

The Pennsylvania State University

The Graduate School

College of Nursing

DEMYSTIFYING JOB SATISFACTION IN LONG-TERM CARE:
THE VOICES OF LICENSED PRACTICAL NURSES

A Dissertation in Nursing

by

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Submitted in Partial Fulfillment

of the Requirements

for the Degree of

Doctor of Philosophy

May 2014

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ABSTRACT

Background. Licensed Practical Nurse (LPN) job satisfaction is a critical issue facing any stakeholder concerned with advancing the health of the nation's elderly. Increasing job satisfaction and decreasing job dissatisfaction has been found to improve staff retention and ultimately result in improved patient outcomes. Given the aging United States population, the projected nursing (RN and LPN) shortage, predominance of LPNs as the primary licensed nurse in long-term care settings, and the lack of LPN workforce research it is essential to understand the key attributes of LPN job satisfaction and job dissatisfaction in long-term care settings.

Purpose. The goal of this study is to examine the attributes of long-term care LPNs' job satisfaction and dissatisfaction. **Methods.** A qualitative, focus group study was conducted at six long-term care institutions in the Philadelphia metropolitan area. A purposive sample of 4 to 12 LPNs in each of the six focus groups (n = 37) participated in a 90-minute focus group session. Herzberg's motivation/hygiene theory (1959) provided the theoretical basis for the conceptual framework for this qualitative study. The focus group methodology allowed the researcher to utilize the collective power of individual and group discussion, resulting in rich data. Data analysis began immediately following completion of the first focus group session and included open coding, condensation, and abstraction. Utilization of member checks, expert verification, and maintenance of an audit trail contributed to trustworthiness. **Results.** Four themes including value (sub-themes: value of the "work" itself and recognition), *real* connection, empowerment (sub-themes: role identity and voice), and growth contributed to LPN job satisfaction and one theme, working conditions (sub-themes: unrealistic workload and equipment) contributed to LPN job dissatisfaction. The dissatisfier, working conditions, was also found to potentially

impact the LPNs' ability to experience job satisfiers, thus preventing improved LPN job satisfaction. **Conclusions:** This study contributes to the literature by providing job satisfaction and job dissatisfaction data specific to the LPN in the long-term care setting. The four key attributes (value, *real* connection, empowerment, and growth) of LPN job satisfaction in long-term care settings are congruent with other research findings specific to RN, overall nursing staff, and direct care worker (DCW) populations, and align with some of Herzberg's (1959) intrinsic motivators. In addition, the job satisfaction attributes identified in this study align with the major tenets of transformational leadership, referred to as the 4 I's, inclusive of idealized influence, inspirational motivation, intellectual stimulation, and individualized consideration. The depth of understanding of these attributes is enhanced; providing specific details to assist administrators and staff in addressing concepts such as LPN role identity and empowerment and providing opportunities in addition to the RN career path (i.e. specialty certification), thus contributing to LPN job satisfaction. In contrast to Herzberg (1959), only one dissatisfaction attribute, working conditions, was identified. Working conditions, inclusive of unrealistic workload and equipment can impact the LPNs' ability to achieve overall LPN job satisfaction. The four attributes constitute four pieces of the LPN job satisfaction experience. The job dissatisfaction attribute, working conditions, can prevent the LPN from experiencing job satisfaction. Thus, it will be essential for supervisors/administrators to address issues related to working conditions, allowing job satisfaction to prevail, potentially improving LPN retention, and positively impacting patient outcomes. This is critical to meet the current and future health care needs of the United States' elderly in long-term care settings.

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Funding Acknowledgement

The Laurie Gunter Research Fund supported the author of this dissertation.

Personal Acknowledgements

Thanks for the guidance, wisdom and dedication of my dissertation chair, Paula Milone-Nuzzo. Her selfless availability, continual coaching and constant encouragement serve as a role model for many. Extreme gratitude is extended to all the members of my dissertation committee (Janice Dreachslin, Judith Hupcey, and Lisa Kitko). I learned immensely from each of these scholars and give thanks for their knowledge, time commitment, and continual pursuit of excellence. A special thanks is also extended to the Penn State College of Nursing faculty/staff and the following colleagues for their support and contributions in conducting the focus groups, analyzing data, and preparing the manuscript: Fran Ward, L'Tanya Taylor, Michele Carpenter, Nancy Bowman, and Cara Bicking Kinsey. Their contributions were invaluable. Most importantly, this dissertation is dedicated to my family, particularly my husband, sons and daughter-in-laws, and my parents. This journey would not have been possible without my husband's unwavering and loving support. To my parents, I thank them for instilling in me strong self-determination, a positive attitude, and the vision to recognize the unique abilities and contributions of all people. Lastly, I thank the host sites and the LPNs who participated in this study. I remain amazed by the incredible women and men, who as LPNs selflessly care for our elderly and others in need. Often they are unrecognized for their unique contributions to health care. I thank them for who they are, what they do, and challenge them to continue to grow and excel in their professional and personal lives.

Chapter 1: Introduction

Job satisfaction of health care workers is a critical issue facing any stakeholder responsible for delivery of high quality health care in the United States. Increasing job satisfaction and decreasing job dissatisfaction can improve staff retention and ultimately result in improved patient outcomes (Bowers, Esmond, & Jacobsen, 2003; Hayes et al., 2012). Given the projected demand for health care workers, job satisfaction is a timely and important issue.

A nursing (RN and LPN) shortage, partially abated by the current recession, is predicted to intensify over the next 15 years due to the increasing numbers of adults age 65 years of age or older, expansion of health insurance coverage to tens of millions of Americans, and advances in technology (Buerhaus, 2010). All care settings, including long-term care settings (see conceptual definitions), will be impacted.

Research on job satisfaction and job dissatisfaction to date, focused primarily on Registered Nurses (RN), Direct Care Workers (DCW – also referred to as CNA or nursing assistant) and the overall nursing staff (RN, LPN and DCW) workforce, supports an association between job satisfaction and nursing staff retention (Brannon, Barry, Kemper, Schreiner, & Vasey, 2007; Hayes et al., 2012; McGilton, Tourangeau, Kavcic, & Wodchis, 2013; Morgan & Konrad, 2008; Stone & Dawson, 2008). Multiple factors such as organizational climate, communication, leadership, workload, autonomy, and compensation have been significantly and positively associated with nursing and DCW job satisfaction and job dissatisfaction (Abraham & Grant, 2008; Cohen-Mansfield, 1997; Cummings et al., 2008; Cummings et al., 2010; Donoghue & Castle, 2009; Engström, Skytt, & Nilsson, 2011; Probst, Baek, & Laditka, 2010; Scott-Cawiezell et al., 2004; Solomon, 2009). In the last decade, research focused on the DCW in long-term care settings has demonstrated a relationship between the DCWs' job satisfaction,

turnover, and the quality of patient care (Bowers et al., 2003; Castle & Engberg, 2005; Dellefield, 2008). Despite research literature (Dellefield, 2008; Castle & Bost, 2009) that supports the implementation of programs (e.g., WIN A STEP UP [supervisory training – coaching], LEAP [empowerment], ACT NOW [peer mentoring]), and suggests strategies (e.g., process redesign or enlisting the services of a staff retention specialist) to improve job satisfaction and retention; high turnover rates prevail in long-term care settings. In fact, the average turnover rate is 71% for CNAs and 49% for nurses (Utley, Anderson, & Atwell, 2011). These continued turnover rates indicate the need to carefully examine the current literature on job satisfaction and job dissatisfaction and identify potential gaps that need to be addressed.

One gap identified was the small amount of research focused on LPN job satisfaction and job dissatisfaction. This is striking considering the fact that from 1997 to 2007 nursing homes have increased LPN hours per resident per day, while decreasing RN hours per resident per day (Seblega, Zhang, Unruh, Breen, Paek & Wan, 2010). Pennsylvania statistics from the Department of Health (2012) echo this continued trend reporting LPNs as the predominant licensed nurses in nursing homes (10,921 full time LPNs and 9,172 full time RNs).

Given this gap in our knowledge, a thorough analysis of job satisfaction and job dissatisfaction from the perspective of LPNs working in long-term care is warranted. This research will provide an in-depth description of the factors LPNs working in long-term care perceive as affecting their job satisfaction and job dissatisfaction.

Statement of Problem

Aging population. The demographics of aging continue to change in the United States (US) accelerated by the aging of the “Baby Boomers” born between 1946 and 1964 who began turning 65 in 2011 (Federal Interagency Forum on Aging Related Statistics, 2012). The older

adult population is projected to almost double by 2030, growing from 35 million to 72 million, when compared to the year 2000 (Federal Interagency Forum on Aging Related Statistics, 2012). This group will represent 20% of the total US population (Federal Interagency Forum on Aging Related Statistics, 2012) and due to their considerable chronic disease burden will place increasing demands on the United States health care system. Nursing home care will be among the health care needs. In fact by 2020, an estimated 12 million older Americans will need long-term care (Medicare, 2009). To provide care for these individuals, the demand for health care workers is projected to increase (BLS, 2012). During this same time period, a nursing shortage is predicted to intensify (Buerhaus, 2010). Taken together, these facts create a compelling, urgent need for a stable nursing staff, particularly in long-term care settings.

Nursing shortage (RNs and LPNs). By 2015, a 20% shortage of nurses is predicted for the nation (Health Resources and Service Administration, 2011). In Pennsylvania, the LPN shortage is predicted to be 10,100 (25%) (Pennsylvania Center for Health Careers, 2011). This projected LPN shortage is particularly concerning in Pennsylvania, because of the state's considerable older adult population. Pennsylvania ranks fourth in the nation in the number of residents age 65 and older (US Census Bureau, 2010).

Role of LPNs in long-term care settings. Newly licensed LPNs employed in long-term care soared from 44.5 % to 54.2% from 2003 to 2012 (NCSBN, 2013). In contrast, newly licensed RN employment in 2011 was 13.1% (NCSBN, 2012). About 70% of licensed nursing care is provided by LPNs rather than RNs (American Health Care Association, 2011). Strikingly, 43.4% of newly licensed LPNs indicated that they have administrative duties and LPNs working in long-term care facilities were more likely to have administrative responsibilities than LPNs working in a hospital (32.4 percent versus .8 percent respectively) (NCSBN, 2013). These

workforce trends demonstrate that LPNs are an integral part of the skill mix in long-term care settings.

Job satisfaction, staff retention, and patient outcomes. Nursing staff retention in long-term care is a focus of many reports, including the Institute of Medicine (IOM) Report (2008) *Retooling for an Aging America: Building the Health Care Workforce*. Turnover is a critical issue in long-term care evidenced by a recent report indicating the annual turnover in nursing homes is 49 % for nurses and 71% for NAs (Utley et al., 2011). Similarly, one year earlier, Donoghue (2010) reported nursing home annual turnover rates of 56% for RNs, 51% for LPNs and 75% for NAs. Research supports an association between job satisfaction and many factors in long-term care identifying five primary domains: pay, work itself, work environment, management and personal factors (Abraham & Grant, 2008; Cohen-Mansfield, 1997; Scott-Cawiezell et al., 2004; Cummings et al., 2008, 2010; Castle, Degenholtz & Rosen, 2006; Castle & Bost, 2009; Probst et al., 2010). A positive correlation between nursing staff's job satisfaction and nurse's and DCW's turnover have also been established (Brannon et al., 2007; Castle et al., 2006; Morgan & Konrad, 2008; Robison & Pillemer, 2007). Furthermore, high nurse turnover has been linked to poor patient outcomes, including incidence of infection, re-hospitalization, and pressure ulcers (Castle, 2005, 2009; Castle & Anderson, 2011), which when taken together support the need to fully understand the dimensions of job satisfaction.

Gaps in job satisfaction and job dissatisfaction literature. The majority of the research studies found that examined the phenomena of job satisfaction and job dissatisfaction in long-term care utilized a descriptive correlational design (Care and Kazanowski, 1994; Castle et al., 2006; Heponiemi et al., 2011; Karsh, Booske, & Sainfort, 2005 and Noelker et al., 2009). Few qualitative studies were found when searching for research focused on job satisfaction and job

dissatisfaction in long-term care (Cherry, Ashcraft, & Owen, 2007; Fläckman, Fagerberg, Häggström & Kihlgren, 2007; Leurer, Donnelly & Domm, 2007; Moyle, Skinner, Rowe & Gork, 2003). Job satisfaction and job dissatisfaction research has primarily focused on RNs, senior management, nursing staff in general (failing to delineate between LPN and RN), and/or DCWs. There was a dearth of literature related to the LPN specifically.

Purpose of the Study

The overarching goal of this study was to build an understanding of the factors contributing to long-term care LPNs' job satisfaction, through an examination of the attributes of LPN job satisfaction and dissatisfaction. A qualitative focus group methodology was employed.

Significance of the Study

The IOM (2010) *Future of Nursing* report recognizes the unique contribution of LPNs in long-term care, including supervision of DCW and other non-licensed individuals. Furthermore, the IOM (2010) *Future of Nursing* report indicates that RNs, when faced with work overload and unsafe conditions in acute care, can delegate to LPNs as a solution. Given the empirical evidence that does exist indicating a relationship between job satisfaction and variables such as leadership attributes, autonomy, resource adequacy, and workload (Castle, 2007; Choi, Flynn, Aiken, 2011; Havig, Skogstad, Veenstra and Romøren, 2011; Harahan et al., 2011; McGilton, Hall, Wodchis, & Petroz, 2007; Stone & Dawson, 2008; Walker, 2008), the need to understand this impact on the job satisfaction of specifically the LPN is essential.

Extensive studies exist examining the concept of job satisfaction in long-term care. LPNs, however, are not the primary focus of many of these studies. Given the 51% turnover rate of LPNs in long-term care settings (Donoghue, 2010), projected increased workforce demand for LPNs (BLS, 2012) and the fact that LPNs often provide more hours of care per day per resident

than RNs (Harrington, Carrillo, LaCava, 2006) this identified gap in the literature requires immediate attention to gain needed information on LPN job satisfaction. The information gained will hold implications for the future development of strategies to promote nursing staff job satisfaction and retention, which is critical in light of the increased health care needs of the United States' aging population.

A study by the U.S. Department of Health and Human Services indicated that people who reach age 65 would likely have a 40 percent chance of entering a nursing home. About 10 percent of the people who enter a nursing home will reside there five years or more (Medicare, 2009). The 2008 IOM report, *Retooling for an Aging America: Building the Health Care Workforce*, calls for fundamental workforce reform to care effectively for older adults. Health care workforce was defined broadly and LPNs were mentioned as being especially important to the care of older adults in long-term care settings. The report advocates for an increased skill set and size of the workforce to care effectively and efficiently for older adults with diverse needs. Awareness of older adults' unique backgrounds, personal preferences, culture, values, traditions, and family preferences are essential to providing individualized care. The report states, "The committee recommends that more be done to increase the breadth of geriatric experiences among health care professionals and to ensure geriatric competence of all providers" (p. 182).

Complicating this workforce need and call for reform is the nursing shortage. Projected job growth for RNs and LPNs is anticipated to be greater than the average rate (14% for all occupations), estimated to be 26 and 22 percent respectively between 2010 and 2020 (Bureau of Labor Statistics Occupational Outlook Handbook, 2012). The median age of the nursing workforce (RN and LPN) exceeded the median average of all United States workers in 2011. Specifically, the average age of employed LPN/LVNs in 2011 was 43.2, compared to an average

US worker age of 42.1 (Bureau of Labor Statistics, Current Population Survey, 2012). This increased age of the LPN workforce intensifies the potential for a staffing crisis in long-term care settings.

Given the link established in the literature between job satisfaction, nursing staff turnover and patient outcomes and the current and projected workforce statistics (i.e. nursing shortage intensified by nursing staff turnover and aging population) the need to focus on the phenomena of LPN job satisfaction and job dissatisfaction in long-term care, utilizing a qualitative approach, is warranted.

Conceptual Framework

Herzberg's motivation/hygiene theory (two factor theory) (1959) provided the theoretical basis for this qualitative research study. Herzberg, Mausner and Snyderman (1959), studied 200 engineers and accountants, hypothesizing that two different variables, termed hygiene and motivator factors, impact employee job satisfaction or dissatisfaction. Carefully crafted questions guided the interview, asking the respondents to describe memories of their job, which elicited both negative and positive feelings. Upon interpretation of the data, a two-dimensional need structure was determined, with one need system that emerged aligned with the avoidance of dissatisfiers (hygiene [maintenance] factors) and a parallel system that emerged related to satisfiers (motivator factors).

Herzberg's (1959) two-factor theory delineates satisfaction and dissatisfaction as two separate and distinct dimensions, independent of each other-not at opposite ends of a continuum. Herzberg's (1959) theory purports that to improve employee work attitudes, it is essential for administrators to recognize and address both dimensions. Dissatisfiers (hygiene factors [also called maintenance factors]) create dissatisfaction if they are absent but do not necessarily

improve job satisfaction. They are preventative in nature. These factors are extrinsic to the work itself and include company policy and administration, supervision, salary, interpersonal relations, and work conditions. Company policy and administration was found to be the single most important determinant of job dissatisfaction (Herzberg et al, 1964). In contrast, satisfiers (motivator factors) contribute to personal or psychological growth and increase job satisfaction (Herzberg et al., 1964). They arrive from intrinsic conditions of the job itself, such as achievement, recognition, the value of the work itself, potential for growth, and advancement and responsibility. These intrinsic factors were found to be highly interrelated. All of these intrinsic factors have to do with the job itself, the elements of the job or the intrinsic content of the job versus the context in which the job was done (Herzberg et al., 1964). The context in which the job is done is related to the extrinsic factors. See Table 1.

Extrinsic Factors Also known as Dissatisfiers (Maintenance [Hygiene])	Intrinsic Motivating Factors Also known as Satisfiers
Company policy and administration Supervision Salary Interpersonal relations Work conditions	Achievement Recognition Value of the work itself Potential for growth Advancement Responsibility

Table 1. Extrinsic and Intrinsic Factors based on Herzberg et al. (1959)

Herzberg's theory (1959) parallels Maslow's theory of need hierarchy, relevant to the human's need to engage in higher order work. Herzberg, like Maslow noted that feelings of self-actualization and growth are true motivators. However, Herzberg's attention to the two distinct factors, one leading to job satisfaction and one leading to job dissatisfaction, adds an additional

dimension to Maslow's theory. Herzberg emphasized that satisfaction is not a continuum but uniquely related to the factors that promote job satisfaction and job dissatisfaction. Thus, just safe and pleasant working conditions with a fair wage, devoid of higher order work, will not make for a satisfied worker. Lack of motivator factors does not result in job dissatisfaction; however, presence of motivators results in enhanced job satisfaction (Herzberg et al., 1959). Likewise, maintenance factors (hygiene factors) prevent job dissatisfaction from occurring; however, they do not increase job satisfaction without the presence of motivator factors. The following statement from Herzberg et al. (1964) summarizes effectively:

Man tends to actualize himself in every area of life, and his job is one of the most important areas. The conditions that surround the doing of a job cannot give him this basic satisfaction; they do not have this potentiality. It is only from the performance of a task that the individual can get the rewards that will reinforce his aspirations. (p. 114)

Herzberg et al. (1964) also discussed the interrelationship of factors within the intrinsic or extrinsic groupings, highlighting the interrelationship of two intrinsic factors, achievement and recognition. Achievement was found to be able to stand independently of recognition; however, recognition was rarely found independent of achievement. Therefore, a human can experience good feelings and thusly job satisfaction related to achievements in their job role apart from receiving recognition. However, recognition, would rarely contribute to job satisfaction in the absence of achievement.

Herzberg's theory has been used to guide job satisfaction research in a variety of disciplines including the health-related field for several decades (Byrne, 2006; House, 1990; Hunt et al., 2012; Parker, 1984; Sharp, 2008). Hunt et al. (2012) tested the utility of the Herzberg theory as it relates to RN retention in nursing homes, concluding that the Director of Nursing

tenure and other extrinsic factors (i.e. ownership and payer mix) had the strongest association with RN retention in nursing homes. However, intrinsic factors (i.e. employee recognition, career ladders) did not have as strong an association as expected by Herzberg's theory. Parsons, Simmons, Penn, and Furlough (2003) examined the relationship between task rewards and extrinsic factors in a state sample of 550 CNAs. Nearly one third of the CNAs indicated their dissatisfaction and plans to resign relative to factors such as poor pay, lack of recognition, and inability to make decisions. Lastly, Chenoweth, Jeon, Merlyn, and Brodaty (2010) found that nurses in nursing homes reported satisfaction with work but dissatisfaction with their work environment. All of these studies cited support components of Herzberg's theory; however, no studies were identified examining specifically the LPN.

Koelbel, Fuller and Misener (1991) expanded Herzberg's theory and applied it to research on nurse practitioners. Koelbel et al. (1991) found that individuals perceive intrinsic and extrinsic factors from their own personal viewpoint, reflecting a personal view of job satisfaction. This view is impacted by demographic variables such as gender, education, age, and length of experience as a nurse practitioner. In contrast, Herzberg et al. (1964) suggested that a clear conclusion could not be drawn concerning demographic characteristics of the individual and job satisfaction. Likewise, a study by Monahan and McCarthy (1992) indicated that despite demographic differences of participants, the nurse aides reported similar opinions about what they liked and disliked about their jobs. The job satisfaction literature examined had limited references to the impact of demographic variables on job satisfaction. McGilton et al. (2007) did identify a correlation between birthplace and first language with job satisfaction. Thirty-three percent of the total variance in job satisfaction was explained by supervisory support, stress, birthplace, and first language spoken of the DCW. The extant literature relevant to the

phenomenon of job satisfaction in long-term care settings did not indicate a recurring correlation between demographic variables and job satisfaction. Thus, the Herzberg (1959) dual factor motivation/hygiene theory model of job satisfaction will be utilized as a conceptual framework for this research project.

This qualitative research study will provide an in-depth examination of intrinsic (motivational) factors and extrinsic (hygiene/maintenance) factors of LPN job satisfaction and job dissatisfaction in long-term care settings from the perspective of the LPN. Herzberg's theory will provide the conceptual framework to conduct this study.

The model in Figure 1 depicts how the distinct attributes labeled by Herzberg et al. (1959) as extrinsic motivators impact LPN job dissatisfaction, while the distinct attributes labeled by Herzberg et al. (1959) as intrinsic motivators impact LPN job satisfaction. The two half circles of the model are disconnected, as job dissatisfaction and job satisfaction are two separate and distinct dimensions.

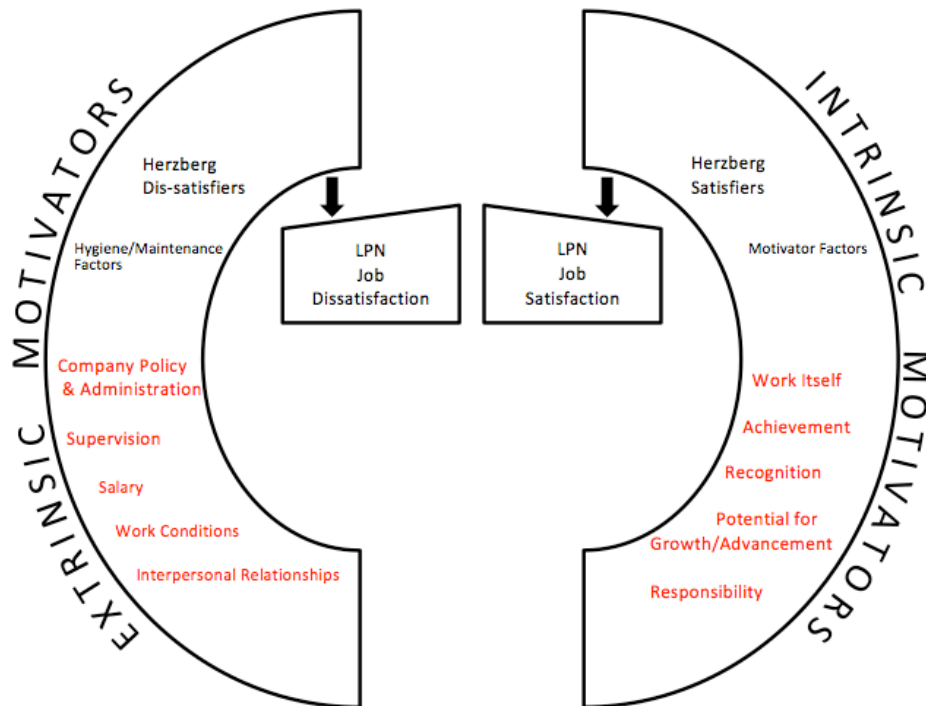


Figure 1. Conceptual Framework Based on Herzberg et al. (1959)

Research Goal/Aims

This qualitative research describes and explains the phenomena of job satisfaction and job dissatisfaction among LPNs employed in long-term care settings. The following research goal and questions guided this study.

Specific Aim:

To determine the attributes of LPN job satisfaction and job dissatisfaction in long-term care settings.

Research Question 1

How do LPNs explain the key factors that contribute to job satisfaction in long-term care settings?

Research Question 2

How do LPNs explain the key factors that contribute to job dissatisfaction in long-term care settings?

Conceptual Definitions

Job Satisfaction- The extent to which people like their job.

Job Dissatisfaction- The displeasure that an employee experiences in their job setting.

Extrinsic Factors (Hygiene factors, Maintenance factors)- Dissatisfiers that arise from the work environment and include: company policy and administration; supervision; salary; work conditions; and interpersonal relations (Herzberg et al., 1959).

Intrinsic Factors (Motivator factors)- Satisfiers that arise from the performance of the job itself and include: the work itself; achievement; recognition; potential for growth and advancement; and responsibility (Herzberg et al., 1959).

Long-term Care- Services that includes medical and non-medical care provided to people who are unable to perform activities of daily living (Medicare, 2014).

Long-term Care Setting- Inpatient unit where people who have a chronic illness or disability receives medical and non-medical care. Generally referred to as nursing homes.

Licensed Practical Nurse (LPN) (Also known as a Licensed Vocational Nurse (LVN) in some states)- A graduate of an approved nursing educational program who has successfully passed NCLEX-PN and is licensed to practice.

Nurses- Health care professionals defined as including RNs and LPNs.

Nursing Staff- Individuals providing care to clients with health care needs; inclusive of RNs, LPNs and DCW (also known as certified nursing assistant [CNA] and nursing assistant [NA]).

Registered Nurse (RN)- A graduate of an approved nursing educational program who has successfully passed NCLEX RN and is registered and licensed to practice as a nurse.

Assumptions

There were four assumptions for this study:

- Job retention is influenced by job satisfiers and job dissatisfiers.
- LPNs can experience both satisfiers and dissatisfiers while working in a long-term care setting.
- LPNs are likely to continue working in long-term care settings where they are satisfied and not dissatisfied.
- Job satisfaction and job dissatisfaction do not exist on a continuum. One does not preclude the other.

Summary

The growing need for a health care workforce to care for the increasing elderly population of the United States underscores the need for examination of the concept of job satisfaction and job dissatisfaction in long-term care. By 2020, 12 million older Americans will need long-term care (Medicare, 2009). The 2008 IOM report, *Retooling for an Aging America: Building the Health Care Workforce* calls for workforce reform in long-term care and specifically mentions that LPNs are important to the care of older adults in long-term care settings. Workforce reform involves understanding the needs of the workforce, particularly job satisfaction, as the correlation between job satisfaction and employee retention has been well established in the extant literature.

