THE TRANSITION EXPERIENCE FOR REGISTERED NURSES NEW TO

CASE MANAGEMENT IN THE COMMUNITY

by

© Kelly Kean

A Thesis submitted to

the School of Graduate Studies in partial fulfillment of the

requirements for the degree of

Master of Nursing

School of Nursing

Memorial University of Newfoundland

June 2016

St. John's   Newfoundland and Labrador

ABSTRACT

Case management is increasingly being used within today's healthcare system in an effort to reduce healthcare costs while meeting the complex needs of populations within the community. Registered nurses (RNs) are often recruited for the role of case managers in the community because of their specific skill set and ability to navigate the healthcare system. There is a vast amount of literature related to the client and system benefits of case management, the roles and responsibilities of RN case managers, and job satisfaction among RN case managers. However, there is a literature gap noted in relation to the transition experience for RNs new to case management in the community setting. This research study used grounded theory methodology, guided by Glaser and Strauss (1967) to explore the process of RNs transitioning to case management in the community setting. Eleven RNs new to case management in the community were interviewed using semi-structured interviews. Data analysis was carried out using the constant comparative method. Three stages of adjusting to case management in the community were identified: slugging it out, seeing the job as it is, and finding the way. By gaining an understanding of this transition experience, recommendations for nursing practice and administration, education, and research that are based on the evidence from this study can be implemented to improve the transition experience for RNs new to case management in the community setting

Keywords: case management, community, grounded theory, job satisfaction, Registered Nurses, role strain, transition

ACKNOWLEDGEMENTS

complete this research study. I am grateful for their values toward education and for instilling these same values in me since childhood.

Finally, I would like to thank my loving husband Jason for supporting me in completing my thesis and for his understanding and patience throughout this process. His unconditional love is my greatest treasure.

THE TRANSITION EXPERIENCE FOR REGISTERED NURSES

Table of Contents

List of Figures

List of Appendices

Chapter 1: Introduction

Case management is currently being used within the community setting as a means to meet the evolving needs of the aging population and to relieve some of the growing demands on the health care system (Alberta Health Services [AHS], 2010; Bently, 2014; Hollander, Chappell, Prince, & Shapiro, 2007; Joo & Huber, 2013). In addition, registered nurses (RNs) are often recruited as case managers within the community because of their unique skill set, such as communication skills, trust-building abilities, clinical assessments, and overall knowledge of the health care system (College and Association of Registered Nurses of Alberta [CARNA], 2008; Canadian Nurses Association [CNA], n.d.; Conti, 1996; Park, Huber, & Tahan, 2009; Registered Nurses Association of Ontario [RNAO], 2003; Schmitt, 2005).

Case management is defined by the National Case Management Network (NCMN) as:

> A collaborative, client-driven process for the provision of quality health and support services through the effective and efficient use of resources. Case management supports the clients' achievement of safe, realistic, and reasonable goals within a complex health, social, and fiscal environment (2009, p. 7).

Within the health care setting, case managers work collaboratively with clients and health care professionals to utilize a strengths-based approach to promote the highest level of functioning, independence, and quality of life possible for their clients. Case managers often work with clients that are living with debilitating symptoms of multiple chronic conditions and require health care system navigation on a regular basis. It is assumed that

RNs have an in depth understanding of complex health conditions and the health care system and are therefore sought out as case managers (CARNA, 2008; CNA, n.d.; Conti, 1996; Park et al., 2009; RNAO, 2003; Schmitt, 2005; Sutherland & Hayter, 2009). Moreover, the public perceives RNs as trustworthy and non-threatening partners for achieving good health outcomes (CARNA, 2011). Therefore, RNs are well suited to connect clients with the appropriate health and social services, mobilize resources, and are able to help clients understand and cope with their illness, which enables them to manage their health more effectively in the community (CNA, n.d.).

This study examined the process of adjusting to case management among RNs in the community setting. I was interested in learning about the transition experience for RNs new to case management in the community setting because without an understanding of their experience, it will be difficult to provide support and ensure a successful transition to case management. The background to this research issue, the rationale and problem statement, the purpose, and the research questions are outlined in the remainder of chapter one.

Background

Canada's health care system is currently evolving to meet the changing and diverse needs of its population. The aging population and changing disease patterns are key influencers of health system trends (CNA, 2006). The CNA (2006) recognizes that Canadians are living longer; therefore, it is expected that the incidence of chronic illnesses, such as diabetes, chronic obstructive pulmonary disease (COPD), and arthritis, will increase and people, as well as the health care system, will be managing these

illnesses within the community. A report by the House of Commons (2012) indicated that the first of Canada's baby boomers reached 65 years of age in 2011; therefore, Canada's population has begun the expected shift to reflect a greater proportion of adults over 65 years of age. According to Statistics Canada (2012) there were almost 5 million adults older than 65 years of age in Canada in 2011 and accounted for 14.8% of the entire population and it is expected the number of Canadian seniors will increase to 10 million by 2036. Along with the aging population comes a burden of chronic disease. Statistics Canada also reported that 85% of seniors aged 65-79 have at least one chronic disease. This number increased to 90% for seniors greater than 80 years of age. Moreover, the Canadian Institutes of Health Research [CIHR] (2013) reported that 24% of seniors have three or more chronic diseases and account for 40% of all health care users.

Within the Canadian health care system, case management is used to meet the needs of populations while efficiently and effectively reducing costs through appropriate use of healthcare resources (Bergen, 1992; CNA, n.d.; Cunningham, Kizziar, Wilson, & Zander, 2012; Kneafsey, Long, Reid, & Hulme, 2004; MacDonald, Schreiber, & Davis, 2005; NCMN, 2009; Park et al., 2009; Tonges, 1998). More specifically, case management is viewed as a means to decrease utilization of acute care services and improve health outcomes for the aging population (AHS, 2010; Bently, 2014; Hollander et al., 2007; Joo & Huber, 2013).

Within North America, the field of social work initially introduced the term case management in the 1970s (MacDonald et al., 2005; Thornicroft, 1991). However, Keeling and Bigbee (2005) noted that nurses in the United States performed case

management for the underprivileged population who lived in the community as early as the late 1800s. Although case management has an extensive history in community health nursing, the unprecedented rapid changes of various populations' needs, especially the older population, and the need to address extraordinary health care costs are only now bringing case management to the forefront as a method of care in an era of health care reform (Cesta, 2012). Case management has become a widely accepted RN role (CARNA, 2008; CNA, n.d.; Conti, 1996; Park et al., 2009; Schmitt, 2005), although case management education is mostly limited to on-the-job training and continuing education courses and is not a focus within current nursing curricula (Schmitt, 2005). The lack of formal case management education in the nursing curricula may cause inaccurate role expectations and a lack of preparedness among RNs new to case management, which may lead to a difficult transition experience. Although the number of RNs practicing in the field of case management was not disclosed, the CNA (n.d.) reported a need for more case managers to help support clients living with multiple chronic conditions in the community. In an effort to support this emerging trend in community health care, it is critical to examine the transition experience for RNs new to case management in the community setting to understand the support required to sustain them in their new role and to achieve positive health outcomes for their clients and the entire health care system.

Rationale and Problem Statement

My career as a RN case manager in the community setting began in 2012 and lasted for approximately 2 years. During my transition to case management in the community setting, I learned that the transition period was one that came with many

challenges, which led me to become interested in this area of nursing research. I wanted

to know: How do other RNs new to case management in the community setting

experience their transition? Are there common stressors experienced by RNs new to case

management in the community setting? Are there common factors that help RNs new to

case management in the community? When do they begin to feel comfortable in their

new role?

There is a vast amount of literature related to the client and system benefits of

case management, the roles and responsibilities of RN case managers, and job

satisfaction among RN case managers. However, only one research study directly

explored the experience of RNs' transition from a direct caregiver to a new case manager

(Schmitt, 2006). Schmitt's (2006) participants included RNs who had no prior experience

with case management and who worked within payer environments, such as health

maintenance organizations, case management vendors, and Workers' Compensation

insurance carriers. The participants were limited to RNs who had previously worked as

direct caregivers in acute health care settings. However, the findings from Schmitt's

study do not provide an understanding of the transition experience among RNs new to

case management with various other clinical backgrounds who are working in the

community, which is a major limitation to achieving an in depth understanding of this

transition experience. This literature gap poses a problem for the advancement of case

management in the community setting. Without an understanding of the transition

experience of RNs new to case management in the community setting, it is difficult to

provide adequate support and ultimately retain this group of professionals.

Purpose of the Study

The purpose of this study is to examine the process of transitioning to case management in the community by RNs. This research uses grounded theory methodology to develop a substantive theory on the transition experience for this population. More knowledge of this transition experience will help customize orientation programs to meet the needs of the RN case manager. Furthermore, adequate support during this transition period will lead to increased job satisfaction, which will in turn create more positive health outcomes for the clients utilizing case management in the community setting (Walsh, 2009).

Research Question

The research question for this research study is "What is the transition experience of RNs new to case management in the community setting?"

Chapter 2: Literature Review

According to Glaser and Strauss (1967), researchers using grounded theory methodology should refrain from conducting a literature review prior to data collection to avoid assumptions that may impose upon the emerging theory. However, Corbin and Strauss (2008) encouraged researchers to engage with the literature prior to data collection and throughout the entire research process. For this study, a preliminary literature review was conducted to gain a better understanding of the history of case management and the various case management models used within the Canadian health care system. In addition, the literature review provided information related to the outcomes of case management at the client and system level. Insight into some of the common issues faced by case managers was achieved as well. Finally, the preliminary literature review helped with the development of questions used in participant interviews. A conscious effort was made to prevent the literature from imposing on data collection and analysis (Corbin & Strauss, 2008). Additionally, a literature review was also conducted after data analysis to compare and contrast the findings from this study to other research findings.

The Cumulative Index to Nursing and Allied Health Literature (CINAHL) and PubMed electronic databases were used to conduct the literature search. Search terms included case manager, nurse case manager, care coordinator, care manager, care management, job satisfaction, job stress, and role transition. Most of the literature reviewed was related to the client and system benefits of case management (AHS, 2011; Ballew & Mink, 1996; Brokel, Cole, & Upmeyer, 2012; Canadian Home Care

Association [CHCA], 2007; Chow & Wong, 2010; Cunningham et al., 2012; Duke, 2005; Hammer, 2001; Jennings-Sanders & Anderson, 2003; NCMN, 2009; Park et al., 2009; Tahan & Campagna, 2010), common stressors among RN case managers (Keffer, 1997; McLaughlin, Miller, & Wooten, 1999; Moffat, 2014; O'Donnell, 2007; Randall, 2007; Schmitt, 2006; Smith, 2011; Tonges, 1998), and role ambiguity among RN case managers (Jamison, Ross, Hornberger, & Morse, 1999; Schmitt, 2006; Smith, 2011; Tonges, 1998; Waterman, Waters, & Awenat, 1996). Moreover, case management was largely discussed throughout the literature as occurring in structured settings, such as hospitals and other health care facilities (Cesta, 2012; Cunningham et al., 2012; McLaughlin et al., 2014; O'Donnell, 2007; Schmitt, 2006; Smith, 2011; Tonges, 1998; Waterman et al., 1996; Yoshie, Saito, Takahashi, & Kai, 2008).

Only one study (Schmitt, 2006) directly explored the transition experience from direct caregivers to RN case managers. However, there was a plethora of literature available related to the transition experience for new nursing graduates (Casey, Fink, Krugman, & Propst, 2004; Chandler, 2012; Chang & Hancock, 2003; Cho, Laschinger, & Wong, 2006; Dyess & Sherman, 2009; Ellerton & Gregor, 2003; Etheridge, 2007; Gallagher, 2012; Halfer & Graf, 2006). Some key elements of new nursing graduates' transition experiences included feeling incompetent in their new role (Chang & Hancock, 2003; Etheridge, 2007; Gallagher, 2012; Halfer & Graf, 2006), having difficulty organizing and prioritizing workloads (Etheridge, 2007; Halfer & Graf, 2006), feeling fearful of physicians (Chandler, 2012), feeling isolated; (Casey et al., 2004; Dyess &

Sherman, 2009; Gallaher, 2012), and having difficulty communicating with clients and families (Ellerton & Gregor, 2003).

Schmitt (2006) used focus groups as the research methodology to interview 11 RNs new to case management who had previous experience as direct caregivers about their experiences with assuming case manager roles within a payer environment. Study participants admitted they had little knowledge about the expectations of a RN case manager and felt they were unprepared to handle day-to-day stressors of their new role; this led to the common theme of role strain throughout the study. They expressed time-task orientation, interactions and relationships, and professional identity as significant sources of role strain. New time management and prioritization skills had to be learned on the job as there was a major shift from being a caregiver for 12 hours to managing cases over an unspecified period of time. Participants reported they felt uncomfortable forming longstanding therapeutic relationships with clients. Furthermore, their interactions with other health care professionals proved to be particularly challenging. For example, one participant explained that she was accustomed to following physicians' orders as a direct caregiver and she found it difficult adjusting to the new role of discussing client options and treatment rationales with physicians. Within a hospital setting, physicians are often viewed as having authority over health care decisions; however, RN case managers work collaboratively with physicians, and other disciplines, to develop an appropriate plan of care. Schmitt explained that many participants expressed they never envisioned themselves being in the role of a case manager and many viewed their role as less important than that of direct caregiver. These feelings

created a negative professional self-image, which was found to be a significant source of role strain among RNs new to case management.

While there were some similarities between Schmitt's (2006) findings and the literature related to the transition experience for new nursing graduates, there were significant differences as well. For example, new nursing graduates reported feeling fearful of physicians (Chandler, 2012). Schmitt's findings provided evidence that RNs new to case management had difficulty interacting with physicians because they were not accustomed to collaborating with physicians as equal contributors to the client's plan of care and not because they felt fearful. In addition, Schmitt explained that RNs new to case management had difficulty learning new time management and prioritization skills because of the major shift that occurred from being a caregiver for 12 hours to managing cases over an unspecified period of time. Furthermore, while new nursing graduates expressed difficulty communicating with clients and families (Ellerton & Gregor, 2003), RNs new to case management were unique in that they felt uncomfortable forming longstanding therapeutic relationships with clients.

The study by Schmitt (2006) helped to provide valuable insight into the transition experience for RNs new to case management; however, the RN participants did not practice as case managers in a community setting. Moreover, they were limited to RN case managers that previously practiced as direct caregivers. Since RN case managers in the community setting come from a wide variety of clinical backgrounds, it is important to explore the transition experience among RNs new to case management from different clinical backgrounds in order to provide a more comprehensive picture of the transition

experience. This may lead to the provision of adequate support for all RNs new to case management. There was no literature found in the CINAHL or PubMed databases that focused on the transition experience for RNs new to case management in the community setting.

In order to have a better understanding of case management in the community setting and RN case managers' roles, it is important to consider how case management is used in today's health care system. In addition, it is necessary to understand the common stressors faced by RN case managers throughout the health care system. Finally, it is critical to examine the current research that discusses the transition process of RN case managers from previous direct caregiver roles and non-community health settings, as this may provide insight into the transition experience among RNs new to case management in the community setting.

Case Management within the Health Care Setting

The escalating health care cost in Canada is a key driver for health care reform. According to Kodner (2009), integrated care was introduced as a method to achieve better access to health care services, seamless health care transitions, and system efficiencies. Although there is no universal definition of integrated care (Armitage, Suter, Oelke, & Adair, 2009; Hollander et al., 2007), case management is identified as its key component (Kodner, 2009). Across Canada, case management is most frequently used in the community setting by multiple health care disciplines, including medicine, social work, nursing, and occupational therapy (AHS, 2011). Case management is used to address the health and social needs of several populations in the community including the

homeless population, clients living with debilitating mental and physical illnesses, as well

as the senior population (AHS, 2010). Similar to integrated care, there is not a single

accepted model of case management within the literature (McGeehan & Applebaum,

2007). However, the fundamental purpose of case management is to promote the highest

possible quality of life and independence for clients and facilitate seamless transitions

through various health care providers and services while supporting the health care

system's sustainability through effective and efficient resource utilization (AHS, 2011).

  Case management models. Case management models within Canada's health care

system as defined by AHS (2010) include integrated models, strength-based models,

clinical models, transitional models, team models, medical models, and consumer-

directed models. Integrated models are used to plan and coordinate fragmented health

care services for clients with multiple physical or mental illnesses. Strength-based models

are used to help the case manager build on clients' strengths and achieve client

independence. Clinical models are used to help clients with co-morbid conditions achieve

optimal health outcomes and manage their illnesses outside of an acute care setting.

Transitional models are used for clients that return to the community setting after a

hospitalization to help them self-manage their illness in the community and improve

access to community resources, such as family physicians and pharmacists. Team case

management models are used to meet the multidimensional needs of clients through an

interdisciplinary approach to care. According to Huber (2002), the goals of a medical

case management model is to help clients throughout the continuum of a specific disease

achieve better health outcomes and reduce costs for the client and the health care system.

Finally, consumer-directed case management models means the client or an informal

caregiver takes on the role of a case manager and directs the care to meet the client's

needs (AHS, 2010). In this model, the health care professional will act as an advisor,

advocate, and/or educator to support the client in managing their own health needs

(Davis, Cornman, Lane, & Patton, 2005; McWilliam et al., 2004). Terra (2007) explained

that case management models are required to adapt to changing health care environments

in order to meet the needs of the population. This means it is possible for multiple models

to be used within the same health care setting.

Case managers are responsible for carrying out a variety of functions at both the

client and system level (AHS, 2011; Ballew & Mink, 1996; Tahan & Campagna, 2010).

At the client level, these functions include, engaging the client and building trust,

assessing the client's strengths and needs, identifying and setting goals, accessing

appropriate resources and overcoming system barriers to access these resources,

coordinating care, reassessing the client and evaluating the client's health outcomes, and

disengaging from the client–case manager relationship while connecting the client to

other community resources that may be of benefit (AHS, 2011; Ballew & Mink, 1996;

Tahan & Campagna, 2010). Case managers are expected to move fluidly between each

function on a day-to-day basis–sometimes carrying out several different functions for one

client throughout any given day (Ballew & Mink, 1996).

Expected outcomes of case management. Several expected client outcomes of

case management have been identified in the literature. These outcomes include

improved quality of life, timely access to health care services, decreased caregiver

burden, increased satisfaction with the health care system, increased sense of empowerment, client-centered goal development and achievement, and improved health status (AHS, 2011). In 2007, the Canadian Home Care Association (CHCA) released a report that demonstrated the benefits of case managers in the community for clients with chronic disease, which included improved clinical outcomes and client confidence. Although empirical results were not provided in the CHCA's report, several research studies have evaluated the effectiveness of case management on client outcomes (Brokel et al., 2012; Chow & Wong, 2010; Hammer, 2001; Jennings-Sanders & Anderson, 2003). Brokel et al. (2012) conducted a longitudinal study that examined outcomes among 512 clients with multiple chronic diseases who received community-based case management services over four years. To analyze the data over time, Brokel et al. used a time series, repeated-measures design. Interestingly, participants demonstrated an improvement in symptom control and self-care. In addition, they experienced an improvement in quality of life as evidenced by quality of life indicators used by the authors, which included self-concept, health status, pervasive mood, economic status, achievement of life goals and close relationships.

The findings from Brokel et al. (2012) support the results from a randomized controlled trial conducted by Chow and Wong (2010). The authors were interested to determine if a nurse-led case management program improved the quality of life for clients receiving peritoneal dialysis. Patients admitted to renal units and capable of using a telephone were selected for the study and randomly assigned to the experiment or control groups. Prior to hospital discharge, participants in the experimental group

received a comprehensive education program from a nurse case manager and a 6-week nurse-led case manager telephone follow up. Data from 43 participants were analyzed from the experimental group and data from 42 participants were analyzed from the control group. Participants from the experimental group reported an overall higher quality of life and experienced improved emotional state, less body pain, improved social functioning, and fewer issues with day-to-day activities.

