs such as LEAP and Coaching Supervision; (b) policy considerations for RN and LPN National Council Licensure Examination (NCLEX) content; and (c) enhanced preparation of nursing home administrators and managers to meet the organizational challenges inherent to this industry.

References


Appendix

Interview guide

1. Tell me about the things that nurses and nursing assistants do together. Sample probes:
   - What, when, how and why do nurses and nursing assistants work together to provide resident care?
   - Formal, informal processes? [learned about at orientations, things that are done by everyone, things that you think management expects, things that are sometimes done by some people]
   - How and when do nurses/nursing assistants talk about assignments (i.e., actual resident assignments, questions, concerns, observations, suggestions, time management)?
   - Can you give me some examples?

2. [If the participant is a nurse or nursing assistant] Sample probes:
   - What parts of your job make it easier or harder for you to do these things?
   - Do you have any recommendations for different ways to do these things?

3. [If the participant is not a nurse or nursing assistant] How are you directly or indirectly involved with the things that nurses and nursing assistants do together? Sample probes:
   - Formal/informal processes?
   - Can you give me some examples?
   - What parts of your job make it easier or harder for you to do these things?
   - Do you have any recommendations for different ways to do these things?

[##4 & ##5 will be asked if not specifically addressed in answers to the above questions]

4. Tell me about supervision of nursing assistants. Sample probes:
   - Who is involved in supervision of nursing assistants?
   - What is supervision?
   - What kinds of things are done as part of supervision process? Formal/informal processes? Direct/indirect?
   - Can you give me some examples of situations that involved supervising nursing assistants?
   - What makes it easier or harder for you/other employees to supervise nursing assistants/be supervised?
   - Do you have any recommendations for different ways to supervise/be supervised?

5. Tell me about the nursing assistant performance appraisal process. Sample probes:
   - What kinds of things are done as part of the nursing assistant performance appraisal process? Formal/informal? Direct/indirect?
   - Who is involved, when, & how?
   - [If applicable] What parts of your job make it easier or harder for you to participate in the formal/informal nursing assistant performance appraisal process?
   - [If applicable] What makes it easier or harder for other employees to participate in the formal/informal nursing assistant performance appraisal process?
   - Do you have any recommendations for different ways for employees to participate in formal/informal performance appraisals?
   - How does the appraisal process tie in with the ways in which supervision of nursing assistants occurs?