Although considerable research attention has been devoted to job satisfaction in long-term care settings, it has focused on RNs, senior management, nursing staff in general, and/or

DCWs. No attention has been focused specifically on long-term care LPNs' job satisfaction or job dissatisfaction. The high (51%) annual turnover rate of LPNs in long-term care settings (Donoghue, 2010), projected workforce demand for LPNs (BLS, 2012), lack of research on LPNs in long-term care settings, and meager strides in job satisfaction improvement in long-term care taken together call for the voices of LPNs to be heard regarding factors contributing to their job satisfaction and job dissatisfaction. The in-depth knowledge gained about job satisfaction and job dissatisfaction in long-term care LPNs will create a roadmap for systematically addressing the needs of the LPN workforce throughout long-term care settings.

Chapter 2: Review of the Literature

Overview

Job satisfaction is a critical issue in health care. Stress mounts when job satisfaction wanes and staff retention may be adversely impacted (Karsh et al., 2005; McCarthy et al., 2007; Li et al., 2010) and patient outcomes may suffer as well (Bowers et al., 2003; Castle & Engberg, 2005; O'Brien-Pallas, Murphy, Shamian, Li, & Hayes, 2010). Given the current and predicted nursing and allied health shortage, identification of factors contributing to job satisfaction can lead to increased staff retention. Over the next 15 years it is reasonable to assume that demand for nurses will grow (Buerhaus, 2010). A huge task looms ahead, which involves replacing aging health care workforce baby boomers while also increasing the total supply of nurses. Buerhaus (2009) suggests that these recessionary times create an ideal opportunity to assess nursing staff's attitudes towards their jobs, particularly their level of job satisfaction, as current staffing is minimally impacted by a nursing shortage. Understanding the phenomena of job satisfaction and job dissatisfaction should ultimately result in the implementation of strategies to increase nurse staff job satisfaction, thus increasing staff retention. As the nursing shortage storm hits, the recession recedes and nurses leave the workforce in droves; LPN job satisfaction and job dissatisfaction in long-term care can be important factors that will increase nursing staff retention, contributing to the cadre of research initiatives aimed at improving the health of our elderly.

In response to Buerhaus and others, numerous research studies have examined job satisfaction and job dissatisfaction and retention of health care employees (Bowers et al., 2003; Donoghue & Castle, 2007; Ejaz, Noelker, Menne, & Bagaka, 2008; Menne, Ejaz, Noelker, & Jones, 2007; Morgan & Konrad, 2008; Parsons et al., 2003; Rubin, Balaji, & Barcikowski,

2009). Despite this, staff turnover remains an industry concern. In recent years and spanning several decades, studies have predominantly focused on RNs, particularly in hospital settings (Cowden, Cummings, & Profetto-McGrath, 2011). As governmental initiatives, such as Health Care Reform drive care out of the acute setting and into the community, research studies have demonstrated an increased interest in job satisfaction in long-term care. This change in patient care access parallels the aging baby boomers (Barry, 2011). It is estimated that the number of persons needing assisted or alternative living arrangements will increase from 15 million in 2000 to 27 million in 2050 (U.S. Department of Health and Human Services [HHS], 2003). Critical to the care of this group are nurses, particularly LPNs. Given the projected shortage of LPNs, dominance as a licensed nurse in this setting, and continual upward hiring trend for LPNs in nursing homes (NCSBN, 2010) the workforce need is compelling. These facts, combined with the dearth of research literature examining LPN job satisfaction, underscore the need to understand long-term care LPNs' job satisfaction and job dissatisfaction.

In the last decade, job satisfaction research has examined many different types of health care providers working in long-term care settings. A plethora of research projects have focused on examining the internal and external stressors impacting DCWs in long-term care settings and the relationship to job satisfaction and staff retention (Stone & Dawson, 2008; Zontek, Isernhagen, & Ogle, 2009). This research emerged relative to the amount of unlicensed care provided by the DCW (8 out of every 10 hours of paid care received by a long-term care consumer [PHI, 2001]). In addition, studies utilizing a sample of nursing staff (RNs, LPNs and DCWs) and/or senior management in long-term care have dominated the literature. Conclusions with this population indicate that a positive association exists between leadership and job satisfaction. Following an extensive literature search on CINAHL, PubMed, and ProQuest, few

LPN job satisfaction or job dissatisfaction research studies were identified. Two articles were noted in academic journals related to job satisfaction and LPNs in long-term care settings.

Harahan et al. (2011) reported the results of a project “LVN LEAD” that developed, piloted and evaluated a leadership/supervisory training program for LVNs. Practical nurse perception of job satisfaction was examined and the relationship between job satisfaction of DCW’s working in an institution where the “LVN LEAD” project was implemented was also examined. DCW’s ratings of LVN’s supervisory skills improved following the training program. Specifically the DCW ‘s survey question, “My charge nurse is supportive of progress in my career, such as further training” showed a statistical difference following the training program (Harahan et al., 2011). In addition, LVNs perceived an improvement in their work relationships when they utilized their strengthened supervisory skills. Harahan et al. (2011) concluded that nursing homes that support and implement LVN supervisory training are likely to realize increases in staff satisfaction, decreased staff turnover, and improved patient outcomes.

Rubin et al. (2009) examined job satisfaction of a small group of nursing staff (n = total of 12, RNs, LPNs and DCWs) working in an Appalachian nursing home utilizing a mixed methods design, inclusive of a quasi-experimental focus group intervention and individual interviews. One aspect of the focus group discussion included strategies to better communicate with each other. Pre and post focus group, all participants completed a job satisfaction survey. The study did indicate a statistically significant difference between pre and post positive attitude scores on the job satisfaction scale. Major limitations, however, included the size of the sample (n = 12), mixed staffing groups (did not delineate between RN, LPN or DCW results) and the Appalachian setting. Given the small number of studies on job satisfaction and the fact that no studies focused specifically on LPNs

the need for undertaking a study exploring job satisfaction in LPNs working in long-term care is evident.

Despite compelling workforce data, indicating increasing LPN employment in long-term care settings (NCSBN, 2010; Bureau of Labor Statistics, 2012; HRSA, 2013) and the IOM (2010) *Future of Nursing* report indicating an essential need for leadership skills for nurses in all settings and at all levels, limited related research persists. In long-term care settings, the LPN often takes on the role of supervisor and leader. Although RNs are ultimately responsible for supervision and delegation of staff, LPNs often assume this role as the charge nurse on the unit (Harahan et al., 2011). In fact, anecdotal evidence suggest, at times LPNs/LVNs are the only nurses in the nursing home, other than the director of nursing (Harahan et al., 2011). Harahan et al.'s (2011) research study on the LEAD program, a leadership program for LPNs identified that few RNs were employed in the participating nursing homes and that LPNs were responsible for supervision of front line workers. Could this lack of RN access and supervision contribute to LPN job dissatisfaction? Conversely, could this supervisory role of the LPN contribute to job satisfaction, as empirical literature suggests a relationship between job satisfaction and autonomy/empowerment? (EngstrÖM et al., 2011; Stone & Dawson, 2008; van den Berg, Landeweerd, Tummers, & van Merode, 2006; Walker, 2008). The lack of RNs in long-term care, coupled with persuasive population and workforce statistics and job satisfaction and retention issues in long-term care settings, creates a need to study the phenomena of job satisfaction and dissatisfaction among LPNs. Given the gap in our knowledge, relative to the LPN in long-term care settings, an analysis of job satisfaction and dissatisfaction from the perspective of the LPN is needed.

This proposed research will provide an in-depth qualitative analysis of the factors LPNs identify as affecting their job satisfaction and job dissatisfaction. “What works” and “what does not work” from the perspective of the largest licensed nursing group in long-term care is likely to uncover key information relevant to LPN job satisfaction and job dissatisfaction in long-term care. A review of literature follows, inclusive of: search strategy; workforce overview of nurses and direct care workers; job satisfaction; job dissatisfaction; limitation of research studies; and a chapter summary.

Search Strategy

Job satisfaction. CINAHL was searched using the terms “job satisfaction” and “LPNs or LVNs or licensed practical nurses or practical nurses” and “nursing homes” yielding a total of 28 results. PubMed was searched utilizing the same terms yielding 12 articles. It was also searched utilizing the terms “job satisfaction” and “nurse” and “nursing home/long-term care” yielding 75 articles. Search limits included English language only and human populations.

Job dissatisfaction. CINAHL was searched using the terms “job dissatisfaction” and “LPNs or LVNs or licensed practical nurses or practical nurses” and “nursing homes” yielding a total of 6 results. PubMed was searched utilizing the same terms yielding 12 articles. It was also searched utilizing the terms “job dissatisfaction” and “nurse” and “nursing home/long-term care” yielding an additional 6 articles. Search limits included English language only and human populations.

Final sample. Elimination of 25 articles due to duplication (8 duplicates were identified in the original job satisfaction search and 17 out of the 24 dissatisfaction articles were originally identified in the job satisfaction search and thus eliminated as duplicates) yielded a sample size

of 114. Further elimination following abstract review and an addition of four historical references resulted in a final sample size of 110, which were reviewed in full text. See Figure 2.

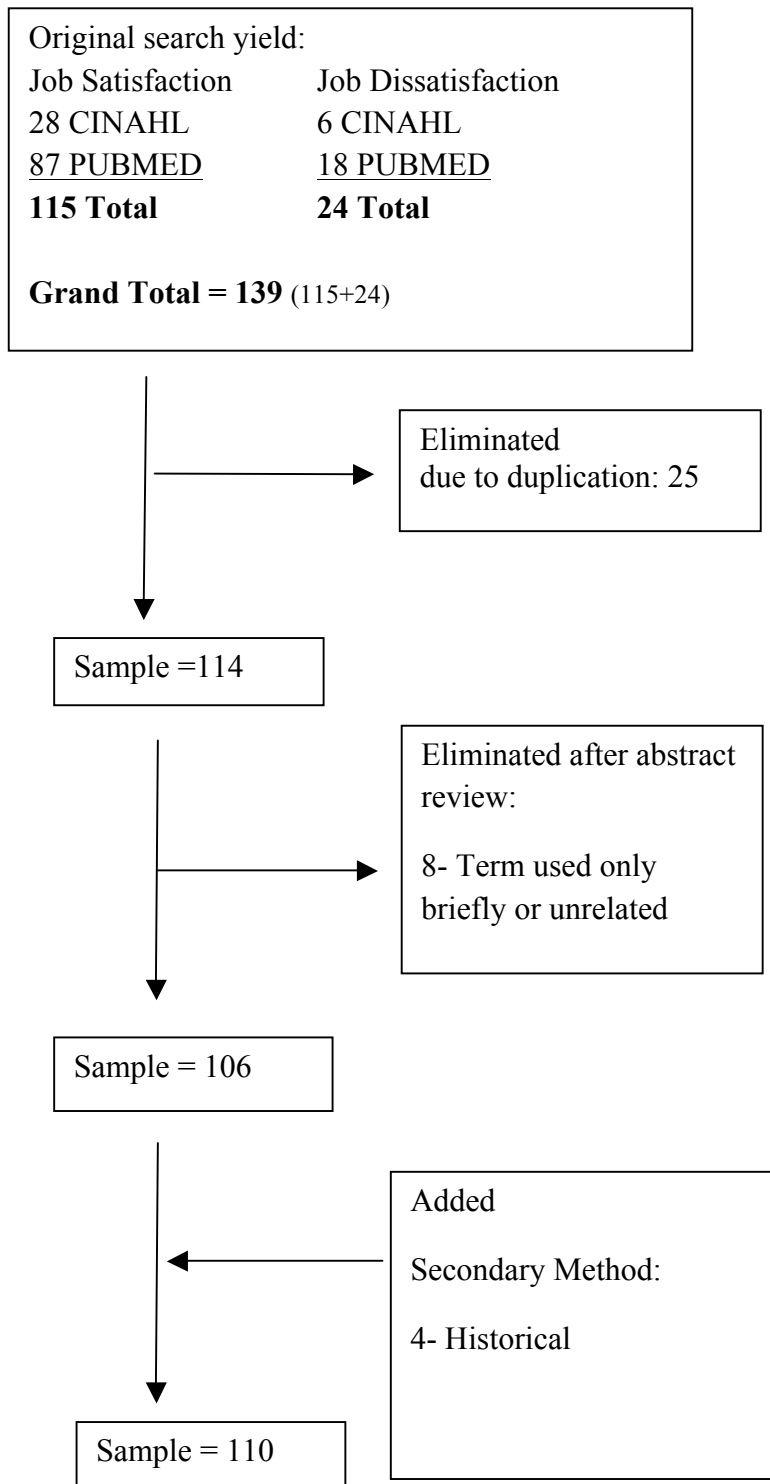


Figure 2. Search Strategy Job Satisfaction and Job Dissatisfaction and Nurses

Workforce Overview of Nurses and Direct Care Workers

The U.S. workforce consists of 2.8 million RNs and 690,000 LPNs working in the field of nursing or seeking employment in 2008 - 2010 (HRSA, 2013). The growth in the nursing workforce (RN and LPN) has outpaced United States population growth, resulting in an increase in LPNs per capita by approximately six percent. Furthermore, in the 2000s the LPN workforce grew by 15.5% (HRSA, 2013). Despite these numbers, a nursing workforce shortage currently exists and is predicted to exist for the next several decades. Projected RN and LPN job growth, impacted by the aging nursing workforce (median higher than the average median for all United States employees) is anticipated to be greater than the average rate. Pennsylvania also reflects a nursing shortage; however, the trend is slightly different than the national perspective. The 2015 high estimate shortage for RNs and LPNs is predicted to be 16,000 (10.4%) and 10,100 (25%) respectively (Pennsylvania Center for Health Careers, 2011). The percentage of LPN shortage is predicted to be more than double the RN shortage. This trend could be related to the fact that Pennsylvania ranks fourth in the nation in regard to the number of elderly persons residing in the state (US Census, 2010).

The aging populace, coupled with the increasing average age of health care workers, the nursing/allied health faculty shortage, and the increased demands of the health care system resulting from Health Care Reform initiatives creates the perfect storm for the health care workforce throughout the next decade. Over next two decades, every day, 10,000 baby boomers will cross the threshold of age 65 (Barry, 2011). The situation forecasts a workforce crisis as the number of older patients, with increasingly complex health needs outpaces the number of competent health care providers needed to adequately care for them.

National entities support the role of the LPN. For example, in the Reflection and Dialogue document, *Recognizing the Vital Contributions of Licensed Practical/Licensed Vocational Nurse* (2011) the National League for Nursing indicates that the LPN/LVN is a valuable member of the nursing community and significantly contributes to improving the health of the nation, particularly in long-term care facilities, nursing homes, and community-based settings. Likewise, the 2008 IOM report, *Retooling for an Aging America: Building the Health Care Workforce*, calls for fundamental workforce reform to care effectively for older adults and mentioned LPNs as especially important to the care of older adults in long-term care settings. The IOM (2010) *Future of Nursing* report echoes this sentiment recognizing the need for LPNs. The report indicates that RNs when faced with work overload and unsafe conditions in acute care, can delegate to LPNs as a solution. The IOM (2010) report recognizes the unique contribution of LPNs in long-term care, including supervision of DCW and other non-licensed individuals and encourages increased education for nurses at all levels. The report states, “Licensed practical/vocational nurses (LPN/LVN) are especially important because of their contributions to care in long-term care facilities and nursing homes (p. E3).”

Direct care workers (DCW) are dominant caregivers in long-term care, providing 70-80% of the direct care to residents in nursing homes (IOM, 2008). DCW include job titles such as home health aides, CNAs, personal and home care aides, nurse aides and orderlies. Nurse aides, orderlies and attendants are expected to increase by 20% from 2010 to 2020, faster than the average for all occupations (BLS, 2012). In Pennsylvania, the direct care workforce exceeds 130,000 representing men and women of various ethnic backgrounds (Pennsylvania Center for Health Careers, 2007). Retention is an ongoing industry struggle with this low-paid group of workers (Castle et al., 2007, Harrington et al., 2000). Turnover of CNAs has been estimated as

high as nearly 100% and overall staff turnover at 70% (Harrington et al., 2000). Given the current recession, a more recent survey reported an average turnover rate of 49% for nurses and 71% for CNAs (Utley et al., 2011). LPNs often are the charge nurse supervising DCWs in long-term care settings (Harahan et al., 2011). Thus, turnover of DCWs, resulting in continual new DCW hires, impacts the LPNs job role. The nursing shortage creates a critical need to examine retention of nurses and DCWs. A correlation has been demonstrated between positive job satisfaction and retention of nursing and DCW staff (Brannon et al., 2007; Morgan & Konrad, 2008; Stone & Dawson, 2008).

Job Satisfaction

Job satisfaction is described as the extent to which people like their job. Multiple theories exist attempting to describe the phenomenon of job satisfaction. Herzberg's (1959) two-factor motivation-hygiene theory delineated satisfiers (motivating factors) and dissatisfiers (hygiene/maintenance factors), which are related to job satisfaction. He concluded that satisfiers (motivator factors) contribute to personal or psychological growth and increase job satisfaction (Herzberg et al., 1959). Dissatisfiers (hygiene factors also called maintenance factors) create dissatisfaction if they are absent but do not necessarily impact job satisfaction. Herzberg emphasized that employers must address both motivator and hygiene factors to improve employee job satisfaction and prevent job dissatisfaction. Job satisfaction and job dissatisfaction are the phenomena of interest in this study. Herzberg's (1959) theory will provide the conceptual framework to guide this research.

Job satisfaction and nursing staff. Nursing staff is defined as individuals providing care to clients with health care needs; inclusive of RNs, LPNs and DCWs. DCW, also referred to as a NA is a critical member of the health care team in long-term care. Retention is an ongoing

industry struggle with this low-paid group of workers (Castle et al., 2007; Harrington et al., 2000) and for RNs and LPNs (Utlely et al., 2011). Job satisfaction correlates to retention, thus job satisfaction is important in improving retention.

LEAP (an acronym for Learning to use tools and resources; Empower care and competence; Achieve commitment; and Produce opportunities for growth) is an example of a program implemented in long-term care settings aimed at improving job satisfaction. This is a multi-prong program, which combined nursing supervisory training with strategies for enhancing DCWs' empowerment (Hollinger-Smith & Ortigara, 2006). Significant improvements in ratings of job satisfaction ($p < 0.001$) were found for both DCWs and nurses (Hollinger-Smith & Ortigara, 2006) following implementation.

Farrell and Frank (2007) through examination of a movement from an institutional to an individualized model of care in a urban nursing home identified decreases in turnover rate, and a lower incidence of pressure ulcers following implementation of more than 100 quality initiatives focused on individualized care. The implementation of consistent staff assignment was noted to create a work environment that built on the intrinsic motivation of staff members - the opportunity to form and sustain close relationships with the patients (Farrell & Frank, 2007). Turnover declined and residents at high risk for pressure ulcers declined from 25% to 11% (Farrell & Frank, 2007). Turnover was reported for all licensed staff collectively, thus, the LPN was not examined specifically.

Job satisfaction and compensation. An association between compensation and perceived quality of care and job satisfaction was established by Castle et al. (2006). Studies by Wiener, Squillace, Anderson, & Khatutsky (2009) and Stearns and Darcy (2008) provide significant evidence that wages increase retention. The studies examining compensation in a

long-term care setting examined the DCW specifically. For example, Baughman and Smith (2010) examined the use of a Medicaid wage pass through program to increase the salaries of DCWs. They concluded that states that initiated these programs increased salaries by 12% and improved retention. However, Baughman and Smith (2010) caution that this increase in pay may not be sufficient to remedy issues of DCW shortage and retention in the nursing home market due to the complexity of the issue. Medicare and Medicaid, in a report to Congress in 2001, indicated that nurse aide salaries would have to increase 10 – 25% to ensure adequate staffing. Given the state of the federal deficit in 2011, this is not likely. Herzberg's theory (1959) would purport that salary is a dissatisfier and not a satisfier. Thus, salary increases may prevent job dissatisfaction but not necessarily improve job satisfaction. This creates a need to examine other influences related to the retention of staff in long-term care settings.

Job satisfaction and stressors (Personal and job-related). Numerous studies have examined job satisfaction and concluded that there is a positive association between DCWs' stressors (personal and job-related) and job satisfaction and retention (Bowers et al., 2003; Ejaz et al., 2008; Menne et al., 2007; Parsons et al., 2003). Cohen-Mansfield's (1995) model identified personality factors and personal stressors (i.e. financial and family problems, lack of family support) of nursing home staff as determinants of job stress. Furthermore, Zontek et al. (2009) suggested that psychosocial factors, such as stress and job satisfaction should be considered to decrease injury rates and increase retention among DCWs. The study identified that at both one and three years of tenure, job satisfaction was a predictor of DCW injury. Zontek et al.'s findings indicated that DCW job satisfaction did align with high workloads, low decision latitude, and low social support.

Another widespread implementation, Better Jobs Better Care a multi-state demonstration and applied research project, addressed psychosocial factors as essential elements for a quality job program for DCWs (Stone & Dawson, 2008). Nine essential elements were identified, inclusive of three broad categories: compensation, opportunity for advancement, and organizational support (Stone & Dawson, 2008). The project identified that supervisors who set clear expectations and require accountability, and at the same time encourage, support, and guide have created essential components of a quality job program for DCWs (Stone & Dawson, 2008). This quality program leads to improved job satisfaction. Similarly, Brannon et al. (2007) indicated that both low and high intent to quit are associated with the assessment of the quality of supervision DCWs receive. Respondents did not rate supervision as particularly low with a mean of 3.12 (4 indicating highest-quality). The risk, however, of being in the group with the high intent to leave was reduced by 30% when other factors in the model were controlled (job tenure, race, educational level, and self efficacy). Several other researchers have identified an association between a nursing supervisor's leadership style and job satisfaction/retention (Kuokkanen, Leino, & Katajisto, 2003; Parsons et al., 2003). Tourangeau et al. (2010), unlike others, did not find a significant relationship between leadership and either job satisfaction or turnover intention. However, high turnover intention was associated with lower job satisfaction, higher emotional exhaustion, burnout, more outside job opportunities, weaker group cohesion, lower personal accomplishment, and higher depersonalization (Tourangeau et al., 2010). Some of these variables identified by Tourangeau et al. (2010) are inclusive of organizational climate.

Job satisfaction and organizational climate. Organizational climate has been significantly correlated to DCW job satisfaction. Probst et al. (2010), utilizing a cross-sectional analysis of data from the 2004 National Nursing Assistant Survey, concluded that organizational

climate, among other variables, including supervisor behavior were positively associated with NA job satisfaction and resultant reduced turnover. Organizational climate is described as the “culture” of an organization, which influences employee behavior. Benjamin Schneider (1975) defined organizational climate as a mutually agreed internal environmental description of an organization’s practices and procedures in which members have agreed upon perceptions of the environment. These perceptions occur at the individual and shared perception level (Anderson & West, 1996). Organizational climate, specifically, a supportive practice environment, has been significantly associated with higher RN job satisfaction in long-term care settings (Choi et al., 2011). Likewise, nursing leadership behaviors, such as providing encouragement and guidance, as well as the climate of a health care organization have been positively associated with DCW job satisfaction and inversely related to staff turnover (Probst et al., 2010; Stone & Dawson, 2008).

Job satisfaction and communication. Focus groups implemented during the pilot phase of The Win-A-Step-Up program reported that problems existed related to lack of communication and teamwork between front line nurses and DCW (Morgan and Konrad, 2008) contributing to DCW turnover. These findings were consistent with the findings of Noelker et al. (2006) and Brannon, Zinn, Mor, and Davis (2002). Lapane and Hughes’ (2007) qualitative study of nursing staff (RNs, LPNs, and DCWs) in 25 North Carolina nursing homes echoed the need for communication among nursing staff and reported other key themes including the importance of staff recognition, adequate staffing levels, supportive management, flexible work schedules, support for new nurses, and professional development. This study did not differentiate between RNs and LPNs in their findings. This has been a trend noted in the literature, contributing to the dearth of LPN specific research in long-term care settings.

Job satisfaction and autonomy. Autonomy has been a consistent finding related to job satisfaction in all levels of nursing staff (Bigbee, Gehrke & Otterness, 2009; EngstrÖM et al., 2011; Stone & Dawson, 2008; Walker, 2008). Bigbee et al. (2009) examined the practice patterns of public health nurses in Idaho and found that autonomy, among other concepts, contributed to the nurse's job satisfaction. EngstrÖM et al. (2011) found similar results examining a related concept of empowerment. In a convenience sample of over 572 elderly caregivers, they concluded that factors related to psychological empowerment resulted in 40% variance in job satisfaction. Specific to DCWs, the Better Jobs Better Care project identified nine essential elements of a quality job program for DCWs contributing to job satisfaction, including participation in decision-making (Stone & Dawson, 2008). Lastly, Walker's (2008) findings, exploring the effect of the medication NA role on the stress of the nurse in long-term care, supported a correlation between empowerment and decision-making and the level of the nurses' job satisfaction. Decision-making and autonomy are concepts also discussed relative to leadership.

Job satisfaction and leadership, including extrinsic rewards. Leadership is critical to achieving high quality productivity and outcomes across disciplines. As Chou, Boldy, and Lee (2002) state, "management and leadership are pivotal to staff satisfaction" (p. 215). Kouzes and Posner (1995) state that leadership is "the art of mobilizing others to want to struggle for shared aspirations" (p. 30). They assert that leadership is not reserved for a few charismatic individuals, "it is a process ordinary people use when they are bringing forth the best from themselves and others" (2002, p. 23). The recently released IOM Report, *The Future of Nursing, Leading Change Advancing Health* echoes Kouzes and Posner's (1995) belief that leadership is inclusive of many individuals. The report states that leadership at all levels, from bedside to boardroom, is

paramount to insure that nurses can be deployed actively and emerge as strong partners in the health care team. Espousing leadership as an essential role of nursing at all levels is a paradigm shift for many in nursing, as often nurses do not begin their career with thoughts of becoming a leader (IOM, 2010).

The prevailing sample utilized in nursing leadership research has been experienced nurses, employed in middle and senior management level positions (Aroian, Patsdaughter, & Wyszynski, 2000; Hasemann, 2004; Hunt et al., 2012). The LPN in long-term care, however, is a model example of a nurse who may assume a leadership role very early in their career, often immediately following licensure. NCSBN LPN job analysis data confirms that 32.4 percent of newly licensed LPNs employed in long-term care settings perform administrative duties (2013). Likewise, the IOM (2010) *Future of Nursing* report states that some LPNs/LVNs supervise DCW in long-term care settings. This leadership role as a novice nurse with limited education (12 -18 months) may contribute in some way to LPN job satisfaction. Whether this is a negative or positive factor, has not been established in the literature.