Hammer (2001) described the results of a community-based case management program that was implemented at a rural community based hospital in the United States. The health outcomes for 25 clients who were case managed for 12 months were measured. Although the tool(s) used to measure the client outcomes were not disclosed by the author leading to concerns about the study's credibility, Hammer reported there were significant improvements in clients' cognitive, physical, and nutritional functioning and found that there was an improved efficiency in linking clients with required health care services. Jennings-Sanders and Anderson (2003) conducted a prospective qualitative study to describe how older breast cancer clients perceive case managers in the community. The researchers found that in addition to improving overall health outcomes, women over the age of 65 with breast cancer perceived nurse case managers in the community as an effective means to help manage multiple co-morbidities, provide support and education, provide assistance with activities of daily living, and help navigate the health care system.

Case managers are responsible for collaborating with other health professionals, building professional relationships, developing partnerships with clients, families, and

other professionals, educating others about the role of a case manager as well as

providing education to clients and families, advocating for the appropriate use of

resources, documenting, conducting community assessments, identifying and removing

system barriers that impact client care, and facilitating healthy transitions (AHS, 2011;

Ballew & Mink, 1996; Tahan & Campagna, 2010). Several expected system outcomes of

case management have been identified in the literature; these include appropriate

utilization of resources, efficient and cost effective health care system as service gaps and

duplication are reduced, optimized system flow for clients and staff by integrating

services though formal linkages to other service sectors and the community, and public

support reflected in client satisfaction surveys (AHS, 2011). In the report released by the

CHCA (2007) that demonstrated the benefits of case managers in the community for

clients with chronic disease, appropriate utilization of limited health resources was

identified as a key system outcome; however, no empirical evidence was used to support

this finding.

Duke (2005) provided a summary of a project that was implemented by Pitt County

Memorial Hospital and the Brody School of Medicine at East Carolina University

Geriatric Clinic. The purpose of the project was to examine the effects of a community-

based case management program for frail older clients in the community and what effect

this would have on health care utilization among this population group. Participants

received case management of medical and social conditions, telehealth assessments for

the medically compromised, hospice use and acceptance for end-of-life care needs, and

education about specific care needs and concerns such as fall, stroke, and pneumonia

prevention, dementia, depression, delirium, diabetes, dental care, constipation, polypharmacy, end-of-life issues, skin care, and nutrition. Data related to system outcomes were collected one year after the project was implemented. Overall, there was a 13% decrease in hospital admission, 38% decrease in emergency room visits, 22% decrease in length of stay, and 74% decrease in total hospital cost.

Hammer (2001) reported an increased number of emergency room visits with a decrease in hospital admissions 2 years after a community-based case management program was implemented for clients who were identified as high-risk clients or high users of costly health care services. These findings resulted in overall health care system savings. Hammer explained that after the community-based case management program, clients sought emergency care when needed rather than allowing their health to become an inpatient crisis level of care. In addition, there was an increase in physician office visits by program participants; however, Hammer identified that case managers linked participants with a primary care physician in the community, which meant fewer participants visited the emergency room for their primary care needs.

Common Stressors

Common stressors among RN case managers have been identified throughout the literature, and include interactions and relationships with other health care professionals (Randall, 2007; Schmitt, 2006; Smith, 2011; Tonges, 1998) and ethical dilemmas (Keffer, 1997; Moffat, 2014; O'Donnell, 2007; Randall, 2007; Schmitt, 2006; Tonges, 1998). These common stressors will be reviewed and discussed in the following section.

Interactions and relationships. Collaboration is a very important function among all health care professionals, and is especially important for case managers. RN case managers routinely work with a wide variety of professionals that include, but not limited to, occupational therapists, dieticians, physicians, discharge coordinators, business executives, and government personnel and they must be able to collaborate effectively with each of these professionals to achieve positive health outcomes for their clients.

Randall (2007) used a qualitative research design to understand interaction and relationship challenges encountered by case managers in the community. Data were collected from 36 key informants in Ontario, with representatives from case managers, managers, and external partners. Randall explained that the case managers did not typically deliver health care services to clients in the community; however, they were responsible for coordinating the delivery of services to clients by private partners, determining clients' eligibility for services, and monitoring the clients' ongoing progress. Therefore, the case managers were responsible to monitor the frequency and duration of services provided by other health care professionals and to manage resources. Case managers reported confrontations with other health care professionals that provided direct services to clients due to their financial accountability within the health care system. Furthermore, many RN case managers identified that they lacked the leadership skills to confidently advocate for services required by their clients and many felt intimidated by experienced professionals, especially government officials.

Tonges (1998) conducted a quantitative study to measure the intended and unintended effects of case management on job satisfaction and well-being. Findings from this study support the findings from Randall's (2007) study. RN case managers reported frequent interactions with other health care professionals that led to high levels of job stress among participants. Schmitt (2006) also found that RN case managers reported job stress from unanticipated dynamics in their professional relationships with other health care professionals and non-medical partners, such as business executives. RN case managers need to have the ability and confidence to access and negotiate with other professionals within the health care system in order to achieve successful client and system outcomes (Smith, 2011). These findings suggest the importance of providing support for RN case managers with respect to building professional relationships with other members of the health care team.

Ethical conflicts. Case managers experience unique ethical conflicts within various health care settings (Keffer, 1997; Moffat, 2014; O'Donnell, 2007; Randall, 2007; Schmitt, 2006; Tonges, 1998). Ethical conflicts occur primarily because of the case manager's responsibilities to contain health care costs while ensuring clients receive the appropriate services and care to achieve optimal health outcomes (Keffer, 1997; Moffatt, 2014; O'Donnell, 2007; Randall, 2007; Schmitt, 2006; Tonges, 1998). Using an interpretive phenomenological research approach, O'Donnell (2007) interviewed 15 RN case managers in both hospital and community settings in an effort to gain insight about ethical concerns experienced by RNs as they transitioned into their new case management role. O'Donnell identified several themes, which summarized RN case managers'

experiences related to ethical conflicts in their role. The primary theme uncovered by the author was titled "Case Management as a Balancing Act." O'Donnell explained that case managers are required to balance clients' needs and limited organization and community resources along with various system-orientated goals, such as cost-containment. Similarly, Keffer (1997) reported that case managers must try to balance competing obligations to their clients, employer, and society, which may lead them to experience ethical dilemmas throughout their careers. Furthermore, O'Donnell uncovered that the participants perceived dealing with conflicting goals as normal day-to-day functions of the RN case manager, which may lead to significant distress over time (Moffat, 2014). In addition, participants in O'Donnell's study reported that they were unfamiliar with how health care organizations make financial decisions and were therefore unable to make informed judgments and decisions regarding various health care options for their clients. This finding is related to Moffat's (2014) claim that a major source of distress among case managers is their enormous accountability with minimal authority.

O'Donnell's (2007) findings were echoed in Randall's (2007) qualitative study, in which case managers reported feeling uncomfortable making decisions related to resource allocation because of their financial responsibility to their employer and their responsibility to advocate for services that are in the best interest of their clients. RN case managers felt their employers perceived the financial objective as the most important and clients' needs were secondary, contradicting core values such as justice and promoting health and well-being in the Code of Ethics for Registered Nurses (CNA, 2008). Furthermore, Schmitt (2006) found that RNs felt uncomfortable as they transitioned into

their role as a case manager where they experienced a culture shift that was focused on financial objectives. Schmitt reported that RN case managers often struggle with achieving a balance between allocating public dollars and being accountable to their professional regulatory body. In addition, Tonges (1998) conducted a quantitative study using a cross-sectional correlational design to collect data regarding perceived job characteristics and workplace well-being outcomes among RN case managers in an acute care setting. Tonges found that RN case managers reported ethical dilemmas related to their value of ensuring all available resources are exhausted to improve clients' health outcomes and to their new role, which requires more attention to resource management. The findings from these studies make it evident that RN case managers require support to relieve the stress surrounding the ethical burden created by their responsibility to the client and their employer, or health care system.

Role Ambiguity

Role ambiguity, in terms of RN case managers, has been defined as "uncertainty on the part of the case manager as to what his or her role within the organization actually is and what is expected by colleagues" (Smith, 2011, p. 183) and has been identified as a major cause of job stress among new RN case managers (Schmitt, 2006; Smith, 2011). The most prevalent rationale as to why RN case managers experience role ambiguity is the wide variation of case management models being used in both acute care and community settings, which has led to poor role definitions for RN case managers (Lamb, 1992; Park et al, 2009; Tonges, 1998; Yoshie et al., 2008; Zander, 2002).

Jamison et al. (1999) conducted a study using a grounded theory approach to discover the processes of implementing a case manager role on a medical-surgical unit at an acute care facility. The authors conducted observations and interviews with 17 participants, all of which worked on the medical-surgical unit. Constant comparative analysis was used to uncover the basic social psychological problem from the data, which was role ambiguity. Jamison et al. found that RNs new to case management experienced role ambiguity due to lack of clear expectations, inconsistencies in roles and responsibilities among other case managers, and a disparity from personal and employer expectations related to role function. Similarly, Waterman et al. (1996) used a qualitative design to examine the concerns and perceived needs of new case managers on a rehabilitation unit at an elderly care hospital and found that RNs new to case management experienced anxiety and confusion related to their role functions. In Schmitt's (2006) qualitative study, RNs new to case management who have transitioned from their role as a direct caregiver expressed that they were not aware of the roles and responsibilities of a case manager prior to entering the job, which left them unable to anticipate areas in which they may need extra support. Interestingly, a quantitative study conducted by Tonges (1998) yielded similar results and identified that RN case managers experienced significantly higher levels of role ambiguity, which led to more job stress than nurses working as direct caregivers. Although some of these studies are dated, these findings suggest that RNs new to case management lack knowledge upon entering their new role and changes must be made to undergraduate education programs, orientation programs,

and existing support methods (Smith, 2011) to facilitate smooth transitions among RN

case managers.

Summary of Literature Review

Case management is commonly used by multiple health care disciplines within

various health care settings as a means to control cost and improve client health outcomes

(Joo & Huber, 2013). Empirical evidence illustrated that case management has been

found to improve overall client health outcomes (Brokel et al., 2012; Chow & Wong,

2010; Hammer, 2001; Jennings-Sanders & Anderson, 2003), client self-management

(Brokel et al., 2012; Jennings-Sanders & Anderson, 2003), and system efficiencies

(Hammer, 2001). Furthermore, it is widely accepted that RNs are well suited to be case

managers in the community because of their unique skill set, such as communication

skills, trust-building abilities, clinical assessments, and overall knowledge of the health

care system (CARNA, 2008; CNA, n.d.; Conti, 1996; Park et al., 2009; RNAO, 2003;

Schmitt, 2005). A review of the literature identified the various functions of case

management, expected client and system outcomes, common stressors, and the issue of

role ambiguity among RN case managers. In addition, a significant amount of literature

was found related to the transition experience for new nursing graduates into practice.

Without close examination of the literature, one may conclude that the transition

experiences for new nursing graduates and RNs new to case management are similar;

however, significant differences were noted. A knowledge gap related to the transition

experience for RNs new to case management in the community setting currently exists. In

order for RNs new to case management in the community setting to receive adequate

support, an understanding about their unique transition experience is crucial. Insight into

their transition experience can help guide the development of high quality and relevant

orientation programs, may increase job satisfaction among RN case managers in the

community setting, and ultimately create more positive health outcomes for the clients

utilizing case management in the community setting (Walsh, 2009).

Chapter 3: Methodology

The methodology used to conduct this research was grounded theory as outlined by Glaser and Strauss (1967). This methodology seeks to generate explanations of human behavior that are grounded in qualitative data. An advantage of generating a theory grounded in the data is that the theory can then be used to explain how individuals behave as they do in certain situations. Emerging concepts are linked to the data and embedded in the context of the participants' lives (Morse, 2001).

Grounded theory uses a symbolic interactionist perspective to study human behavior and interaction. Symbolic interactionism focuses on the meaning of events to people in everyday settings. Individuals come to understand self and others through interpretation and meanings of social interactions (Blumer, 1969). The researcher's task is to acquire and understand the meaning of the participants' interactions and behaviors through the participants' lens (Blumer, 1969).

Grounded theory generates either substantive or formal theory that is grounded in the data. Formal theory is a broad comparative analysis of several diverse substantive groups, whereas a substantive theory is focused in one particular area (Glaser and Strauss, 1967). Because I wanted to focus specifically on case management by RNs in the community, my goal was to generate a substantive theory. This was achieved by simultaneous data collection, categorization, and analysis of data, a process known as the constant comparative method (Glaser & Strauss, 1967). Because my interest was to generate a substantive theory of the process of transitioning to case management for RNs, grounded theory was the appropriate methodology to gain an understanding and develop

empirical knowledge related to this transition experience. Finally, grounded theory is an appropriate method to guide research in areas where there has been little research done, such as RNs working in case management. The research was undertaken to discover the psychosocial process that RNs new to case management in the community setting experience as they transition to a new role.

Methods

In this section, I will describe the participants and methods of recruitment, data collection, methods of data recording and analysis, the research setting, ethical concerns, and trustworthiness of the study.

Recruitment of participants. According to Streubert and Carpenter (2011a), participants of grounded theory research "should be chosen based on their experience with the social process under investigation" (p. 131). The target population for this study included a sample of English-speaking RNs that have been working as case managers in a community setting for a minimum of 6 months to a maximum of 2 years. I chose a minimum of 6 months because it is recommended that orientation programs for RNs within specialty areas have a time frame of 6 months (Association of Registered Nurses of Newfoundland and Labrador [ARNNL], 2003). I was unable to find an Alberta document that outlined best practice guidelines related to time frames for nursing orientation. Furthermore, the time frames recommended by the Association of Registered Nurses of Newfoundland and Labrador (ARNNL) are currently used as best practice guidelines for nursing orientation and have not been revised since 2003. I acknowledge that RNs new to case management in the community setting may not have received 6

months orientation; however, it is noted in the literature that it can take up to 6 months

for a RN to feel comfortable in his or her new role (Janes, Beck, & Denny 2002). I have

chosen a maximum of 2 years because according to Benner (1984), this is the time it

takes for nurses to become competent within a new nursing role and setting. Although

Benner's work is dated, the levels of nursing experience, which range from novice to

expert, continue to be useful to help understand the stages in which new and experienced

nurses go through as they embark upon a new nursing role.

Purposive sampling was used to recruit participants for this study. Individuals

were chosen based on their ability to give information related to their transition

experience to case management in the community setting. Participants were recruited

through two methods: (a) community agencies and (b) using snow ball sampling.

Participants were recruited from various community agencies within an Alberta city in

which RN case managers are promoting quality health and supportive services for

vulnerable populations, such as clients affected by mental illness, cognitive loss, and the

elderly. The participants that were recruited are experts because of their experiences with

the social process under investigation. My research objective was narrow in that it only

focused on bridging the knowledge gap for one particular transition experience for a

single group of professionals within nursing. Prior to participant recruitment, a letter (see

Appendix A) was sent to community program directors within Alberta Health Services

(AHS) that requested approval to recruit potential participants and to carry out the

research study. Participant recruitment included a poster (see Appendix B) that was

distributed to RN case managers' offices throughout the various AHS community work

settings. Furthermore, the poster was emailed as an attachment to employees within AHS. The poster outlined the purpose and significance of the research study as well as my name, status, and contact information.

Snow ball sampling was also used as a method to recruit participants. This means participants were invited to suggest other colleagues that were interested in participating in the study. One participant suggested three colleagues, all of whom met the inclusion criteria and agreed to participate. Prior to speaking with other potential participants, I ensured they agreed to be contacted.

Recruitment continued until theoretical saturation was reached and no new codes were developed from the data. Theoretical saturation is the point in which categories are well developed and further data collection and analysis do not provide further insight into the experience that is being studied (Corbin & Strauss, 2008). According to Corbin and Strauss (2008), sample sizes for grounded theory studies can only be determined when the researcher truly believes that all concepts have been developed from the data and will also fit well with any new data that can be generated.

Data collection. Semi-structured interviews were used (see Appendix C) to guide the data collection process. Interview guides help the researcher locate a starting point for data collection (Bach, Ploeg, & Black, 2009). Questions explored participants' transition experience into their new role as a RN case manager and the participants were encouraged to add any information they felt was pertinent to the topic and not addressed during the interview process. With the permission of each participant, the interviews were digitally recorded and I made field notes during the interview. Writing field notes is a

process described by Corbin and Strauss (2008) as writing down ideas, or key words that are generated during data collection that can be used to help generate new research questions and explore new data. These notes allowed me to ask questions as new data were generated (Streubert & Carpenter, 2011a). Given the nature of grounded theory, the research questions were refined as data were generated and analyzed. For example, during one of the first interviews, I made a note that the participant referred to her work as a "black hole that doesn't get filled." I wrote these words down as it cued me to explore participants' workload during future interviews with other participants. The length of each interview was approximately 45 minutes. One interview completed for each participant.

Data recording and analysis. Consistent with grounded theory methodology, data collection and analysis occurred simultaneously (Chenitz & Swanson, 1986). The raw data collected from the interviews were stored on a flash drive and then transcribed to Microsoft Office Word files. In addition, I kept a reflective journal that recorded memos consisting of my analytic thoughts and ideas about each interview. Memos, or interpretive summaries, were written after every interview to reflect the participants' stories and facilitate the development of the emerging theory. Memos were used to note my perceptions of the data and a means to record ideas that require further exploration. They are written by the researcher to transform data into theory after the researcher leaves the field (Corbin & Strauss, 2008). Memos enable the researcher to work with concepts rather than raw data and they often stimulate new insights into data (Corbin & Strauss, 2008).

In this study, the constant comparative method (Glaser & Strauss, 1967) was used to discover the main categories that account for the variation in data. The digitally recorded interviews were transcribed into separate documents and codes were recorded within the 1-inch margins of each document. Codes refer to concepts that are derived from the researcher's interaction with data. Coding involves techniques such as asking questions and making comparisons between the data and then developing concepts derived from the data in terms of their properties and dimensions (Glaser & Strauss, 1967). In other words, I examined the interview data, line by line, identifying persistent words and phrases and themes within the data set. Level one codes, or in vivo codes, were developed using open coding–a process which involves reviewing the data line by line in order to break it apart and create tentative concepts related to sections of the data (Corbin & Strauss, 2008). Comparative analysis was then used to examine each code for similarities and differences. Level two or intermediate coding was used to develop categories through selecting significant proportions of the text and linking categories that shared similar properties and dimensions. Level three coding was used to identify categories, or the main theme, which integrates all lower-level categories and reflects the central theme of all categories (Chenitz & Swanson, 1986; Glaser & Strauss, 1967).

To facilitate an understanding of data analysis, the following is an example of data coding. One participant stated, "I was fortunate enough to have my manager. If it wasn't for her, I would be lost and picking up pieces of I don't even know what." Another stated, "My manager was really good about talking with me if I needed help or facilitating anything if I needed." The memo for the first statement was "Participant feels

fortunate to have help from her manager" and the level one code was "Feeling fortunate

to have help from manager." The memo for the second statement was "Participant

perceives being able to openly discuss concerns with management as a very important

part of the transition process" and the level one code was "Discussing concerns with

manager". In the second level coding, I compared these two pieces of data and

summarized it as "Feeling supported by management." The core concept and level three

code was support, which is a sustaining factor during the transition to case management

in the community setting.

      Setting. All 11 face-to-face semi-structured interviews took place in a private and

quiet conference room that I requested from the community agency prior to data

collection. All interviews took place at a different location; however, the conference

rooms were equipped with adequate lighting and comfortable temperatures. The

interviews were conducted at a time that was convenient for the participant and free from

interruptions.

Ethical Considerations

      As I am a graduate student at Memorial University of Newfoundland, the Health

Research Ethics Authority (HREA) reviewed the research proposal. The HREA uses the

Tri-Council Policy Statement (Canadian Institutes of Health Research, Natural Sciences

and Engineering Research Council of Canada, & Social Sciences and Humanities

Research Council of Canada, 2010) as a guide to ensure respect for human dignity is

maintained throughout the research process. Prior to the start of the research, permission

to conduct the research was obtained from HREA (see Appendix D) and the Northern

Alberta Clinical Trials and Research Centre (see Appendix E). A budget (see Appendix F), required by the HREA, is included as well.

After each participant contacted me and showed interest in participating in the study, a detailed verbal explanation of the study was given via telephone. A detailed written consent form (see Appendix G) was distributed to the participants via email after they received the verbal explanation. Participants were asked to sign the consent form and return it if they agreed to participate in the study. I collected the signed letter from the participants in person prior to starting the interview; therefore, there were no postal costs for the participants. Participants were given sufficient time to read and process the written information. They were informed of their freedom to withdrawal from the study at any time verbally and in writing. In addition, consent was validated at the beginning of the interview and I explained the purpose of the study before the digital recording had commenced.

Confidentiality was maintained throughout the research process. As explained by Streubert and Carpenter (2011b), achieving true anonymity in qualitative research is impossible. I conducted face-to-face digitally recorded interviews; therefore, I was able to link data to each participant. However, I ensured participants of anonymity and confidentiality of any future publications or presentations of the research by assigning numbers to interviews and transcriptions of the interviews. In addition, participants were informed that the digitally recorded interviews will be maintained on a password protected flash drive and placed in a locked filing cabinet located in my locked office at my location of work for a period of five years as per HREA guidelines. After five years,

the data on the flash drive will be erased. I was the only person who had access to the

locked cabinet containing the research information and I will continue to have sole access

for the remainder of the five years.

During the time of recruitment and data collection, I was the Nursing Professional

Practice Lead for the same program in which the participants worked. Therefore, prior to

the start of each interview, I reinforced that the research was not affiliated with the

program in which they worked and was strictly being carried out to fulfill the

requirements for a graduate degree. The research did not pose any physical risks and the

interview questions did not elicit an emotional response from the participants.

Rigour

Traditionally, empirical knowledge in nursing has been derived from randomized-

controlled quantitative studies, which has been perceived as being the only method to

yield dominant realities (Arnold & Sherwen, 1986; Holmes & Phil, 1990; Parse, 1999;

Porter, 2010; Whelton, 2000; White, 1995). Due to a shift towards postmodernism and

the appreciation of multiple truths (Corbin & Strauss, 2008), qualitative methodologies

such as grounded theory have been receiving more attention. Throughout the study, I

employed several strategies to ensure rigour of the research. Several criteria to ensure

qualitative studies' rigour have been outlined by Guba (1981), and have been widely

accepted by other qualitative researchers. These are credibility, dependability,

confirmability, and transferability. Credibility means that the researcher measured or

tested what was actually intended. Dependability ensures that another researcher will

yield the same results if the study were repeated. Confirmability refers to the steps taken

by researchers to ensure findings are generated from participants' experiences and not influenced by their own perceptions. Transferability refers to the ability to apply the findings to other situations.

To achieve the study's credibility, I used peer debriefing, which is explained by Lincoln and Guba (1985) as a method that involves discussing the researcher's findings and analysis with an external person in an effort to help the researcher gain insight into personal biases and assumptions that may affect conclusions drawn from the data. To carry out peer debriefing, I discussed the data and my analysis with my thesis supervisor on an on-going basis. My supervisor, who is familiar with this method of data collection and analysis, was able to ensure consistent coding of data. Peer debriefing ensured the participants' transition experience was measured appropriately and prevented my own assumptions from affecting the data analysis. I ensured the results were dependable by adhering to the proper data analysis guidelines of grounded theory. In addition, each stage of the research process was explained and rationale for the methodology used was provided. This detailed coverage allows the reader to evaluate the appropriateness of the research process and the necessary information to determine if similar results would be found if the study were repeated, thereby making the study dependable. This study met the confirmability criterion because I maintained a clear and detailed audit trail (Lincoln & Guba, 1985) during the research process, which included notes from raw data, data reduction and analysis products, data reconstruction and synthesis products, and also notes that explained procedures, designs, strategies, and rationales, or process notes. The audit trail provided a clear understanding of each decision that was made during the

entire research process (Lincoln & Guba, 1985) that moved from the raw data to the

theoretical explanation of the transition process of RNs new to case management in the

community setting. It provided confirmation that the findings were not influenced by my

own perceptions or assumptions about the data. Finally, transferability will be met by

reporting the findings in a clear manner such that members of the public will be able to

determine if the findings can be applied to similar situations.

Chapter 4: Findings

This chapter contains the findings of a study that explored the transition experience for RNs new to case management in the community setting. In this chapter, I present the process of transition into case management as the RN participants experienced and described it in their interviews. The findings from this study were categorized into the stages that participants moved through as they adjusted to case management in the community setting. I have also highlighted several factors that had significant influence on how participants adjusted to the transition. Finally, a summary will complete this chapter.

Participant Demographics

At the beginning of the interviews, demographic data were collected. Eleven RNs participated in the study, all of whom were female. All participants had at least 2 years of nursing experience. Four participants had between 2-5 years of nursing experience; three had 6-10 years; two had 11-15 years and; two participants had over 20 years of nursing experience. Five participants worked in acute care prior to starting their role as a case manager; three worked in community health; two worked in a clinic; and one participant worked within the health department for the provincial government. Seven participants had been working as a RN case manager in the community for 1-2 years while four had been working as a RN case manager in the community from 7-11 months. Most participants were RN case managers for older clients living in assisted-living environments. Some of these clients had significant cognitive decline and required a secured unit for safety purposes, while other clients required assisted-living due to a

decline in physical functioning and did not live on a secured unit. Three participants were

RN case managers for clients under 65 years of age who lived in support homes. These

clients required support due to mental health concerns, such as depression and

schizophrenia.

Overview of the Stages

The core category in the process of the participants' transition is "adjusting to

case management in the community" (see Figure 1) because participants were unfamiliar

with case management and this is how they described their transition process; one in

which they had to constantly adjust to meet the demands of the new role.

Stages of "Adjusting to Case Management in the Community"

Stage 1	Stage 2	Stage 3
Slugging it out ⟹	**Seeing the job as it is** ⟹	**Finding the way**
• Overwhelmed in the beginning	• Wanting more job resources	• Gaining knowledge through experience
• Feeling alone in the job	• Lack of role clarity	• Implementing coping strategies
• Feeling stressed in the role	• Feeling solely responsible for client health outcomes ⟸	• Still not fully comfortable
• Lack of expectations ⟸		
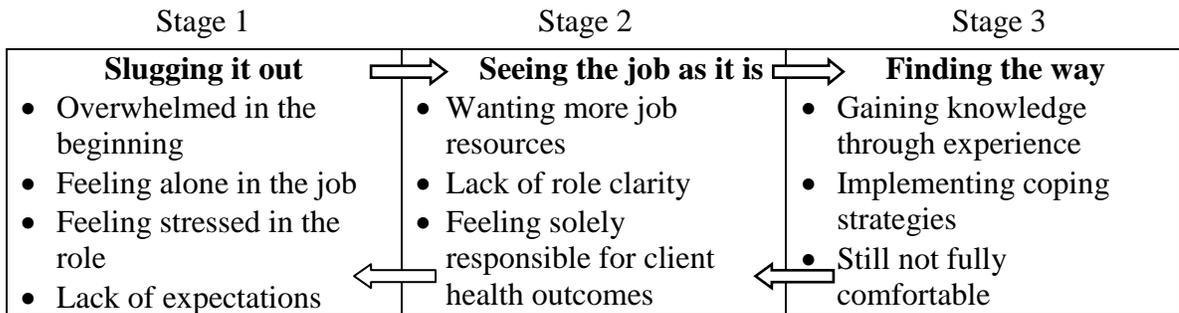
Sustaining/Constraining Factors

Support	**Relationships**	**Job Satisfaction**
• Support from Clinical Nurse Educators (CNEs)/managers	• Operator	• High/Medium Job satisfaction
• Support from colleagues	• Staff	• Case manager as desirable job
	• Clients/Families	• Case manager more desirable than acute nursing
	• Health care professionals	• Work schedule appealing
	• Communication	

Figure 1. The process of transition for RNs new to case management in the community setting.

The findings from this study were categorized into three stages that participants moved through as they adjusted to case management in the community setting: (a) slugging it out, (b) seeing the job as it is, and (c) finding the way. Each stage of the process is characterized by the participants' experiences that reveal their thoughts and feelings as they adjusted to the transition. Although the stages appear distinct, the nurses begin their experience in stage one and move back and forth as they adjusted to case management. The identified sustaining/constraining factors had a significant influence on how participants adjusted to the transition and are explained in detail within this chapter.

Stage 1: Slugging It Out

The first stage of "adjusting to case management in the community" has been identified as "slugging it out." The phrase "slugging it out" was expressed by a participant who was trying to capture key elements of her transition experience. Although not quoted by others in this study, the in vivo code "slugging it out" accurately describes the first stage of the transition for all of the new case managers. The phrase "slugging it out" represents the ongoing struggles by all the participants. For example, they all described their struggle with the significant amount of learning required to carry out their roles and responsibilities. "Slugging it out" also represents the struggle experienced in relation to the sense of isolation in their new role. Furthermore, participants struggled with the high level of job stress experienced, especially in the beginning of their transition to case management. Additionally, the phrase "slugging it out" represents the determination, commitment, and perseverance required to make it through the difficult transition in order to provide optimal care for clients.

Overwhelmed in the beginning. When asked to describe what it was like when they first started as a RN case manager in the community, a common response from most participants was that they felt overwhelmed. The RN case managers described feeling overwhelmed for a variety of reasons, including having a heavy workload, experiencing a steep learning curve, having insufficient time to process the new information, learning how to navigate the electronic documentation system, Medical Information Technology (MEDITECH), having an unconducive work environment, and having an inadequate orientation process. One participant described feeling overwhelmed upon starting her new role by stating:

Oh very overwhelming. I felt lost. Like I didn't know where to start and how to handle different situations. And, at this site, there isn't a doctor that is good about participating   in rounds or anything like that. He just shows up when he wants. I had a lot of   admissions. I just found it very overwhelming. I had lots to do and I didn't know how to prioritize my time. During my buddy shifts, everything was stable so I wasn't able to do a lot of hands on learning like you get when you do buddy shifts in acute care.

Most expressed that they felt overwhelmed because of a steep learning curve that occurred once they started their new job.

It was pretty overwhelming. It was a huge learning curve. And when I first started

they said it'll be six months to a year learning curve. But yeah, it was

overwhelming. All the different types of tasks you have to learn. And just all the

different roles. All the little things.

Two participants stated that they were given sufficient learning material, including documents and access to electronic resources; however, there was insufficient time to process the information. One explained, "It was very overwhelming. There was a lot of good information. I had two or three books of information that we had gone though. But the time to process it wasn't there."

There were three participants who specifically identified learning MEDITECH during their orientation as overwhelming. Learning MEDITECH proved to be challenging in the beginning and they explained that they continued to struggle with navigating this electronic documentation system. One described learning MEDITECH by saying, "Even learning MEDITECH. In the classroom, we had to listen and then go and do it. That doesn't work for me. I struggled with MEDITECH and I'm probably still struggling."

None of the participants had previous experience with MEDITECH; however, some recognized that their experience with computers and technology may have helped them with learning how to use MEDITECH. One participant stated, "MEDITECH was good. I can see challenges for people who maybe aren't technologically savvy but I was able to pick it up okay." Another stated, "I heard horror stories about MEDITECH, but I haven't had any problems. I grew up with computers so it's relatively easy for me."

Furthermore, some participants stated that their working environment was not conducive to learning, which exacerbated their feeling of being overwhelmed in the beginning. Their attention was continuously being pulled away from learning the job due to numerous distractions within their work environment.

They put me in a facility where there were a lot of concerns being expressed by

the staff that were already there. It was a facility that did not have the organization

that is here. It was a facility that had problems and it was very busy and very…I

really don't know how to say it. I don't want to say disorganized because the staff

there weren't disorganized, but the system was. It was a situation where I went in

to learn a job, but because of the things that were happening there, it wasn't

possible. So that added to the confusion.

Participants also reported feeling overwhelmed with the orientation process.

Interestingly, there were inconsistencies reported among them in regards to the amount of

time for orientation to case management in the community. There was some variation

related to the orientation period among the participants. Five participants stated their

orientation lasted about 1 month; two stated it was 6-8 weeks; one said her orientation

lasted about 2 weeks; and two were unable to recall but stated the orientation was

"lengthy." It is not clear why the orientation process differed, as all had worked for the

same program within AHS. One participant described the orientation process as

disjointed.

It seemed as though it was spread out over a period of time. It seemed a little bit

disjointed. It was a bit overwhelming the way it was spread out. Usually, when

you get a job, you do your orientation, it's pretty straightforward, you go on the

unit. But, this seemed to be spread out.

Eight participants stated that they felt overwhelmed after their orientation had ended at a

time when they had to carry their own heavy caseload. Intense feelings of stress and

anxiety continued after they should have been equipped with the knowledge to take on the role as a RN case manager in the community.

The common experience described above in the first stage of the process of "adjusting to case management in the community" was that of "feeling overwhelmed in the beginning." The participants identified a steep learning curve and a lack of time to process the new information as contributing factors to feeling overwhelmed. Furthermore, some identified learning MEDITECH as overwhelming in the beginning; however, this was not experienced by everyone. Participants ultimately conquered the learning required in their new role; however, it was something they struggled with from the beginning. They were required to face the struggle on a daily basis or "slug it out" to function in their new role.

Feeling alone in the job. Participants reported that they felt alone as a RN case manager in the community and struggled with a sense of isolation in their new role. Nine participants had offices at the facility where their clients lived; of those, six shared an office with another case manager while three worked alone. Only two participants had clients that lived in support homes and these participants were based out of a central office where other case managers worked as well. Although most worked with at least one other case manager, many reported that they felt isolated at their work site. One participant who worked with another RN case manager at her office described feeling alone in the job.

There are a lot of barriers. We're very isolated in our own site. And depending on

> how many clients you have at your site, it's either you or your colleague who may
>
> or may not have more experience than you.

This case manager identified working alone as a barrier to fulfilling her role as a RN case

manager in the community even though she shared an office with another case manager.

Therefore, sharing an office with only one other case manager may not be adequate to

alleviate feelings of isolation. She further explained that she felt there was limited support

available at her work site, which was in contrast to what she was told during her

application interview for the RN case manager position.

> When I first interviewed for this role, they [interviewers] actually assured me that
>
> there's a lot of support and resources out there so you're never alone as a case
>
> manager. But when you're settled into this role you find out that you are very
>
> much alone. And if you're not clinically strong or confident in your decisions,
>
> you're hooped.

Although she shared an office with another RN case manager, it was evident that there

was some unease with not having a large support group within her work environment.

However, those who worked as the only case manager at the facility expressed the

greatest anxiety about working alone. One participant explained that she found it very

difficult not having someone at her site to go to for advice or to share ideas:

> Especially when I was left here alone and I had no idea what I was doing. It's
>
> really hard not having another person with Alberta Health Services with me at the
>
> site. I felt very out of place with the operator and all of their expectations. So, I

found that really difficult. I couldn't go to somebody directly and get advice about

my role.

An operator is the organization or agency external to (AHS) that delivers publicly funded

continuing care health services. She later elaborated on her feeling "out of place with the

operator".

And I felt that it was ten against one so I'll just kind of do it. I think I would

benefit from having another case manager here and having someone to talk to and

bounce ideas off of. It feels like them [operator] against me here.

From this statement, it is clear that the participant believed that sharing an office with

another case manager or AHS employee would provide her with support when working

within the demands of the operator staff. Due to her lack of knowledge in case

management, she did not have the confidence to assertively deny unreasonable requests

from the operator. By using the phrase "ten against one," suggests she felt alone in her

efforts to carry out her role appropriately. This is linked to a description made by another

participant related to confidence in the case manager role. She stated, "It's different

because you're by yourself so you have to build a backbone and be confident." Some

participants who shared an office with another case manager expressed gratitude and

sympathized with those case managers who are working alone.

Many of the participants experienced a lack of formal mentorship at the beginning

of their new role as a RN case manager in the community. One expressed her frustration

with a lack of mentorship by saying:

I was paired up with a CNE [Clinical Nurse Educator] who came out to the site

once and then we had one follow up phone call to talk about issues and what can

help but there was no follow up after that. So it was like, we know these are the

challenges but then it was just dropped. I think if there was more mentorship, kind

of like once a month for the first few months, to kind of help you with certain

things. Because there are some things that you get from guided mentorship. There

are certain things that I wouldn't have asked. There are some things I wouldn't

call and ask unless I had a burning question that I needed answered.

It is evident that she did not believe the support received from the Clinical Nurse

Educator (CNE) was adequate to facilitate a good transition to case management. Others

shared similar stories. For example:

I did have a buddy, a CNE to mentor me, but unfortunately, she wasn't very

familiar with the case management role. And it was very difficult for her to help

me organize my caseload. She was here to help me crisis manage rather than case

manage.

She explained that although she was assigned a formal mentor, she did not receive

adequate support in the beginning to help organize her caseload. Others shared this

experience. Many reported that they were unable to organize their caseload because of

too many urgent issues. There was an expressed need for ongoing support during periods

of high workloads to ensure other important aspects of their work did not fall further

behind. One case manager explained a constant sense of crisis.

Well, they [managers] give us these 6 priorities, which we're supposed to follow. But it's very challenging when you have these priorities and you're always having to crisis manage. How do you prioritize when you always have…I mean, what's more important? I know client care is important but when your work gets behind because you're dealing with client issues then you're kind of at fault. There's no one there to give you that extra support. There's no one there to come in and do your RAIs [Resident Assessment Instruments] or monthly [client] visits or whatever else. Your site is on fire and there is no one around to help.

The experience of "feeling alone in the job" was supported by the participants' experience of isolation at their work sites. Those who were the only case manager at the site expressed these feelings as more intense than those that shared an office with a colleague. Furthermore, there was an expressed dissatisfaction with the level of initial and ongoing support received by mentors. This lack of support led to feeling a sense of helplessness as they were left to face the struggles of their new job, or "slug it out" alone.

Feeling stressed in the role. Several sources of job stress were described during the "slugging it out" stage of adjusting to case management in the community. These sources include heavy workloads, unrealistic expectations of RN case managers, ongoing nature of their work, and the emotional demands of their job. Eight participants described heavy workloads as a significant source of stress during their transition to case management. Specifically, one participant expressed that she was unable to provide the standard of care she expected of herself and expected by others because of having such high caseloads.

> I find the caseloads high. Currently, my main caseload is 43 but I'm covering 24 from my previous caseload until someone takes over for me. So there are a lot of things I can't meet. I can't meet certain standards just because my caseload is too high. I can't do my monthly [client] visits. So my old caseload is suffering because that's not my priority.