Evidence exists linking nursing leadership in long-term care to DCW's job satisfaction and retention, which further impacts the quality of care provided to clients (Bowers et al., 2003; Harvath et al., 2008). Nurse leadership behaviors, such as encouragement, guidance and organizational climate have been positively associated with DCW job satisfaction, resultant reduced turnover and creation of a quality job program for DCWs (Probst et al., 2010; Stone & Dawson, 2008).

Nursing leadership research often examines the relationship between leadership behaviors/style and patient outcomes (patient satisfaction and patient safety) and employee outcomes (job satisfaction, intent to stay and retention) (Bishop et al., 2008; Bowers et al., 2003;

Bowles & Bowles, 2000; Castle, Engberg, Anderson, & Men, 2007; Tourangeau, Cranley, Laschinger, & Pachis, 2010). Positive employee outcomes, inclusive of job satisfaction and decreased nursing turnover were identified when nurse managers practiced transformational leadership (Doran et al., 2004; Larrabee et al., 2003). Larabee et al. (2003) utilized a non-experimental, predictive design to investigate the relative influence of RN (n = 90) attitudes, context of care and structure of care on RNs' job satisfaction and intention to leave. The convenience sample included RNs working in a 450-bed university medical center in West Virginia. Results supported the influence of nurse's attitude on job satisfaction, emphasizing the importance of a work milieu where participatory management and psychological empowerment thrives. Predictors of empowerment were found to be hardiness, transformational leadership style, nurse/physician collaboration, and group cohesion. Application of these results is limited due to the homogenous and non-random sample.

Vandenberghe, Stordeur and D'hoore (2002) conducted a study with nurses (n = 1059) in 16 Belgian hospitals concluding that providing rewards and transmitting a sense of mission to employees contributes positively to retention of employees. Generalizability of this study's findings to the United States may be limited due to the potential cultural differences in Belgium.

A study by Cowden et al. (2011) found similar results; identifying a positive relationship between transformational leadership, supportive work environments, and nurses' intention to stay in their current positions. The utilization of transformational leadership behaviors in health care organizations, as demonstrated in these studies correlate positively to employee outcomes, such as job satisfaction and negatively to employee outcomes such as burnout (Nielsen, Randall, Yarker, & Brenner, 2008). Rosengren, Athlin and Segesten's (2007) findings demonstrated that the leader being available and present was a key behavior correlating to positive patient

outcomes. This behavior is reflective of Bass' (1985) description of individual consideration and idealized influence, relevant to transformational leadership.

Job satisfaction and other variables (Nursing staff). A multitude of variables have been identified to be associated with job satisfaction, including ownership of the long-term care facility. According to Choi et al. (2011), nurses (RNs) working for a non-profit nursing home had greater job satisfaction than did RNs working in for-profit nursing homes. In an earlier study, issues such as poor staff cohesiveness were reported by nurses as contributing negatively to job satisfaction (Care & Kazanowski, 1994). Appendix A provides an overview of research studies and the variables associated with job satisfaction in long-term care.

Job Dissatisfaction

In the last several decades, research focused on employee work attitudes has predominantly examined the broad concept of job satisfaction (Abraham & Grant, 2008; Cohen-Mansfield, 1997; Cummings et al., 2010; Donoghue & Castle, 2009; Probst et al., 2010; Scott-Cawiezell et al., 2004; Solomon, 2009), identifying attributes, which are positively associated with job satisfaction. Although fewer in quantity, some research studies have specifically examined job dissatisfaction (Care & Kazanowski, 1994; Moyle et al., 2003). No definition of job dissatisfaction applicable to this research study was identified in the literature search. For purposes of this research proposal, job dissatisfaction will be defined as "The displeasure that an employee experiences in their job setting." The job dissatisfaction research findings discussed below align with several of the variables identified by Herzberg as dissatisfiers (hygiene factors).

Factors associated with job dissatisfaction. An existing data set, 2005 Canadian National Survey of the Work and Health of Nurses (RNs, LPNs, and registered psychiatric nurses), was analyzed by Wilkins and Shields (2012) to examine job dissatisfaction in relation to

an employer provided support program (i.e. child care assistance and fitness or recreation programs). The data subset utilized, however, consisted solely of full time RNs (n = 2993) employed in acute care or long-term care settings. Findings indicated that employer-provided support programs are protective against nurses' job dissatisfaction (Wilkins & Shields, 2012). In contrast to employer-supported programs, Cherry et al. (2007) explored nursing home (five nursing homes in West Texas) LVNs' and CNAs' perceptions about the regulatory environment and job dissatisfaction through a qualitative study using semi-structured interviews. LVNs and CNAs reported that the presence of the surveyors often created a tense, uncomfortable atmosphere. In addition, excessive paperwork, ineffective communication, frequent deaths, combative and uncooperative residents, and inadequate staffing also reportedly contributed to job dissatisfaction.

Moyle et al. (2003) and Care and Kazanowski (1994) studied the phenomena of job satisfaction and job dissatisfaction. Utilizing a focus group study, Moyle et al. (2003) examined job satisfaction/dissatisfaction of nurses and assistants-in-nursing (n = 27) in Australia, identifying low staffing levels as a contributing factor to nurses and assistant-in-nursing dissatisfaction. Other factors identified included: working with unskilled or inappropriately trained staff; completing laborious tasks such as documentation; perceiving tensions within role expectations; and the increasing need to be available for overtime (Moyle et al., 2003). Workplace flexibility, residents, and working within a team environment were also identified as factors contributing to job satisfaction.

Staffing was also identified as a factor impacting job dissatisfaction in a descriptive correlational survey of RNs (n = 347) living in northern, central New England (Care & Kazanowski, 1994). Care and Kazanowski (1994) concluded that nurses experiencing poor staff

cohesiveness, poor staffing, tremendous workload, negative relationships with administrators, and inadequate salary were more likely to experience job dissatisfaction. The aforementioned predictors of job dissatisfaction mirrored many of the dissatisfiers identified by Herzberg (1959) three decades earlier. Strumpf (1995) identified some similar findings, including that job dissatisfaction exists when there is a lack of a sense of autonomy; peer identification; challenge to develop new skills; and recognition and positive feedback about performance. These findings parallel Herzberg et al.'s (1959) dissatisfier, supervision; however, Herzberg et al.'s (1959) satisfier of recognition also aligns with these findings. Lastly, McHugh et al.'s (2011) cross sectional study examining survey data from 95,499 nurses found that nurses providing direct patient care reported more job dissatisfaction than nurses working in other settings where direct care was not provided (hospital [24%], nursing home [27%], and other settings (e.g., Pharmaceutical industry) [13%]).

In conclusion, the majority of the research studies reviewed examining the concept of job dissatisfaction have identified similar factors to those factors originally identified by Herzberg et al. (1959) as dissatisfiers (hygiene factors). However, none of the studies reviewed examined the LPN specifically. The RN was often the sample population or the term nurses or nursing staff was utilized with no delineation regarding exact job roles. Examining both job satisfaction and job dissatisfaction among LPNs working in long-term care settings is important and timely in light of their considerable job turnover (i.e., 51% annually) (Donoghue, 2010).

Limitations of Research Studies

Many of the nursing job satisfaction and dissatisfaction research studies conducted in long-term care utilized correlational and cross-sectional designs. Job satisfaction measurement tools are readily available and have dominated data collection methods (i.e. Brayfield & Rothe,

1951; Smith, Kendall, & Hulin, 1969). A descriptive correlational design, in contrast to an experimental design only establishes relationships; no causality can be inferred.

No experimental designs and few quasi-experimental designs were noted in the literature examined. Reasons could be numerous, including the complex nature of a long-term care facility (i.e. high turnover) that could threaten internal validity, specifically experimental mortality.

Fewer qualitative designs were noted (Cherry et al., 2007; Fläckman et al., 2007; Jeong & Keatinge, 2004; Leurer et al., 2007; Moyle et al., 2003). These studies focused on nursing staff as a whole and/or the research was conducted outside the United States. Utilization of qualitative research methods provides a rich description of a phenomenon and can provide answers never before uncovered.

In addition, research in long-term care settings has focused on the RN, DCW and nursing staff's job satisfaction and to a lesser degree, job dissatisfaction of these groups. Limited research exists examining LPN job satisfaction or job dissatisfaction in long-term care settings, despite the LPNs presence in the long-term care workforce. Given the unique job roles of these health care providers, an exploration of the LPNs' job satisfaction and job dissatisfaction was warranted. A qualitative approach allowed the researcher to follow up on initial responses to questions in order to elicit greater depth of information regarding this complex phenomenon of job satisfaction.

In conclusion, the ability to establish causal inference was limited due to the lack of studies employing experimental designs and few studies using quasi-experimental designs. As well, the depth and richness of study data were limited due to the lack of qualitative studies. Lastly, a gap exists due to the minimal amount of LPN job satisfaction and job dissatisfaction research. These limitations in the research literature on the topics of job satisfaction and job

dissatisfaction in long-term care may contribute to the ongoing challenges regarding nursing staff retention. The limitation of experimental design and causality was not addressed in this research study. This study addressed the dearth of LPN job satisfaction and job dissatisfaction research and the need for an in-depth qualitative exploration of this complex phenomenon.

Summary

The critical mass of elderly living in the United States underscores the need for examination of the concept of job satisfaction and job dissatisfaction in long-term care. Furthermore, a correlation between job satisfaction, nursing staff retention, and positive patient outcomes has also been demonstrated. Given the predominance of descriptive correlational designs and the overall lack of LPN research examining job satisfaction and job dissatisfaction, research questions remain unanswered. Meager strides in job satisfaction improvement in long-term care, evidenced by the turnover rate of LPNs in long-term care settings (Donoghue, 2010), projected increased workforce demand for LPNs (BLS, 2012), and the fact that LPNs often provide more hours of care per day per resident than RNs (Harrington et al., 2006) warrant an in-depth qualitative analysis of job satisfaction in long-term care settings, from the perspective of the LPN. Qualitative research attempts to understand the phenomenon from the perspective of the participant, yielding deep, rich data. This in-depth knowledge learned from the LPNs has the potential to create a roadmap for systematic improvement of related workforce issues throughout long-term care settings.

Chapter 3: Methods

The purpose of this chapter is to describe the qualitative research methods chosen to conduct this study examining the phenomena of job satisfaction and job dissatisfaction among LPNs employed in long-term care settings. Given the aging population, the predicted national shortage of LPNs, and the important role that LPNs fill as the majority licensed personnel in long-term care facilities; research focused on LPNs working in long-term care settings is an important and timely undertaking. This study addressed the gap in knowledge regarding LPN job satisfaction and dissatisfaction in the long-term care setting. Focus group methodology was employed to provide an in-depth view of the phenomena of interest. Numerous research studies in the last several decades have examined the phenomenon of nursing staff job satisfaction (Abraham & Grant, 2008; Cherry et al., 2007; Choi et al., 2011; Moyle et al., 2003; Rubin et al., 2009; Walker, 2008). However, these studies have predominantly examined the satisfaction of RNs or DCWs, but not specifically LPNs. The methodological approach often employed in nursing job satisfaction research in nursing homes has been primarily quantitative in nature; specifically, descriptive, correlational research designs, thus minimizing the depth of understanding job satisfaction. There has been less research related to job dissatisfaction, and similar to job satisfaction research it has been primarily descriptive correlational in design. It is also important to note that job dissatisfaction research is often a component of a research study, which has primarily focused on the phenomenon of job satisfaction.

Much of the job satisfaction research has measured job satisfaction through the use of survey instruments (e.g. Brayfield & Rothe, 1951; Cammann, Fichman, Jenkins, & Klesh 1979; Smith, Kendall, & Hulin, 1969). Job satisfaction surveys are questionnaires used to evaluate dimensions of job satisfaction. This has narrowed the focus of job satisfaction research to

particular components of the job and characteristics of the worker (Moyle et al., 2003). In contrast to the use of a survey, focus group methodology can examine participants' job satisfaction and job dissatisfaction experiences, which are not restricted to the topics included in a questionnaire. This is critical as job satisfaction and job dissatisfaction are complex phenomena impacted by many variables, including the work environment. The comparisons that participants make during focus groups regarding other's opinions and experiences are a critical source of insight regarding complex behaviors (Morgan & Krueger, 1993). A qualitative approach, particularly a focus group methodology allowed the researcher to probe deeper, beyond the components of the job itself and the individual themselves, to themes that emerge among the groups. Connecting the collective power of individual and group discussion contributed to the collection of rich data to more fully understand the attributes of LPN job satisfaction and job dissatisfaction.

Specifically, this chapter explores the essential dimensions of focus group methodology. The advantages and disadvantages of this design, including a cost perspective will be presented, as will rationale for selecting this approach. In addition, a description of the research procedures, setting and sample, data collection, data analysis, and human subjects protection are presented. Trustworthiness, credibility, transferability, dependability, and confirmability are discussed, along with limitations.

Essential Dimensions of Focus Group Methodology

Focus groups, originally referred to as group interviews, emerged when Emory Bogardus (1926) conducted social psychological research to develop a social distance scale (Dilorio, Hockenberry-Eaton, Maibach, & Rivero, 1994). Almost three decades later this method became well known through the work of sociologists Lazarsfeld and Merton (Morgan, 1997). Together

they developed group interview techniques to examine people's reactions to wartime propaganda. After the war, Merton and his student, Kendall, (1946) published an article "The Focused Interview" in the *American Journal of Sociology*. This work led to a publication by Merton, Fiske, and Kendall (1956) entitled *The Focused Interview: A Manual of Problems and Procedures* (Morgan, 1998). As a result, Merton is often credited with developing the focused interview with groups (Kitzinger, 1994).

Despite this early academic research, focus groups became synonymous with market research (Munday, 2006). This was a natural fit as a premise of the methodology was that many consumer decisions are made in a social context as a result of discussion with others (Robinson, 1999). In the last two decades, focus group methodology has been utilized extensively in nursing research studies focused on topics including, but not limited to: nursing care delivery; staff communication; care of the elderly; nursing education; and program evaluation (Houser, 2003; Morrison & Peoples, 1999; Hupcey, Clark, Hutcheson & Thompson, 2004; Loeb, Penrod & Hupcey, 2006; Rubin et al., 2009).

A focus group is defined as "a qualitative research technique used to obtain data about feelings and opinions of small groups of participants on a given problem, experience, service, or other phenomenon" (Basch, 1987, p. 414). According to Morgan (1997), focus groups can be utilized in a self-contained manner as a basis for a complete study. This was the strategy employed in this study. LPNs' feelings and opinions relative to job satisfaction and job dissatisfaction were examined utilizing focus group methodology. The primary aim of a focus group is to describe and understand meanings of a select group of people, generally homogenous in composition, regarding a particular topic or phenomenon from their own perspective (Liamputtong, 2011). The moderator/facilitator commonly has a series of open-ended questions

that guides participants through an in-depth exploration of a topic, creating a permissive, non-threatening environment and encouraging open discussion of the research topic (Greenbaum, 1988; Krueger, 1994). Group dynamics is a key component of focus group methodology, as it can encourage the participants to take the research in new and unexpected directions (Kitzinger, 1995). Dreachslin (1998) concurs stating, “Focus group methodology can harness the power of human interaction by capitalizing on relationships, allowing insights to emerge that typically may not occur” (p. 813). Thus, focus groups allow researchers to probe further on specific topics as themes emerge in the discussion (Ayala & Elder, 2011). Krueger (1994) maintains, “The focus group interview works because it taps into human tendencies...we are a product of our environment and are influenced by people around us” (p. 10-11). These concepts were employed in this study.

Advantages and Disadvantages of Focus Group Methodology

Advantages. Focus groups are a useful and effective method for deriving collective opinions, beliefs, and values (Halcomb, Gholizadeh, DiGiacomo, Phillips, & Davidson, 2007). According to Morgan (1998), focus groups, as a qualitative methodology, draws on three fundamental strengths: exploration and discovery; context and depth; and interpretation. For this research study, the areas of context, depth, and interpretation are highly applicable. Context and depth enable the researcher to understand the complex influences behind peoples’ thoughts and experiences (Morgan, 1998). Focus groups encourage participants to share, listen, and compare their perspectives regarding a given topic or phenomenon through in-depth discussions. As such, hearing the participants’ views and seeing how they react to each other allows for a rich discussion, revealing a wide range of opinions, and identifying similarities and dissimilarities regarding a phenomenon. Findings are important given the predominance of job satisfaction

research, which has focused on non-LPN participants (RN and DCWs). One-on-one interviews could also have accomplished this outcome. Focus groups, however, can produce synergistic results, not obtained through one-on-one interviews, as synergy can generate more than the sum of individual comments. Some researchers describe almost a magical synergy that occurs in the focus group setting (Morgan, 1997). However, Morgan states, “My own preference is to be much more explicit about the aspects of group interaction that can provide insights into participants opinions and experiences” (Morgan, 1997 p.13). This process of sharing and comparing was advantageous given the complex nature of job satisfaction. In addition, many previous research studies examining the phenomena of job satisfaction and job dissatisfaction have utilized a descriptive correlational design (job satisfaction tool), collecting data at the individual level. Collecting data at the group level provided new insights into the phenomena of job satisfaction and job dissatisfaction through follow up on participant initial responses to questions, eliciting a greater depth of information from other focus group participants.

Kitzinger (1995) notes a few other advantages including several sampling advantages such as: including participants who can not read or write; encouraging participants who may be reluctant to participate in a one-on-one interview; and promoting contributions from those who feel that they do not have much to say. Although, inclusion criteria of being an LPN eliminates the possibility of a participant who can not read or write, the two other sampling advantages were applicable.

Disadvantages. Disadvantages also can exist when utilizing focus group methodology. Of critical importance is the risk of conformity and unwillingness of individuals to disagree with each other, often referred to as “group think”. This could lead to biased data (Dilorio et al., 1994). In addition, members may be unwilling to discuss sensitive information in a group setting.

The depth and detail provided by each individual participant can be minimal due to time constraints and size of the group. Careful planning, relative to size of focus group is critical. The skill of the facilitator is an important factor in addressing this concern. Attrition of participants can occur following confirmation of volunteers scheduled for each focus group session. Oversampling of the host institutions and of the LPN participants was implemented to address the issue of attrition.

Cost. Lastly, the cost advantage of a focus group is debated. Some sources suggest that focus groups are quick and inexpensive (Beyea & Nicholl, 2000). Although this can be logical when compared to individual interviews, other researchers view the process of analysis as extremely arduous and the costs of recruiting as negating any cost savings (Mansell, Bennett, Northway, Mead, & Moseley, 2004; Morgan, 1998). In addition, if a skilled moderator is hired, costs can be considerable. Morgan (1998) does indicate that focus groups can be cost effective given careful planning and special resources, such as a researcher who is already experienced as a focus group moderator and has access to appropriate meeting room space. I did have focus group experience, thus minimizing this cost. In addition, host institutions provided in-kind private meeting space to conduct the focus groups.

In conclusion, focus group methodology is a good fit for this research study. According to Morgan (1998), focus groups as a qualitative research method, guide group discussions to generate a rich understanding of participants' beliefs and experiences. Direct observation may be more appropriate for studies of social roles and formal organizations but focus groups are a well-suited method to study attitudes and experiences (Kitzinger, 1995). The phenomena of job satisfaction and job dissatisfaction encompass both attitudes and experiences. According to Hupcey (2010) focus groups are typically used for problem identification, program planning, and

program implementation. This aligns with the examination of LPN job satisfaction and job dissatisfaction in long-term care and the possible identification of future implications for related strategies to improve job satisfaction and job dissatisfaction. Krueger (1994) states that focus groups are most beneficial when the phenomenon of interest occurs in a natural setting where participants impact each other and gain insights into attitudes and opinions about the phenomenon of interest. The natural setting of long-term care facilities is well suited for focus group studies. Lastly, my experience in conducting focus groups and professional linkages with the network of nursing homes in the Philadelphia area contributed to successful oversampling of eight facilities and achievement of data saturation.

Key Components of Focus Groups Contributing to Trustworthiness

According to Morgan (1997) there are key components to designing effective focus groups and increasing validity, referred to as trustworthiness in qualitative research. Trustworthiness is described as the extent to which the findings represent reality (Morse & Field, 1995) and encompasses the quantitative based concepts of external and internal validity. Four criteria outlined by Lincoln and Guba (1985) including credibility, transferability, dependability, and confirmability were used to establish trustworthiness of the data. Credibility was established through the utilization of verbatim quotes and key informant member checks, allowing participants to provide feedback regarding the accuracy of comments and resultant themes that have emerged. At the completion of each focus group, participants were requested to provide an Email contact if they were interested in participating in member checks. In one session, two participants volunteered. However, when contacted, only one was available. Thus, there was one participant per focus group who performed a member check. Within one to two weeks following each focus group, the member check was completed via telephone interview. The LPN focus

group participant who volunteered to participate in a member check validated initial themes that emerged from the data; confirming and providing clarification (occurred in one focus group member check) where needed. Member checks elicited a high degree of congruency, confirming the accuracy and completeness of the summary of the respective focus group transcript. No conflicting information emerged. Three of the LPNs participants who provided member checks commented that the summary (wrap up) overview presented near the conclusion of each focus group, requesting participants' views on accuracy of interpretation of comments during the discussion, contributed to the congruency. According to Hupcey (2010), potential verification with the original participants helps to strengthen the analysis. Thus, participant verification utilizing member checks contributed to trustworthiness.

External validity or transferability refers to generalizability. Descriptions of time and context of the focus groups, along with demographics of the setting and sample of LPNs are presented which allows the reader to make informed assessments regarding generalizability, as suggested by Tourangeau, Cummings, Cranley, Ferron, & Harvey (2010). The utilization of two facilitators (moderator and assistant moderator) as noted in Table 2, along with other noted items, such as number of focus groups scheduled per day and the audit trail contributed to dependability and confirmability.

Focus Group Key Points	Rationale
Consists of approximately 6 – 8 members	Morgan (1997) indicates that the majority of focus groups consist of 6 to 10 participants per group
90 minutes in length	Morgan (1997) indicates that the majority of focus groups, last 60 to 120 minutes

Focus Group Key Points	Rationale
<p>Six long-term care settings will be identified to host focus groups (six focus group sessions)</p>	<p>Morgan (1997) indicates that the majority of focus groups, three to five groups per project. Six sites will be identified related to the number of participants in each group being six</p> <p>Multiple focus groups allow for assessment of data saturation (Lincoln and Guba, 1985)</p> <p>Krueger (1994) and Morgan (1997) suggest that three to six focus groups are adequate to achieve data saturation</p>
<p>Audio-record focus group sessions</p> <p>No more than two focus groups per session</p>	<p>Minimizes confusion of data collected when debriefing (Morgan, 1998)</p>
<p>Field notes taken by the assistant moderator will record body language, intonation and interaction amongst participants. Notes regarding methods will also be recorded</p>	<p>Contributes to confirmability and trustworthiness</p>
<p>Debriefing meeting between moderator and assistant moderator immediately after session</p> <p>Audio-record debriefing session</p> <p>Discuss any relevant field notes and any unusual events</p> <p>Highlight and discuss any methodological insights</p>	<p>Contributes to confirmability and trustworthiness</p>
<p>Maintain audit trail throughout</p>	<p>Maintains replicability and contributes to dependability and trustworthiness</p>
<p>Member Check by key informants</p>	<p>Contributes to credibility and trustworthiness</p>

Table 2. Focus Group Key Points and Rationale

Setting and Sample

Setting. Permission was obtained to conduct the research at eight long-term care facilities that provide skilled level of care and employ LPNs as a primary front line caregiver (i.e., LPNs account for at least 50% of the licensed FTE skill mix). This represented purposeful over-recruitment of two facilities, in excess of the six needed for the study to allow for possible attrition. These facilities were located in the Philadelphia Metropolitan Division (designated five county area including Philadelphia, Chester, Delaware, Montgomery and Bucks Counties), which constituted the settings for this study. Philadelphia Metropolitan Division was chosen due to the feasibility of travel (time and cost perspective) and the ability to identify diverse types of facilities (ownership, religious affiliation, union affiliation and size).

Long-term care facilities were ultimately selected based on administrative interest and support of the research project, as well as the criteria listed below:

- Currently Licensed by the Pennsylvania Department of Health
- In-patient census of greater than 60 beds (60 bed facilities have particular Medicare guidelines relative to staffing mix [i.e., full time Director of Nursing]).
- Currently has a Director of Nursing

Sample. For the purpose of this study, I employed a purposive sampling technique. According to Polit & Beck (2008), purposive sampling (also known as a judgmental sampling) is based on the belief that the researcher can hand pick participants typical of the population and familiar with and knowledgeable regarding the phenomenon of interest. Purposive sampling seeks out participants who have exposure to the phenomenon of interest and interest in the topic (Sevier, 1989). Interest in the subject was evidenced by the LPNs' response to the posted flyer and interest in the proposed research study. The utilization of purposive sampling is common in

focus group methodology (Clark, Maben, & Jones, 1996; Morgan, 1998). According to Morgan (1997), selecting participants for focus groups is focused on minimizing bias versus achieving generalizability.

Homogeneity of the sample was another important concept considered. Morgan and Scannell (1998) state, “When participants perceive each other as fundamentally similar, they can spend less time explaining themselves to each other and more time discussing the issues at hand” (p. 59). Morgan (1997) lists the following background variables that should be considered in forming mixed or segmented groups: sex, race, age and social class. According to Morgan and Scannell (1998), similarities on key experiences can override demographic differences. As the LPNs in this study had similar key experiences and segmenting would have been costly and time prohibitive, demographic (sex, race, and age) information was collected but participants were not segmented. Social class was not collected as its relationship to job satisfaction has not been noted in the literature.

In conclusion, the focus group participants were homogenous, only including LPNs. However, they were heterogeneous in terms of demographics such as age, race/ethnicity, and years of experience. Descriptive data on both the setting and focus group participants were collected and are outlined in the section below “Demographic Information”.

Demographic Information. Information describing the facilities serving as the settings for this study was obtained via a publicly accessible document (Pennsylvania Department of Health-Bureau of Health Statistics and Research Data Nursing Home Report). Data specific to the long-term care settings under consideration for study settings were reviewed prior to making contact to ensure diversity in terms of institutional size and ownership. Ownership included profit or non-profit status, including religious affiliation.

Demographic data specific to the LPNs participating in the study were collected as they arrived at the focus group session. A brief paper and pencil questionnaire was administered. See Appendix B, LPN Focus Group Demographic Survey.

LPN demographic characteristics collected included longevity in position, years of experience, age, race/ethnic background, and enrollment in a RN program. Age was collected based on generational categories. This enhanced discussion relative to results obtained and allayed participant concerns related to potential identification by a specific reported age. The results are presented as aggregate demographic data.

Recruitment. Using multiple focus groups allows for assessment of data saturation (Lincoln & Guba, 1985). A goal of six host sites for the focus groups was set based on costs and time constraints. Identification of an additional two sites did occur to assist with achieving saturation. Thus, a total of eight sites' signed letters of commitment and were approved by Pennsylvania State University Institutional Review Board. Ultimately, due to attrition, focus groups were conducted at six host sites.

An Email was sent to the nursing home administrator and/or Director of Nursing explaining the research project, the host facility inclusion criteria and responsibilities of the commitment. Follow up individual phone calls and/or personal visits clarified information, answered any remaining questions, and confirmed participation.