During my interviews, I did take note that some case managers had fewer clients than others. The rationale for this inconsistency was not clear. One participant recognized that some of her colleagues had smaller caseloads and she questioned if she would be able manage her workload more effectively with fewer clients. She stated, "Sometimes with 50 clients, I wonder if I should have a smaller caseload. Because I know others that have 30 or 40, which seems to be more manageable." Another participant explained that lowering case managers' caseloads would help decrease the level of stress experienced. She stated: "Smaller caseloads. And from what I've been told, the caseloads are only going to get bigger! They [managers] are going to have to bring in somebody else here. So caseload is definitely a factor [of job stress]."

Similarly, another stated:

> More case managers to lower the caseload. I mean forty is enough to keep you busy all the time. It is the little things that come up that cause you to fall behind and it's hard when you fall behind.

> Interestingly, all shared a similar sentiment in that they believed the expectations

of the case manager are unrealistic. More specifically, workloads were increasing without any workload reduction strategies from management.

> I feel like there's a lot put on us from management. Like the extra duties they
> want us to do. Like, safety-risk plans and more interventions in MEDITECH. The
> [client] conferences after six weeks and every year…those are doable. But I just
> feel like there is always more and more they want case managers to do, but
> nothing they want us to stop doing and there is not a lot of resources to help us be
> more efficient.

One case manager explicitly stated that increasing workloads without any workload reduction strategies was a direct cause of job stress and attrition.

> I think the paper work is becoming a bit ridiculous. Our caseloads are big enough
> and we can manage but when you keep adding more and more things to do
> without taking anything away, it becomes overwhelming. I mean, it might only
> take 10 or 15 minutes to do, but when you're doing that for 40 people…if you
> [managers] are going to add that much time to someone's work schedule you need
> to see when they are able to do it. That is when you see stress. Caseloads get
> behind. I've seen it here. People have gotten stressed out and had to leave the job.

Another case manager reflected on previous jobs whereby discussions with staff and managers occurred to determine appropriate workload levels. She expressed a desire for managers to adopt this strategy.

> When they [managers] are bringing new stuff in for us to do, they need to
> remember to take some stuff away. If there is an expectation that now you need to
> do this, now you need to do that, you take something away. I'm very much an
> advocate of that because I've worked with managers before who have done that.

One participant expressed a sense of powerlessness related to the ability to effectively address the concerns related to the heavy workloads of a case manager. "I know that it [workload] is not going to change. The way our government is going. The expectations of us in our jobs. They [managers] just want to pour more and more on us." This statement reflects her belief that workloads will become heavier as time goes on and she is unable to successfully advocate for a more appropriate workload.

Others described heavy workloads of case management in the community as a never ending job. It is interesting to note that several participants compared working as a RN case manager in the community to working as a RN in acute care. They described feeling stressed due to the ongoing nature of their work. "It [case management] is not like shift change in acute care where someone can take over your work. If you're sick or you're not here, it [work] just keeps piling up. It's like a black hole that doesn't seem to get filled." Another shared a similar experience by saying, "And just with the mental health, it [the job] is always going to be an ongoing thing. Making sure showers, baths, and outings are being done. The job seems to be never done." One participant described case management as emotionally exhausting. She compared the physical exhaustion she experienced working in acute care to the emotional exhaustion experienced in her new role. "It's exhausting more so than acute. Trying to figure people out. Not physically exhausting like acute, but emotionally."

As RN case managers in the community, they explained that they are often the only support available for clients, especially those affected by mental illness. They noted that families are often unavailable or unwilling to help clients achieve positive health

outcomes and they find community and health care services are difficult to navigate; therefore, some clients do not access available resources. It is not surprising, then, that some participants described feeling solely responsible for the health outcomes of their clients, which created a high level of stress.

> It [case management] is emotionally taxing. It's always a constant battle to remove yourself from the situation and go on about your life. You feel that you are their one support and I always think that maybe if I could have made those couple phone calls, could I have fixed that sooner?

Furthermore, she explained that she was informed her job was going to be stressful during her application interview. However, the level of stress she experienced was not expected.

> When I did the interview, they [interviewers] asked how I handled stress. They told me the job was stressful. They told me that they have had people cry. They told me that if you have a bad day and you feel like crying and quitting, you can't quit on us. You have to pull though and seek help. I told them I only cry when I laugh! So I wasn't anticipating this much.

There was one common notion shared among most participants–an inability or unwillingness to work long-term as a RN case manager in the community. Several participants shared that they believed they would move away from case management in the future; however, one stated that she planned to start a new job within a few weeks. She shared that her high level of stress as a RN case manager in the community

manifested into physical symptoms, such as an inability to sleep. She related her inability

to stay in the role due to the high level of stress.

> I was in the job for four months and I wasn't sleeping. And I've never been like
>
> that. I've never been stressed out that much. And this job stressed me out so much
>
> that I had to take a week stress leave! And that really changed how I thought
>
> about my job. No job is worth that much. You're trying to care for a lot of people
>
> and you're always having to deal with complaints.

Another acknowledged a level of satisfaction from her job; however, she felt she was

being pushed beyond her limits. "I love this population and I get a lot of satisfaction from

helping my clients. But I know my limits and I can't stay here." In addition, two

participants shared that they desired a work-life balance and that case management, as it

is at present time, would not allow them to meet these goals.

> I think it [case management] is hard to do long-term. I can see the burn out
>
> getting…I don't really want to say burn out. I think down the line if I want to
>
> have kids, I don't know how attainable that would be. I feel they [managers] are
>
> not flexible with all the requests for leave and the coverage.

Another stated, "I think it's important to have that work life balance where I'm not at

home thinking about work. I'm okay with doing that sometimes, but not all the time. Not

where I'm on all the time." It is interesting to note that one participant recognized a high

turnover rate among case managers. She reflected upon her job as interesting; however,

she acknowledged that support for RN case managers is a key factor for retention. She

shared a desire to determine the cause for attrition by saying:

We [participant and colleague] went to a Christmas party and there was no one

there that we knew. I think we knew two people out of the whole group. And so

why is that happening? It's not a bad job. It's an interesting job. You need the

proper equipment. You need the proper chairs so you don't get backache. You

need good support, which I have got here. This site is wonderful. We need to look

at that and ask why and work on that.

It is clear that participants felt stressed in their role as a RN case manager during

the "slugging it out" stage of the process of "adjusting to case management in the

community." Most described high workloads as a significant cause of job stress.

Participants declared that the nature of case management is different than that of acute

care and that they experienced some degree of emotional exhaustion that was unexpected.

They explained that they did not want to remain working as a RN case manager in the

community due to high levels of job stress within the role.

Lack of expectations. All participants had little to no knowledge about case

management prior to starting their role as a RN case manager in the community. For

example, one participant stated, "It's a whole different world than working in acute.

You're stepping into a fresh environment that you've barely been exposed to. Even

during our schooling we didn't learn about case management." Similarly, another who

previously worked for another health zone explained that she was not familiar with case

management. "I had no clue. I wasn't sure because the zone that I worked in, it [RN case

manager] wasn't a position that was held there. I had no knowledge really. I really didn't

have any idea [about case management]." One participant previously worked in settings

where there were case managers; however, once she started as a case manager in the community, she found her role to be very different from those she previously observed. "Well, I kind of had a little bit of background because there were RN case managers working on the military base. But that's quite different from what we do."

Due to the previous lack of knowledge related to case management, it is not surprising that they expressed having little or no prior expectations about the role. Several acknowledged their lack of role expectations and reached out to people who had an understanding of the role of a RN case manager in the community. One participant stated:

> I didn't have any expectations. But I had some sort of idea because I talked to my manager before I started my job. When I was hired, I asked her about what my job was going to be like. I also spoke to a colleague's wife because she had experience in this area of nursing. However, she was in Home Care. So what she told me was a little bit different than what actually happened.

Another reached out to a colleague prior to starting her new job to gain a better understanding of the RN case manager role in the community. By doing this, she also established a source of ongoing support during her transition. As this participant explained:

> After I applied for the job, I spoke to a case manager that I knew and she told me all about the job. Because I wanted to make sure it was what I wanted to do. I think it was good too because I asked her if I had any problems can I call you? She said "Yeah, sure!"

For some, reaching out to people who had a better understanding of the RN case manager role in the community setting was beneficial. For others, it did not prove to be as effective. These participants expressed disappointment in the vague role descriptions given by people who they assumed would be able to provide a clear understanding of case management and their role. One participant reflected on her application interview experience to describe her lack of role expectations. She stated, "No I didn't, not really. I didn't know anything about it. And unfortunately, when I was being interviewed, my interviewers were very vague and it seemed that they did not know a lot about the role themselves." Another stated that she only received vague descriptions when she asked a case manager about the role:

> I know another case manager through a friend and she was telling me about the role. She didn't go into much detail though. She was pretty vague. She told me that you visit your clients once a month, you have case conference, you do assessments and that was where she left it. So I had no clue really what I was getting into.

These interview texts effectively represent the lack of RN case manager role expectations prior to starting their new job. Additionally, those who did have expectations about their new role discovered that their expectations were inaccurate, which caused them confusion. One participant explained that she did not expect her role to be as medically driven by saying:

> I guess it's more medically driven than I thought. I don't know if it's just the site I am at. With this role, you can be a social worker or an occupational therapist. So I

think the site   uses me a lot for medical advice. That wasn't what I expected. I

thought it was more about client advocacy and getting things together.

Some felt that once they started to take on the role of RN case manager, they realized the

role consisted of responsibilities that exceeded the descriptions provided during

orientation. One described her experience by saying, "When they describe case

management, they use very generalized terms and I guess there are some aspects that fall

under that, but not really. It's a lot more than what's said."

Case management is not something that the participants had any prior knowledge

about, although it is becoming an increasingly common career for many RNs. As a result,

the participants of this study had little to no expectations as to what their role would be

like prior to beginning their new job. Most attempted to reach out to people they knew

who had a better understanding of their role. Others were left without knowing the details

of their role and were left to slug it out as they figured the role out for themselves.

Sustaining/constraining factors. I have identified several factors that either

helped or hindered the participants' process of adjusting to case management in the

community (see Figure 1). I have grouped these factors into three categories: (a) support,

(b) relationships, and (c) job satisfaction. Throughout this section, I will discuss these

factors and how they have helped or hindered the stage of "slugging it out" during the

process of adjustment to case management in the community.

Support. During the interviews, I asked participants what helped facilitate their

transition to case management in the community setting. Support from colleagues,

managers, and CNEs was identified as a significant factor that helped them during their

transition into case management, particularly during the "slugging it out" stage. One

participant acknowledged her colleague as a significant source of support in the "slugging

it out" stage by saying:

> I know my co-worker that sits beside me. She is a social worker. I probably
>
> wouldn't have lasted this long if it wasn't for her. She has such great knowledge
>
> about the community and what's out there for clients. She is very organized. So it
>
> has been great for me to be able to ask questions to her as they come up. Without
>
> her, I wouldn't have been able to make it as far as I have. I know there are
>
> practice leads and clinical nurse educators and all that, but they don't have the
>
> support home knowledge.

Some case managers felt that their colleagues were acting as informal mentors during the

beginning stages of their transition to case management. Specifically, two stated that their

colleagues provided them with tremendous amounts of support while they were learning

MEDITECH:

> She [colleague] was a RN case manager as well! She had been in this job for
>
> about two years already. She had a lot of knowledge. I mean, your basic nursing
>
> skills like meds [medications] and pathophysiology, we were both kind of equal
>
> on. But there were certain things of case management where I was like "What do I
>
> do here?" That was related to things of our job that you don't learn anywhere else.
>
> Like learning how to use MEDITECH. So I leaned very heavily on my mentor for
>
> quite a long time actually.

Another echoed this experience:

Because she [colleague] knew MEDITECH. She knew the system. She knew how

everything worked. She is cool and calm and a very bright girl. So consequently

she was a good mentor. And I thought you know something? That's what people

need! Maybe to put them at a site, you don't need to be working there, but put

them at a site with someone who knows the system so they can see how things are

done. It would make things so much easier when they go somewhere else.

Sharing an office with at least one other case manager was viewed as a good

source of informal support while adjusting to case management in the community. Those

that did share an office with another case manager acknowledged this as a significant

support system and sympathized with other case managers that were working alone. One

participant identified her colleague as a major source of support and stated, "I don't know

how people [case managers] do it who are in a facility and are not surrounded by this

support group. Because you can't just ask questions by turning your chair." Another

made a similar observation by stating, "I really have no idea how case managers who are

at sites by themselves...I don't know how they do it!"

Managers were recognized as a significant source of support when participants

felt alone and unsure in their role. Most described their managers as helpful, resourceful,

and accessible throughout the "slugging it out" stage. One participant stated, "I was

fortunate enough to have my manager. If it wasn't for her, I would be lost and picking up

pieces of I don't even know what." Another stated, "My manager was really good about

talking with me if I needed help or facilitating anything if I needed." Finally, another

acknowledged her manager as a significant source of support by saying, "You know

what, other than the mentor, my supervisor was very supportive. She was open to questions."

Most participants identified support from CNEs during the "slugging it out" stage as a sustaining factor to adjusting to case management in the community setting. For example:

I think the educators are definitely good. They are very accessible because there is quite a few of them for the program. So that was really good. Also, I don't know what else. Primarily the educators and other case managers. Like, asking them questions. So, yeah! Educators and colleagues.

Another acknowledged support from the CNEs and managers as a sustaining factor during her transition.

I think that the managers and CNEs are very supportive. If you called them they don't say "That is kind of silly, why did you ask that?" They will give you the answer or help you work towards the answer. So I find them very helpful. I have had other roles in acute care where the CNEs and managers were not very helpful. So I really like how supportive they are here.

Although some participants identified support from CNEs as a sustaining factor during their transition, two expressed disappointment in their lack of case management knowledge. For example, one participant identified support from CNEs as a constraining factor during her transition.

I've went to the CNEs before about different nursing procedures in the community and they were able to guide me through it. But with the support

homes, it's not the physical it's the mental and I feel there is no support around

that.

Another stated, "Our CNEs are not very well educated in the case management role. So

when you're calling them and asking them for answers, they respond with 'Let me get

back to you, I'll have to find out.'"

It is clear that support from colleagues, managers, and CNEs is a significant

sustaining factor during the transition to case management, particularly during the

"slugging it out stage." Most participants were adjusting to a job where they felt isolated

and alone in their new role and having these supports created a sense of connectedness.

Some, however, identified support from CNEs as a constraining factor due to their

limited knowledge in case management and therefore inability to answer case

management related questions.

Relationships. Three participants described their professional relationship with

clients and families as a sustaining factor whereas two described their professional

relationship with clients and families as a constraining factor during their transition to

case management in the community. Participants felt stressed and overwhelmed in the

beginning of their transition; however, building professional relationships with clients

and families was identified as a positive aspect of their work during this time. They

explained that establishing professional relationships with their clients and families and

providing assistance to them are motivating factors for continuing their work as a RN

case manager.

I think overall that I have a pretty good trusting relationship. My heart goes out to my clients. I have one who lived on the streets all his life. He felt so overwhelmed coming here. Can you imagine? Coming here and looking at this place after being homeless all your life? He was like "I've never had this before." He told me he's like a fish out of water. But I've been able to get his trust. He has terrible wounds. He is actually into PGS [pressure gradient stockings] this week! He looks so good. Today, at 1 o'clock, I have an ILS [Independent Living Skills] worker coming here so they can start taking him out for his shopping. He has no family. Those types of things really help me keep doing my job.

Others also reported a sense of satisfaction from helping their clients and expressed that they enjoyed feeling valued and being viewed as a resource for their clients.

I think I have a good relationship with most of my clients. It did take quite a while to develop because I don't see them often. But whenever I meet the families or see my clients, I make sure I say hello. I think it's positive and I'm a good contact person when they have problems with the operator. And I can offer good advice when they need it.

Participants explained that building professional relationships with clients and families was an easy aspect of their job in the beginning.

[The professional relationships are] Really good, I think. I have gotten to know them [clients] all. I interact well with them. The families have been really good and accessible. They come to me with concerns. I found those relationships really easy to build and maintain.

In contrast, some participants identified building and maintaining professional relationships with clients and families as a constraining factor during the "slugging it out" stage. Some were working with clients and families that had negative experiences with previous case managers and other health care professionals. Therefore, building and maintaining trust with these clients and families required a significant amount of work, which contributed to participants' feelings of stress in the beginning of their transition.

> At first, [the professional relationships with clients and families were] very rocky. Very unstable. The families were very defensive and on edge. There has been a lot of turnover at the site. Both with AHS and site staff. Their trust was already down the toilet right from the get go. So it was a very difficult road to develop some trust and reassurance that some sort of follow up would be completed. That was the biggest concerns from families. That there was no follow up. Or lack of adequate client care from site staff. But now since I've been there as a constant for them, it has been a lot better.

Furthermore some clients and families did not have clear expectations about the RN case manager role. As a result, it was common for clients and families to have unreasonably high expectations of the case manager. One participant stated, "Some families have unreal expectations on the case manager. They want things done right away and then they get upset when it's not." Most participants that I interviewed experienced job stress during the "slugging it out" stage of their transition to case management. Trying to satisfy families that have unreasonable expectations is a constraining factor as it creates a further job stress for the RN case manager.

Job satisfaction. The work schedule of a RN case manager in the community was a motivating factor to take on the role.

> To be honest, my job in acute care was cut. It was what they called reassigned. So I had to find a job within AHS that I liked. This [case management] was my first choice. The reason being is that I have a family. I have a young daughter so I can stay at home with her. No nights or weekends, unless I really wanted to. So that was the reason why I decided to work here.

Despite the challenging transition, the work schedule of a case manager in the community was satisfying and sustained them in their role. One participant stated, "It was a challenging transition. But in the end, I do enjoy the Monday to Friday. The stability of having that schedule. The routine. Knowing that I don't need to ask anybody to switch shifts for appointments or anything."

Similarly to how they compared the stress they experienced as a RN case manager in the community with the stress they experienced as a RN in acute care, some participants also compared the schedule of a RN case manager in the community to that of a RN working in acute care. One participant stated that she was unable to continue with shift work and that is why she sought out a RN case manager position. "It was due to my health. I couldn't do night shifts anymore so that's why this job caught my eye."

As previously discussed, high levels of job stress were experienced, especially in the beginning stage of their transition to case management. However, the stress they experienced as a RN case manager is less than what they had experienced in other job settings, particularly acute care. For example, "It's much less stressful than acute care. I

don't go home exhausted where I just crawl into bed and that's it. But, there are still days that I'm stressed out." Another shared a similar sentiment by saying:

> In acute care, I go home but I wonder what did I miss? If I did, what are the implications? This is a little more laid back. Not that it's less important, just more laid back. Some things can wait until the next day.

Finally, another participant stated:

> I guess I just realized that it's a different pace in community. It's not supposed to be rush rush rush. Things can wait. If I don't think it's a priority at the time, it gets pushed to the side and dealt with later.

> Satisfaction with their work schedule was identified as a motivating factor to

seeking out a job as a RN case manager. In addition, it was explained that although their new job as a RN case manager in the community may be stressful, it does not exceed the stress they felt while working in an acute care setting, which contributed to their job satisfaction and has sustained them in their role.

Support provided by colleagues, managers, and CNEs in the beginning stages of the participants' transition to case management in the community was a significant sustaining factor. Although some disappointment was shared related to the CNEs' lack of case management knowledge, participants were very pleased with the support received. During their stressful transition, they explained that building relationships with clients and families provided them with a sense of satisfaction in their new role. Although several expressed frustration with some clients' and families' high expectations of them, they essentially perceived these relationships as a sustaining factor in the "slugging it

out" stage. They explained that their stable work schedule provided them with job satisfaction and ultimately sustained them in their role as they were "slugging it out" in the beginning. Furthermore, participants explained that, although their new role can be stressful, it is not as intense as what they experienced in acute care.

Stage 2: Seeing the Job as it is

During the second stage of the basic social process "adjusting to case management in the community," all participants shared experiences related to job resources, role clarity, and provision of health services and client care. The theme of this stage shifted from feelings and experiences about their own personal well-being to describing concerns for the well-being of their clients. They began seeing the job as it was and were able to identify specific things that were problematic.

Wanting more job resources. During the interviews, concerns were expressed related to a lack of resources within job. Specifically, it was recognized that a lack of resources could negatively affect client health outcomes. Most commonly, participants identified a lack of policies and procedures to guide them in their new role. One participant explained her frustration with not having clear guidelines by saying.

> Managers are busy, as they have multiple sites. So it can be very hard to reach them. Our CNEs are not very well educated in the case management role. So when you're calling them and asking them for answers, they respond with "Let me get back to you, I'll have to find out." Or they'll say "this is how I would do things." So it's not very easy to find a policy and procedure to get the answers that you want.

This participant spoke about a need for policies and procedures related to case management; however, another identified a lack of resources to inform nursing care.

> I found there wasn't very clear policies and procedures. Like, if this happened to your patient, you need to do this. Like a policy binder. This is the protocol for catheters. This is a protocol for wounds. Better wound orientation would have been better. I did the wound   course, but especially coming from government, I had no idea about some of the products and it changes so much.

It is interesting to note that this participant recognized her previous nursing experience in government was a contributing factor to her knowledge gap. This was the only participant who did not have direct nursing care experience and the only one who expressed a need for resources to guide nursing care. She went on to say that standardized policies and procedures could have had a positive impact on her transition experience.

A lack of education about existing resources was also identified as a concern. One participant who worked as a case manager for clients living in support homes explained that she had a significant knowledge gap related to existing community resources. She identified this knowledge gap as a potential barrier for helping her clients achieve optimal health outcomes.

> With support homes specifically, there needs to be more education regarding our resources. On numerous occasions, I felt like my co-worker would be a good practice lead for support homes specifically because it's a completely different model outside of the DAL [Designated Assisted Living facilities] sites. Just with processes and how things are done. [There needs to be] support for [case

managers working in] support homes. My manager is busy and she has DAL sites

as well. Just to have someone before I speak to my manager. And that aspect in

orientation as well. And maybe something that outlines all the resources that are

out in the community. Something that can be right in front of the case manager.

Like toenails, DATS [Disabled Adult Transit System], taxi chips, etcetera. Just

something that you are always using and have it right in front of you.

Within the above description she identifies her co-worker as a potential formal support

for RN case managers working with clients that live in support homes. I will address this

within the sustaining/constraining discussion of this section. Another participant

described experiencing difficulty when she tried to apply the knowledge learned during

orientation to her day-to-day responsibilities. She identified ongoing education sessions

in the form of mentoring as strategies that would have helped her retain much of the

information presented during orientation.

I wish there were more education pieces we could attend. A lot of the classroom

training I have forgotten about so I think it would have been better if there was

more mentorship. Because MEDITECH is so different when you're doing it on a

client rather than test clients.

Another participant shared a similar sentiment by simply stating, "More education. More

workshops would help."

Others identified their busy schedules as preventing them from attending existing

education sessions. One participant expressed frustration with her busy schedule and

inability to attend education sessions by saying, "More time for education [would help].

It's hard to take the time out of your schedule to attend education. It seems like you just finished charting your monthly visits and you need to start all over again."

Once they started seeing the job as it is, they identified that there were limited resources offered to assist them when they were unable to meet the expectations of their job due to a high workload. Furthermore, they shared that they did not feel comfortable asking their managers for help or extra resources during busy times because they did not want to be perceived as failures in their job–although it would have ultimately benefitted themselves and their clients.

> It would be nice if we get behind on that [completing the Resident Assessment Instruments] we could pull someone in who is casual. That's something you don't want to ask for because you will seem like a failure in your job and what will my supervisor think? Being able to access that might help.

Another participant, who had been working as a RN case manager for approximately one year, shared that she did not feel comfortable when asking for help even though she recognized the need for more resources to fulfill the responsibilities of her new role. "I need someone to call and help me work through things. And I have done it but everyone is so stretched. And I'm feeling like I should know this by now. So I don't want to ask."

Some participants questioned if the right people are doing the right tasks. Administrative staff were identified as a potential resource to help with various tasks, such as data-entry, to allow more time for case managers to spend with clients.

> I'm wondering if some of the things that are being inputted could be done by administrative staff. And then nurses can spend more time with the clients. More

time actually reviewing things. It's just input of information that you basically

got. You know, I go to the [client's] room and I do make notes because I can't

remember everything. I did that in [my previous job in] the community. And it

was the secretaries that inputted the information. They would input the

information. If it was wrong, we would change it. We would dictate it and they

would record it.

Another participant stated: "As a nurse, I like to connect with people. When you're

constantly doing computer stuff, you can't meet all these families, even though that's an

expectation of you, but it's just not happening."

It is apparent that a lack of resources in the form of policies and procedures,

education, and human resource management, was a concern. Frustration was expressed

with the lack of job resources because it limited the ability to spend time with clients. The

participants valued having access to education in an effort to maintain nursing

competencies as well as expand on case management competencies.

Lack of role clarity. The lack of role clarity experienced in the "slugging it out"

stage continued into the "seeing the job as it is" stage of the transition to case

management. Participants explained that they were not given a clear description of their

new RN case manager role upon entering the job. Furthermore, some shared that they still

do not have a clear understanding because the role was never defined for them. For

example, one case manager who had been working for almost two years stated:

It was very vague when it was explained to me. And looking back on it, it still

isn't explained very well. There is no clearly defined role. This is what you're

supposed to do but there are a lot of grey areas.

Another shared a similar opinion. "I think it would be good to have a more clearly

defined role. It needs to be outlined that this is what a case manager needs to do and this

is what you're involved in."

Most participants identified that other health care professionals did not have an

understanding of the case manager role, which created barriers to providing optimal

services for their clients. More specifically, they identified a lack of clarity about the RN

case manager role among the site staff and operators. One shared her frustration related to

a lack of role clarity among site staff and operators.

They think a lot of it is my job. Like coordinating discharges has totally fallen on

me, when it is supposed to be a shared responsibility. And when I try and clarify,

it was taken negatively. There is a lot of misunderstanding around me working for

the client. They think I work for the site and I am suppose to do whatever they

want me to do. Anytime you try to be client-centered and have different ideas, it

feels like it's not taken very well. There's a lot of role confusion.

Another participant echoed this experience by stating, "I have a clear understanding of

my role but the operators definitely don't understand my role. I think I do anyways.

There are some grey areas in there."

Participants shared that they are often asked by site staff and operators to become

involved in issues that are unrelated to their roles and responsibilities. As a result, they

were unable to effectively perform their role. One in particular expressed a great deal of

frustration about being pulled into issues that are not a part of her role. She believed a clearly defined role would solve this problem among RN case managers in the community. She stated:

> Sometimes, what happens, I don't think the facility staff quite understands what our role is. And they do see us as a care manager. We need to be very careful because if you take on that responsibility, you're not able to do the job you're supposed to do. I don't have time to do both jobs.

Another participant explained that the lack of role clarity among the site operators where she works cause her to go beyond the role of a RN case manager and fulfill responsibilities intended for site staff.

> I think they ask me to do a lot of what they're supposed to do. And coming in new, I didn't really know what I was supposed to do so I kind of just did it. And there was a huge staffing change here at the site. People were fired and it was a very weird environment here for a while so they asked me to do a lot that wasn't a part of my job.

It was identified that other health care professionals, such as physicians, did not have a clear understanding about the role of a RN case manager in the community, which resulted in frustration. One participant explained that the physician who visits clients at the site in which she works relied heavily on her for things that are beyond her role. As a result, her workload increased because she tried to meet the demands of her job, as well as fulfill the other tasks perceived to be a part of her role by the physician. She stated:

I feel she is not entirely aware of our role and the things we do. For instance,

making referrals. She thinks that it's the case managers job to refer to Regional

Palliative but it's the physician's job to refer. So I've been getting push back on

that. And contacting the families. She thinks that it's the case manager's job to

contact families for any concerns she has. Even if it's something like hygiene

care, she still thinks the case manager should contact family.

When I asked what could improve their transition experience to case management

in the community, many discussed finding ways to improve role clarity as an important

strategy. One participant explained that time and energy was spent trying to determine

who is supposed to be doing the various tasks for clients.

I think more clarity, and this is a big one, between the site and the case manager's

roles and responsibilities. There is a lot of tugging around this is my job to do this

is your job to do. It seems like when I push back it was kind of taken negatively.

Another presented a similar strategy to improve the overall transition experience. She

stated:

I guess having clear-cut roles and responsibilities would be very helpful. We do

collaborate with the site but our roles are very much intertwined. The grey areas

are very grey. And when push comes to shove, the responsibility seems to lie on

the case managers. So I think the operators need better education with the site

staff and a little more confidence in them. Then things would be a lot easier.

Blurring of the nurse and case manager role in the community created confusion

during the transition. One participant discussed how her role as a RN case manager does

not include providing direct care to clients; however, she felt an internal ethical dilemma when her nursing knowledge and expertise were not utilized.

> I guess when it comes to patient safety. It's always a daily dilemma. We are registered nurses but we are not hands on. So when clients are having health issues, where do we fit in? Are we not supposed to be hands on because our role is not hands on? But we're nurses by nature! So that's where you find the difficult, I guess ethical, boundaries.

Another shared a similar experience.

> A case manager can be an occupational therapist or a social worker. The case manager that I replaced was a social worker. If the staff came to her because Mrs. So and So doesn't look very good and she is tachycardic and asks her "What should I do?" The social worker would look at the LPN and say: "I don't know! You're the nurse. You tell me!" I was told that we weren't supposed to but the LPNs who I work with now they know me and know I'm a RN. They come anyways. There was one LPN who wasn't very strong clinically and she came all the time. I can't turn her away. I know that they are supposed to be dealing with issues. But when you're a RN you're a RN. So there are times when you need to just take charge sometimes.

One participant, motivated by her intrinsic value of helping clients, felt the need to step outside of the case manager role and provide direct nursing care, "My colleague can say 'You know what, I'm not a nurse.' She is able to do that. For me, I expect from myself that I should know and I should help them. And how can I not?"

Although they shared a strong sense of responsibility to help their clients and site staff, some believed they were being taken advantage of by the site staff and operators because of their nursing background. For example:

> I find they'll get busy with other clients and they'll just depend on me to deal with clients. So things that they should be calling the family about they're like "Can you do it for us?" or "We're really busy" or "I think you should be doing this." Like blood work. They are not good about following up with blood work or asking the doctor if there are concerns. Because I'm here, I think they are more dependent on me. And when I tell them that it isn't my role they're like "Well, can you help us? We're really busy." And then I just do it because I'd rather just get it done.

She continued to explain that the site staff depended on her because of her nursing knowledge and skills. She recognized that other regulated health care professionals that are employed by the site should have completed the client care that she provided. She explained:

> Especially with assessments of wounds and stuff. The stuff that they can do themselves. Like a wound that does not need a [wound] protocol, I don't need to see. But I find no matter what, they will say "You need to go see this lady." And when I do assess, I really didn't have to see her. Or if a client has a rash or something. They need me to look at it before anything is done about it. I think they're very dependent on me.

Another participant felt stressed in her role because she was assuming a lot of LPN responsibilities.

> And then having to follow up with the LPN. They're professionals and they
> should be able to manage their own stuff. There are some good ones here, but
> then there are some that take the easy way and don't want to do anything. I think
> if they actually did their jobs, I would be less stressed because there isn't so much
> for me to do.

Role clarity was a concern during the transition to case management in the community. The case managers experienced high workloads which increased due to other demands related to a lack of role clarity. Some expressed a sense of moral distress as they transitioned into a role without clear guidelines about when they needed to intervene in client health issues. Others expressed high levels of frustration because they were expected to perform duties that are within LPNs' scope of practice, such as basic wound care and physician follow-up.

Feeling solely responsible for client health outcomes. A common characteristic among the case managers was their deep sense of responsibility to ensure their clients received quality care during their journey through the health care system. Not only did they feel responsible for the care the clients received in the community, they also felt responsible for the care clients received in hospital, during a period of health instability. One participant described a situation in which she struggled to advocate for her client in the acute care setting when the client's health status was deteriorating. She struggled to

communicate with all members within the client's circle of care and to fulfill her responsibility of ensuring her client's health care wishes were respected.

> [There was] one regarding a palliative client and the family wanting different plans of care. The site and the family were not on the same page for management [of the client's care]. So that was tough. I had the resource of GCATT [the Geographical Complex Assessment and Treatment Team] so they helped me work through that a lot. She was going to the hospital a lot and they kept changing the goals of care designation. Two members of the family wanted a different course of treatment. So it was hard trying to advocate to get comfort care. I was doing a lot of communicating with the hospital and she was being moved around a lot and I think the hospital really dropped the ball with this client. You do a lot of communicating with the charge nurse but I don't know. Sometimes it is tough because many different physicians in the hospital see the clients. So for that client, I just worked with GCATT a lot because the client wasn't their own decision maker so having a lot of conversations with the husband and making sure we knew what he wanted.

Additionally, they identified the challenges encountered while trying to advocate for their clients living in the community. I noted a sense of helplessness from one participant when she shared the following experience of having to advocate for a clients who suffered a brain injury.

> Brain injury clients in the support homes are tough because they are not a perfect fit because they have behaviors but are not able to learn that their behavior is

wrong. So I find that operators get burnt out so they want to move them out of the house. But it's their home! And we should be able to get the adequate support in their home to keep them there. But if the operator is not willing to follow the care plan or they become burnt out it's a tough one.

She went on to say:

But I feel sometimes we just don't know how to move forward. So with my client with the brain injury things have been done to try to keep her in the house. The [client's] guardian wants to keep her in the house. It's the operator who is making the demands and is thinking "Well, if we send an eviction notice maybe they [Alberta Health Services] will move faster on getting her moved out. But why are we moving her out? So that hasn't been dealt with yet.

It is obvious that she struggled to ensure the client received quality care in the most appropriate setting. She felt stuck and unsure about how to move forward and help these clients. It was clear from her tone of voice that she felt very frustrated with the health care system and felt responsible for the client's physical-psycho-social well-being even though there are many external factors involved–many beyond her control.

Participants also shared that they felt ultimately responsible for the health outcomes of the clients living in the community even though they were not providing direct client care. They explained that they were uncomfortable with delegating care to staff who worked at the site in which their clients lived. One case manager described feeling very stressed because she believed some regulated health care professionals, to

whom she must delegate client care, did not hold themselves accountable for the care delivered to the clients on a day-to-day basis.

> Also, delegating to site staff. As a RN, I am accountable for my actions and when I need to delegate to someone who is not accountable or do not perceive themselves as accountable, that is a big stressor. That just depends on the site you're at. We get that a lot. So you constantly need to be on. People always change every day, I mean the clients. I check my email at home, I know we're not supposed to, but otherwise I feel lost when I come back. So I do that in order to stay connected while I'm away from the site.

Some recalled having a caseload of over 60 clients. Therefore, it is unreasonable to expect that the participants can visit with each client on a daily basis to assess their health status. They explained that they are supposed to rely on the assessment skills of the site LPNs to inform them of a change in clients' health status. Furthermore, they explained that they were supposed to rely on site staff to carry out client-specific care plans that they have developed. Another participant shared that she felt uncomfortable relying on the site staff to provide her with the necessary client health information and took it upon herself to check daily on her clients. Furthermore, she identified that the site staff have not followed the care plans developed for the clients, thereby adding to her frustration. She stated, "So we can't do our jobs because we are always making sure the clients are safe. We need to check that our care plans are being reflected in their charting. We are always following up on that."

During the "seeing the job as it is" stage "adjusting to case management in the community," case managers focused on trying to deliver quality care to their clients in less than ideal circumstances and within environments in which they had little or no control. They tried to find a balance between meeting the demands of their job and working with site staff and operators to ensure the care received by the clients is appropriate and meeting their needs. Furthermore, they started to get a clearer picture of their role; however, they were frustrated with the lack of role clarity and lack of job resources because they recognize these factors as barriers to providing quality care to their clients.

Sustaining/constraining factors. Similarly to the "slugging it out" stage, I have identified several factors within the "seeing the job as it is" stage that either helped or hindered the process of adjusting to case management in the community (see Figure 1). These factors are grouped into two categories: (a) support and (b) relationships.

Support. As the case managers began "seeing the job as it is", they continued to describe support from colleagues and managers as a significant sustaining factor during their transition to case management in the community. Within this stage of their transition, a lack of role clarity and role blurring was identified as a significant concern. In particular, role confusion existed among the site staff and participants. Some participants identified their co-workers as mentors and a supportive resource during a time when they were unsure about the tasks that should be completed within their new role. One participant stated:

I was very glad that I had a mentor. Because I'm going to be honest, there would

have most likely been things that they [operator staff] would have asked me to do.

And I would have said "Sure!" where she would have said "No, no. That's not

your job. The LPN can do that." So knowing when to delegate was difficult,

which we need to do. But I didn't know when and where to do that. But that has

changed now.

Interestingly, I noticed that participants did not talk about how the support from

their colleagues and managers helped them as it did in the "slugging it out stage."

Instead, they talked about how this support ultimately helped their clients living in the

community. One participant discussed that she did not have a sufficient knowledge of

community resources to help her clients. She identified her colleague as a significant

source of support that helped her identify what community resources may be accessed to

help improve her clients' health outcomes. "[My colleague] has such great knowledge

about the community and what's out there for clients. She is very organized. So it has

been great for me to be able to ask questions to her as they come up." This participant

went on to explain that the formal resources, such as CNEs, did not provide the level of

support required during this stage of her transition. She identified that CNEs lacked the

knowledge related to the setting in which her clients lived. She stated, "I know there are

practice leads and clinical nurse educators and all that, but they don't have the support

home knowledge. So it's kind of like fend for yourself." This participant did not perceive

the CNEs as helpful during the "seeing the job as it is" stage of her transition to case

management.

Support from managers was commonly described as a sustaining factor during the "seeing the job as it is" stage. During this stage a desire for more job resources and a lack of role clarity emerged. Most participants discussed with their managers concerns they were having and subsequently received assistance from their managers to help them effectively problem solve. For example, one participant explained that once she started working with her caseload, her manager gave approval for a casual RN case manager to help lower the workload at her site. She also explained that her manager provided ongoing coaching for her and her colleague as she had experience as a RN case manager. Furthermore, this participant stated that her manager provided suggestions, based on her previous experience as a RN case manager, about ways RN case managers can support each other in their roles.

> I had a couple of good managers. They were helpful. So, I can't complain about the managers. They have been helpful. When I came here all of the assessments were out of date. At first, it took me a day to do each one, you know what it's like. Then my manager said she had more bad news. She said all of the care plans needed to be updated. But she sent in somebody to help me get things up to date. In doing that, she allowed me to keep things up to date. I don't have that stress of thinking, you know, my goodness! There were almost 40 care plans not up to date. How do I get these up to date? I don't like to work like that. I like to be ahead of the game. I like to work effectively and efficiently. So when she sent somebody to help me with those, it helped. And also, she had been a case manager for a long time. She was helpful in teaching. Actually, she taught [my

colleague] and I some things that she knew. She had mentioned that the case

managers at one time would meet together in a group to bounce things off one

another. We asked her "Where did you learn all of this?" And she told us they use

to meet. And we thought that's what we need now! To meet not as a big group.

The case managers. What are the concerns? How did you address this? She

showed us quick ways of doing things. There's no need to go the laborious way.

If there's a quick way, do it. It's just the same. It gets the same result and

everything else. To bring those meetings back with just the case managers would

be good idea, really.