A commitment letter was requested and obtained from the administration of each facility. Following confirmation of facility participation, the nursing home administrator was requested to facilitate the distribution of a flyer announcing the research study and the call for research participants. The flyers were posted in easy LPN access areas (i.e. break rooms, time clock area). The flyer included introductory study information, participants' inclusion criteria, date, time, and

location of focus groups at their institution, incentive for participation, and a telephone number and Email address for the principal investigator. The LPNs agreed to attend the focus group sessions during their personal time. The timing of the sessions was coordinated to minimize travel time and maximize convenience. Thus, the session was scheduled just prior to or at the completion of an assigned shift.

According to Clark et al. (1996), it is essential for participants to volunteer and not “be volunteered”. Thus, it is important that the participants are volunteers and not selected by administration. Being volunteered by an administrator could create a possibility of coercion. In addition, the quality of the focus group method is largely dependent on the interaction among the participants, which could be stifled if a non-threatening open environment was not created. Krueger (1994) maintains that we are a product of our environment and influenced by people around us. It is essential that participants feel free to openly share at the focus group sessions. Thus, interested participants voluntarily contacted the principal investigator and were screened relative to stated inclusion criteria. LPN inclusion criteria included the following:

- Employment in the current facility for greater than 6 months at 0.5FTE or greater (Minimize attrition risk)
- Job description includes some supervision of staff (i.e. DCW)
- Willingness to participate in one 90-minute focus group session, during a 4-week period of time
- Willingness to consider volunteering as a key informant following the focus group session to verify accuracy of themes derived from data collected during the focus group
- Willingness to consent to participate in research study

Size of the focus group was a careful consideration. Recommended size of a focus group varies from a low of 6 to a high of 12, although differences exist among focus group experts. Dilorio et al. (1994) indicate that the range can be from 4 to 12, with 8 being the ideal number of participants. Krueger (1994) indicates that the group should be small enough to allow full participation and sharing of insights but large enough to share diversity of perceptions. Groups below six members can be difficult to sustain discussion and groups greater than 10 can be difficult to control. Morgan (1998) also discusses size and emphasizes the importance of calculating size of the group, relative to the complexity of the phenomenon (number of questions) and length of the session. Lastly, Morgan (1997) states, “Small groups work best when the participants are likely to be both interested in the topic and respectful of each other” (p. 42). Given this information, a focus group size of 6 to 8 was the goal, with a range of 4 to 12 acceptable.

Interested LPNs were contacted with the full details of participation in the research study explained verbally and/or in writing. Recruitment was assisted through a careful explanation of the LPNs’ commitment, their valuable contribution to the nursing profession and the potential improvement of quality of care. All who met the criteria were confirmed to participate in the scheduled focus group and received brief Emails, serving as reminders regarding the scheduled focus group date, time, and location. The above strategies minimized the risk of “no-shows” on the day of the focus group sessions. The focus group sessions occurred immediately following, or just prior to the LPN’s assigned work shift to maximize convenience. The need for confidentiality was explained as outlined in the Informed Consent Form, Appendix C. Each focus group session began with obtaining informed consent and answering any related questions.

An informal meeting with administrators and LPNs employed in long-term care facilities in Chester County in 2012 agreed that a focus group session of 90 minutes, inclusive of a box meal and a \$30.00 Wawa gift card (incentive) would be conducive to LPN participation. Given this information and the length of the focus group question guide, 90 minutes was designated as the length of the session including both the focus group and demographic survey completion. Thus, this study's proposed design (i.e. six-eight participants, 90 minutes in length and a goal of six host sites) used the principles outlined in Table 2. In addition, only one focus group session was conducted per day, decreasing possible confusion when debriefing (Morgan, 1998).

Strategies for Minimizing Attrition

Attrition is a concern when utilizing focus group methodology. Some researchers advocate planning for attrition and thus assigning at least two or more extra participants per focus group. Conversely, this can result in an unmanageable group if no attrition occurs (Morgan & Scannell, 1998). Morgan (1997) suggests over-recruiting by at least 20% of the total number of required participants. The goal was to identify nine participants per focus group. Thus, if attrition occurred, the group would not fall below the range of six to eight participants. If less than four participants were available (Dilorio et al., 2004) the session was postponed. Despite oversampling, recruitment strategies, and repeated attempts to reschedule the session, two host institutions were unable to meet the minimum requirements for participants. Final number of institutions hosting focus group sessions was six.

Inclusion criteria for LPNs included employment at their current facility for greater than 6 months at 0.5 FTE or greater. This assisted in minimizing attrition as turnover can be greater during the employees' probationary or provisional hiring period.

Time Line

Morgan and Scannell (1998) suggest creating a time line to assist in planning a focus group study, see Figure 3. The planning, recruiting, moderating, analysis, and reporting occurred over a 12-week time period. Recruitment began on week three and also occurred in week seven, as Email reminders and/or phone calls were made to participants of focus groups scheduled in weeks eight and nine. Analysis began immediately following moderating the first focus group on week six and continued through week ten. Reporting is noted on weeks seven and nine and reflected the need to report data to key informants who were participating in member checks.

Week	1	2	3	4	5	6	7	8	9	10	11	12+
Planning	x	x	x									
Recruiting			x	x	x		x					
Moderating						x	x	x	x			
Analysis						x	x	x	x	x		
Reporting							x		x		x	x

Figure 3. Time Line for Project Completion

Adequate planning resulted in six 90-minute focus groups, comprised of 4 to 12 LPNs, and conducted at each six different long-term care facilities. This resulted in a sample size of 37. The sample was homogenous relative to job description. Details of the recruitment process and final number of LPN participants per focus group are outlined in Chapter 4.

Krueger's (1998) six steps essential to a research study was utilized to guide this focus group methodology. A discussion of these steps follows, inclusive of sequencing of questions to maximize insight, process for capturing and handling data, coding of data, participant verification, debriefing between moderator and assistant moderator, and sharing preliminary and latent reports with participants and stakeholders.

Sequencing and Development of Questions

Krueger (1998) suggests two options for developing questions for the focus group guide: topic guide and questioning guide. The topic guide lists topics or issues relevant to the phenomenon of interest. The list consists of words or phrases that remind the moderator of the focus of the discussion. Professional moderators often utilize this approach in market research (Krueger, 1998). Advantages include the speed in developing the topic guide and the conversational and spontaneous tone of the questions. Disadvantages include increased difficulty with analysis (questions may be asked differently by the moderator), risk of inconsistency between moderator and assistant moderator, and decreased feedback obtained in pilot test of questions. The questioning guide consists of a sequence of questions developed in complete conversational sentences and is often utilized in public, non-profit, and academic environments (Krueger, 1998). This type of guide contributes to the efficiency and quality of analysis as the questions are clearly stated, thus also creating consistency between focus groups. Disadvantages include the increased time to develop the question guide compared to the topic guide and awkwardness of the moderator, as the questions can seem stilted and insincere (Krueger, 1998). Based on the stated advantages and the plan to utilize focus groups for academic research, the questioning guide was chosen for this study.

Planning questions carefully is essential to conducting focus groups. Krueger (1998) identifies five key strategies for planning questions, including asking open ended questions, asking participants to “Think back”, avoiding the use of “Why” (instead utilize use terms such as “What” or “How”), keeping questions simple, and avoiding use of examples. In addition, Krueger (1998) identifies five different categories of questions (i.e. opening, introductory, transition, key, and ending) each with a distinct function. The level of importance of the type of

question impacts the time spent on the question and intensity of analysis (Krueger, 1998). All of these strategies were employed as noted in Table 3. Table 3 also includes the actual focus group questions utilized in the Question Discussion Guide.

Focus Group Questions	Type of Question	Key Points (Krueger, 1998)
<p>Tell me your name, how long you have been an LPN, the nursing unit you work on and what you like most and least about your job?</p>	Opening Question	<p>Designed to be answered quickly</p> <p>Everyone answers</p> <p>Gets conversation flowing</p>
<p>We often hear people talk about job satisfaction. How would you describe job satisfaction? How would you describe job dissatisfaction?</p>	Introductory Question	<p>Introduces the topic or phenomenon to be examined</p> <p>Provides an opportunity for participants to reflect on their experiences related to this topic</p> <p>Questions foster conversation and interaction among participants</p>
<p>Think about the last 3 months, have you had any experiences that have contributed to your job satisfaction or job dissatisfaction as a LPN in LTC?</p>	Transition Question	<p>Serve as the link between introduction and key questions</p> <p>Participants begin to become aware of how others view the topic</p> <p>Assist the participant to view the topic from a broader perspective</p>
<p>JOB SATISFACTION</p> <p>There have been several factors associated with job satisfaction in the literature (show visual of achievement, recognition, value of the work itself, potential for growth, advancement, responsibility (e.g. autonomy), leadership (e.g. communication). What factors contribute to your job satisfaction as a LPN working in this LTC setting?</p>	Key Questions	<p>Two to five questions depending on length of focus group</p> <p>Two key questions with five sub-questions will be utilized.</p>

Focus Group Questions	Type of Question	Key Points (Krueger, 1998)
<p>What factors would you suggest changing to improve your job satisfaction?</p> <p>What does your organization do best that contributes to your job satisfaction?</p> <p>What does your organization do poorly that contributes negatively to your job satisfaction?</p> <p>What does your leadership do best that contributes to your job satisfaction?</p> <p>What does your leadership do poorly that contributes negatively to your job satisfaction?</p> <p>Of all the reasons for job satisfaction we discussed, which two are most important to you?</p> <p>JOB DISSATISFACTION</p> <p>There have been several factors associated with job dissatisfaction in the literature (show visual of company policy and administration (e.g. employer provided support programs), supervision, salary, interpersonal relationships, work conditions (e.g. regulatory environments, experiencing low staffing levels, poor staffing).</p> <p>What factors contribute to your job dissatisfaction as a LPN working in this LTC setting?</p> <p>What factors would you suggest changing to decrease your job dissatisfaction?</p> <p>What does your organization do best that decreases your job dissatisfaction?</p> <p>What does your organization do poorly that contributes to your job dissatisfaction?</p>		

Focus Group Questions	Type of Question	Key Points (Krueger, 1998)
<p>What does your leadership do best that decreases your job dissatisfaction?</p> <p>What does your leadership do poorly that contributes to your job dissatisfaction?</p> <p>Of all the reasons for job dissatisfaction we discussed, which two are most important to you?</p>		
<p>Job satisfaction and job dissatisfaction have been found to be associated with nursing staff turnover. Please list the top three practices that you believe would most increase your intention to stay in your job as a LPN in LTC.</p> <p>(Provide a visual summary) How well does this capture what we said here today?</p> <p>Have we missed anything important to this conversation regarding LPN job satisfaction?</p> <p>First focus group only: This is our first in a series of focus group to be conducted over the next several weeks. Do you have any advice on how to improve the process?</p>	Ending Questions	<p>All Things Considered Question (Allows participants to clarify position)</p> <p>Summary Question (Moderator or assistant moderator gives short (2-3 minutes) oral summary, remembering to cite key phrases utilized in discussion)</p> <p>Final Question (Utilized to determine if any critical items have been overlooked)</p> <p>Note: Following the first focus group session, no change in the focus group question discussion guide was suggested by the LPN participants</p>

Table 3. Question Discussion Guide (Krueger, 1998)

Krueger (1998) also stresses the importance of sequencing the questions. Krueger (1998) states, “The question sequence is the hallmark of focus group interviews and the reason that we use the word focus in the title” (p. 37). Krueger (1998) recommends that clear, consistent background information be provided including the purpose of the study and how the information is being utilized. This will minimize any tacit assumptions (Krueger, 1998). Questions should be arranged to flow from general to specific, positive to negative, uncued before cued and participant categories prior to other categories (Krueger, 1998). Positioning participant categories prior to other categories is important if the participant is to rank categories established by literature or other outside sources. The participant should be asked to first state and rank their own categories prior to ranking a list of categories from literature or experts. I did utilize a visual listing of job satisfaction attributes from the literature to prompt the discussion, as noted in the focus group discussion guide. As Krueger (1998) suggested, the participants first had the opportunity to suggest some their own categories due to the sequencing of questions in the focus group discussion guide.

The question guide was developed to elicit the most robust responses. First, the questions were identified based on evidence from literature and a draft was created. The questions were read out loud to a colleague to assess the conversational tone of the questions (Krueger, 1998). Next, the questions were piloted with several other groups, including a member of the research team (assistant moderator), two RNs who work with LPNs, and two LPNs working in long-term care. This group was asked for feedback on how to reword, thus increasing the clarity of questions. The question guide was updated. Next, a mock focus group was conducted with an LPN group (n=4) to further assess timing of the questions and clarity. The question guide was again updated as suggested. According to Krueger (1998) feedback is the hallmark of quality.

Several revisions occurred prior to utilization with the first focus group. This contributed to the validity of the discussion guide questions. At the conclusion of the first focus group session the participants were asked to share any strategies to improve the process. None were noted.

Process for Collecting and Handling Data

Focus group sessions were audio-recorded to enhance my ability to use verbatim quotes and accurately recall the discussion. Two digital recorders were utilized, placed at each end of the table, thus avoiding any possible loss of data due to recorder malfunction. A transcriptionist assisted me in providing verbatim transcripts of the discussions. LPN participants were assigned a unique number and stated this number prior to making a comment during the focus group session. Transcripts were de-identified (personal and institutional data), resulting in clean transcripts. A unique letter and number code on the transcripts identified focus groups and participants. All data were stored in password-protected computers. As recommended by Hupcey (2010), accuracy of the data was viewed as the responsibility of the researcher. This contributed to credibility. Field notes (recording body language, intonation and interaction amongst participants) scribed by the assistant moderator were maintained in a secure, locked location.

Analysis was verifiable through an audit trail (dependability). An audit trail was maintained throughout the research process, beginning with the recordings from the focus groups, inclusive of the oral summary (key points) presented by the moderator. This summary (presented to participants on flip charts) provided an opportunity for participants to amend or confirm the prevailing concepts or themes from the group discussion. Participants primarily agreed with the summaries but on some occasions did provide additional clarity regarding the key points presented. The audit trail also included the debriefing session (credibility) between

moderator and assistant moderator immediately following the focus group and the participant verification (member check) process.

Moderator role/Assistant moderator role. The moderator is described as a facilitator, encouraging discussion of inconsistencies within and among participants (Kitzinger, 1994). In this role, I was alert to recognize particular phrases that may indicate group norms. In addition, I utilized conflict between participants to encourage participants to qualify why they believe what they do (Kitzinger, 1994). As Morgan (1998) states, “What distinguishes focus groups from any other form of interview is the use of group discussions to generate data” (p. 32). As a moderator, I strived to be flexible yet focused through the group sessions while utilizing the Questioning Discussion Guide. Recommended techniques by Dilorio et al. (1994) such as probing, stimulating discussion with word association, and asking participants to tell stories regarding their experiences were utilized. In addition, the three types of probes (detail oriented, elaboration and clarification) identified by Patton (1990) were also utilized.

The assistant moderator scribed field notes (in a notebook) recording body language, intonation, and interaction among participants and monitored the tape recorders, providing for extra batteries when needed. Positioned near the door, the assistant moderator minimized distractions, such as late arrivals or an urgent message from the nursing unit for a participant, and assisted with refreshments. In addition, the assistant moderator played an integral role in the debriefing process, particularly highlighting relationship of “words” to related non-verbal information in field notes.

The assistant moderator recently completed a master of science in nursing degree, inclusive of qualitative research coursework, participation in a research project, focus group knowledge preparation, and completion of Penn State University Institutional Review Board

training. Her general knowledge base of qualitative and basic research methods was evident, particularly during debriefing and data analysis.

Debriefing between moderator and assistant moderator. Debriefing between the moderator and assistant moderator occurred immediately after the focus groups and was recorded and/or written notes maintained. Debriefing is essential to immediately discuss any relevant field notes and any unusual events that occurred during or immediately after the focus group session. Debriefing was utilized to discuss any unclear questions, record methodological insights and problem solve for the next scheduled focus group session.

Location and set-up. According to Morgan (1998) the setting should be viewed as neutral and non-threatening. This was an important consideration given that the focus group sessions were conducted at the participants' place of employment, immediately prior to or following their assigned shift. The room utilized was removed from both the direct patient care area and the administrative area. The setting was arranged, encouraging eye contact (Duffy, 1993). Long narrow tables were avoided. Refreshments were located to the rear of the room, easily accessible, but removed from the table, minimizing distractions. Adequate lighting and temperature was evaluated and achieved. Potential distractions in the immediate environment were not an issue, except at one facility where a staff member needed to relocate to another office. See Figure 4 for a typical room set up utilized. Room availability and set up was excellent at all facilities and met all of the criteria noted above. Often a board meeting room was utilized, resulting in ideal table configuration. At two facilities a less ideal classroom type environment was available; however, the movement of tables resulted in a set-up as viewed in Figure 4.



Figure 4. Focus Group Room Set Up

Image courtesy of David Castillo Dominici / FreeDigitalPhotos.net

Expert Verification

Expert verification (following focus group open coding and abstraction) was also employed. A doctoral prepared researcher read in entirety all scripts from each focus group, analyzed data and confirmed achievement of data saturation. A team of four nurse educators (MSN or PhD degree), with qualitative research training and experience, participated in various discussions and assisted in data abstraction and condensation, contributing to trustworthiness.

Process for Coding and Analyzing Data

Analysis must be immediate and not delayed. According to Krueger (1998), analysis should seek to enlighten, identifying information currently unknown about the phenomenon or confirming previous research findings (Krueger, 1998). Data shared should be reviewed for the following (Krueger, 1998):

Frequency: How often was it said?

Extensiveness: How many people said it?

Intensity: How strong was the opinion or point of view?

In addition, a series of questions recommended by Krueger (1998) were utilized to assist in conducting the data analysis and preparing the report. See Table 4.

Questions suggested to assist with analysis and discussion (Krueger, 1998)
What was previously known and then confirmed or challenged by this study?
What was suspected and then confirmed or challenged by this study?
What was new that was not previously suspected?
What implications do these results have for the product or service?

Table 4. Questions Utilized for Analysis (Krueger, 1998)

According to Polit and Beck (2008), qualitative analysis is a critical, tedious task as it organizes, provides structure to and elicits meaning from research data. Qualitative content analysis requires a careful review and examination of narrative data to identify recurring themes. These themes emerge during analysis through a systematic coding process.

Analysis is not a distinct step but a fluid step in the research process, flowing throughout data collection. Content analysis will occur as the researcher is continually analyzing and reanalyzing during the data collection process to capture the “essence” or universal meaning of the experience. Content analysis is a systematic and objective way to describe and quantify phenomena (Sandelowski, 1995). This is a continual, cyclical, interactive process that occurs during and after the data collection period and involves breaking down the data into small units representing similar content, naming these units and grouping these units into categories, which represent similar concepts. The researcher then diligently searches for patterns and connections between the categories.

Analysis was completed within the group and across the groups utilizing open coding, condensation and abstraction techniques. Categories identified were reviewed with the assistant moderator, doctoral prepared researcher, and other nurse educators and researchers to verify conclusions. According to Kitzinger (1995), a focus group research report should illustrate talk between participants rather than isolated quotes taken out of context. Morse and Field (1995) noted that qualitative analysis is a “process of filtering data together, of making the invisible obvious, of linking and attributing consequences to antecedents. It is the process of conjecture and verification, of correction and modification, of suggestion and defense” (p.126). I reminded the co-moderator and other participants of these key components of focus groups, while analysis was taking place.

Inductive versus deductive analysis. There are two approaches to content analysis, inductive and deductive. The purpose of the research study drives the choice of analysis (Elo & Kyngas, 2007). Deductive analysis is generally utilized when testing a theory as the structure of analysis is operationalized from previous knowledge or theory. In inductive analysis, the categories are derived from the data itself and move from the specific to the general (Elo & Kyngas, 2007). An inductive content analysis approach was utilized in this study as testing of Herzberg’s (1959) theory is not the aim of this research. The study’s aim, “To determine the attributes of LPN job satisfaction and job dissatisfaction in long-term care settings.” aligns more closely with the use of inductive content analysis. The process utilized included open coding, condensation and abstraction.

Open coding, condensation and abstraction. Open coding occurs as the text is read and headings are noted describing all aspects of the content. An explanation of the process of condensation (involves shortening while preserving the core) and abstraction (emphasizing

interpretations on a higher logical level, resulting in creation of categories and themes on varying levels) follows (Graneheim & Lundman, 2004), concluding with an overview of the actual process utilized in this research study.

Graneheim and Lundman (2004) emphasize the importance of selecting the unit of analysis. They suggest that the most suitable unit of analysis is whole interviews; in this research study the unit of analysis was the focus group sessions. Next a meaning unit is identified.

Graneheim and Lundman (2004) consider a meaning unit to be words, sentences or paragraphs that are related to each other through their content and context. The label of a meaning unit is referred to as a code. The origin of the codes can be exact words used by participants, words drawn from social or health sciences, or a name the researcher believes best describes the information (Creswell, 2013). Codes should be understood in relation to the context (Graneheim & Lundman, 2004). In focus group research it is important to remember the context is a group of individuals.

Next the list is grouped according to categories, collapsing those that are similar or dissimilar. Creating categories is a key feature of content analysis. According to Krippendorff (1980) a category is a group of content that shares a commonality. Categories are described as broad units of information that consist of several codes aggregated together to form a common idea (Creswell, 2013 p. 186). This involves several thorough readings resulting in categories being freely generated (Burnard, 1991). This process involves decision-making whether data “belongs” to a certain category (Elo & Kyngas, 2007). Creswell (2013) explains that these categories can be viewed as a family (category) with children (sub-categories) and even grandchildren (sub-sub categories). Finally, abstraction involves grouping subcategories with

similarities or dissimilarities together as categories and likewise grouping categories together as main categories (Dey, 1993). Themes begin to emerge. This process was utilized in this study.

A theme is described by Polit and Hungler (1999) as a recurring regularity within and across categories. A theme answers the question “how” and can be viewed as a thread through condensed meaning units, codes and categories (Graneheim & Lundman, 2004). Meaning units, codes, and categories can fit into one or several different themes.

Analysis by question versus theme. Krueger (1998) describes analysis of data from focus groups as detective work, containing clues indicating trends and patterns that reappear among the different focus groups. The researcher should carefully analyze the data, paying attention to the range and diversity of experiences. Strategies in this study utilized during the focus group included: listening for inconsistent opinions and probing for understanding (i.e. “Earlier you or...said...now you have indicated.... can you help me understand?”); identifying evidence (i.e. ideas, opinions and feelings) that repeats and is common to participants; and evaluating solo opinions, as they may be important but must be approached with caution (Krueger, 1998). When a new big idea emerged, this idea was analyzed relative to other data collected and relative to findings from job satisfaction and job dissatisfaction related literature.

Krueger (1998) describes two approaches to focus group analysis, analyze by question and analyze by theme. Analyze by question, recommended for academic oriented studies (Krueger, 1998), will be utilized in this study. This approach recommends each individual question is analyzed (in contrast the analyze by theme method, immediately identifies themes and data is analyzed relative to identified themes) first in each individual focus group, followed by analysis that examines all of the questions collectively in each focus group, ending with an analysis of questions across the six different focus groups conducted. During each level of

analysis I identified consistent units of meaning and common themes among participants. This approach utilized a horizontal approach versus a vertical approach to analysis, analyzing across the six focus groups. This approach was recommended due to the homogeneity (LPNs only in each focus group) of each focus group (Krueger, 1998).

Data analysis - Specific steps. Given the expert strategies listed above, the following data analysis process was implemented. The open coding process began within 24 to 48 hours following the focus group session. I initially listened to the focus group session digital tapes while reviewing the related field notes. A transcriptionist assisted in transcribing the digital recordings. In addition, I transcribed tapes aided by Dragon Speak, which improved time management, while maintaining accuracy. This contributed to my immediate immersion in the data. Transcripts were read and reread several times until a deep immersion occurred. Each word and line was read and reread, resulting in the emergence of key words and concepts. Microsoft office tools were utilized to assist in the process, along with the highlighting of paper transcripts.

First all focus groups were analyzed individually. The codebook was created as words and phrases were sorted and themes emerged from within each focus group, specific to job satisfaction or job dissatisfaction. Next, the analysis was completed across all focus groups. Initially the codebook included 27 individual codes. Many of these codes collapsed into similar categories, resulting in a first revision to 15 categories, then a second revision to 11 categories. The final analysis resulted in four job satisfaction themes and one job dissatisfaction theme. A total of six subthemes were noted. This analysis was accomplished through creation of tables that were inclusive of codes, categories and accompanying exemplars. Specificity to job satisfaction versus job dissatisfaction was carefully examined – revisiting both transcribed text, field notes, debriefing, and member checks. Next, the themes were compared across focus groups, as each

focus group's transcripts and resultant analysis became available. Ultimately, all focus group sessions were analyzed collectively. The themes were written and rewritten until major themes and sub-themes emerged from the data. At this point, a nurse researcher read the transcript from each focus group and confirmed data saturation and identified key themes. However, other reviewers created renewed discussion regarding whether the themes were exclusive to job satisfaction versus job dissatisfaction. As a result, I again immersed myself in the original transcripts; field notes and debriefing notes; and participated in major discussions with research/nurse educator colleagues. What was not said but was noted in the field notes was also examined, as this may have contributed to the analysis process. New insights were gained, some categories were collapsed and as a result themes renamed and new sub-themes emerged. Throughout the process, all information was utilized in the analysis process including transcripts of focus group and debriefing sessions, field notes (body language, gestures, tone of voice), and information obtained immediately following the focus group session (it is important to note that this occurred after the cessation of the focus group) and during member and expert checks. Clear steps and creation of a data trail were maintained, contributing to trustworthiness. See Appendix D for a summary of the data analysis steps utilized in this study.

Sharing Preliminary and Latent Reports with Participants and Stakeholders

Preliminary analysis of de-identified information was shared with key informants during member checks. Final analysis and a summary report of de-identified aggregate findings for the entire sample will be shared with all LPN participants and all administrators of host sites.

Protection of Human Subjects

Approval for this research study was obtained from the Institutional Review Board (IRB) at The Pennsylvania State University. The moderator and assistant moderator completed

appropriate IRB approved training (i.e. CITI training) and signed a confidentiality agreement as required of all investigators by the Institutional Review Board at The Pennsylvania State University.

Participants were notified at the beginning of the focus group session that their participation is voluntary. Commencing participation in the focus group did not prohibit the participant from leaving the focus group. They may decide to leave the focus group at any given point in time. Participants signed a written consent form. The issue of confidentiality was explained in detail at the beginning of each focus group session and participants were reminded regarding confidentiality at the completion of each focus group session. Participants were assured that no identifiable data will be connected to the transcripts from the focus group sessions, however, individual de-identified quotes and aggregate de-identified data will be shared in the final report.

A \$30.00 Wawa Card was utilized as a participant incentive to thank the LPNs for responding to the original flyer, participating in the 90 minute focus group session, and agreeing to consider volunteering for the participant verification process.

Digital recordings and any scribed assistant moderator notebooks were kept locked and transcribed tapes were stored on a password-protected computer. All transcripts were de-identified and clean transcripts were utilized for analysis.