Interestingly, she believed there was tremendous value in meeting with other RN case

managers. She recognized there is much support to be given and received by RN case

managers and that by meeting as a group, common problems and concerns can be

identified and effective strategies that have been used by others can be shared among

colleagues.

   Relationships. Professional relationships with other health care professionals

were described as both a sustaining and a constraining factor during the transition to case

management in the community. Most commonly, participants particularly enjoyed

working with physicians in the community. They believed physicians viewed them as a

valued member of the health care team and a key factor to ensuring the best possible

health outcomes for clients. One participant reflected on her experiences with physicians

while working as a RN case manager in the community.

They [the physicians] have been great. I was expecting a little more…I don't

know how to say it. In the hospital you get, from physicians, this expectation that

you're beneath them and you do what they say and when you make suggestions

they are not well received in an acute setting. So far in the community setting,

they are more open to suggestions than what I'm used to. We see them more and I

was expecting a little bit of conflict. There wasn't! Usually, making a suggestion

to a doctor isn't well received. So this is nice! Faxing doctors and they respond

right away.

Another described an open and trusting relationship with community physicians. She

stated, "The doctors are excellent here. They know they can come to me and give their

opinion and they know they can come to me for mine. Oh, it's excellent." Finally,

another participant described her relationship with one of the physicians that visited the

clients at her site as positive, even though they do not see each other often. She stated:

It's good. I work with one physician who rounds on Tuesdays. But, I'm not here

most Tuesdays. So, I don't get to see her. But we know each other. My

communication with the LPN is really good so I'm kept in the loop. I can get in

touch with the physician very easily as well, so that's how we communicate.

Some participants described their professional relationship with community

physicians as a constraining factor during the "seeing the job as it is" stage of their

transition to case management in the community. They described physicians as hesitant

to trust the suggestions they had made related to the care of their clients. One participant

acknowledged that a high rate of case manager turnover might have impacted her

professional relationship with the physician. She also acknowledged that they had different personalities with respect to how to handle different client situations.

> At first, the site physician was reluctant to follow my suggestions if I had some. I think it was because I was new and he didn't know me. There was a lot of turnover at the site and I think it was just because of his personality. He is pretty laid back and doesn't view a lot of things as a priority where I want to nip it in the bud before it becomes a bigger problem.

Another participant reflected upon her professional relationships with physicians in the community as both a sustaining and constraining factor during her transition to case management in the community. She explained that it took time to develop a professional relationship with the community physicians that visited the site in which she worked. She also explained that some physicians relied on her to do many tasks that were not part of her RN case manager role because they did not trust the site staff to perform many of their duties; this added to her high workload.

> They are challenging. They do question the LPNs' ability to really critically think and to do proper assessments. It was very sour first when I got to this site because none of that stuff was actually being done. Some of the physicians rely on the case managers to get things done for follow up because the site staff do not follow up. They are available to talk when you need them for client concerns. They are easy to talk to once that trust factor is developed. That constant person is here that they can reach. So it takes time to build that trust and relationships with physicians.

Poor communication between case managers and site staff was described as a barrier during the transition to case management. Participants reported feeling additional stress in their role as they were unable to depend on the site staff to inform them of critical client information that might impact their plan of care. For example:

From my first year of experience, all I know is that I need to cover my butt. I need to make sure the staff understand. Here is this care plan that is pretty precise and I ask the staff if it is accurately reflecting the client's needs. I never get a response. And then when something happens, the staff say that they didn't know this or didn't know that. Have you looked at the care plan?

Another participant recognized that poor communication among the site staff had caused some client care to be overlooked. Interestingly, this case manager reported that she and the site manager implemented a communication book whereby she and the site staff write down any relevant client information that needed to be shared as a strategy to improve communication. She stated:

We started a communication book now because I would give a message to a LPN and they wouldn't pass it on, so the site manager and I made the communication book and we write things down. Things like when a referral is sent, so every LPN is expected to look back on that.

One participant reflected upon her own communication skills and acknowledged that this was an area of weakness, or a constraining factor during this stage of her transition. She explained that her communication had lacked clear direction and that she was learning to

be more assertive with site staff. She also stated that they do regular client reviews as a strategy to improve communication.

> Sometimes, I feel like maybe I don't express myself appropriately. For example, they may think that I'm telling them more directions than they want. I just want to be clear and I will follow up. Like, if urine needs to be collected. Well I'm going to ask if it was collected. But when I ask, they don't know. I'm learning how and when to give them direction. We do weekly client reviews now here at the site, so I find that really helpful for follow up. It's mostly us telling them.

She further explained that efforts to improve communication between RN case managers and site staff were effective strategies to improve role clarity.

> But communication back again. If you communicate to me about who is going to do what with those grey areas. And I've gotten better at that. I'm like "Okay, are you going to look after that?" I had to learn that on my own because when I was at [another facility] I was working as a charge nurse, too.

> Finally, there was one participant that described a positive relationship with her immediate manager. However, she also described feeling undervalued by senior management, which was a constraining factor during this stage of her transition. As a RN case manager, she communicated concerns and potential strategies to address the concerns; however, she perceived that senior management did not listen to her ideas.

> I have a really good manager, but I think a lot of the barriers come down to communication. We communicate up to our managers. But, I find there is a lot of bureaucracy. It's really hard to explain. In [this program] there is a lot of upper

management that has a say in front line matters when they don't even know what's going on. Not our direct managers, but the ones above them. I think that's the big barrier. Because when you communicate something or suggest something they are like "Oh, no." And then we are like "Okay." So it's a role where you are limited. You're like, "I guess my opinion doesn't matter." I think that's the biggest barrier. Even though you are working front line, your opinions are not listened to or valued.

Support provided by colleagues and managers during the "seeing the job as it is" stage of the transition to case management in the community was a significant sustaining factor. One participant described inadequate support from CNEs during this stage because she believed they did not have a good knowledge about her clients, the setting in which her clients lived, and the community resources available to help her clients. Most explained that building professional relationships with other members of the health care team, particularly community physicians, was largely a sustaining factor during this stage of their transition. Poor communication between case managers and site staff was the most commonly identified constraining factor during this stage of the participants' transition to case management in the community. Interestingly, participants discussed the strategies in which they helped implement to improve their communication with site staff. Finally, one participant explained feeling undervalued when she communicated concerns to senior management because she believed that her expressed concerns and opinions were not heard.

Stage 3: Finding The Way

During the third stage of the basic psychosocial process "adjusting to case management in the community," participants described having a deeper understanding about their role. They explained that their increased knowledge and understanding was achieved through experience and that they used various strategies to help them cope with the demands of their new role. Even in this final stage of their transition, most shared that they were still finding the way and were not fully adjusted to their role.

Gaining knowledge through experience. It was generally recognized that knowledge and understanding about the role of a RN case manager in the community was achieved through performing the job. Although information received during orientation was helpful it was acknowledged that most learning occurred while actually doing the job.

> Although the orientation was helpful, it wasn't until I started doing the job on my own that I learned the role. It wasn't until I came to the site and I was at my desk trying to figure out my own pace.

It was felt that taking a direct approach and facing the challenges within the job helped them learn the role. "The only thing that has helped me is to learn the role head on. Dealing with the problems every day. Trying to find a solution. And again, trying to find people to help guide you through your questions." Another participant simply stated, "It's learn as you go."

Participants described gaining knowledge about the roles of other health care professionals once they settled into their own role. This acquired knowledge enabled

them to refer clients to the appropriate health care professional when faced with issues that were outside of their nursing expertise. One participant explained that before she achieved a deep understanding of the role she did not feel comfortable reaching out for help. She stated, "I think before I thought the case manager had to handle it all. But really, I learned to refer to our occupational therapist or Geographical Complex Assessment and Treatment Team or social workers for whatever you need."

Learning that occurred through performing the job was described as a positive experience. Intriguingly, one participant explained that her job has become less interesting now that she is no longer learning the role of a RN case manager.

It was more interesting when I didn't know what I was doing because learning is interesting. Now I know what I'm doing. MEDITECH can be very boring as can the RAI. The problem is, you do a RAI and it's the same questions. Sometimes, I stop and think, "Oh! I'm doing this one on Sally? Or did I enter in that for Jane? Or, was that the RAI I did on Joe?" Because it all merges together! And it's repetitive. It's like working in a factory. Did I put the wheel on that one or did I miss it because I was daydreaming? You know, did I put the corn in the wrong pot? It becomes very monotonous.

The above interview texts emphasized the value of time and experience for RNs new to case management in the community to become acquainted with their role, as well as the roles of other health care professionals with whom collaboration must occur. It is noteworthy that one participant described the job as "boring" after she had gained a deeper knowledge of the role. I will address this again in my discussion of the findings.

Implementing coping strategies. By the time most participants reached the stage "finding the way" they had identified various coping strategies they used as they adjusted to case management. They continued to use the identified strategies on an ongoing basis to help them cope with the stress from the demands of the job. For clarity, I have grouped these strategies into three main categories. These are: prioritizing, letting go of control, and using personal strategies.

Prioritizing. A key strategy identified as helping them find the way in their new role as a RN case manager was prioritizing. The participants came from various backgrounds; however, most had acute care nursing experience prior to starting their case manager role. Many identified that it took time to understand what aspects of their job were urgent and what aspects were non-urgent. One participant who worked in acute care prior to starting case management stated:

> I know how to handle different situations now. I also know that if I don't get my RAI done in 2 weeks, no one is going to die from it. I just know how to prioritize better. Deal with urgent things now.

Similarly, another shared that she learned everything cannot be accomplished within one day and is now better able to identify what tasks can wait.

> Prioritizing. I think that's the big thing. In the beginning, I didn't know what was a priority. So I have to do all of this and I only have a day? But now I can prioritize and you know what? If this doesn't get done and this doesn't get done, it'll get done tomorrow.

One participant recognized that there would always be interruptions during the work day; however, knowing how to prioritize and maintaining a schedule was key in helping her cope with the demands of case management.

> When I first started I had an awesome system. But then it fell apart. So I had to build it back up. You need to set time. Staff will still be coming to you but you need a schedule and you need to prioritize.

Another explained that she scheduled blocks of time to accomplish the various case management tasks. She described the strategy by saying, "I try and prioritize and try to do work in blocks of time. Like, set aside half a day to do the RAIs and half a day to do care planning."

> Although prioritizing is an effective coping strategy for most, some participants identified that they continue to struggle with this skill; however, they recognized it is something they need to do to function effectively in their role.

> Sometimes, I get overwhelmed with trying to figure out what is my priority. I try to use my iPhone [calendar] as much as I can to space in things. I have actually pulled out my day-timer book because I'm a paper person. I have my week all wrote out so I can see what it looks like and I put in what I need to do.

Likewise, another reported:

> I feel like everything needs to be handled right away. And that's why I had to take three weeks off from this role just because I was overwhelmed with everything. So everything seemed to be higher priority to me than someone who understood a

little better and was able to determine what was urgent. I have a better

understanding now, but it's still not perfect.

Prioritizing is an important skill, for both RNs and RN case managers. Due to the

nature of case management in the community, participants had a difficult time

distinguishing between urgent and non-urgent tasks. However, learning to distinguish

between these tasks was essential in helping them prioritize effectively. This was

something that was learned over time and did not develop during their job orientation.

Letting go of control. Prioritizing various case management tasks was an

important strategy to function effectively as a case manager in the community. However,

it was also acknowledged that it is impossible to plan for everything and case managers

must be able to react to change in an effective manner.

At first, I started booking everything a month in advance but then something

would come up and I would have to deal with it. And that can take two days. And

then very rarely will you catch all of your clients that are scheduled for that day.

So you need to be constantly reorganizing your schedule.

She went on to explain that it took time for her to learn how to respond to changes in her

schedule based on things that were out of her control.

You need to shuffle things around quite often. I don't plan way in advance now. It

doesn't work to plan my monthly visits two weeks in advance. Things don't

always work out the way I have it scheduled. I find a week worth of planning is

good for me and my caseload.

One case manager shared her frustration about having to respond to urgent interruptions during her busy schedule. However, she has learned to become flexible with her schedule to allow for these interruptions as this is a reality of her work environment and often beyond her control. She stated:

> Because there are some days here that I am dealing with other things and I don't even get to the to-do list. So those days are frustrating. But urgent things pop up that you need to deal with. It might not be the whole day but it may be half the day.

From the interview texts, it is clear that they believed that having a planned schedule is important; however, they have learned that the community environment offers little structure and they must be prepared to deal with the unexpected and allow for flexibility within their schedules in order to effectively function within their role.

Using personal strategies to cope. Most of the study participants shared the perception that case management is a stressful job. It is not surprising, then, that most described their personal ways of coping with this stress. A strategy used by several case managers to help them cope with the demands of case management was establishing professional boundaries. Interestingly, they not only discussed establishing boundaries in the context of their clients; they also discussed establishing professional boundaries with staff that worked for the contracted service providers, or site staff. For example, one case manager referring to her experience with a site operator who she believed held a negative view of women in the workforce, stated:

> There are a couple that talk to women like they're beneath them and I do not
>
> tolerate that. I make that clear that you are to talk to me on an equal level. You
>
> need to set boundaries right from the beginning.

She explained that her assertive approach enabled her to set professional boundaries with

the operator, which helped establish a positive professional relationship. In addition, she

explained that establishing clear boundaries helped improve the lack of RN case manager

role clarity among the site staff and operators.

> I think if something comes up and I handle it, they will call me again. But then I
>
> just need to direct them to the right person and explain what I do. So you just need
>
> to set those clear boundaries.

Similarly, another stated, "Assertiveness and boundaries. Now, I can say 'You know

what? That's not my problem. You go figure that out.'" These participants shared how

they handled repeated requests from site staff for things that fall outside of their RN case

manager role.

> Establishing professional boundaries was discussed as an important strategy when

working with clients who had mental health issues. This was something that was learned

on the job.

> With my lack of experience with mental health, I had to learn to keep that
>
> distance and watch and not take things at face value. You can be easily
>
> manipulated with this population. So it has been a big learning curve for me. And
>
> taking into account that it's not malicious. It's their illness. That's what made it

scary. Mental health is not something I sought out. You definitely need to draw a line and maintain your professionalism.

Case management in the community differs from the work of acute care nursing. The participants explained that they sometimes feel like they accomplished very little during a day at work. Unlike acute care, there is no one to take over the work at the end of your shift; therefore, the work is waiting for you when you return. Interestingly, one participant developed a strategy to help feel a sense of accomplishment. She stated:

Well, making my to-do list. Keep making sure that I look at it. Make little boxes and when that little red check mark is in the box it gives you a sense of accomplishment. It makes you feel like you got something done today. Then you can take a deep breath and say "Okay. I've dealt with this, what's next?" Then you go back to your to-do list.

Finally, one participant recognized her experience and maturity as a significant factor that has helped her cope with the demands of her job during her transition to case management in the community by saying:

I think it was my maturity [that helped me]. Knowing how to adjust your tone, your approach with certain types of people. I don't think the younger RNs would be able to identify those areas quite yet. I think life experience has helped me interact with clients and families. My knowledge base was surgical, which encompasses a lot of things. But with this job, you're dealing with people in their homes and not in an environment where there are ill and not at their best. We get

>to see clients in their comfort zone and not our comfort zone. There's a big
>
>difference.

This case manager has considered the power balance shift in her new role. She had

experience in acute care nursing, where nurses are perceived to possess more power than

the clients. In the community setting, however, RN case managers are guests in their

clients' lives and having good interpersonal skills is necessary to effectively execute their

professional roles.

RNs new to case management in the community setting have developed and/or

implemented several strategies to help them cope with the demands of their job. Although

prioritizing is an important skill within the general nursing profession, participants for

this study were required to adapt to a new setting with different priorities. Flexibility and

being able to let go of control also proved to be important coping strategies among some

participants. Finally, participants graciously shared what they do on a more informal or

personal level to help cope with the demands of case management in the community.

Still not fully comfortable. Most of the case managers reported that they had

come to feel more comfortable in their role and their comfort level continued to increase

with time. Although they are not fully comfortable, they are finding their way. There

were only three who reported feeling completely comfortable in their role within the first

two years and they reported receiving a great deal of support from the colleague in which

they shared an office. One stated:

>There's still the occasional thing I need to go to [my colleague] for or I would go
>
>to somebody else. I would say my comfort came on gradual. Probably, I would

say within a couple of weeks of working with [my colleague]. My comfort level

began to improve. And since then, it's improved tremendously. Seriously. Once I

was working with her and I knew she could show me things. I would be on the

phone with her 10 times a day. But now I don't need to phone her as much.

Sometimes she will come across and say "[Participant], I haven't heard from you

in three days. I wondered if you were still here." So I know it's better. It's

difficult to say exactly when. It came on gradual.

Another stated, "I'm just starting to get to the point where I'm not wondering if I have

forgotten anything." She explained that when she first started working as a RN case

manager, she would often be at home thinking if there were tasks that she did not

complete. At the time of the interview, she reported having a better sense of the role and

the expectations.

Some participants reported that they are aware of the expectations of them in their

role and that they have an understanding of how to complete the various tasks within

their role yet at times they are not fully comfortable.

It has in the respect that I'm more familiar with the system and how it works.

Like, with referrals. It has become easier. But the expectations of the case

manager are huge. It still all falls back on you. I just mean that when something

goes wrong, it seems the case manager is always the one that gets the heat. They

are always the one that gets blamed.

Similarly, another reported:

I would say close to the six months mark. I felt like I had a better grasp of fitting

in the monthly visits and stuff like that. In terms of my role, I'm still getting

comfortable in it. People say I'm doing a good job and I'm fulfilling everything.

My timelines are met and all that, but I feel the stress on me. So again, maybe

that's me not grasping my role properly. So, I think I need to adjust some stuff so

I can function properly.

Two participants identified that they were beginning to feel comfortable in their

new role as a RN case manager in the community; however, they also felt that their

confidence decreases during periods of high client activity. One stated:

But I still feel that it's pretty high paced and it's hard to keep up because there are

so many transitions with patients. Either they are transferring sites, or they are

needing alternate levels of care and I just feel like when that happens…When

there is a lot of activity… I get behind on other things like the RAIs and the

monthly [client] visits.

She went on to state:

I think I do feel comfortable. I'm still not fully comfortable. I would say I'm

about 80% comfortable because now I'm changing sites so that's kind of like

starting a new job. So I would say [I started to feel comfortable] maybe in

December. But I still don't know if I'm all the way there.

Another participant with approximately nine months of RN case management experience

described having a positive overall comfort level in her role; however, she explained that

she continues to experience days where she feels challenged and unsure in her role.

97

Similarly, another who has been working as a RN case manager for 18 months reported that she has mostly grasped her role but is uncertain about how to perform particular aspects of her job.

> I just got a list of service authorizations that are all outdated. I went through them and I don't understand what's wrong with it. I don't get it. I still feel like I need that…not one- on-one…but I need someone to call and work me through things.

> Most participants expressed an increased comfort level within their role as a RN case manager in the community. It is important to note that their established comfort level is something that was attained gradually through experience in the role. Although they reported an overall increased comfort level, many reported that they still did not feel entirely comfortable within their role.

During the "finding the way" stage of the transition process to case management in the community, participants reported that they gained most of their knowledge about case management once they completed orientation and began working with clients. Only when they were "at their desk" did they achieve a deeper understanding of their role. Most shared a variety of coping strategies used to deal with the demands of their job. Although most participants shared an increased comfort level in their role, they also explained they are still not fully comfortable. It is important to note that, based on these findings, some RN case managers required a significant amount of time to find their way within their role as they continue to adjust to case management in the community.