Summary

The key factors assessed in choosing focus group methodology were presented, along with a discussion regarding the lack of qualitative research; concluding that focus group methodology is the best fit to provide an in-depth view of LPN job satisfaction and job

dissatisfaction in long-term care settings. Details regarding the study design and methods utilized were delineated.

A purposive sample of 4 to 12 LPNs participated in a 90-minute focus group session at six different long-term care facilities. Inclusion criteria for both the facilities and the LPNs were clearly defined. The rigor of developing the focus group discussion guide was presented, along with specific details regarding the management of focus group sessions. Steps to maximize trustworthiness during sample selection, data collection and data analysis, and maintenance of an audit trail were explicated.

Kitzinger (1995) states that the group dynamic is a key component of focus group methodology, as it can encourage the participants to take the research in new and unexpected directions. The group as the unit of data analysis is critical to focus group methodology (Krueger, 1998) and was the focus of analysis in this study. The findings can be utilized to create strategies to improve LPN job satisfaction and decrease job dissatisfaction, resulting in a more stable long-term care nursing workforce.

Chapter 4: Results

This chapter presents a description of the six focus groups conducted, inclusive of the demographics of the focus group host institutions and focus group participants. In addition, analysis of the data and essential LPN job satisfaction and job dissatisfaction themes are described.

Six focus groups were conducted utilizing a qualitative focus group methodology to describe and explain the phenomena of job satisfaction and job dissatisfaction among LPNs employed in long-term care settings. A focus group question discussion guide was developed and utilized in each of the focus groups to address the aim and provide answers to the research questions listed below.

Specific Aim:

To determine the attributes of LPN job satisfaction and job dissatisfaction in long-term care settings.

Research Question 1:

How do LPNs explain the key factors that contribute to job satisfaction in long-term care settings?

Research Question 2:

How do LPNs explain the key factors that contribute to job dissatisfaction in long-term care settings?

Data were analyzed within and across the six LPN focus groups. Open coding, condensation, and abstraction resulted in the identification of five themes: value, *real* connection, empowerment, growth and working conditions. Four themes, inclusive of value (subthemes: value of the “work” itself and recognition), *real* connection, empowerment

(subthemes: role identity and voice), and growth contributed to LPN job satisfaction. The theme, working conditions (subthemes: unrealistic workload and equipment) was the only factor identified as contributing to the LPNs' job dissatisfaction. These themes impact LPN job satisfaction or job dissatisfaction in long-term care settings. See Table 5.

Job Satisfaction Themes	Job Dissatisfaction Themes
1. Value Value of "work" itself Recognition	1. Working Conditions Unrealistic workload Equipment
2. Real Connection	
3. Empowerment Role Identity Voice	
4. Growth	

Table 5. Themes Contributing to LPN Job Satisfaction and Job Dissatisfaction in Long-Term Care Settings

The exemplars presented demonstrate that the four themes specific to job satisfaction can increase or decrease the job satisfaction of the LPN. Likewise the one theme, specific to job dissatisfaction, can increase or decrease the amount of job dissatisfaction experienced by the LPNs. In addition, the LPNs described that working conditions acted as a potentially dominant factor and could override the ability to achieve job satisfaction even when job satisfaction themes were present. While most of the themes were evident across all focus groups, some slight differences existed. These will be noted as each theme is discussed.

An overview of the demographics of the health care facilities and the characteristics of the LPN focus group participants are provided followed by the findings and a chapter summary. Each theme and sub-theme is presented with supporting exemplars.

Demographics

Long-term care facilities. Eight long-term care facilities were contacted and agreed to host an LPN focus group. This represented purposeful over-recruitment of two facilities, in excess of the six needed for the study and provided extra assurance to assist in achieving data saturation, particularly if the recommended minimum of four participants was not met, resulting in a canceled meeting. Ultimately, six of the eight facilities located in three different counties in the Philadelphia Metropolitan Division hosted the LPN focus groups. Ownership included government entities, non-profit corporations, and religiously affiliated institutions located in rural, suburban, and urban areas. Union and non-union institutions were represented. No for-profit corporations participated. There was one for-profit corporation in the original eight host sites identified, however, I was unable to achieve the required minimum number of focus group participants. Aside from this difference, the two non-participating host sites had a demographic profile that was consistent with the agencies that participated in the study. Facilities were described as stand-alone nursing homes or nursing homes located within a continuing care retirement community and ranged in size from 113 to 467 licensed beds. Lastly, the Centers for Medicare and Medicaid Services (CMS) overall star rating for the six participating and the two non-participating host sites ranged from two stars to five stars. CMS created the five star rating system to assist consumers in comparing nursing homes and understanding key areas to examine (i.e. health inspections, staffing and quality measures) when choosing a nursing home. A five star rating represents a facility with above average quality, conversely, a one star rating represents below average quality (Medicare, 2013). See Table 6.

Demographic Categories of Host Institutions (Aggregate Data)		Number of Host Sites	Percentage
Ownership			
• Government-County		2	33.3%
• Corporation-Non-Profit		4	66.7%
Religious Affiliation			
• Yes		3	50.0%
• No		3	50.0%
Size			
• 100 - 200 beds		4	66.7%
• 201 – 300 beds		1	16.7%
• 301 – 500 beds		1	16.7%
Location			
• Urban		1	16.7%
• Suburban		3	50.0%
• Rural		2	33.3%
Medicare Star Rating			
• Two		1	16.7%
• Three		2	33.3%
• Four		1	16.7%
• Five		2	33.3%

Table 6. Demographic Categories of Host Institutions (Aggregate Data)

LPN focus group participants. A total of 37 LPNs participated in six focus groups, with a range of four to twelve participants per group. On average, one LPN who had registered for the focus groups did not attend. However, LPNs also arrived at the focus group without previously registering with the primary investigator. These LPNs were screened according to the inclusion criteria and subsequently invited to join the focus group. Details of the recruitment process and final number of LPN participants per focus group are outlined in Table 7.

Date of Focus Group	Participants Confirmed *	Attrition	Additional Participants	Final Number of Participants*
	Prior to Focus Group Date	Confirmed but did not attend	Arrived at Focus Group*	
06/11/2013	5	1	2	6
06/13/2013	8	1	5	12
06/18/2013	6	1	1	6
06/19/2013	6	1	0	5
06/26/2013	5	1	0	4
07/11/2013	4	1	1	4
*Met inclusion criteria				

Table 7. Recruitment Process, Inclusive of Final Number of Participants

Focus group participants included only one male. The majority of participants self-reported as white/non-Hispanic (84%) and 16% reported being black/non-Hispanic. This distribution differs from the national norm, which consists of 24% of LPNs reporting as black/non-Hispanic (HRSA, 2013). The predominant age category of the LPNs was 33 - 48 (51%), representative of the national average age of 43 years of age (Bureau of Labor Statistics, Current Population Survey, 2012). The second dominant age category, 49 - 67, accounted for 32% of the LPN participants. Thus, 84% of the participants would be identified as the Generation X and the Baby Boomer Generation. Generation Y, inclusive of age categories 18 - 24 and 25 - 32 years of age totaled only 16% (8% each) of the participants. The majority of the LPNs were licensed as an LPN for 11 - 20 years (38%), with only 8% reported being licensed two years or less or being licensed 31+years. Employment status was predominantly full time (84%) and most participants were not enrolled in an RN program (76%). Less than 19% were employed for two years or less in their current position. See Table 8 for details.

Demographic Categories of LPN Participants (Aggregate Data)		Number of LPN Participants	Percentage
Gender			
• Female		36	97.3%
• Male		1	2.7%
Race			
• White		31	83.8%
• Black		6	16.2%
Age			
• 18-24		3	8.1%
• 25-32		3	8.1%
• 33-48		19	51.4%
• 49-67		12	32.4%
Years Licensed as LPN			
• 0-2		3	8.1%
• 3-5		7	18.9%
• 6-10		7	18.9%
• 11-20		14	37.8%
• 21-30		3	8.1%
• 31+		3	8.1%
Years Employed*			
• 0-2		7	18.9%
• 3-5		9	24.3%
• 6-10		7	18.9%
• 11-20		12	32.4%
• 21-30		2	5.4%
Employment Status			
• Full Time		31	83.8%
• Part Time		6	16.2%
Enrolled in RN Program			
• Yes		9	24.3%
• No		28	75.7%
*Employed as a LPN in current position			

Table 8. Demographic Categories of LPN Participants (Aggregate Data)

Job Satisfaction Themes

Four themes, inclusive of value (subthemes: value of the “work” itself and recognition), *real* connection, empowerment (subthemes: role identity and voice), and growth contributed to LPN job satisfaction. The probe of, “What makes you happy?” was utilized during the focus

group sessions when discussing job satisfaction. Findings, including discussion of the themes and sub-themes and supporting exemplars are provided.

Value. The theme of value was defined as the importance, usefulness and worth of the LPNs' role in the long-term care setting and was noted within and across all six LPN focus groups. LPNs described value in two distinct ways: being valued for the true essence of the “work” itself exemplified as a resident experiencing positive health outcomes and/or an improved perception of well being and being recognized for the quality of their work at both an individual resident and a team level.

“...I feel like we could have job satisfaction, if they value our work.”

Two sub-themes, inclusive of value of the “work” itself and recognition were identified. The subthemes were discussed from the perspective of the resident/family and colleague/administrator. An in-depth description of these subthemes follows including supporting exemplars.

Value of the “work” itself. The value of the “work” itself was defined as feeling useful or important to the resident, family, colleague or administrator. A sense of purpose, enhanced by safeguarding the resident through trust, advocacy, and effective problem solving contributed to their value of “work” itself, overall value, and resultant job satisfaction. The LPNs also described value as the positive impact of their delivery of care to both the resident and family.

“... Unfortunately... her husband, suddenly found out he had cancer and he was dying. But she came in one day and she stared me right in the face and said, ‘You helped me through these first couple months; you need to know that in your heart. You need to really understand how much you helped me ...it made me realize, one of the things I do

love is the whole family piece and if helping him helped her and vice versa, then I thought, wow, that's a good day.”

“...The families trust us to take care of their people, you know, when they're not around. They know they can go away for a weekend and the first thing they ask is... are you going to be on and who's going to be the aide? ... they know the regular people and if you have the regular people, they can just kind of, whew, I'm good, we can go and I know I can just call and check in and everything is good.”

“I just had a resident that went out for an outside appointment... the resident came back... who was mildly confused...and there was a check and a paper signed by the resident that she agreed to a research study at the doctor's office. I called the doctor's office and asked him what the study was about ...the resident was not competent enough to make her own decisions and sign this paper and I felt that they took advantage of her. Yeah, she's getting \$15 and that's nice, but you need to call the facility and the family...and with that, I felt like they were taking advantage of the resident to perform their study, to get the results, so it was satisfying to do that but dissatisfying that they would take advantage of the resident...”

In addition, this sense of purpose was enhanced by job duties that contributed to the resident's perception of well being versus performance of tasks, such as administering medications.

“I think on an average day my satisfaction has very little to do with the meds but if there is a day someone is really feeling bad, and I sat on her bed next to them... who had a worry or anxiety ... then I can go home that day and say, ‘You did okay today.’ That was a good day.”

Value of the “work” itself was also described as the LPNs’ role in identification of a resident’s health needs and resultant positive outcomes. This could be inclusive of an emergent health crisis or chronic issue (i.e. healing of a resident’s wound).

“Being able to use my assessment skills and pick up emergency situations. It was actually on the same unit, same day, within an hour, that I had sent two people to the emergency room that were admitted. One with heart failure, who had a pacemaker that was failing... So when you pick up an emergency situation or problem that they are having and get it remediated that feels good.”

Lastly, the resident’s successful achievement of their goals resulting in transfer to a more independent level of care contributed to the LPNs’ value and job satisfaction.

“What I like most about my job is seeing the satisfaction of my residents going from their lowest point to their highest point - graduating from that transitional care to go back to their independent living.”

Recognition. Recognition was also a sub-theme of value. Recognition was defined as receiving some type of specific reward (i.e. a celebration event), receiving feedback relative to job performance (i.e. formal evaluation, informal evaluation, and salary adjustment), implementing employee incentive programs, and receiving assistance from supervisors in recognition of the LPNs’ job diligence.

LPNs described the importance of events that specifically recognized nursing for high quality work versus events that recognized all staff. The type and frequency of recognition resulted in either a positive or negative impact on job satisfaction. In addition, when evaluation of staff performance was inconsistent with staff performance this negatively impacted job satisfaction. Recognition such as employee incentive programs was described as positively

affecting LPN job satisfaction. Supporting exemplars follow, organized by type of recognition (i.e. specific rewards, formal evaluation, informal evaluation, employee incentive programs, and supervisor assistance).

Specific rewards. Specific rewards were defined as employee rewards received in acknowledgement for a job well done. The LPNs described specific rewards as including employee recognition days, periodic special gatherings and employee special privileges.

“...I would also like to say, and not that anyone is more important than the other, but why don't you single us out and say, nurses this is your day - this is for you... Dietary this is your day - this is for you, instead of combining it all together. Because it makes it seem like ho-hum it's just a normal day. Make it a special day for us, not just the same thing every day.”

“Referring back to what number four said about getting positive acknowledgment. We get this one glorified week in May where you get some ice cream sundaes and baskets... If they spread that out for the year, rather than e-mails that always say 'Ladies'. Like... 'Wow, good week everyone.' Even if they're lying, just fake it. I mean it – just throw out the positive and maybe you can get some back. “

“They used to have a good work morale. Employee of the month, they stopped it. That used to be something you look forward to, the employee was recognized. It could be anyone from dietary, housekeeping, nursing, receptionist, unit clerk, whatever... the person had a parking spot.”

Formal evaluation. Formal evaluation was defined as the supervisor administered evaluation. The LPNs described the importance of thoughtful and fair evaluations based on job performance.

“It's just when we have evaluation time - you can be a very good nurse or any kind a staff member - you get the same evaluation or the same raise. You can bring things up to them like - this happened or that happens and they will say, ‘it doesn't matter.’ So... You are really just a screw in the wheel ...”

“There is always room for improvement - that we all know. But when you have someone who calls off all the time, or does a sloppy job, doesn't care about their work and you're trying to do your best - about however you can - you get the same evaluation.”

“It just has to get done by this date in January, so they get a whole bunch of papers together and they check off what they think is appropriate to give you that medium score - because no one can be perfect and no one should be absolutely zero, because if you are, then you can't be here....”

“...There is 10%, as in every facility I'm sure, that aren't so wonderful but they're treated the same as the wonderful employees and that's because you need to document on them, you need to write them up, give them education, educate them on things and sometimes there's not enough hours in the day to do it and you just kind of pass it by. And then...I go to do their evaluation and you know in your mind that this person is not as good, that A is not as good B but there's nothing in A's file for me to write that on their evaluation so they get the same raise as B who is wonderful.”

Informal evaluation. Informal evaluation was defined as feedback received from residents, families, and colleagues or administrators related to job performance. LPNs described this feedback as verbal positive comments recognizing a job well done.

“...satisfaction is having the family member of a resident acknowledge that you are helping them and that you are doing a good job. I was just called an angel on earth the other day and that really affected me. Sometimes we hear a lot of negative things and to hear the positive things really help. Not just with the residents and the residents’ families but with our upper management. Um...that they recognize a job well done.”

“The treatment nurse took a vacation...so I did the treatments full-time for two weeks. The wound practitioner...said, ‘You did a great job...’ When the treatment nurse came back she said, ‘Oh the wounds look wonderful, you did a great job, thanks for hanging in there.’ So there was this one sheet that was not completed in its entirety. So I got called down, and they stated that this is unacceptable; this is inexcusable... so I completed another line or two. And I said, ‘Is that what you are talking about?’ ‘Oh yeah, yeah, I am on the phone and I cannot talk now.’ So that was the thanks I got for doing the work of the RN for 2 weeks.”

Employee incentive program. Employee incentive program was defined as established programs designed to improve/reward employee performance. LPNs described these programs as an employer initiative that provides a tangible incentive to recognize a job well done.

“...I think it would be nice if we - someone would just say - with upper management - a job well done or even an employee incentive program.”

“There is no incentive program. If you could earn a half day or something...you quickly recognize that I called out Monday three weeks ago, but you do not recognize that I've been here six months prior working doubles and I'm tired. Even if they occasionally said they will allow you to come in at nine o'clock...we work on the floor with three nurses... why do we all need to be here at seven, when we can not even all start passing meds at that time...maybe they can't do that, but they can do something.”

Supervisor assistance. Supervisor assistance was defined as the supervisor acknowledging the value of the LPN and offering to assist. LPNs described the supervisor who recognized the employee's great effort and positive job performance and offered to assist, when needed.

“...you do so much and it's not that you want credit for the work but you just want someone to recognize that yes, you do a lot. Maybe sometimes step up and help.”

“I respect my supervisors who may be hard and expect a lot of me but it's nothing that they wouldn't do themselves. And if they're willing to pitch in, get a cart and say I haven't done these meds in a while but I can sure help and work for an hour, I think I can get these couple out.”

Real Connection

The second theme *real connection* was defined as a relationship based on a deep, ongoing bond and was noted within and across all six LPN focus groups. The LPNs described this bond as existing with residents, families, colleagues, and administration. The connection that existed was often described as being a “family” or experiencing a “family like” atmosphere. Truly caring for each other's well-being and feeling like you are a special part of each other's lives were key

components of this connection. Ultimately, this connection was described as giving meaning to their day and contributing to job satisfaction. Exemplars follow organized by the source of the connection.

“I get a sense of calm if I get a chance to feel like I’m being more a part of their lives, then just, here’s your medicine or you know here’s your Ensure or here’s your prune juice. You know what I mean? It’s... the connection.”

Residents.

“Sometimes you come in there and you chat and listen, just being with the resident...I will give you an example...I shouldn't say this but my husband passed and when I came back to work, do you know who was my therapist? The resident, who was alert. They would sometimes say, ‘Nurse how are you doing? Are you okay?’ And I was like, ‘Yeah.’ But just being around them...”

“...when you come to work, and you interact with the resident, they just make your day. And there are times I say to the resident, ‘You know what, I come for you all. You are the ones who make me come back to work every single day.’ ...so even though the job is stressful, the residents, they bring us together.”

“We have some residents whose family only come once in a while, younger residents, and I look at them and I say, ‘We are your family too.’ Because we are here seven days a week and we are part of your family, too. And they accept us.”

“I mean the personal satisfaction and the personal growth you can have and fulfillment from the residents is really...they’re just the best.”

Family.

“We have people come, years later, after the resident has passed on, and they still come back in or send us a note or send us something at Christmas time... I have one lady, whose mother passed; she has been gone for quite a few years...she comes in on certain holidays and plays the piano for the residents.”

“I would say comforting the family members of a mother or father that they are losing... that is dying. ... Sometimes I have cried with them and then they come back and say ‘I’m glad you were there.’”

Colleagues.

“What I like most about my job are my co-workers. Um.... We’re like a family.”

“Ok. And, and how do you view... from a job satisfaction viewpoint, the relationship between the RN and the LPN?” ... “I think that it’s good. I think that we are a family here and I think that we really do have a good support system and a good staff.”

“What I like most about the job is the interaction between myself and the patients. And I like coming to work because I like um... the staff, the coworkers. I enjoy interacting with them as well and working as a team.”

Administrator/supervisor. The LPN described a real connection with the administrator/supervisor as experiencing a feeling that they care about you on a personal level. Confidentiality and active listening were described as important components of the real connection.

“Director of Nursing is wonderful...She’s a sweetheart. She cares about you on a level that’s not about work. She cares about you as a person and will listen to you and says come into my office and vent to me if you need to vent your frustrations. And she doesn’t

necessarily take that somewhere else, it stays in the room and just talking to her makes me feel better.”

“There’s budget and with what she has to deal with, I really think she does try and keep us staffed. She does actually fight for us for different things and everything that we may need...she really cares.”

Conversely, a limited or negative administrator/supervisor connection, characterized by a feeling of being a nuisance, impacted job satisfaction adversely. In addition, LPNs described an administrative philosophy that did not support the LPNs establishing a *real* connection with the residents.

“Feels that if you just felt more welcome when you got here. Some days you really feel like you are a bother to the management - like you are in the way. If they just made it feel more comfortable to be here - like we are part of the family too - not just the residents. You feel like you could be replaced tomorrow. Ta-ta, see you...”

“The residents often start the conversation with us. You can walk into any resident’s room, and they will ask, ‘How are your kids today? How’s that baseball game going?’ They want to hear that. Who wants to come in and just say, ‘Here’s your pills, take them.’ ...and we sit there and gawk at them. Really? I know I wouldn’t like that and I know 90% of you here don’t, so we make casual conversation. And then if administration sees that... it’s like, ‘What are you doing? That’s a no-no. You can’t talk to them. Get to work. You have physician’s orders to write, you have rounds with the doctor.’”

Empowerment. Empowerment was the third theme described by the LPN participants as impacting their job satisfaction. This theme was noted within and across all focus groups.

Empowerment was defined as the LPNs ability to have control over their job responsibilities and

their licensed nursing role within the constraints of their defined scope of practice. This includes being able to work to the full extent of their potential, being respected for their knowledge base and their contributions to the health care team.

The LPNs described how role identity and voice contributed to a level of empowerment. The opposite was also described. Subsequently, the LPNs described feeling a lack of power to accomplish their job duties and care for the resident. Often this also prohibited a “real connection” with the resident from occurring. A discussion of the sub-themes of role identity and voice, along with supporting exemplars follows.

“The thing I like the least ... they do not let us work up to our potential...”

Role identity. Role identity was defined as the responsibilities, including professional and job duties, which the LPN has within the context of the health care team. LPNs described the inconsistencies impacting the LPN’s identity in the long-term care setting. LPNs described their role as affected by the residents’ and supervisors’ misperceptions regarding regulations and the role of the LPN. This misperception and/or lack of understanding of the LPN regulation and LPN knowledge base was described as resulting in varied utilization of the LPN in long-term care, complicating role identity.

“Residents will think it... I want an RN. I wanted an experienced RN ...occasionally, though they ask, ‘Where did you go to school?’ I tell them right out, that I am an LPN. I am not waiting for them to fish for, ‘Are you an RN, “real nurse”?’ ...But what is the good part is after they know me and that they can count on me, the letters or the lack of letters is not the important thing. It is that I am good at my job and I have a rapport with them.”

“Probably with the years that I have done this I have seen it go almost full circle in long-term care. In 1972 when I started, staffing was terrible and the resident care was just as needy as it is today and then as an LPN we were charge nurses...that's where I really got to where I'm at and enjoyed being an LPN because for every skill I was able to do I would build on top of another skill, and another skill, and it gave me job satisfaction. It is kind of deflating now. But I am still on my game now trying... and it's not for job advancement...it is just ...keeping the pride of being an LPN...other than that, the healthcare system today is saying it has to be done by these others who have more... whether it is an RN or nurse practitioner or a doctor or therapist...So I guess I'm just getting a little jaded with it all - but I see it all coming around 360 degrees, as to where it was when I started.”

Differences that exist among LPN job roles at various employers also contributed to the role identity theme and impacted job satisfaction.

“...At my prior employer there was a lot more independence for the LPNs. It is different for me to learn how to use the chain of command here. At the last employer it was more, we got our observations and called the doctor - if they needed to go to the hospital we called 911 and then reported back. Whereas here, as number four said, you find something wrong, you notify your unit manager and go with what they say and what they say goes whether - however you feel about it.”

“... there are things at this facility that LPNs do at other facilities that we are not permitted to do, that are within our scope of practice...”

In addition, the LPN's ability to differentiate their job role from the job role of the DCW and the RN in the long-term care facility was also a contributing factor.

“I feel that I’m doing several people’s jobs. I’m the NA, I’m the wing nurse.”

“When I think about it, I am glad I am an LPN. But the responsibility that I have...I should have went back to school to be an RN. Because I feel like the responsibility that we have as an LPN, might as well...”

“...I worked here for two years, brand new nurse, 20 years old...they made this position where they put me in a supervisory role. I didn’t want to do it, they begged me to do it...they said try it for 90 days. They never came back to me after 90 days. I’m still doing the job for 11 years now... I learned on my own and I have to say that the RN supervisor in the house calls me probably ten times a shift to ask me questions. So I really feel that I do what an RN does but I don’t have an RN behind my name.”

“They’re called observations and RNs do assessments. They’re the exact same questions and we answer them...the exact same way... because we’re an LPN, it’s an observation.”

Voice. Voice was a sub-theme of empowerment. Voice was defined as the LPNs’ ability to be heard in their job role as a member of the health care team, and in their profession as a nurse. LPNs described the varying degrees at which their voice is heard in the long-term care setting. They were undervalued for their ability to provide pertinent resident care data. In addition, exclusion of LPNs at resident care meetings, despite their in-depth knowledge of the residents was articulated.

“So we being the primary nurses are not involved in morning meetings where they discuss the residents. Where it is occupational therapy, physical therapy... where as, we are the ones who are the primary, who are doing their medications, who know where they are along with the aides - that take care of the residents on a daily basis.”

“We are with these residents every day. We know them. Social worker or activities, they see them now and then. They don't know these people and I don't think they put in the context of how well we know a resident.”

LPNs also described how administration did not listen to their voice when nursing unit based or systemic institutional issues occurred.

“They want to change, you know, our med administration, they want to change it to more like morning and afternoon, instead of such strict times, but yet we sit and have these morning circles and meetings...and us nurses are trying to say, ok these are the problems we're having, but these are some things that I think maybe will work, and then your administrator kind of blows you off basically. ‘Well I don't think that's going to work.’”

“They do room changes. We as the nurses know that particular people are not going to work together as roommates. One likes it hot, one likes it cold. One's TV is loud, one goes to sleep early. Those kind of things. I would like to be more included in that decision making.”

“The one thing I think I would like to say about the leadership type is ummm, when they do meet with us, it's not to discuss issues that we feel there are on the floor. When they meet with us, there is an agenda and that is the topic and do not go out of the realm of that topic.”

Similarly, the absence of voice was also described as not being informed of changes that had an impact on the LPN job role.

“Just to let us know certain things... an example, I have a NA that has changed her hours. I was never told about it. So here she comes at this certain time and I'm like, ‘What are you doing here?’ ‘Well didn't they tell you I'm trialing this time?’ And then the

trial was done and I didn't know about it, and I was getting used to it.

So...communication."

Micromanagement contributed to the lack of voice of LPNs. Inconsistent communication within administration and with subordinates was also a contributing factor. The LPNs described the fear of reprimand, despite best efforts, as impacting voice.

"The thing I like least is not being told something, then being told something, and then they change it. And they say that they told you and they didn't. That's the problem."

"...You were always so concerned about the Monday morning quarterbacking - the re-evaluating of what you did, that you are totally overcompensating. I think there is micromanaging because I find myself calling my superior, 'Is this okay if I do it this way?' Because the next day they're going to tell me that I shouldn't have done it that way. This way I can say that I did talk to my superior and that it was cleared."

"I worked in an underwear factory when I was 17, a sweatshop, and I had to raise my hand to go to the bathroom. That's the way I kind of feel."

"I would have to say the micromanagement...you cannot think for yourself, however, you been educated and you have some experience..."

"It's more or less - I think of the LPN as, in this setting, as a 'Yard dog on a very short leash' you know, you let the dog go, but you can only go so far, you have to come back, you can't wander too far. I think the running joke of this facility for the LPNs is... critical thinking. You have to run everything past your direct superior. You know, you cannot think outside the box or if you question something, then somehow...how dare you."

Growth. The fourth theme growth was defined as the LPNs' continual movement towards more professional fulfillment in their job role and profession as a nurse. The overall

theme of growth was identified within and across all of the focus groups as contributing to the LPNs' job satisfaction. Some specific differences were noted across focus groups and are described below. LPNs described growth as an opportunity, inclusive of educational opportunities, expanded job duties, and clinical career ladders. Educational opportunities included RN career pathways and continuing education programs, inclusive of certification options. When describing an educational pathway, LPNs were not solely focused on access and support to attend RN educational programs. Instead, the ability to grow as an LPN through continuing education and specifically certification programs was also expressed as an important factor in job satisfaction.

"I would say potential for growth - because if there is that potential for growth that will make you want to achieve more and to advance."

"The potential for growth, like within the realm of LPN...because many times, ...different nurses say, 'Well go get your RN.'... Well I'm not really in a point in my life right now where I can devote the time to getting my RN...but as far as potential for growth, I did...get certified as a dementia practitioner and I loved it ... potential for growth...like I said the RN for me...it's just not in my realm right now. So..."

"I think our education is also good... Sometimes they go out on a limb, especially with the program we just had on dementia. They really put a lot of money into continuing education and certifying us to do things and to get education beyond what we have here."

"...The potential for growth and advancement...I really think it would be a great thing here if we allowed our nurses to have different clinical ladder type recognition. We have it for our nurse's aides..."

"Moving up a career ladder. It was a strong satisfier for me."

Continuing education was important to the LPN but computer training programs were not seen as a viable substitute for “in person” educator training sessions. The need to discuss issues and have answers to questions was essential. In three out of six of the facilities, the LPNs described a decrease in the administration’s encouragement of LPN growth (i.e. continuing education, certification) in recent years.

“It wasn’t a computer you... listened to, then you answered ten questions. I mean you had a question, you actually had a person that could answer your question and I think when they did away with that, I think we’re missing a big piece of the puzzle...for me, if you want to teach somebody...I just don’t think that by sitting and listening to a computer...”

“You can't move up - they don't even guide you in the direction - you got to do all of the work yourself to figure it out. They don't even give you the guidance to say, ‘Oh I got this in the mail - this certification - why don't you do this?’...Staff development is changing, she is trying to help with that, but for right now it's not there.”

“Well our top administration has just changed hands...new people have taken over, however, our old ones were pretty good. They encouraged students to pursue education, they encouraged you to go to school and always do better...they offered you a lot of in-service, CPR, certified in IVs....”

“Potential for growth, it was really great at one point - they used to really encourage you to go to school. They would always have signs up about grants and stuff. But now it is like null and void...you have to go through a whole lot of steps to even get information about some type of grant for you, for school. So the potential for growth and advancement, I think they need to improve at the job.”

The importance of administrative support if enrolled in a RN program was also articulated.

“There are a lot of us ... going back to school... I do feel that in...in my little group of some of the girls that I’m back in school with, that administration, meaning just the DON and ADON above me, not really past that level...they’re very supportive of that...very accommodating with schedules and things like that... they are very flexible where maybe they don’t need to be as flexible, you know, maybe we wouldn’t get that somewhere else... But I do think that they are very accommodating for those of us who want to continue our education.

Lastly, LPNs described the possibility of expanded job duties as another important possibility for growth. At the completion of one focus group, a participant shared that the greatest satisfaction she had received in many years of employment was the assignment of new additional duties. This encouraged her to pursue greater knowledge in the area of wound care.

“I’m also thinking about my superiors have given me some extra responsibilities lately and given me the chance to do other things here and that has really opened my eyes...really made me feel good at the end of the day that they have enough confidence in me to know that I can do different things.”

Job Dissatisfaction Theme

Only one job dissatisfaction theme, working conditions, was identified as contributing to LPN job dissatisfaction. The probe relative to job dissatisfaction, asked “What makes you unhappy at work?” Originally there were several codes that emerged as job dissatisfiers. However, as analysis continued, the dissatisfiers discussed were either identified as components of working conditions or were not consistent among participants and/or across groups. These

concepts included items such as excessive volume of workload; inadequate resources (i.e. staffing and equipment); concerns regarding “not enough time”; and the burden of bureaucracy resulting in continual policy changes/documentation mandates. The staffing issue was described as including access to an RN for collaboration and having adequate numbers of DCW to meet resident care needs.

Three focus groups did discuss company policy, as a dissatisfier, however, regulatory agency mandates, as the descriptor for company policy, was the consistent concept among participants and across all focus groups. Regulatory agency mandates contributed to the workload burden of LPNs and therefore was included in the subtheme of unrealistic workload. The LPNs described how the senior management of the company did not have control over the policies that were contributing to job dissatisfaction. Ultimately, the government mandates contributed to the dissatisfaction of the LPN.

“The NHA, DON, ADON - they are only doing what has been requested of them by the government, by the standards of care. I don't feel like they are purposely trying to make our jobs miserable. I think it is out of their hands and out of their control.”

“I truly believe that they have no control over most of what they implement here. [Referring to senior administration].”

Lastly, salary was mentioned as a dissatisfier by a few participants in four of the six the focus groups. Salary was viewed as competitive but due to the unrealistic workload, sometimes perceived as inadequate. However, as discussion ensued the majority of the participants stated that salary was not a key component of job dissatisfaction. Thus, salary was not identified as a theme.

In conclusion, working conditions was identified as the only job dissatisfier, inclusive of the subthemes of unrealistic workload and equipment. In addition, staffing issues and regulatory mandates contributed to the subtheme of unrealistic workload. The findings, including supporting exemplars follow.

Working Conditions

Working conditions was defined as the conditions in which a person works, inclusive of the physical environment and factors affecting job stress level and degree of job safety. The LPNs described working conditions as the various elements in the surrounding work environment that collectively impact their ability to perform job duties effectively. This included factors such as workload, staffing (i.e. availability, competency, and ratios of all staff), paperwork, regulatory mandates, and adequate equipment. The overall theme of working conditions, inclusive of the subthemes of unrealistic workload and equipment was identified by the LPNs across all focus groups as contributing to their job dissatisfaction. However, some specific differences existed across focus groups and are described below.

“For me, work conditions and again it comes down to staffing – huge for me... There is always another form to fill out, new policy - and I really do not think that they realize what we do in an eight hour day, to make sure it looks all good on paper at the end of the day. I just think it's a little - somewhat unrealistic.”

“...The work conditions. Sometimes just getting a simple blood pressure you're finding...because you're sharing the same blood pressure machine with three other wings or a pulse ox because somebody took it home or it's broken.”

The sub-theme of unrealistic workload was noted across all groups, whereas, equipment was identified as a factor in only three of the six groups. However, when questioned, all LPN

participants agreed that unavailable equipment would contribute to their level of job dissatisfaction. Inconsistent, unavailable, and unreliable staffing and regulatory demands (i.e. paperwork) contributed to the unrealistic workload. LPNs articulated that sub-standard working conditions caused a feeling of frustration, contributing to their job dissatisfaction. Likewise, if working conditions improved, the LPN's experienced less job dissatisfaction, with no direct impact on LPN job satisfaction. However, working conditions can indirectly impact job satisfaction by preventing the LPNs' ability to achieve job satisfaction through other themes, specifically value, *real* connection and empowerment. The sub-themes of unrealistic workload and equipment will be described in more detail. Exemplars of how working conditions can impact the LPNs' ability to experience job satisfiers follows.

Unrealistic workload. Unrealistic workload was defined as the perception that work demands rendered on the LPN in terms of time, volume, and quality outcomes were excessive. All of the focus groups identified a theme of unrealistic workload impacting LPN job dissatisfaction in long-term care settings. The LPNs described unrealistic workload as a volume of work that was impossible to complete effectively given the time constraints and resources available. In addition, the LPNs shared that the governing facility, regulation agency, and administrative staff do not fully comprehend the magnitude of the LPN job duties and the variables, which can challenge even a seasoned LPN's time management skills. As a result, LPNs articulated that the administrators/supervisors were unable to fully understand the complexity of the resident care delivered and/or they were so burdened by their own workload that they are non-effective in collaborating with the LPN. They described their frustration when the administrators/supervisors focused on a few unresolved issues or not completed tasks versus the vast amount of work accomplished.

“I think next to the word corporate, as far as this facility, in the dictionary is the term, ‘Trying to fit a square into a circle.’ ...it’s easy to sit and say this is what has to be done. Come down here, I’d like them to come down here to any one of my shifts, come down here and walk beside me and help me get it done. Let me see you do it, and then I have no problem doing it but sometimes I feel as though what comes from corporate as the expectations are not feasible.”

“Lucy on the assembly line – dropping the candies in 10 min. before the end of the shift because you just can't get it all done.”

“We could do, and we do, 300 different tasks in a day and you could do 299 of them right but that one you are going to get called on the carpet about. Now don't get me wrong, if it's something very serious it needs to be addressed...I don't think they really realize what were doing on the floor for eight hours.”

“It was a holiday so of course upper management was MIA [Missing In Action] and I somehow got left on the floor by myself with only an RN and we have 46 residents and I am a new nurse - that was petrifying. I had to do a cath, trach care, and an admission too - and I worked a double.”

Staffing issues and regulatory mandates contributed to the subtheme of unrealistic workload. The supply and availability of licensed and non-licensed staff, specifically, the lack of DCWs to provide quality resident care, consistency of caregivers, and limited access to an RN for collaboration was identified. RNs were described as being in meetings and not accessible for RN - LPN collaboration regarding resident health care issues. In addition, the LPNs described a lack of administrative timely response to requests for urgent staffing needs of the nursing unit

and a failure to provide adequate coverage for staff absences, thus impacting their level of dissatisfaction. The following exemplars support these statements.

“One of my major dissatisfactions is similar to number three, only it wasn’t like an acute emergency type situation...when I work my shift, it’s sun downing time...I have two aides and myself and things can get pretty crazy. So there’s three of us and 24 of them...and it’s like okay, who’s gonna fall, who should I hurry up and get to...there have been times when we have had some very combative behavior ... I say I need some help. ‘Okay, I can’t come right now but I’ll be there when I can.’ An hour later when everything’s calmed down...our hair’s turned gray and uh we’re out of breath ...they show up. ‘What do you need?’ ‘Umm, nothing now.’ ‘Oh, okay.’ So I’ve asked time and time again, may I please have an aide for four hours over the sun downing time just to give me an extra pair of hands and pair of eyes so that care can get done without the fear of someone else falling. And I hear, well, we’re kind of trying to work on it. I’ve been all the way to the top and it’s well, we did budget that in for next year...this is next year and I’m still not seeing an extra body. I’m not even getting consistent people and I understand that they have their frustrations too, but, you know, that’s one thing that I get very dissatisfied with.”

“Again for me it is the understaffing issue. Because that has a direct effect on how I am able to deliver care that I was supposed to give. It is frustrating at times when you have to rush through things where you really can't give your undivided attention - that is very frustrating at the end of the day. You know you probably could've done a better job on something if you had just the adequate staffing to do it.”

“Work conditions are great. They do supply us with the materials to complete the job. But what we need...supervisors...there used to be more help and now there is like none. But they still want us to do our job in a timely manner.”

The impact of an unrealistic workload on the resident’s quality of care and the LPN’s fear of creating an unsafe environment was described as impacting job dissatisfaction.

“... Work conditions, because when you work short you are over worked and underpaid, underappreciated, stressed-out, and angry. Things happen - people fall - now I’m upset. Do you know what I mean? It snowballs from there - so what could you do if you only have X amount of aides? I mean - it is not your fault that the person fell. But when they hit the floor, a cloud of doom comes over you. You are like ‘oh shit’ and if there is blood drawn you are like ‘oh my God, I can’t believe it’. And you know if that happens before twelve that sets the tone for the day. I don’t want to talk to you - you don’t want to talk to me - you act like it’s my fault because we don’t have the staff. You feel like I’m lazy nurse now because I didn’t help you with a shower but I have 40 people up here that I cannot shower and I cannot dress...”

“It is frustrating when you go home at the end of the day and because of their expectations of you, you are constantly worrying about what you did wrong, what you forgot...you are worried if you’re going to get counseled the next morning or written up for something – that is frustrating...not enough staffing, not enough time in the workday to complete all the work that is expected of you... I have this vision in my head that there is a gentleman behind the desk with a bowtie who has no medical experience at all and makes all these rules and regs [sic] coming from the state as to what we need to do, what forms need to be filled out... but they do not correlate that with staffing. They say a 50-

bed unit can have two nurses and four aides. But they do not take in the acuity level of these residents...the people who make these decisions never show us how to implement it in an eight-hour shift. Just try to do it.”

Equipment. Equipment was defined as the supplies or tools needed to accomplish the LPN job role. LPNs described equipment as including basic resident items (i.e. soap, k-Y jelly, linens), monitoring equipment (i.e. blood pressure machine, bladder scan), therapeutic equipment (oxygen tank), and large facility equipment (i.e. computers). Furthermore, the LPNs described this equipment as missing or not functioning effectively. LPNs in three of the six focus groups described the lack of basic supplies and diagnostic equipment as contributing to their job dissatisfaction. LPNs in the other three groups did not describe an issue with availability of equipment, but when questioned, all LPN participants agreed that unavailable equipment would impact their level of job dissatisfaction. The availability of adequately functioning equipment impacted morale and productivity and created a barrier to the LPN experiencing the factors impacting job satisfaction (i.e. value, *real* connection and empowerment).

“...it all boils down to if they just had the things they needed to do their job. It can be simple like something like soap. I buy soap for the floor because we don't always have the soap in the med room to wash our hands.”

“And then the computer - it has its issues, it goes down, it goes goofy. Then it goes off for two hours and you got to quickly try to do everything because they want us out on time. So there are work conditions besides the people stuff...”

“Washcloth, towels, briefs. They're screaming about it but there's nothing I can do. I don't have them. I don't know where they are. I'm running around the building - calling

other floors when I shouldn't have to do that. We should have them. The simplest things can set the day spiraling downward if you just don't have them. It sounds dumb but..."

Working conditions impacting job satisfaction attributes. Working conditions, specifically unrealistic workload of other staff (i.e. DCWs and RNs), left little time for the LPN to perform their actual LPN job role duties. These demands often originated from inadequate staffing patterns, including inadequate DCW staffing and RN delegation issues. As a result, the LPNs described two extremes: their need to assist with the delivery of basic care (i.e. DCW tasks) and the inconsistent approach of the RN who will delegate a resident who is unstable to the LPN.

"... So I find that I'm doing two people's jobs instead of one. So that's definitely dissatisfaction for me... It's taking away my time with the residents as their nurse, instead I'm their NA."

"The RNs on the floor, they do have respect for us. But they have so many meetings and stuff to go to that they push their work out on us. Instead of helping us, they put it on the plate... if doctor so-and-so calls tell him such and such and such and such, as they're walking off the floor..."

In addition, the LPNs described that the dissatisfier, working conditions could impact their ability to achieve overall job satisfaction by interfering with the LPNs' ability to experience job satisfaction attributes, specifically, value - recognition, *real* connection, and empowerment. The LPNs' working conditions, specifically their unrealistic workload and the resultant recognition or lack of recognition of others (i.e. colleagues, administrators) impacted these attributes. For example, lack of recognition of the complexities of the workload by

administrators and colleagues can adversely affect job satisfaction. Likewise, demands of excessive tasks can act as barrier to value, *real* connection, and empowerment.

“I just think the time crunch with med passes. I feel like most of my day is just consumed with giving out meds. It’s all day, like I don’t feel like I get into doing dressings or talking with the residents or actually doing what the residents need me to do um...because I have all these meds to give out.”

“Our facility has very high expectations, with very little room for error. I would say most of us nurses are very conscientious about what we do. We do try to cross the t’s and dot the i’s. But it is very difficult to do this in an eight-hour time period, when you have so much regulation and to make sure it is all done the way it should be.”

Lastly, regulatory/accreditation demands, particularly paperwork required to be in regulatory compliance, contributed to the LPNs’ unrealistic workload and adversely impacted job satisfaction. Paperwork as referenced by the LPNs was inclusive of both hard copy and electronic communication. The paperwork burden is described as impacting the LPN’s ability to have a *real* connection and provide quality care for the residents. The LPNs described the burden and fear of regulatory compliance as a factor contributing to job dissatisfaction and impacting their level of empowerment.

“...There is so much put on us some days that you just feel like you don’t want to touch this piece of paper for the second and third time or document something... but it’s sad for me when I say to the supervisor, ‘You know I didn’t even get a chance to really talk to some of my residents today.’”

“... I feel as the years passed and the days pass, we get further and further away from the resident. It’s all about filling out the paper. To me, that’s not why I’m here.”

“We're here because of the resident and I think with the money and the policies and everything else, including the regulations - that gets lost.”

Summary

In summary, four themes value (sub-themes: value of the “work” itself and recognition), *real* connection, empowerment (sub-themes: role identity and voice), and growth contributed to job satisfaction and only one theme, working conditions (sub-themes: unrealistic workload and equipment) contributed to job dissatisfaction. These factors can impact job satisfaction and job dissatisfaction on a continuum. The exemplars provided both increased or decreased the amount of job satisfaction or dissatisfaction experienced by the LPN. For example, if a *real* connection is unable to occur due to an agency mandate, the LPN will be less satisfied. Conversely, a family like atmosphere on the nursing unit, facilitating a *real* connection, will increase job satisfaction.

The four themes identified as contributing to job satisfaction did not contribute to job dissatisfaction. Only one theme, working conditions, inclusive of subthemes unrealistic workload and equipment was identified as a dissatisfier. Regulatory demands and staffing contributed to the sub-theme of unrealistic workload, impacting job dissatisfaction.

The dissatisfier of working condition was described by the LPNs as potentially impacting the LPNs ability to achieve job satisfaction. Working conditions, inclusive of the sub-themes of unrealistic workload and equipment can prevent the LPN from being able to experience the job satisfaction themes, specifically, value, *real* connection, and empowerment.

Chapter 5: Discussion

Overview of Significant Findings

The overarching goal of this study was to build an understanding of the factors contributing to long-term care LPNs' job satisfaction, through an examination of the attributes of LPN job satisfaction and dissatisfaction. Qualitative focus group methodology was employed utilizing Herzberg's motivation/hygiene theory (1959) as the conceptual framework guiding the study.

The LPNs' predominance as a licensed workforce provider in long-term care settings, coupled with the aging United States population confirmed the significance of this study. Data were analyzed within and across six LPN focus groups. Qualitative data analysis resulted in the identification of five essential themes: value, *real* connection, empowerment, growth, and working conditions. The first four themes contributed specifically to job satisfaction, while the last theme, working conditions, contributed to job dissatisfaction. Related sub-themes were also identified for value, empowerment, and working conditions. These themes are the essential attributes contributing to the LPNs' job satisfaction or job dissatisfaction in long-term care settings. Although there was only one attribute identified as essential to LPN job dissatisfaction, the LPNs described how this dissatisfier, working conditions, can impact the ability to experience attributes of job satisfaction.

A discussion of the findings focused on the attributes identified and their relationship to the current scientific literature follows. The findings' similarities and dissimilarities to Herzberg's theory will be offered. Because leadership is a significant variable in both nursing practice and education, the findings of this study will be examined in relation to the major tenets

of transformational leadership. Strengths and limitations of the study will also be addressed. Lastly, implications for future research are proposed.

Application of Findings to the Scientific Literature

Job Satisfaction Attributes.

Value. Value, inclusive of value of the “work” itself and recognition is a key LPN job satisfaction attribute. This is congruent with Herzberg et al.’s (1959) findings, listing value of the “work” itself and recognition as intrinsic motivators of job satisfaction. Value of the “work” itself was described as the LPNs’ role in identification of a resident’s health needs and resultant positive outcomes. Furthermore, how their work was viewed as important and meaningful to residents and families contributed to job satisfaction. In the DCW population, Choi et al. (2011), utilizing data from the 2004 National Nursing Assistant Survey, concluded that the perception of being valued by the employer was positively associated with job satisfaction. Likewise, Pavlish and Hunt (2012) noted that recognition was as a factor that contributed to meaningful work of nurses in acute care nursing settings.

Recognition by both residents/families and administrators/colleagues was noted as a key factor in job satisfaction. The LPNs described how a resident/administrator’s words/actions and other types of recognition contribute to their job satisfaction. Similar to a study by Duffield, Roche, Blay, and Stasa (2011), the LPNs also identified the positive impact of receiving praise and recognition from their supervisor/administrator. Duffield et al. (2011) examined the impact of leadership of nursing care managers on staff satisfaction and retention. Influences on staff intent to leave included “Praise and recognition for a job well done”. Likewise, LPNs in this study shared the benefit of receiving positive informal evaluation from management. Lastly,

nurses in nursing homes also identified recognition as the best predictor of job satisfaction (Cabigao, 2009).

In this study, characteristics and method of recognition were also discussed as important to job satisfaction. Staff recognition, both at the personal and team level, was discussed by the LPNs as contributing to job satisfaction. The LPNs also noted the importance of receiving recognition through a thorough evaluation process (formal and informal) that was consistent with staff performance. LPNs shared frustration when employees who do not perform well receive similar evaluations to employees who are giving more than 100% everyday. Lapane and Hughes' (2007) qualitative study of nursing staff (RNs, LPNs, and DCWs) in 25 North Carolina nursing homes reported similar findings regarding the need for recognition. Specifically, the DCW's lack of recognition, including feedback on job performance was a frequent source of stress. This was less of a source of stress for the overall nursing staff, although the nursing staff did not delineate the LPN and RN as sub-groups.

Parsons et al. (2003) examined the relationship between task rewards and extrinsic factors in a state sample of 550 CNAs and arrived at similar conclusions. Nearly one third of the CNAs in their study indicated their plans to resign relative to several factors including lack of recognition. Only Hunt et al.'s study (2012) was not congruent with the current study's findings. Hunt et al. (2012) tested the utility of the Herzberg theory as it relates to RN retention in nursing homes, concluding that intrinsic factors (i.e. employee recognition, career ladders) did not have a strong association with RN retention. Lastly, Zwink et al. (2013) explored the perceptions of inpatient acute care nurse managers employed at a Magnet hospital regarding factors that influence retention and nurse satisfaction. Staff recognition, support, peer relationships, and mentor relationships by their director were factors that influenced their decision to remain in the

nurse manager role and increased satisfaction. Thus, in addition to recognition, relationship was also a key factor in job satisfaction and retention. An in-depth discussion of the theme *real connection* follows, which is described as a relationship.

Real connection. The attribute of *real connection* was a recurrent theme across and within all the focus groups, described as a relationship based on a deep ongoing bond with residents, families, and coworkers. Words such as “family”, “a treasure” and “always there for each other” were utilized by the LPNs to describe this connection. This real connection existed among staff and residents alike. A team-like atmosphere, where people truly cared for each other and provide friendship and mutual support, was described as essential for job satisfaction. Real connections with supervisors/administrators were also an essential component of this attribute.

Several studies support this finding. Farrell and Frank (2007), through examination of a movement from an institutional to an individualized model of care in an urban nursing home, identified decreases in turnover rate, and a lower incidence of pressure ulcers following implementation of more than 100 quality initiatives focused on individualized care. This movement increased the staff’s opportunity to form and sustain close relationships with the residents through the implementation of consistent staff assignment. Consistent staff assignment was noted to create a work environment that built on the intrinsic motivation of staff members, creating close relationships with the residents (Farrell & Frank, 2007). Creating these relationships was consistent with my findings of *real connection*.

Chiu et al. (2009) studied clinical nurses in Taiwan concluding that job related social support might decrease the turnover in nurses. Job related social support was also identified in DCWs in long-term care (Stone & Dawson, 2008). The Better Jobs Better Care was a multi-state demonstration and applied research project, which addressed psychosocial factors as essential

elements for a quality job program for DCWs (Stone & Dawson, 2008). Nine essential elements were identified, inclusive of organizational support (Stone & Dawson, 2008). Organizational support from the employer strengthening the core caregiving relationship between the resident and DCW is an essential element in this quality program leading to improved DCW job satisfaction.

Empowerment. All of the LPN focus groups discussed empowerment as an essential attribute of job satisfaction. Empowerment was impacted by the role identity of the LPN, lacking clarity and definition, and lack of voice. Although job descriptions and state nursing practice regulations exist governing the licensed LPN's practice, LPNs in this study described an inability to work to their potential, particularly related to problem solving and decision-making. LPNs described their lack of inclusion in important nursing unit and resident based decisions, despite their knowledge of the situation and/or patient. Their participation in team care planning meetings was also generally not requested.

States regulate LPN scope of practice, which can contribute to the LPNs' role confusion. Corazzini, Anderson, Mueller, Thorpe, and McConnell (2013) concluded that states varied considerably regarding their nurse practice act. In addition, several states, including Pennsylvania, were silent regarding key aspects of nursing care, such as assessment (Corazzini et al., 2013). The variability and lack of clarity of the state nurse practice acts contribute to the LPN's role confusion and resultant inconsistencies regarding assessment and problem solving. Corazzini et al. (2013) found when RNs were available for collaboration, the LPN contributions to assessment resulted in improved patient outcomes. In the absence of RN collaboration, LPN assessment could lead to detrimental care outcomes, namely increased restraint use. In addition, Corazzini et al. (2013) noted concerns regarding lack of clarity in nursing practice related to the

LPN role in supervision and delegation, concluding that this lack of scope of practice clarity could result in institutions viewing the role of the LPN and RN as interchangeable. Role identity has an impact on the job satisfaction attribute of empowerment. The LPNs in this study described role confusion relative to lack of clear supervisory expectations and role blurring between LPN and RN responsibilities. Supervisory/administrator micromanagement contributed to the LPNs' perception of not being able to problem solve, further contributing to the role confusion. This micromanagement existed despite LPN education and competency.

The LPN often feared making a decision due to the potential administrative reprimand, if the decision was viewed in a negative manner. Thus, they found themselves continually confirming planned implementations even if they were confident of the decision. The LPNs described a continual process of asking the supervisor, "Is it okay if I do it this way?" This was strategic, to avoid a possible reprimand.

Lack of a clearly defined role and a perceived lack of empowerment were described as contributing negatively to their job satisfaction. Conversely, LPNs who felt empowered cited this as a critical attribute of job satisfaction. A relationship has been established in the literature between empowerment and job satisfaction and turnover. Previous RN and DCW research studies report similar findings. Hauck, Quinn Griffin and Fitzpatrick (2011) examined the relationship between structural empowerment and anticipated turnover among critical care nurses and found that those who were more empowered had a lower anticipated turnover score. Zurmehly, Martin, and Fitzpatrick (2009) concluded similarly with a sample of 1355 RNs and O'Brien-Pallas et al. (2010) reported that higher levels of role ambiguity and role conflict were associated with higher turnover rates and high turnover rates were associated with lower job satisfaction. Rai (2013) also concluded that role conflict is negatively correlated with job

satisfaction in long-term care staff. Research involving DCWs echo these findings. Zontek et al.'s (2009) study examined the effects of psychosocial factors on DCWs' injuries and found that DCW level of job satisfaction did align with low decision latitude along with high workloads and low social support.