Sustaining/constraining factors. I have identified several factors within the "finding the way" stage that either helped or hindered the participants' process of

adjusting to case management in the community (see Figure 1). These factors are grouped into three categories: (a) support, (b) relationships, and (c) job satisfaction.

Support. As participants began finding the way in their transition, they continued to describe support from colleagues and managers as a significant sustaining factor during their transition to case management in the community. One participant described "venting" to another case manager as a significant source of support. She stated "Venting. But I guess that's the best way to do it! If you're not venting, how else are you supposed to, you know, shed any light to your problems". Similarly, another simply stated, "Talking about [the challenges with my manager] is good." She did not share an office with another case manager; therefore, having the ability to talk about the ongoing challenges with her manager was viewed as a source of support.

Relationships. During the final stage of their transition, case managers had confidence in knowing when it was appropriate to make a referral for their clients to another health care professional. The process of making referrals helped them create professional relationships with other members of the health care team, such as occupational therapists, social workers, and physical therapists. Overall, they identified their professional relationship with these health care professionals as positive and as a sustaining factor during the "finding the way" stage of their transition to case management in the community. They explained that there was a mutual respect between them and other health care professionals and working collaboratively made their jobs more satisfying. One participant explained that she enjoys working with other health care professionals in her role.

> [I refer clients to] social workers all the time, ILS workers, occupational therapists and physical therapists, a couple times I have gotten behavior specialists from Alberta Hospital. Oh yes. All of the teams have been great. It's nice to have that mutual respect amongst all disciplines and no one thinking that one is better than the other.

Another shared a similar experience.

> I think the MCS [Multidisciplinary Consult Services] team from Alberta Health Services is really good. The occupational therapist is on the ball with new clients. She is really accessible. Social work I found a little harder to get a hold of because they are short staffed. I have gotten a lot of support from Alberta Health Services staff.

> Finally, one participant reflected upon her experiences with other members of the health care team and described them as positive. However, she shared that there have been times when the health care professional went beyond what they were asked to do for the client, which created extra work for the participant. She explained that her clients had mental health issues and it was important for health care professionals to not go beyond what the client agreed to within their plan of care because it affected the level of trust established between her and her clients.

> They've been positive. Sometimes it's difficult when you make a referral and they go outside of what you asked for. Usually there is a reason why it's specifically one thing. So sometimes I need to backtrack and fix some things. But generally, it's been positive.

Job satisfaction. Most participants experienced high workloads and high levels of stress in their role as a RN case manager. Moreover, even in the final stage of "finding the way," they continued to report feelings of uncertainty and high levels of stress. Why, then, did they stay in their RN case manager role? Despite the numerous challenges in their role, most reported having a high or medium level of job satisfaction. Specifically, they believed they had made a positive impact to their clients' lives, which gave them a great deal of satisfaction. The job satisfaction experienced is a significant sustaining factor during the "finding the way" stage of their transition to case management in the community. One participant described loving her case manager role and had no intentions on looking for another nursing position in the foreseeable future.

> I would have to say at least a nine [out of 10]. It is at least a nine. There are a couple little things. Like vacation. I mean, but what do you do about vacation? I love the hours. I love the site. I love the staff that are here. If I have an issue, I know I can talk to them about it. I love my supervisor. I really do. There have been a few situations where I have   helped somebody and I have been like "Awwww. This is what I come to work for!" I have no plans on moving. My manager and I were joking and she asked if I wanted the supervisor position. I said "Nope!" I don't want it. I love it here.

Many echoed experiences about the satisfaction obtained from helping their clients. One participant stated, "But overall, I like the job because I like the clients. I think if I can make a bit a difference in their life comfort-wise, then fine!"

One participant explained that her role as a RN case manager in the community has enriched her personal life, despite the challenges in which she reportedly faced on a daily basis. She stated, "There are definitely challenges. Overwhelming probably daily. But all in all it has been good. Being a young person, it has enhanced my life. Things like taxes I know a bit more about. It has enriched my life." Interestingly, she explained that her job satisfaction varies from day-to-day. She stated, "There are days when it's a 10 [out of 10] and there are days when it is a two."

Overall, participants experienced positive professional relationships with other members of the health care team. They explained that their relationships with other health care professionals developed once they had more experience in their role as a RN case manager and developed a sense of confidence in knowing when to access their services for their clients. These positive professional relationships were identified as a significant sustaining factor during the "finding the way" stage of the transition. Finally, participants described case management in the community as very stressful and challenging. However, they also described receiving a high level of satisfaction in their role. They were the main contact for their clients and received joy from improving clients' health outcomes. High job satisfaction was also identified as a significant sustaining factor during the final stage of transition to case management in the community.

Summary

The process of transitioning to case management for the RNs working in the community was one that required much adjustment. Previous nursing education and experience were not enough to enable the participants to cope with the many complex

issues related to the new role. The realization that they were not fully equipped to deal

with these challenges led to the identification of the importance of various forms of

support. Although they proceeded through the process at different rates depending on

their background and current work environment, they all realized the need to move

beyond their current abilities and what they envisioned of the role, to accepting a new

reality, one where they had to persevere to adjust and finally begin to find their way.

Chapter 5: Discussion

A knowledge gap related to the transition experience for RNs new to case management in the community setting existed within the literature. Detailed inquiry into the unique experiences of RNs new to case management in the community setting was needed to support this emerging trend in community health care and to understand the support required to sustain RNs in their new role. The findings from this study provided insight into this transition experience. In this chapter, the basic social process of "adjusting to case management in the community" is discussed. Although only one research study directly explored this transition, there is overlap between the findings from this study and previous research. Participants for this study all used the same case management model to deliver client care; therefore, I was unable to assess how case management models may affect the transition experience for RNs new to case management in the community.

As previously described, 11 RNs participated in the study, all of whom were female. Nursing has traditionally been a female dominated profession, which provides some rationale as to why there were no male participants in this study. Similarly, I was unable to find any research studies related to case management with male RN participants. Demographically, this sample is consistent with other research studies that explored RNs in a case manager role. However, it is interesting to note that in the literature, nurses have the general perception that a RN case manager in the community should be a senior nurse with expertise in community resources, have advanced clinical skills, and have a well-developed multidisciplinary network (Smith, MacKay, &

McCulloch, 2013). These perceptions are not aligned with today's case management workforce as some of the participants in this study graduated nursing school two years prior to taking a case manager position.

Participants in this study had a lack of role expectations prior to starting their position as a RN case manager in the community setting. These findings are consistent with some of the literature. Schmitt's (2006) research study found that new RN case managers lack role insight upon starting their new position. Furthermore, Chuang, Chung, and Liu (2013) revealed that RNs have a significant knowledge gap related to case management principles and the role of a case manager. In contrast, Smith et al. (2013) identified that nurses understand the broader principles of case management, such as coordination of services, advanced care planning, chronic disease management, and promoting self-management and independence; however, knowledge about the roles and responsibilities of a case manager were not explored.

In an effort to gain some expectations about their new role, most participants in this study reached out to people who they believed had a better understanding of their role, such as colleagues and managers. However, participants reported that explanations about their role were often vague and confusing. Furthermore, they reported that the role descriptions provided during orientation were inaccurate, which caused confusion about their role. More specifically, once they started their role, they learned it involved much more than what was explained to them in orientation. These findings support recommendations in the literature for clear job descriptions (Chuang et al., 2013; Conti, 1996; Hogan, 2005; Novak, 1998; Smith et al., 2013.; Tahan & Flarey, 1998) and

comprehensive orientation programs for new RN case managers (Conti, 1996; Novak, 1998; Tahan & Flarey, 1998; Walsh, 2009).

A common finding in this study is that participants felt overwhelmed during the beginning stage of their transition to case management in the community–the "slugging it out" stage. This finding is not surprising considering experienced RNs often feel overwhelmed as they start a new position within the profession (Dellasega, Gabbay, Durdock, & Martinez-King, 2009). Dellasega et al. (2009) identified that experienced RNs struggle and feel overwhelmed with assuming a novice role because their work history has shaped their external and internal expectations, which is sometimes at odds with their actual transition experience. One participant in this study discussed how her orientation to case management was not as "straightforward" as other orientations throughout her career, which led her to feel overwhelmed.

The findings of this study revealed that participants were overwhelmed due to a steep learning curve during the beginning of their transition to case management in the community setting. This was echoed in the literature. Al Sayah, Szafran, Robertson, Bell, and Williams (2014) found that new RN case managers in primary care settings reported a steep learning curve related to performing case management duties. Similarly, Smith et al. (2013) reported that RNs new to case management go through a significant learning curve related to the philosophies of case management, such as facilitating client independence and developing an equal partnership with clients in their care. Waterman et al. (1996) identified that feeling overwhelmed is a common experience among new RN case managers in a hospital setting as well as the community. Interestingly, feeling

overwhelmed was identified in the literature as the most influential barrier to fulfilling the case manager role (Novak, 1998; Smith et al., 2013).

Participants in this study identified learning the electronic documentation system, MEDITECH, as particularly overwhelming in the beginning of their transition to case management in the community. I was unable to uncover literature to support this finding. However, this information provides valuable insights about the transition experience for RNs new to case management in the community setting. The participants who identified MEDITECH as a challenge were RNs with more than 10 years nursing experience. Typically, younger nurses were able to learn this system with ease. Therefore, extra support for more experienced nurses around new technology should be considered to help facilitate smooth transitions.

Case managers have a high degree of autonomy within their professional practice. They often work in settings where their supervisors are not present and sometimes work in an office by themselves. It is not surprising, then, that the case managers in this study reported feeling alone during the "slugging it out" stage of their transition. Most reported feeling isolated at their work sites; however, those who were the only case manager at their site expressed these feelings as more intense than those that shared an office with a colleague. I was unable to locate any research studies with similar findings. However, the literature identified support from colleagues and mentors as key facilitators to fulfilling the role as a RN case manager (Al Sayah et al., 2014; Walsh, 2009). Walsh reported that the Carolina Medical Center in North Carolina implemented a program within the case management department that consisted of an 8-week preceptorship and one-year

mentorship for new case managers. This program resulted in increased job satisfaction and reduced turnover among case managers. Furthermore, Al Sayah et al. (2014) found that easy access to team members and open discussion of issues were key supportive factors for RNs in a case management role. These are consistent with reports from participants in this study who described an appreciation for their colleagues who were informally taking on the role of a mentor. Interestingly, some participants in this study reported that they did receive formal case management mentorship from CNEs at the beginning of their transition. However, participants were disappointed with the mentorship provided because the CNEs had little to no experience in the case management role. This finding supports Hogan's (2005) recommendation that mentors should have case management experience in order to achieve the support required to facilitate a smooth transition for RNs new to case management.

One of the main sources of job stress identified in the literature was heavy workloads (Aukland, 2012; Johansson, 2002; Sargent, Boaden, & Roland, 2008; Tahan & Flarey, 1998). Participants in this study experienced a high level of job stress during the "slugging it out" stage of their transition. Some described their high caseloads as unmanageable, which contributes to heavy workloads and stress within their role. Furthermore, they felt it was impossible to provide the expected standards of care with the current number of clients on their caseload. Sargent et al. (2008) found that nurse case managers experience high levels of stress and anxiety when their caseload reaches 50 or more. Interestingly, some participants in this study specifically stated that caseloads of approximately 40 are manageable. Furthermore, participants expressed frustration related

to caseload inconsistencies among their colleagues. According to Bankston-White and

Birmingham (2015), there is no consistent formula or approach related to staffing ratios

with case management. Due to the wide variety of case management models that are used

in today's health care setting, determining appropriate caseloads has been a challenge

(Lamb 1992; Zander, 2002).

The expectations of the case managers in this study were believed to be

unrealistic. More specifically, participants experienced stress from repeatedly being

asked by their managers to complete more tasks without an assessment of their workload.

Furthermore, they identified some tasks that should be removed from their workload and

given to clerical staff to perform, such as data entry, which would allow them more time

with clients. One participant explained that she spent most of her time inputting data,

which she described as "boring." This finding is in line with the literature. Sargent et al.

(2008) found that case managers are frustrated with the amount of time spent performing

non-clinical tasks and experience increased stress levels due to their heavy workloads.

Additionally, Moffatt (2014) reported that case managers often develop poor self-esteem

at work due to routinely completing demeaning time-consuming duties, such as data

entry.

Participants described feeling more stress within their new RN case manager role

than compared to their experiences of working as a nurse in an acute care setting. Tahan

and Flarey (1998) explained that RN case managers are at a higher risk than direct care

RNs for experiencing elevated levels of stress because of the structure of their role, which

includes being responsible for improving organizational and client care outcomes and

cost-containment. Specifically, participants in this study experienced significant levels of stress in the second stage of their transition–the "seeing the job as it is" stage–because of their perceived sole responsibility for the health outcomes of their clients. Tahan and Flarey explained that these goals are met through multidisciplinary collaboration and RN case managers often require support from their supervisors to help achieve effective teams and reduce the stress felt by the burden of their perceived sole responsibility to their clients. Additionally, RN case managers have extraordinary responsibilities with very little authority (Lancero & Gerber, 1995), which may contribute to feeling stressed in the role. Findings from this study are consistent with the literature. Participants described difficult client situations in which they have tried to advocate and act in the best interest of their clients. However, participants expressed frustration about not having any control over external factors, such as housing options and client and family choices that affect the overall health of their clients.

Johansson (2002) noted that RN case managers are at a high risk for experiencing mental exhaustion caused by routinely dealing with stressful situations. Parallel findings were noted in this research study. Participants reflected on the nature of their work and expressed feeling stress because it never seems complete. Interestingly, one participant in this study compared her case management work to a "black hole that doesn't get filled." Schmitt (2006) found that RN case managers who previously worked as a direct caregiver in acute care experienced job stress associated with time-task orientation. Schmitt reported that RNs new to case management had difficulty adjusting to managing

caseloads over longer periods rather than performing specific tasks during a definite

timeframe.

Motivational factors for seeking a case manager role by RNs were explored in this

study and these factors correspond to motivational factors found within the literature.

Schmitt (2006) reported that the main motivators for RNs to enter the field of case

management are dissatisfaction with their current work situation, particularly long hours,

inflexible work schedules, and physically taxing duties. Similarly, participants in this

study explained that they sought a case management position because they were

discontent with shift work in acute care settings. Additionally, some participants shared

that they could no longer cope with the high physical and mental job stress felt in the

acute care settings. These participants expected case management in the community

setting to be less stressful than acute care. These findings are consistent with the literature

in that RNs do not have a keen interest on becoming case managers based on the role and

what it entails. Rather, RNs view case management as a better alternative to their current

position (Schmitt, 2006).

There was one common notion shared among most participants in this study–an

inability or unwillingness to work as a RN case manager in the community long-term.

Participants explained that while they felt a level of satisfaction from helping clients in

the community, the high levels of job stress caused them to explore other opportunities. I

was unable to find data on attrition rates among RN case managers. However, the Case

Management Society of America (CMSA) (2002) noted that RN case managers are

becoming more difficult to recruit and retain. The findings from this study emphasize the

reality that ongoing support for RNs new to case management in the community setting is required in order to retain them in their positions.

One of the most common findings in the literature is case managers' lack of role clarity (Al Sayah et al., 2014; Jamison et al, 1999; Johansson, 2002; Schmitt, 2006; Smith, 2011; Tonges, 1998; Waterman et al., 1996; Yoshie et al., 2008). The findings from this study correspond to the literature. During the "seeing the job as it is" stage of "adjusting to case management in the community," participants described that they did not have an understanding of their role and that vague role definitions were given to them both during application interviews and upon starting their new job as a case manager. According to the literature, RN case managers experience a lack of role clarity due to the wide variation of case management models being used in both acute care and community settings, which has led to poor role definitions for RN case managers (Lamb, 1992; Park et al., 2009; Tonges, 1998; Yoshie et al., 2008; Zander, 2002). Furthermore, participants in this study identified that other health care professionals such as contracted service provider operators and LPNs, as well as family physicians did not have an understanding of their role as case managers. They described this as a barrier to providing optimal services for their clients. Yoshie et al. (2008) found that the majority of health care professionals, which included physicians, nurses, and social workers, have a poor understanding of case management and the roles and responsibilities of a case manager. Furthermore, Al Sayah et al. (2014) found that poor professional relationships resulted from vague RN case manager role clarity among other health care professionals. Participants in this study reported that establishing positive professional relationships

with other health care professionals, especially physicians, was something that developed overtime. Similarly, it was noted in the literature that trust and mutual respect among RN case managers and other team members occurred through achieving an understanding of roles and results in better coordination of client care; however, learning each other's roles occurred over an unspecified period of time (Al Sayah et al., 2014).

Interestingly, participants in this study identified that they experience blurring of the nurse and case manager role in the community setting, creating confusion during their transition. Most participants worked in collaboration with LPNs hired by contracted service provider agencies. Participants explained that they felt confused due to a lack of clear guidelines related to their role and reported that they are unsure as to when they needed to intervene in client health issues. Additionally, they explained they find it difficult to refrain from performing direct care for their clients. Similarly, Johansson (2002) reflected on her transition to case management and reported that learning to delegate care tasks instead of doing the tasks herself was one of the most difficult aspects of her transition.

Ethical conflicts among RN case managers was another common finding within the literature. Ethical conflicts occur primarily because of the case manager's responsibilities to contain health care costs while ensuring clients receive the appropriate services and care to achieve optimal health outcomes (Keffer, 1997; Moffat, 2014; O'Donnell, 2007; Randall. 2007; Schmitt, 2006; Tonges, 1998). Participants from this study did not report any experiences related to this finding in the literature.

Manager support has been identified in this research study as a significant

sustaining factor during the "slugging it out" and "seeing the job as it is" stages of the

participants' transition to case management in the community. During the "slugging it

out" stage, participants shared that they appreciate their managers' responsiveness to

questions and are grateful for their help in facilitating solutions for client issues.

According to Tahan and Flarey (1998), nurse managers should provide intensive support

for new RN case managers because they often have limited knowledge about case

management. Furthermore, nurse managers that create supportive learning environments

are effective in building trust within their professional relationships with RN case

managers, which is a key component in job satisfaction among RN case managers

(Hogan, 2005).

Some participants shared that during the "seeing the job as it is" stage, their

managers helped them solve problems related to confusion about their new role.

Interestingly, Tahan and Flarey (1998) identified that nurse managers should assist RN

case managers new to their role by operationalizing their job description, which reduces

role conflict, confusion, and ambiguity. Participants did not explicitly state that their

managers perform this task; however, some did explain that their managers provided

guidance around role expectations and responsibilities, which helped sustain them in their

new role. In addition, participants identified they found it helpful when managers drew

from their own experiences as case managers and provided guidance during their

transition. This finding supports Hogan's (2005) stance that managers who have

performed the role themselves are more likely to gain credibility and trust from their

staff.

Currently, there is a lack of case management education in nursing curricula;

therefore, nurses working as case managers learn about the role while "on the job"

(Tahan & Flarey, 1998). Findings from this study provide further evidence for this claim.

Participants reported that they gained most of their knowledge about case management

through experience. By performing the job, participants began to "find the way." They

also reported that some of the information that was presented during orientation was

helpful; however, the most significant learning occurred once they started carrying out

the duties of a case manager. This finding emphasized the value of time and experience

for RNs new to case management in the community to become acquainted with their role.