Rubin et al. (2009) examined job satisfaction of a small group of nursing staff concluding that teamwork must permeate all levels of staff and a mission emphasizing mutual dialogue and empowerment needs to be present in nursing homes. This aligns with my study's finding of the theme empowerment and sub-theme of voice. The relationship of voice was also demonstrated in the Better Jobs Better Care Project. The Better Jobs Better Care project identified nine essential elements of a quality job program for DCWs contributing to job satisfaction (Stone & Dawson, 2008). One of the elements, participation in decision-making, aligns with the attribute of empowerment, specifically the sub-theme of voice. Two of the nine elements identified, training and career advancement, aligned with the attribute of growth identified in this study and were categorized broadly as opportunity for advancement (Stone & Dawson, 2008).

Growth. The LPNs described growth from multiple perspectives, including professional development as an LPN (i.e. achieving certification in a specialty area), progression on a career pathway to RN, and an increase in more complex job responsibilities, including supervision. Clinical ladders were highlighted as a positive strategy by the LPN participants, which would contribute to their growth. Clinical ladders exist in long-term care settings for DCWs; however, they are generally not available for LPNs. In contrast, clinical ladders are commonplace in magnet designated acute care facilities and contribute to job satisfaction (Paplanus, Bartley-Daniele, & Mitra, 2013). The LPN participants in some institutions stated that the DCWs had clinical ladders and would view establishment of a clinical ladder for LPNs as a positive impact

to job satisfaction. When LPNs in institutions without DCW clinical ladders were questioned regarding the positive impact of establishing clinical ladders; all concurred that this strategy would improve their job satisfaction.

Several studies found a relationship between staff growth and job satisfaction. Harahan et al. (2011) concluded that nursing homes that support and implement LVN supervisory training are likely to realize increased staff satisfaction, decreased staff turnover, and improved patient outcomes. Programs such as LEAP (an acronym for Learning to use tools and resources; Empower care and competence; Achieve commitment; and Produce opportunities for growth), implemented in long-term care settings, are aimed at improving job satisfaction through promotion of staff growth. LEAP is a multi-prong program, which combined nursing supervisory training with strategies for enhancing DCWs' empowerment and promoting nursing staff growth opportunities (Hollinger-Smith & Ortigara, 2006). Significant improvements in ratings of job satisfaction ($p < 0.001$) were found for both DCWs and nurses (Hollinger-Smith & Ortigara, 2006) following implementation. Likewise, Lapane and Hughes' (2007) qualitative study of nursing staff (RNs, LPNs, and DCWs) in 25 North Carolina nursing homes reported key themes including the importance of support for new nurses, and professional development.

In this study, access to professional growth opportunities (i.e. continuing education, certification), were noted to have decreased in recent years. LPN participants described a decrease in administrative marketing of growth opportunities and less money available to pay for certifications and other trainings. Leurer et al. (2007) reported similar findings in a qualitative study, which explored the insights of RNs from diverse practice settings relative to staff retention. Professional development was a major theme identified in this study. The long tenured RNs reminisced regarding the amount of professional development available and accessible early

in their careers, compared to current limited resources. Overall, LPNs in this study described educational opportunities as highly valued; however, on-site accessibility and administrative support had decreased in recent years.

Job Dissatisfaction Attribute

Working conditions. Working conditions, inclusive of unrealistic workload (staffing and regulatory demands) and equipment was the only job dissatisfaction attribute identified in this study. Workload is defined as the perception of work demands rendered on the employee in terms of time, amount and speed (Rai, 2013). Rai (2013) identified that workload was associated with low job satisfaction in long-term care staff. Similarly, Chenoweth et al. (2010) found that nurses in nursing homes reported dissatisfaction with their work environment. Working conditions were often studied in relationship to nursing staff turnover, which is related to job satisfaction. For example, Gormley (2011) found that work environment was related to anticipated staff turnover and that significant differences in perception of work environment existed between nurses and managers. Managers rated work environment higher than staff on all subscales. This is similar to findings from this study where the LPNs described the inability of the supervisor/administrator and regulator to fully understand the complexities of their job and resultant workload. The LPNs referred to “corporate” being out of touch with the reality of patient acuity and resultant workload.

Staffing also impacted the LPNs’ unrealistic workload in this study. Inconsistent, unavailable, and unreliable staffing contributed to the LPNs dissatisfaction. This included the RN who was described as “in meetings” and not available to collaborate. Seblega et al.’s (2010) findings support this perception identifying a downward trend in RN staffing through 2007 in long-term care settings. Corazzini et al.’s (2013) findings indicate improved quality of care in

nursing homes where nursing practice acts clearly described LPN scope and there was greater RN availability. Moyle et al.'s (2003) findings were also congruent with those of this study, identifying staffing issues as a contributing factor to nurses and assistant-in-nursing dissatisfaction. Staffing was also identified as a factor impacting job dissatisfaction in a descriptive correlational survey of RNs (N = 347) living in northern, central New England (Care & Kazanowski, 1994). Care and Kazanowski (1994) concluded that nurses experiencing poor staff cohesiveness, poor staffing, and tremendous workload, among other factors were more likely to experience job dissatisfaction.

Contributing to this working condition dissatisfier is a person, external to the institutional environment, who makes regulatory decisions resulting in burdensome paperwork, negatively impacting the LPNs' ability to provide quality care. This person, described as, "the man with the bow tie behind the desk" was perceived by the LPNs as detached and uninformed regarding the realities of caring for residents in a nursing home. This disconnect between the regulatory leaders and the reality of nursing care negatively impacted working conditions and resultant job dissatisfaction. Likewise, Zeytinoglu et al.'s (2007) survey of 1396 nurses in three Ontario hospitals concluded staff that perceived deteriorated external work environment (i.e. decision outside hospital, budget cuts, limited resources) and heavy workload have low job satisfaction and high turnover intent. This is congruent with the subtheme in this study of unrealistic workload impacted by regulatory demands.

Lapane and Hughes (2007) found that nurses were more likely than NAs to report stress because non-health professionals (i.e. surveyors) determine how they must do their job. However, Cherry et al. (2007) found similar results with LVNs and CNAs reporting that the presence of the surveyors often created a tense and uncomfortable atmosphere. In addition,

excessive paperwork, ineffective communication, frequent deaths, combative and uncooperative residents, and inadequate staffing also reportedly contributed to job dissatisfaction.

Lastly, equipment was also identified as a subtheme of working conditions. The LPNs described frustration when equipment was faulty, unavailable or inappropriate. This frustration contributed to job dissatisfaction and was often escalated by the DCWs annoyance at the LPN who was unable to quickly resolve the issue. A program, Perfecting Patient Care (work redesign program) was implemented at an organizational level to address similar issues (Castle & Bost, 2009). Redesign measures to improve work conditions such as linen shortages and strategies to decrease patient falls resulted in improved employee job satisfaction scores and improved resident and family satisfaction survey scores.

Findings in Relation to the Conceptual Model

Herzberg's motivation/hygiene theory (two factor theory) (1959) provided the theoretical basis for this qualitative research study. The conceptual model based on Herzberg's (1959) theory is depicted below for reference.

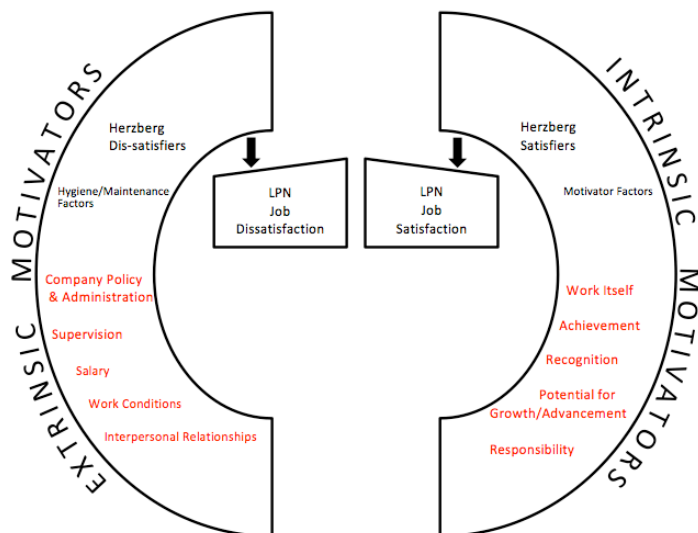


Figure 5. Conceptual Framework Based on Herzberg et al. (1959)

The model in Figure 5 depicts how the distinct attributes labeled by Herzberg et al. (1959) as extrinsic motivators impact LPN job dissatisfaction, while the distinct attributes labeled by Herzberg et al. (1959) as intrinsic motivators impact LPN job satisfaction. The two half circles of the model are disconnected, as job dissatisfaction and job satisfaction are two separate and distinct dimensions, independent of each other-not at opposite ends of a continuum. A discussion follows comparing the job satisfaction/dissatisfaction attributes of Herzberg's (1959) theory to this current study's findings. Table 9 provides a direct comparison.

Job Satisfiers		Job Dissatisfiers	
Herzberg Intrinsic Factors (Satisfiers)	Attributes of Job Satisfaction (LPN Focus Group)	Herzberg Extrinsic Factors (Dissatisfiers)	Attributes of Job Dissatisfaction (LPN Focus Group)
Work Itself	Value – “Work” Itself	Work Conditions	Working Conditions
Achievement	Not Identified	Company Policy/Administration	Not Identified
Recognition	Value - Recognition	Supervision	Not Identified
Potential for Growth/Advancement	Growth	Salary	Not Identified
Responsibility	Not Identified	Interpersonal Relationships	Component of <i>Real Connection</i> (Satisfier)
Not Identified	Empowerment		
Not Identified	<i>Real Connection</i>		

Table 9. Comparison of Herzberg's (1959) Theory Dissatisfies/Satisfiers to the LPN Focus Group Job Dissatisfaction/Satisfaction Attributes

Job Satisfiers. Satisfiers (motivator factors) contribute to personal or psychological growth and increase job satisfaction (Herzberg et al., 1964). According to Herzberg's theory (1959) they arrive from intrinsic conditions of the job itself, such as achievement, recognition, the value of work itself, potential for growth, and advancement and responsibility. Herzberg's theory (1959) parallels Maslow's theory of need hierarchy, relevant to the human's need to engage in higher order work. Herzberg, like Maslow noted that feelings of self-actualization and

growth are true motivators. Findings of this study were congruent with three of the satisfiers noted in Herzberg's theory (1959) and also aligned with Maslow's hierarchy. Congruent satisfiers included value, inclusive of value - value of the "work" itself, value – recognition, and growth. Achievement and responsibility were not identified as satisfiers in this study. Herzberg et al. (1964) discussed the interrelationship of two intrinsic factors, achievement and recognition. Achievement was found to be able to stand independently of recognition; however, recognition was rarely found independent of achievement. Therefore, a human can experience good feelings and thusly job satisfaction related to achievements in their job role apart from receiving recognition (Herzberg et al., 1964). However, recognition, would rarely contribute to job satisfaction in the absence of achievement. As mentioned, achievement was not an identified theme in this study. LPNs described being valued for the true essence of the "work" itself, exemplified as a resident experiencing positive health outcomes and/or an improved perception of well-being and subsequently being recognized for their contributions.

The job satisfaction attribute of growth identified in this study aligns with Herzberg's intrinsic motivator of potential for growth and advancement. Similar to Herzberg's theory (1959), the LPNs described growth as an opportunity, inclusive of educational opportunities, and expanded job duties. In addition, Herzberg et al. (1964) described an intrinsic motivator concept, job enrichment, which is based on the relationship between ability, opportunity, and performance reinforcement. The more ability an employee possesses, the easier an employee can be motivated to do a good job and satisfaction increases (Herzberg et al., 1964). Similarly, the LPNs described how knowledge about a particular new skill when shared with other staff is a job satisfier.

Lastly, Herzberg's intrinsic factor, responsibility, was not specifically identified in this study. Herzberg et al. (1964) described responsibility in terms of the job role, highlighting the

importance of building into tasks greater levels of responsibility, thus allowing employees greater responsibility for planning and controlling their work. Although the concept of responsibility was referenced related to the theme of empowerment, specifically when discussing role identity, the theme of empowerment is distinctly different from responsibility. The theme of empowerment is beyond simply creating opportunities to plan and control your work.

Empowerment was defined as the LPNs ability to have control over their job responsibilities and their licensed nursing role within the constraints of their defined scope of practice. This includes being able to work to the full extent of their potential and being respected for their knowledge base and their contributions to the health care team. Empowerment, inclusive of subthemes of role identity and voice was identified by all participants as impacting job satisfaction. The LPNs described feeling a lack of power to accomplish their job duties and care for the resident. Neither empowerment nor the job satisfier of *real* connection was identified by Herzberg's theory (1959) as job satisfiers or job dissatisfiers. However, other studies, not specific to the LPN population, have reported similar findings (Hauck et al., 2011; Zurmehly et al., 2009; Rai, 2013).

Job Dissatisfiers. Herzberg's (1959) theory identified dissatisfiers, known as extrinsic factors, inclusive of company policy and administration, supervision, salary, interpersonal relations and work conditions. Dissatisfiers (hygiene factors [also called maintenance factors]) create dissatisfaction if they are absent but do not necessarily improve job satisfaction. They are preventative in nature. In contrast to Herzberg et al.'s (1959) five dissatisfiers, only one attribute of job dissatisfaction, working conditions, inclusive of unrealistic workload (staffing and regulatory demands) and equipment was identified in this study. Herzberg et al.'s (1959) four other dissatisfiers were not identified. Some related conversation did occur when the LPNs were discussing working conditions; however, comments were not consistent and thus did not emerge

as a theme. A detailed discussion of Herzberg et al.'s (1959) intrinsic and extrinsic factors alignment to this study's findings follows.

Herzberg et al. (1964) found company policy and administration to be the single most important determinant of job dissatisfaction. However, neither company policy or administration emerged as a distinct theme in this study. The potential impact of company policy and administration on working conditions was discussed by the LPNs and interwoven throughout the focus group sessions but was not a consistent theme. For example, when discussing the subtheme of unrealistic workload and equipment, the administrator's role in recognizing and creating solutions relative to unrealistic workload and availability of safe equipment was discussed. Furthermore, this administrative reference was beyond the health care institution itself and broadened to include the regulatory decision makers at the accreditation, state and governmental level. In fact, this high-level administrative decision maker was viewed as instrumental in addressing working conditions, contributing to job dissatisfaction. Regulatory issues discussed included burdensome and repetitive paperwork and new initiatives, which resulted in frequent mandates adversely impacting time spent with residents. Company policy was a narrow concept that did not include the regulatory and accreditation aspects that the LPNs discussed. Exemplars confirm that company policy was not the essential dissatisfier. The root of the dissatisfier was regulatory and accreditation demands. This concept was encompassed in the sub-theme of unrealistic workload.

Likewise, supervision was not identified as a dissatisfier. However, it was a concept embedded in the LPNs' discussion of all four of the satisfiers, value, *real* connection, empowerment and growth. The supervisors' impact on the LPNs' ability to be valued, recognized, empowered and grow as well as experience a *real* connection is evident in the

exemplars. The effect could be both positive and negative. Salary was also not identified as a dissatisfier. When mentioned during the focus groups, the LPNs comments were inconsistent and mentioned extreme scenarios, such as no pay increase for 13 years or salary was discussed within the context of unrealistic workload. Aside from these references, neither salary nor benefits, was discussed collectively in detail and thus was not an identified theme. Lastly, the dissatisfier of interpersonal relations, in Herzberg et al.'s (1959) work was described as “water cooler” conversation. Although, this did not emerge as a dissatisfier, a different interpersonal connection defined as a deep bond described the satisfier, *real* connection. Thus, *real* connection encompasses concepts well beyond interpersonal relations as described by Herzberg et al. (1959) and is also inclusive of the resident/family relationship.

Although only one job dissatisfaction attribute (i.e. working conditions) was identified, this attribute was described as potentially impacting the LPNs' ability to experience the four job satisfaction attributes. This is in contrast to Herzberg et al. (1959) who described job dissatisfiers (extrinsic factors) as distinct from job satisfiers (intrinsic factors). Although, Herzberg et al. (1959) did communicate the need for supervisors/administrators to implement strategies aimed at addressing both job satisfiers and job dissatisfiers to improve overall staff job satisfaction, the concept of the dissatisfiers potentially impacting job satisfaction attributes, as identified in this study, was not discussed.

Few have disputed Herzberg's theory with the exception of Locke (1976). He acknowledges Herzberg's contribution to job satisfaction research, however, concluded that the idea that dissatisfaction and satisfaction are independent factors is logically and empirically indefensible. Locke (1976) believes the satisfiers and dissatisfiers are separable but interdependent. Herzberg defended his stand and is clear that they are not interdependent.

Similar to Locke (1976), findings in this study indicate that the job dissatisfier, working conditions is separate but interdependent with the four attributes of job satisfaction. The dissatisfier, working conditions, can potentially impact the LPNs' ability to experience job satisfiers. An analogy of a puzzle depicted in Figure 6 can be utilized to describe this phenomenon. The four attributes constitute four pieces of the LPN job satisfaction puzzle. The job dissatisfaction attribute, working conditions, can prevent the pieces of the puzzle from coming together and thus negatively impact the LPNs' overall job satisfaction. McGilton and Boscart (2007) concur in their findings. They reported that all staffing groups mentioned the need for connectedness, similar to the *real* connection satisfier identified in this study. However, the groups also reported that inadequate staffing and workload act as barriers to care providers establishing meaningful one-on-one relationships (McGilton and Boscart, 2007).

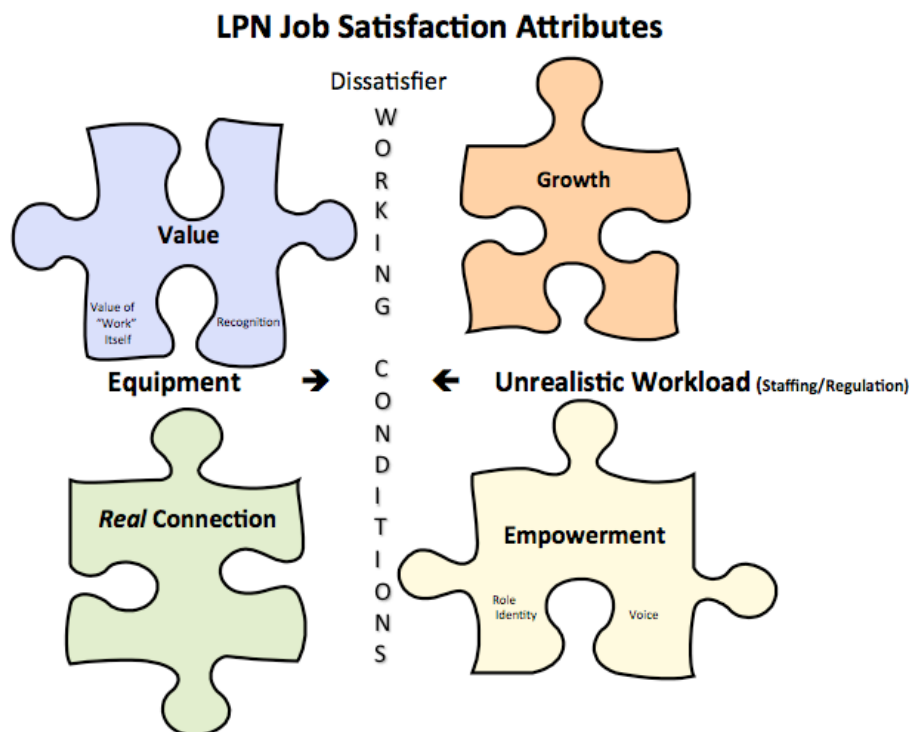


Figure 6. LPN Job Satisfaction Attributes in Long-Term Care

In summary, the findings of this study contribute to the literature through the description of the four attributes of LPN job satisfaction and one attribute of job dissatisfaction. These attributes, as discussed above, align with the literature findings of job satisfaction studies focused on DCWs, RNs and nursing staff (inclusive of RNs, LPNs, and DCWs). However, this study uniquely contributes to nursing science in identifying the potential impact of the job dissatisfier of working conditions on the ability of the LPN to experience the four job satisfiers. For example, the LPNs described the burden of paperwork preventing the ability to have a *real* connection with the resident.

The defined attributes of job satisfaction have been established in previous research with DCWs and RNs. However, in this study concepts specific to the LPN were described. The LPNs discussed how the confusion about LPN/RN role identity occurring in long-term care settings could adversely impact their empowerment, role identity, and resultant job satisfaction. This role confusion included the LPN's perception of both a narrowed and inappropriately expanded scope of practice. The LPNs described how expectations differed not only between facilities but also within facilities and even day-to-day. In addition, the LPN communicated that the accessibility of the RN for collaboration was a critical issue affecting job dissatisfaction.

Lastly, although the relationship between the potential for growth and job satisfaction has been well established in the literature, this study's findings identified the LPNs' need for growth relative to LPN specialty certification and a career ladder. The participants communicated that the assumed pathway for growth is achieving the RN. However, many LPNs expressed that this is not a personal goal; they love being an LPN and want to have opportunities to grow as an LPN.

Despite the diversity of the host sites, including Medicare star scores from two to five, there was congruence on most of the variables across sites. Only one host site was noted to have more LPN positive comments and less LPN negative comments related to job satisfaction and job dissatisfaction. This site was a religious based, non-union, 100-200 certified bed facility and had an overall four star Medicare rating, with a five star rating for quality measures. The findings of this study do not support any direct conclusions relative to host sites; however, the attribute of *real* connection was mentioned in greater frequency and with greater passion at this site when compared to other sites. The sense of family and caring for everyone in the community (i.e. residents, staff, and families) was a strong concept shared by all LPN participants at this site. The ideals of the institution and senior administration were clearly communicated and an inclusive environment existed.

Implications for Future Nursing Practice and Education

The attributes identified in this study as job satisfiers and job dissatisfiers create a roadmap for LPNs and supervisors/administration in long-term care to discuss how to create a long-term care environment where job satisfaction attributes for LPNs can prevail, thus increasing job satisfaction and positively impacting staff retention and patient outcomes. Table 10 lists five implications for future nursing practice and education.

Implications for Future Nursing Practice and Education	
■	Provide training in long-term care settings to administrators and nursing staff regarding the essential attributes of job satisfaction and job dissatisfaction.
■	Provide transformational leadership training in long-term care facilities (both LPN and RN) to improve the nurse's ability to lead effectively, improving job satisfaction.
■	Provide a basic introduction to transformational leadership in nursing education programs (both LPN and RN) to improve the nurse's ability to transition to a leadership role early in their career, improving job satisfaction.
■	Implement a clinical ladder for LPNs in long-term care settings, increasing the LPNs' opportunity for informal and formal growth opportunities.
■	Implement a "magnet type" designation in long-term care, inclusive of strategies that address each of the attributes of job satisfaction and job dissatisfaction, aimed at improving quality of work life for LPNs. Advocate for health policy aligning achievement of LTC Magnet designation with CMS reimbursement.

Table 10. Implications for Future Nursing Practice and Education

Provide training in the essential attributes of job satisfaction and job dissatisfaction.

Training regarding the key attributes is necessary to assist administrators and nursing staff in working towards a common goal of increasing job satisfaction and decreasing job dissatisfaction. As identified in this study, it is essential that both the attributes of job satisfaction (value, *real* connection, empowerment, and growth) and job dissatisfaction (working conditions) be viewed as critical to the overall job satisfaction of the LPN. Herzberg emphasized that employers must address both motivator and hygiene factors to improve employee job satisfaction and prevent job dissatisfaction. This study also described the potential of the dissatisfier, working conditions, to impact the LPNs' ability to experience the job satisfiers. Thus, there needs to be effective management of working conditions, inclusive of staffing, regulatory demands (paperwork), and availability of equipment. When these basic LPN workplace needs are met, management then needs to focus on creating a long-term care environment where the job satisfaction attributes

identified in this study can be experienced. The LPNs' voice needs to be included when creating these strategies. The LPNs also shared the negative impact of regulation mandates and paperwork on their ability to have a *real* connection with the resident/family. Through an understanding of these key attributes, all staff will be empowered to advocate collectively maintaining the ability to experience a *real* connection. When the LPN is valued, recognized for their work, empowered through a defined role and audible "voice", able to have real connections with residents/families and colleagues/administrators, and provided opportunities for growth both as an LPN and on their pathway to RN job satisfaction is experienced. The literature supports a relationship between job satisfaction, staff retention, and improved patient outcomes, thus this creates a potential to impact these variables as well (Castle & Engberg, 2005; Dellefield, 2008).

Provide training in transformational leadership (nursing practice and education).

Given the identified job satisfaction attributes (value, real connection, empowerment, and growth) in this study, intrinsic attributes identified by Herzberg et al. (1959), and current scientific literature supporting a relationship between job satisfaction and transformational leadership (Doran et al., 2004; Larrabee et al., 2003), I propose that job satisfaction will increase in long-term care settings when the basic tenets of transformational leadership are learned and practiced by the nursing and administrative team. In addition, providing a basic introduction to transformational leadership in nursing education programs (LPN and RN) will improve the nurse's ability to transition to a leadership role early in their career. A discussion regarding how the findings of this study and Herzberg's intrinsic/extrinsic factors align with transactional/transformational leadership follows, inclusive of the relationship between leadership, job satisfaction/retention, and quality of care established in the scientific literature.

The relationship between leadership, job satisfaction/retention, and quality of care is suggested by two IOM reports: *Keeping patients safe: Transforming the work environment of the nurse* (2004) and *Retooling for an aging America: Building the health care workforce strategies* (2008), concluding that improving supervisor relationships will increase job satisfaction and result in improved patient care. Dellefield (2008) presents an overview of best practices from studies (1990 and 2007) echoing this need for leadership; concluding that formal training of nurses (RN & LPN) in supervision and management will improve employee and patient outcomes in long-term care settings. Likewise, nurse leadership behaviors [team level], such as encouragement, guidance, and organizational climate have been positively associated with DCW [individual level] job satisfaction, resultant reduced DCW turnover, and creation and implementation of a quality job program for DCWs, (Probst et al., 2010; Stone & Dawson, 2008). Furthermore, evidence exists linking nursing leadership in long-term care to DCW's job satisfaction and retention, which further impacts the quality of care provided to clients (Bowers et al., 2003; Harvath et al., 2008). Specifically, transformational leadership has been positively associated with improved nursing staff job satisfaction and resultant improved staff retention (Doran et al., 2004; Larrabee et al., 2003).

The terms transactional leadership and transformational leadership were defined by Burn (1978). Transactional leadership is a style of leadership through which the leader promotes employees to meet job expectations through rewards and punishment. Active management by exception and contingent reward are two key components. The leader, utilizing a contingent reward style sets goals/expectations and stipulates the reward or associated punishment, reminding one of a carrot-and-stick approach to leadership (Sosik & Jung, 2010). Baughman and Smith (2010) examined the use of a Medicaid wage pass through program to increase the salaries

of DCWs, concluding that states that initiated these programs increased salaries by 12% and improved retention. However, Baughman and Smith (2010) caution that this increase in pay may not be sufficient to remedy retention issues. Similar to a carrot-and-stick mentality created by contingent reward, Herzberg et al. (1959) cautions that management who focuses on the extrinsic factors solely will create an employee who resembles a cocaine addict. Increasing amounts of extrinsic rewards will never be enough. Herzberg's theory emphasizes the need to balance management strategies that both address the intrinsic and extrinsic factors. Thus, transactional leadership strategies (aligned with Herzberg's extrinsic factors) can decrease job dissatisfaction but will not improve job satisfaction and ultimately impact retention and improve patient outcomes. Furthermore, salary was not identified in this study as a key attribute of LPN job satisfaction, suggesting that the monetary rewards used in transaction leadership may not be as valuable to LPNs as they were in previous studies with DCWs.

Active management by exception, reflective of transactional leadership profiles a leader whose focus is on mistakes, complaints, deviation from standards, and infractions of rules and regulations. The LPNs in this study described how these transactional types of leadership strategies do not improve job satisfaction, highlighting their frustration when they are admonished for the one item that was not completed in entirety despite the 299 other items completed. Although transactional leadership, particularly contingent reward, can motivate employees to reach goals it often has limited success related to today's knowledge based economy and the need for both extrinsic and intrinsic motivators to ultimately succeed as an individual and an organization (Sosik & Jung, 2010). Thus, transactional leadership styles, focused on tasks, such as management by exception were demonstrated to be negatively associated with employee and patient outcomes (i.e. patient safety) and conversely, leadership

styles that focus on people, such as transformational leadership, were positively associated (Cummings et al., 2010; Cowden et al., 2011; Wong & Cummings, 2007). Herzberg's extrinsic factor of supervision and company policy/administration would parallel strategies utilized by a leader who employs a transactional management by exception style. For example, utilizing management by exception as a leadership style, a supervisor would strategically look for LPN medication errors and implement immediate corrective action (according to policy). In contrast, a transformational leader would utilize idealized influence (promoting an organizational vision that embraces safe high quality care) to motivate the LPNs to collectively embrace, create, and maintain an organizational culture that values high quality and safe care. The four-job satisfaction attributes LPNs identified in this study align with the four I's of transformational leadership, creating a major implication for nursing practice and education.

Transformational leadership inspires and motivates people to collectively succeed through the leader's effective utilization of the four key components, known as the four I's of transformational leadership. The 4 I's align with Herzberg's intrinsic factors and with the job satisfaction attributes described by the LPNs working in long-term care.

Table 11 provides exemplars that align with the four attributes of job satisfaction, Herzberg's satisfiers, and the four I's of transformational leadership. For example, the LPNs described how characteristics of an administrator such as "caring about you on a level that is not all about work" contributed positively to their job satisfaction. This aligns with the transformational leadership concept of individualized consideration. Thus, implementation of strategies to improve leadership skills of supervisor/administrators at all levels within a long-term care facility will positively impact the presence of job satisfiers in the working environment, positively impacting LPN job satisfaction.

Transformational Leadership Component 4 I's	Description of Component	Herzberg (1959) Associated Intrinsic Factor	Attributes Identified in Findings of this Study	Exemplars (Positive and negative examples included)
Idealized Influence	<p>Leader demonstrates and is consistent in behavior related to ethics, principles, and values.</p> <p>Relationship between leader and follower is not based on policy and regulation, rewards and punishments, but instead on personal understanding of principles and values.</p> <p>Followers witness these ideals and values in action.</p>	<p>Responsibility</p> <p>Value of work</p> <p>Itself</p>	<p>Value</p> <p>-Value of "work" itself</p> <p>Real Connection (Administrator)</p>	<p><i>"It's just when we have evaluation time - you can be a very good nurse or any kind a staff member - you get the same evaluation or the same raise. You can bring things up to them like - this happened or that happens and they will say, 'it doesn't matter.' So... You are really just a screw in the wheel ..."</i></p> <p><i>"I respect my supervisors who may be hard and expect a lot of me but it's nothing that they wouldn't do themselves. And if they're willing to pitch in, get a cart and say I haven't done these meds in a while but I can sure help and work for an hour, I think I can get these couple out."</i></p>
Inspirational Motivation	<p>Provides meaning and challenge to the followers work through development and articulation of a vision.</p>	<p>Responsibility</p> <p>Achievement</p>	<p>Value</p> <p>-Recognition</p>	<p><i>"The one thing I think I would like to say about the leadership type is ummm, when they do meet with us, it's not to discuss issues that we feel there is on the floor. When they meet with us, there</i></p>

Transformational Leadership Component 4 I's	Description of Component	Herzberg (1959) Associated Intrinsic Factor	Attributes Identified in Findings of this Study	Exemplars (Positive and negative examples included)
	Leaders' consistent behavior with mission motivates followers' to exert extra effort in challenging situations.		Empowerment -Role identity -Voice	<i>is an agenda and that is the topic and do not go out of the realm of that topic."</i>
Intellectual Stimulation	Leaders stimulate followers to be creative, think outside the box, and approach old situations in new ways. Encouraged to re-examine assumptions and seek perspectives that are not the norm.	Value of Work Itself Achievement Potential for Growth	Value -Value of "work" Itself Empowerment -Voice Growth	<i>"Being able to use my assessment skills and pick up emergency situations. It was actually on the same unit, same day, within an hour, that I had sent two people to the emergency room that were admitted. One with heart failure, who had a pacemaker that was failing...and when the doctor says 'good pickup' or 'good call' ...that's satisfying because that is what we're here for - to take care of her residents and make sure that they...as well as they can be. So when you pick up an emergency situation or problem that they are having and get it remediated that feels good."</i>

Transformational Leadership Component 4 I's	Description of Component	Herzberg (1959) Associated Intrinsic Factor	Attributes Identified in Findings of this Study	Exemplars (Positive and negative examples included)
				<p><i>“They want to change...our med administration, they want to change it to more like morning and afternoon, instead of such strict times, but yet we sit and have these morning circles and meetings...and us nurses are trying to say, ok these are the problems we're having, but these are some things that I think maybe will work, and then your administrator kind of blows you off basically.</i></p> <p><i>‘Well I don't think that's going to work.’”</i></p> <p><i>“I would have to say the micromanagement...you cannot think for yourself, however, you been educated and you have some experience...”</i></p>

Transformational Leadership Component 4 I's	Description of Component	Herzberg (1959) Associated Intrinsic Factor	Attributes Identified in Findings of this Study	Exemplars (Positive and negative examples included)
Individualized Consideration	Leaders spend time listening, coaching, and mentoring followers. Creating new leaders is a focus. Leaders show empathy, value individual needs, listen to follower's concerns, and assist in time of crisis	Advancement Potential for Growth	Value -Recognition Real Connection Empowerment -Voice Growth	<i>"Director of Nursing is wonderful...She's a sweetheart. She cares about you on a level that's not about work. She cares about you as a person and will listen to you and says come into my office and vent to me if you need to vent your frustrations. And she doesn't necessarily take that somewhere else, it stays in the room and just talking to her makes me feel better." ... I'm also thinking about my superiors have given me some extra responsibilities lately and given me the chance to do other things here and that has really opened my eyes...really made me feel good at the end of the day, that they have enough confidence in me to know that I can do different things."</i>

Table 11. Transformational Leadership 4 I's, Herzberg's (1959) Intrinsic Factors, and Current Study Findings' Attributes

Rosengren et al.'s (2007) findings identified that the leader being present and available in daily work was essential to effective leadership. The utilization of transformational leadership behaviors in health care organizations was found to correlate positively to employee outcomes such as job satisfaction (Nielsen et al., 2008). Likewise, the LPNs in this study described how the accessibility of the RN impacted their job satisfaction. They stated that often an RN is working in the long-term-care facility but detained at meetings for a large portion of the day and thus unable to collaborate with the LPN. This negatively impacts the LPNs' job satisfaction.

The LPN in long-term care may also be a leader, as they assume a leadership role very early in their career, often immediately following licensure. NCSBN LPN job analysis data confirms that a majority of newly licensed LPNs employed in long-term care settings perform administrative duties (2010). Harahan et al. (2011) indicate that anecdotal evidence suggest, at times LPNs/LVNs are the only nurses in the nursing home, other than the director of nursing. Likewise, the IOM (2010) *Future of Nursing* report states that some LPNs/LVNs supervise DCW in long-term care settings. Taken together, with the belief that leadership occurs at all levels of an organization, the role of LPN as a potential leader in a long-term care setting is evident. Transformational leadership training could provide growth opportunities for LPNs contributing to their job satisfaction and the job satisfaction of DCWs.

Lastly, a transformational leader will create a collective vision aimed at achieving high quality patient outcomes and model this vision to others. As a result, the leader will focus on eliminating the dissatisfier and improving working conditions. Efforts to improve work conditions will include advocacy at the institutional, state, and/or national level.

Implement a clinical ladder for LPNs in long-term care settings. The implementation of a clinical ladder, related to the attribute of growth, is suggested to increase the LPNs' opportunity for informal and formal growth. Clinical ladders are commonplace in magnet designated acute care facilities and contribute to job satisfaction (Paplanus et al., 2013). The LPN participants in one focus group stated that the DCWs had a clinical ladder and would view establishment of a clinical ladder for LPNs as a positive impact to job satisfaction. Other LPNs also mentioned a clinical ladder or answered affirmatively when questioned regarding the positive impact of establishing clinical ladders; all concurred that this strategy would improve their job satisfaction.

Consideration of development of a national leadership-training certificate for nurses (RNs and LPNs) working in long-term care should be considered given the alignment of the job satisfaction attributes to the 4 I's of transformational leadership. Likewise, instruction in the basic principles of transformational leadership in nursing education programs (RN and LPN) will assist in preparing new nurses for their role as charge nurses soon after graduation in long-term care settings. Other certifications should be explored and offered to LPNs relative to their role in the care of the elderly. Although some LPN certificates are available, they are limited in diversity of content and often short in length. It is essential to examine key areas of LPN practice such as care of the patient with Alzheimer's disease and assisting the elderly to manage chronic disease processes for growth opportunities. Aligning national certification programs for LPNs in these and similar areas will positively impact job satisfaction. The ability to assume new and different job roles in the long-term care setting should also be explored and aligned with a clinical ladder. Lastly, support for the LPN pursuing a RN degree is warranted.

Implement a magnet type of designation in long-term care settings. The magnet recognition process recognizes health care organizations for quality patient care, nursing excellence, and innovations in professional nursing practice (ANCC, 2014). It is an institution wide designation, currently designated in primarily acute care settings. There are five major magnet model components including transformational leadership; structural empowerment; exemplary professional practice; new knowledge, innovation, and improvements; and empirical quality results. A clinical ladder and shared governance are key components in magnet recognition. Given the attributes identified in this study, a magnet type of designation for long-term care settings would improve the quality of work life for LPNs and other staff in long-term care settings and potentially improve patient outcomes. Cost may prove to be a barrier. Aligning the magnet designation with the implementation of health care policy related to the Centers for Medicare & Medicaid Services (CMS) requirements and reimbursements could improve the likelihood of implementation. Careful assessment of the cost benefit analysis would be warranted.

Strengths and Limitations of the Study

The focus group methodology is a strength of this study as it enabled the researcher to engage the participants in a synergistic dialogue, sharing and comparing thoughts, resulting in deep, rich, detailed data. Given the complex nature of the phenomenon of job satisfaction, this enhanced the researcher's ability to analyze the data. Krueger (1994) stated that focus groups are most beneficial when the phenomenon of interest occurs in a natural setting where participants impact each other and gain insights into attitudes and opinions about the phenomenon of interest. The nursing home setting meets this guideline.

The number of qualified, expert staff involved in the analysis of the data was also a strength. A doctoral prepared researcher read in entirety all scripts from each focus group, analyzed data, and confirmed achievement of data saturation. A team of four nurse educators (MSN or PhD degree), with qualitative research training and experience, participated in data analysis discussions and assisted in data abstraction and condensation. This resulted in the renaming of themes and sub-themes, contributing to trustworthiness. Member checks were also completed for each focus group, allowing participants to provide feedback regarding the accuracy of comments and the resultant themes that emerged. In addition, a summary (wrap up) overview was presented near the conclusion of each focus group to request participants' views on accuracy of interpretation of comments during the discussion, contributing to credibility. The utilization of a co-moderator, representing a different ethnic background, facilitated open dialogue. The diversity of the host institutions, relative to size and location (i.e. rural, suburban and urban areas), and religious affiliation was also a strength.

There are a few limitations of the study that deserve comment. First, all institutions were located in the Philadelphia metropolitan area and ownership consisted of government/county or corporation/non-profit. Thus, generalizability is limited.

An additional limitation was the incongruence of the LPNs' ethnic background compared to the LPN workforce in the United States. In particular, the distribution of black/non-Hispanic at 16% differed from the national norm, which is 24% (HRSA, 2013). Additionally, given the focus group methodology, respondents can feel pressure to respond similarly to the dominant participants. "Group think" can occur. I was aware and observant of this possibility, however, the potential impact of "group think" on the findings is unknown. Socially acceptable opinions can also prevail given the group environment and lack of anonymity among the focus group

participants. My familiarity with some of the participants as a previous instructor or administrator could have contributed to this bias. Participants were assured of the confidential nature of their responses to minimize this limitation.

Lastly, the host institutions all received Medicare overall star ratings of two or above. Thus, the lowest quality nursing homes did not participate as sites and LPNs working in such facilities were not included in the sample. The specific impact of this lack of diversity is unknown and would require further research to determine if a bias exists.

Implications for Future Research

Staff turnover remains a critical issue in long-term care as evidenced by a recent report indicating the annual turnover in nursing homes was 56% for RNs, 51% for LPNs and 75% for DCW (Donoghue, 2010). Furthermore, continued high nurse turnover has been linked to poor patient outcomes, including higher incidence of infection, re-hospitalization, and pressure ulcers (Castle, 2009; Castle & Anderson, 2011). These continued challenges, coupled with the lack of LPN focused scientific literature create a need for continued research of LPN job satisfaction and job dissatisfaction. Table 12 lists suggested implications for future research.

Implications for Future Research
<ul style="list-style-type: none"> ■ Examine the relationship between job satisfaction and job dissatisfaction with a large, diverse LPN population (increase generalizability).
<ul style="list-style-type: none"> ■ Examine the relationship between the LPN and RN state nurse practice acts, including LPN to RN collaboration, and job satisfaction, nursing staff retention, and patient outcomes.
<ul style="list-style-type: none"> ■ Examine LPN empowerment and its relationship to LPN role identity.
<ul style="list-style-type: none"> ■ Implement transformational leadership training program for LPNs and RNs and examine the relationship between the training program and staff (i.e. RN, LPN & DCW) job satisfaction, retention and patient outcomes, including cost-benefit analysis.
<ul style="list-style-type: none"> ■ Implement transformational leadership training in nursing (LPN and RN) curriculum and examine the relationship between the training program and LPN/RN job satisfaction and retention in the first year of hire.

Table 12. Implications for Future Research

Quantitative and/or qualitative research studying the relationship between the job satisfaction/job dissatisfaction with a large, diverse LPN population is necessary to increase generalizability. Given the work of Corazzini et al. (2013) and these findings, a study focused on identifying the relationship between both the breadth and clarity of the LPN and RN state nurse practice act, including LPN to RN collaboration and nursing staff job satisfaction, retention, and patient outcomes should be explored. The relationship between empowerment and the role identity of the LPN, specifically in long-term care settings requires in-depth analysis to understand how empowerment and role identity impact LPN job satisfaction, retention, and patient quality outcomes. Aligned with the suggestion to implement a transformational leadership training program for LPNs and RNs in long-term care settings and nursing education programs, research is needed to assess the impact of the training program and staff (i.e. RN, LPN & DCW) job satisfaction, retention, and patient outcomes. A cost-benefit analysis should also be included in the proposed research. Research in all of these areas is needed to positively impact LPN job satisfaction and decrease LPN job dissatisfaction.

Conclusions

This study contributes to the science by providing job satisfaction data specific to the LPN in the long-term care setting. Minimal research currently exists studying the needs of this group. Given the demand for health care fueled by the aging population, the dominance of the LPN as a licensed caregiver in long-term care, and the projected LPN workforce shortage, the need to fully understand LPN job satisfaction is evident. In addition, research supports an association between job satisfaction, staff retention, and patient outcomes. The four key attributes (value, *real* connection, empowerment, and growth) of LPN job satisfaction in long-term care settings are congruent with other research findings specific to RN, overall nursing staff

or DCW populations and align with Herzberg et al.'s (1959) intrinsic motivators. The depth of understanding of these attributes is enhanced, given the rich qualitative data, providing specific details to assist administrators and staff for improving LPN job satisfaction. For example, growth is a common theme in job satisfaction research. However, this study identified the LPNs' need for growth opportunities beyond the career path to RN (i.e. specialty certification). In addition, the issue of empowerment is further explained relative to the LPN's role identity and voice.

In contrast to Herzberg et al. (1959), only one dissatisfaction attribute, working conditions, was identified. Working conditions, inclusive of unrealistic workload and equipment can impact the LPNs' ability to achieve overall LPN job satisfaction. An analogy of a puzzle was utilized to describe this phenomenon. The four attributes constitute four pieces of the LPN job satisfaction puzzle. The job dissatisfaction attribute, working conditions, can prevent the pieces of the puzzle from coming together. Thus, it will be essential for supervisors/ administrators to address issues related to working conditions, allowing the puzzle to form and job satisfaction to prevail (See Figure 6). The need for available equipment in good working condition, adequate staffing, including RN accessibility for collaboration, and effective management of regulatory demands (i.e. paperwork) will prevent this dissatisfier from adversely impacting job satisfaction, thus, increasing job satisfaction, improving LPN retention, and potentially positively impacting patient outcomes. This is critical to meet the health care needs of the United States' elderly in long-term care settings.

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**APPENDIX A: Variables Examined with Job Satisfaction in Long-Term Care
According to Sample Demographic of Worker Type**

Variable	Sample: Nursing Staff	Sample: DCW	Sample: RN
Compensation	Castle, Degenholtz, & Rosen, 2006; Stone & Dawson, 2008	Baughman and Smith, 2010; Castle et al., 2007; Lapane & Hughes, 2007; Stearns & Darcy, 2008; Weiner et al., 2009	
Workload/ Staffing Levels	Lapane & Hughes, 2007	Castle et al., 2007	Leurer et al., 2007
Career Advancement/ Upward Mobility	Castle, Degenholtz & Rosen, 2006; Stone & Dawson, 2008		Leurer et al., 2007
Leadership Attributes (Communication, coaching, mentoring, collegiality, teamwork)	Häggsström, Skovdahl, Fläckman, Kihlgren, & Kihlgren, 2005; Harahan et al., 2011; Harvath et al., 2008; Havig, Skogstad, Veenstra & Romøren, 2011; McGilton, Hall, Wodchis, & Petroz, 2007; Moyle, Skinner, Rowe & Gork, 2003; Muthny, 1993; Stone & Dawson, 2008; Rubin, Balaji & Barcikowski, 2009	Bishop et al., 2009; Choi & Johantgen, 2012	Choi, Flynn & Aiken, 2011; Heponiemi et al., 2011; Leurer et al., 2007
Respect		Bishop et al., 2008; Bowers et al., 2003	

Variable	Sample: Nursing Staff	Sample: DCW	Sample: RN
Governance of Institution (For – profit - associates negatively)	Noelker, Ejaz, Menne, & Bagaka, 2009		Heponiemi et al., 2011
Autonomy/ Empowerment	EngstrÖM, Skytt, & Nilsson, 2011; Stone & Dawson, 2008; van den Berg, Landeweerd, Tummers, & van Merode, 2006; Walker, 2008; Zurmehly et al., 2009		Bigbee, Gehrke, & Otterness, 2009
Regulatory oversight (associates negatively)	Cherry Ashcraft & Owen, 2007		
Caring for Residents	Moyle, Skinner, Rowe & Gork, 2003; Muthny, 1993		
Pressure to take Shortcuts (associates negatively)	VonDras, Flittner, Malcore & Pouliot, 2009		
Organizational Commitment	Blegen, 1993		
Resource Adequacy			Choi, Flynn & Aiken, 2011
Birthplace	McGilton, Hall, Wodchis, & Petroz, 2007		

APPENDIX B: LPN Focus Group Demographic Survey

LPN Demographic Questions:

1. Are you male or female?

- Male
- Female

2. Which category includes your age?

- 18-24 years
- 25-32 years
- 33-48 years
- 49-67 years
- 68 years or older

3. Which category includes how long you been licensed as a LPN?

- 0-2 years
- 3-5 years
- 6-10 years
- 11- 20 years
- 21- 30 years
- 31+years

4. Which category includes how long have you been employed in your current long-term care position as a LPN?

- 0-2 years
- 3-5 years
- 6-10 years
- 11- 20 years

21- 30 years

31+ years

5. Are you currently enrolled in a RN program?

Yes

No

6. Which of the following categories best describes your employment status?

Working part time

Working full time

7. Are you White, Black or African-American, American Indian or Alaskan Native, Asian, Native Hawaiian or other Pacific islander, or another race not listed?

White/Non-Hispanic

Hispanic

Black or African-American/Non-Hispanic

American Indian or Alaskan Native

Asian

Native Hawaiian or other Pacific Islander

From multiple races

Another race

THANK YOU!!

APPENDIX C: Informed Consent Form

Informed Consent Form for Social Science Research

The Pennsylvania State University

Title of Project: Demystifying job satisfaction in long-term care: The voices of Licensed Practical Nurses

Principal Investigator: Patty Knecht MSN RN ANEF
443 Boot Road
Downingtown, Pa 19335
484-593-5950
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Advisor: Paula Milone-Nuzzo RN, PhD, FHHC, FAAN
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1. Purpose of the Study: The purpose of this research is to examine the phenomenon of job satisfaction and job dissatisfaction among LPNs employed in long-term care settings. The proposed study aims to address the gap in knowledge regarding LPN job satisfaction and job dissatisfaction in the LTC setting by providing an in-depth view of the job satisfaction through rich data that yield key themes and

patterns. We are asking you to participate due to your role as a LPN in a long-term care setting and knowledge of LPN job satisfaction and job dissatisfaction

2. Procedures to be Followed: You will be asked to attend one focus group with approximately 6 to 8 other LPNs. During that session, you will be asked to discuss your job satisfaction and job dissatisfaction. The principal investigator, Patty Knecht, will guide the discussion. The focus group session will last about 90 minutes and will be audio recorded. You must agree to be audiotaped to participate. In addition, you may be asked to attend one brief follow up meeting (15 minutes or less in length) to verify your agreement with the themes identified by the researcher.

3. Duration/Time: 90 minute participation in one focus group session will be required. In addition, you may be asked to participate in a 15-minute session within two weeks following the focus group session.

4. Statement of Confidentiality: Your participation in this research is confidential. The data will be stored and secured at the office of Patricia A. Knecht in a *locked/password-protected* file. In the event of a publication or presentation resulting from the research, no personally identifiable information will be shared.

All participants are required to maintain confidentiality of what was shared during the focus group discussions.

5. Right to Ask Questions: If you have any questions, concerns, and problems about your rights as a research participant or would like to offer input, please contact The Pennsylvania State University's Office for Research Protections (ORP) at (814) 865-1775. The ORP cannot answer questions about research procedures. Questions about research procedures can be answered by Ms Knecht at the contact information listed above.

6. Payment for Participation: You will receive an incentive (\$30.00 Wawa Gift Card) in appreciation for your participation in the entire focus group session. If you did not attend or need to leave early, you will not receive the Wawa Gift Card.

7. Voluntary Participation: Your decision to be in this research is voluntary. You can stop at any time. You do not have to answer any questions you do not want to answer.

You must be 18 years of age or older to consent to take part in this research study. If you agree to take part in this research study and the information outlined above, please sign your name and indicate the date below.

You will be given a copy of this form for your records.

Participant Signature

Date

Person Obtaining Consent

APPENDIX D: Summary of Data Analysis Steps

First Read of Transcript (following transcription) Note: This does not infer to just read once

- Listened to digital recording and read through entire focus group transcript and debriefing of transcript immediately following focus group session

Frequency How often was it said?

Extensiveness How many people said it?

Intensity How strong was the opinion/point of view?

Identified any unusual comments (even if singular)

Annotated as indicated

Highlighted potential quotes

Highlighted key concepts and recurring ideas/themes

Identified meaning units/codes (open coding)

Created categories (inductive - emerges from data) and themes

- Assistant Moderator reviewed analysis and discussed any discrepancies or oversights with moderator (primary investigator)

- Performed Participant Verification (member check contributed to trustworthiness)

- Performed Expert Verification (RNs, doctoral and masters prepared, reviewed identified categories and themes for congruency with data)

Second Read of Transcript

- Created more specific codes as they emerged from the transcript

Abstraction - grouping subcategories with similarities or dissimilarities together as categories and likewise grouping categories together as main categories (Dey, 1993)

- Looked for commonalities across focus groups (Horizontal analysis)

- Performed Expert Verification of Abstraction (RN, doctoral and masters prepared)

Vita

Patricia A Knecht, MSN, RN ANEF

EDUCATION:

2014	PhD, Nursing	The Pennsylvania State University, University Park, PA
1999	Master of Science in Nursing	West Chester University, West Chester PA
1991	Bachelor of Science in Nursing	Immaculata University, PA
1980	Associate of Science in Nursing	Gwynedd Mercy University, Gwynedd Valley, PA

SELECTED PROFESSIONAL EXPERIENCE:

1998-Present	Director	Chester County Intermediate Unit, Practical Nursing Program, Main Campus and West Grove Satellite, Downingtown, PA
1989-1998	Instructor	Chester County Intermediate Unit, Center for Arts and Technology, Brandywine Campus
2013-Present	Board member	Penn Medicine Chester County Hospital, West Chester, PA
2007-2012	Co-chair	Pennsylvania Center for Health Careers, Leadership Council Governor appointed position

SELECTED SCHOLARLY ACTIVITIES:

Linford, M., & Knecht P. (2013). When paradigms shift: Pennsylvania's labor market. Lecture conducted at Pennsylvania Integrated Learning Conference. Pennsylvania State University, University Park, PA.

Knecht, P., & Sosik J. (2012). Transformational leadership of nurse's in long- term care: Propositions and implications for practice. In P. Jacques (Eds.). *Proceedings of the 2012 Institute for Behavioral and Applied Management Conference*. Nashville, TN, 4-6, October, Rhode Island College.

Knecht, P. (2011). Changing your paradigm. Lecture conducted at Assessment Technology Inc. Educator Enrichment Conference. Villanova University, Villanova, PA.

Knecht, P. (2011). Transforming change in nursing education and practice. Distinguished Lecturer at Sigma Theta Tau International Tri-State Consortium 25th Annual Meeting. Philadelphia, PA.

Knecht, P. (2010). Untapped Potential: Retired nurses and educators. Lecture conducted at the National League for Nursing Summit. Orlando, Florida.