Finally, most participants identified various coping strategies that they used as

they adjusted to case management in the community setting. Learning to prioritize

effectively in the community setting was identified as an essential skill. They explained

that they were accustomed to working in an acute care setting where they responded to

tasks with a sense of urgency. In the beginning of their transition, participants believed

everything needed to be completed by the end of the work day. However, as they began

to find their way, they learned how to identify what tasks were a priority and what tasks

can wait until the following day, or even the following week. This finding is supported by

the literature. Schmitt (2006) identified that nurses who transition from a direct care role

to a case manager role require support around learning to prioritize and managing time

effectively in their new job. Furthermore, Schmitt found that new RN case managers are

required to shift their response to client care needs from an immediate reaction to a

strategically planned approach over an unspecified period of time. Schmitt found that

new RN case managers do not anticipate the need to learn how to prioritize in their new

role, which causes them stress in their role. Interestingly, one participant in this study

explained that she required three weeks of leave due to the stress felt by her inability to

prioritize effectively in her new role. However, most participants did not identify this as a

source of job stress.

Furthermore, Schmitt (2006) found that new RN case managers lack a sense of

accomplishment within their role due to the ongoing nature of their work. Results from

this study supported this finding. Some participants described that they make "to-do lists"

to achieve a sense of accomplishment and satisfaction with their work. Schmitt explained

that new RN case managers need to learn different strategies to obtain a sense of closure

with their work; however, specific strategies to achieve this were not explored.

Additionally, they believed having a planned schedule is important; however, they have

learned that the community environment offers little structure and they must be prepared

to deal with the unexpected and allow for flexibility within their schedules in order to

function effectively within their role. This finding is supported in the literature. Schmitt

found that new RN case managers who formally worked in acute care struggle with

working around clients' and other health care professionals' schedules. The inherent

power-shift that occurs in the community setting is something that should be considered

during the transition experience for RNs new to case management in the community.

Several key issues related to the transition experience for RNs new to case management in the community were identified from this research study. These included: (a) lack of expectations about the role, (b) feeling overwhelmed in the beginning, (c) feeling alone in the role, (d) lack of role clarity, and (e) feeling stressed in the role. Throughout this chapter, similar findings from the literature that supported these key issues were presented. The findings from this study provided an in depth understanding of the transition experience for RNs new to case management in the community and moved beyond what was already known about the transition experience for new nursing graduates. The findings from this study can be used to help ensure appropriate interventions are implemented to improve the transition experience for RNs new to case management in the community setting and support them in their role.

Chapter 6: Strengths, Limitations, and Implications

The final chapter of this thesis outlines the strengths and limitations of the research study as well as the implications for nursing practice and administration, nursing education, and nursing research. The chapter concludes with a comprehensive summary of the study.

Strengths and Limitations

Several strengths are noteworthy within this research study. The rigourous methods used, such as peer debriefing, detailed audit trails, and strict adherence to the data analysis guidelines of grounded theory generated results that were credible, dependable, confirmable, and trustworthy. Additionally, grounded theory was the appropriate methodology to use in order to gain an understanding and develop empirical knowledge related to this transition experience. Also, grounded theory was appropriate to discover the psychosocial process that RNs new to case management in the community setting experience as they transition to a new role. Finally, the findings addressed a significant knowledge gap in the literature related to the transition experience for RNs new to case management in the community. The application of these findings may help ensure RNs new to case management in the community receive adequate support during their transition.

There are several limitations within this research study as well. Male participants were not excluded from the study; however, I was unsuccessful at recruiting male RN case managers that have been working in the community setting from 6 months to 2 years. Male RNs experience barriers within the nursing profession, such as a lack of male

mentors and a negative public perception about men in nursing (Lloyd, 2013). Therefore, male RN case managers may experience a different transition than their female counterparts and may require different methods of support. Furthermore, geographical diversity was limited to one city in Alberta. In addition, participants worked within the same program for the same organization. It is difficult to determine if RN case managers working for a different program or organization would have a similar experience of adjusting to case management in the community setting.

In grounded theory, theoretical sampling is used as "a method of data collection based on concepts/themes derived from the data" (Corbin & Strauss, 2008, p. 143). This means that as the researcher begins to collect data, concepts are uncovered from analysis of that data, which further drives data collection (Corbin & Strauss, 2008). Therefore, sampling in grounded theory studies is responsive to the data and not established prior to starting the research (Corbin & Strauss, 2008). While this is a significant strength of grounded theory studies, is it very difficult to perform theoretical sampling within the time frame given to meet graduation requirements and when administrative approval from program directors is required. Administrative approval to recruit RN case managers to participate in this study was received from only one program within AHS. I was unsuccessful at obtaining administrative approval to invite RN case managers from other AHS programs. There were no differences in the case management model used by participants. New insights about the transition experience for RNs new to case management in the community setting may have been achieved if participants from different programs were invited to participate in this study. Similarly, different

perspectives about the transition experience may have been obtained if participants used different case management models to deliver client care.

Finally, during the time of recruitment and data collection, I was the Nursing Professional Practice Lead for the same program in which the participants worked. Some RN case managers may have felt uncomfortable discussing their transition with me due to my role within the program, especially if they had experienced a negative transition. Therefore, another researcher with no connections to the program in which the participants worked may have been able to recruit more participants and therefore may have yielded different results.

Although limitations are present within this research study, the utilization of rigourous methods led to credible results that allows for a better understanding this transition experience. Furthermore, the results can be used as the basis for recommendations to improve the transition experience for RNs new to case management in the community setting.

Implications of the Study

Case management is used within today's healthcare system as a strategy to reduce healthcare costs while meeting the complex needs of populations within the community. RNs are often recruited for the role of case managers in the community because of their specific skill set and ability to navigate the healthcare system. Therefore, the nursing profession will need to be prepared to support RNs as they transition into these relatively new roles. The findings from this study have several implications for nursing practice and administration, nursing education, and nursing research.

Implications for nursing practice and administration. The key issues that RNs new to case management experience during their transition were identified as: (a) lack of expectations about the role, (b) feeling overwhelmed in the beginning, (c) feeling alone in the role, (d) lack of role clarity, and (e) feeling stressed in the role. These have several implications for nursing practice and administration and are closely related. Therefore, they will be discussed in this chapter together.

The findings from this study suggest that comprehensive orientation programs and structured mentorship programs would be beneficial for new RN case managers in the community setting. Participants in this study described feeling overwhelmed for a variety of reasons, including having a heavy workload, experiencing a steep learning curve, having insufficient time to process the new information, and learning how to navigate the electronic documentation system. Therefore, orientation programs should include continuing education that will help new RN case managers learn to prioritize effectively and prepare for the flexibility that is required in order to function within their role. In addition, adequate time to ask questions and process new information should be given during the orientation period to help new RN case managers in the community feel less overwhelmed. To provide better role clarity, orientation programs should include detailed job descriptions to provide RNs new to case management with better role clarity. While nurse administrators are responsible for the development of these job descriptions, consulting frontline case managers in the work will inevitably produce a more accurate description of their role. The need for extra support for more experienced nurses around new technology during their orientation should be considered by nurse administrators to

help facilitate smooth transitions. Finally, some participants described poor communication and professional relationships with several members of the health care team as a barrier during their transition experience. Orientation programs that include information to support and improve communication and team building skills should be considered.

Several sources of job stress were described during the "slugging it out" stage of adjusting to case management in the community. These sources included heavy workloads, unrealistic expectations of RN case managers, ongoing nature of their work, and the emotional demands of their job. Structured and ongoing mentorship programs that provide support and education related to managing time and workload expectations, making sense of role expectations, prioritizing, and problem solving will help RNs new to case management with reducing the amount of stress felt within their job. Furthermore, participants in the study expressed they did not feel comfortable seeking help from their managers for fear of being perceived as unable to do their job. It is important for RN case managers to share their concerns with their managers; however, nurse administrators must create a non-threatening work environment that fosters open communication with and among RN case managers to help facilitate a smooth transition. Moreover, a structured ongoing mentorship program may provide new RN case managers with the support they need without having to seek support from their manager. Interestingly, participants in this study reported that they still did not feel comfortable in their new role; therefore, RNs and nurse administrators should not underestimate the value of time and experience to become acquainted with the case manager role. Additionally, this finding

highlights the need for structured and ongoing mentorship programs in order to retain RNs new to case management in their positions.

Participants reported that they felt alone as a RN case manager in the community and struggled with a sense of isolation in their new role. They also reported that other case managers were a significant source of support during their transition. Based on this evidence, nurse administrators can strategically locate new RN case managers with more experienced case managers when possible. If physically locating a new RN case manager with an experienced case manager is not possible, nurse administrators can help facilitate buddy shifts to ensure the new RN case manager feels supported in their role. In addition, RNs new to case management in the community who are a part of a structured mentorship program may feel less isolated and may develop deeper connections with other members of the team.

Overall, it is important for RNs and nurse administrators to be aware that the basic social process of "adjusting to case management" can be difficult. By having this general awareness, both RNs and administrators can be better prepared to move through each stage more easily as they adjust to case management in the community.

Implications for nursing education. This study has some implications for nursing education. The findings suggest that RNs new to case management in the community setting had little to no role expectations and experienced a lack of role clarity once they started their role. Today's nursing curricula should expose nursing students to case management so new nursing graduates have a better understanding of a case manager's roles and responsibilities. This may lead to RNs seeking out case management

opportunities because it is an area of interest rather than seeking a case manager job only because they perceive it to be less stressful than acute care or because of the stable work schedule. Furthermore, it is important to strengthen the content of community health courses offered in today's nursing curricula in an effort to educate future nurses about case management and accepting clients as partners in reaching optimal health outcomes and health care sustainability. In addition, clinical placements could include opportunities for nursing students to be preceptored by a community case manager in an effort to achieve practical experience in the role before entering the nursing workforce. By achieving a better understanding of the roles and responsibilities of case managers and the changing health care system, RNs new to case management in the community will experience a smoother transition and ultimately remain in the role for a longer time.

      Implications for nursing research. Grounded theory methodology was used to generate a substantive theory of the process of transitioning to case management for RNs. Therefore, further research is required in order to test and refine the theory. Male RNs often experience unique barriers within the nursing profession; therefore, male RN case managers may experience a different transition than their female counterparts and may require different methods of support. In addition, research studies that aim to include participants from more than one geographical location and using different case management models may provide a deeper understanding or offer new perspectives about this transition. Furthermore, it would be interesting to note if the process of adjusting to case management in the community setting is similar or different for RNs based on their years of nursing. Given the small number of participants and difficulty reaching

theoretical sampling, further exploration may be necessary with a larger and more diverse pool of participants including males and individuals in other organizations for further development of a substantive theory that may be later tested in the clinical area. Finally, future research that study the impact of the identified variables, such as having clear expectations about the RN case manager role, on the transition experiences for RNs new to case management in the community setting is another way to test and refine the theory.

Future research studies that test the effectiveness of the identified recommendations that were based on the evidence from this study to support RNs new to case management in the community setting are required. For example, findings from this study indicate that RN case managers who share an office with at least one other case manager received more support than those that work alone. Therefore, further research is needed in order to determine the effect of sharing an office on the transition experience for RNs new to case management in the community. Moreover, future research studies are required to evaluate the effectiveness of more complex recommendations, such as comprehensive orientation and structured mentorship programs, on improving the transition experience for RNs new to case management in the community setting.

Conclusion

The purpose of this research study was to answer the research question: What is the transition experience of RNs new to case management in the community setting? To answer this research question, a grounded theory approach was used. Eleven female, English-speaking RNs that worked as case managers from 6 months to 2 years

participated in the study. Data were collected by conducting one semi-structured interview with each participant.

The findings from this study revealed three stages that participants moved through during the basic social process of "adjusting to case management in the community." Each stage was characterized by participants' experiences that revealed their thoughts and feelings as they moved through the transition process. Several factors that had significant influence on how participants experienced the transition were also highlighted. These factors were referred to as sustaining/constraining factors. The main stages were as follows: slugging it out, seeing the job as it is, and finding the way. During the "slugging it out" stage, participants felt overwhelmed, alone, stressed, and had unclear role expectations. During the "seeing the job as it is" stage, participants had some clarity about case management and the needs of their clients. Participants wanted more job resources, experienced a lack of role clarity, and felt solely responsible for client health outcomes. During the "finding the way" stage, participants described a deeper understanding of their role. Participants gained knowledge about case management through experience and implemented personal strategies to help cope with the demands of their job. Interestingly, even in this final stage of their transition, most participants shared that they are still not fully comfortable in their role.

Following an in depth discussion of the findings, a discussion of the findings in relation to the literature was presented. Overall, most of the findings in this study were supported by the literature. However, participants in this study identified learning the electronic documentation system as particularly overwhelming in the beginning of their

transition. There was no literature to support this finding. Furthermore, ethical conflicts among RN case managers was a common finding within the literature. Participants from this study did not report any experiences related to this finding.

Strengths and limitations of the study were identified, which confirmed its significance and also acknowledged what must be done differently in future studies, such as having a more diverse pool of participants. Although limitations are present within this research study, the utilization of rigourous methods led to credible results that allowed for a better understanding of this transition experience. Furthermore, the results can be used as the basis for recommendations to improve the transition experience for RNs new to case management in the community setting.

The key implications for nursing practice and administration were presented and they included developing comprehensive orientation and structured mentorship programs to support RNs new to case management in the community setting. Implications for nursing education included strengthening the content of community health courses to include case management and offering clinical placements with community case managers so that nursing students can be exposed to case management as a career choice during their nursing education. In addition, implications for nursing research included the need for future studies to test and refine the substantive theory of the process of transitioning to case management for RNs. Furthermore, future studies are also required that test the effectiveness of the evidence-based recommendations generated from this study. In conclusion, this study has added to our understanding of the transition

experience for RNs new to case management in the community setting, and can be used

to help guide future strategies to support and improve that experience.

References

Alberta Health Services. (2010). *Progressing the continuing care strategy: Case management literature review.* Alberta: Author.

Alberta Health Services (2011). *Progressing the continuing care strategy: Continuing care case management framework and guidelines.* Alberta: Author.

Al Sayah, F., Szafran, O., Robertson, S., Bell. N., & Williams, B. (2014). Nursing perspectives on factors influencing interdisciplinary teamwork in the Canadian primary care setting. *Journal of Clinical Nursing, 23,* 2968–2979. doi:10.1111/jocn.12547

Armitage, G. D., Suter, E., Oelke, N. D., & Adair, C. E. (2009). Health systems integration: State of the evidence. *International Journal of Integrated Care, 9,* 1–11. Retrieved from http://www.ijic.org/index.php/ijic/article/view/316/630

Arnold, J. M., & Sherwen, L. N. (1986). Belief systems which influence research in nursing: Implications for preparing future investigators. *Journal of Nursing Education, 25*(8), 325–327. Retrieved from http://web.a.ebscohost.com.qe2a proxy.mun.ca/ ehost/pdfview er/pdfviewer?vid=4&sid=87c347d5-e73f-4bb8-8993 2e05cf661204%40sessionmg r4005 &hid=4104

Association of Registered Nurses of Newfoundland and Labrador. (2003). *Orientation programs for registered nurses: Best practice guidelines*. St. John's: Author.

Auckland, S. (2012). Community matron caseload numbers: A literature review. *British Journal of Community Nursing, 17*, 493–497. doi:http://dx.doi.org/10.12968/bjcn.2012.17.10.493

Bach, V., Ploeg, J., & Black, M. (2009). Nursing roles in end-of-life decision making in

critical care settings. *Western Journal of Nursing Research, 31,* 496–512.

doi:http://dx.doi.org.qe2a-proxy.mun.ca/10.1177/0193945908331178

Ballew, J. R. & Mink, G. (1996). *Case management in social work.* Springfield, Illinois:

Charles C. Thomas.

Bankston-White, C., & Birmingham, J. (2015). Case management directors: How to

manage in a transition-focused world, part 1. *Professional Case Management, 20*,

63–78. doi:10.1097/NCM.0000000000000078

Benner, P. (1984). *From novice to expert: Excellence and power in clinical nursing

practice.* Menlo Park: Addison–Wesley.

Bently, A. (2014). Case management and long-term conditions: The evolution of

community matrons. *British Journal of Community Nursing, 19*, 340–345.

doi:10.12968/bjcn.2014.19.7.340

Bergen, A. (1992). Case management in community care: Concepts, practices and

implications for nursing. *Journal of Advanced Nursing, 17,* 1106–1113.

doi:10.1111/j.1365-2648.1992.tb02045.x

Blumer, H. (1969). *Symbolic Interaction: Perspective and Method*. New Jersey: Prentice-

Hall Publishing Co.

Brokel, J. M., Cole, M., & Upmeyer, L. (2012). Longitudinal study of symptom control

and quality of life indicators with patients receiving community-based case

management services. *Applied Nursing Research, 25,* 138–145.

doi:10.1016/j.ap nr.2011.02.002

Canadian Home Care Association. (2007). *Implementing case management as a strategy for systems integration.* Ottawa, ON: Author.

Canadian Institutes of Health Research, Natural Sciences and Engineering Research Council of Canada, and Social Sciences and Humanities Research Council of Canada, *Tri-Council Policy Statement: Ethical Conduct for Research Involving Humans,* December 2010. Retrieved from http://www.pre.ethics.gc.ca/pdf/eng/tc ps22014/TCPS_2_FINAL_Web. pdf

Canadian Institutes of Health Research, Institute of Aging. (2013). *Living Longer, Living Better,* Ottawa: Author.

Canadian Nurses Association. (n.d.). *Case management and navigation.* Ottawa: Author.

Canadian Nurses Association. (2006). *Toward 2020: Visions for nursing.* Ottawa, ON: Author.

Canadian Nurses Association. (2008). *Code of ethics for registered nurses.* Ottawa, ON: Author.

Case Management Society of America. (2002). *Top ten trends in case management.* Little Rock, AR: Author.

Casey, K., Fink, R., Krugman, M., & Propst, J. (2004). The graduate nurse experience. *Journal of Nursing Administration, 34*(6), 303–311. Retrieved from http://ovidsp. tx.ovid.com.qe 2a-proxy.mun.ca/sp-3.20.0b/ovidweb.cgi?WebLinkFrameset=1&S = LLIJFPFDDBDDC MNHNCIKLHOBENALAA00&returnUrl=ovidweb.Cgi% 3f%26Full%2bText%3dL%2 57cS.sh.22.23%257c0%257c00005110-200406000- 00010%26S%3dLLIJFPFDDBDDCMNHNCIKLHOBENALAA00&directlink=

http%3a%2f%2fovidsp.tx.ovid.com%2fovftpdfs%2fFPDDNCOBLHNHDB00%2
ffs043%2fovft%2flive%2fgv021%2f00005110%2f00005110-200406000-00010.
pdf&filename=The+Graduate+Nurse+Experience.&pdf_key=FPDDNCOBLHN
HDB00&pdf_index=/fs043/ovft/live/gv021/00005110/00005110-20 0406000-
00010

Cesta, T. (2012). The role of case management in an era of healthcare reform, Part 3.
Hospital Case Management, 20(9), 135–138. Retrieved from http://www.lexisne
xis.com.qe2a-proxy.mun.ca/hottopics/lnacademic/?verb=sr&csi=365639&sr=HE
ADLINE(The+Role+of+Case+Management+in+an+Era+of+Healthcare+Reform
+--+Part+3)%2BAND%2BD ATE%2BIS%2B2012

Chandler, G. E. (2012). Succeeding in the first year of practice. *Journal for Nurses in
Staff Development, 28*(3), 103–107. Retrieved from http://www.umass.edu/nursin
g/sites/nursi ng/files/imagefield_thumbs/succeeding%20thr%20first%20year.pdf

Chang, E., & Hancock, K. (2003). Role stress and role ambiguity in new nursing
graduates in Australia. *Nursing and Health Sciences, 5*(2), 155–163. Retrieved
from http://web.a.ebsc ohost. com.qe2a-proxy.mun.ca/ehost/pdfviewer/pdfviewer
?sid=1bb61e29-36b8-4c6c-a8bf-74913b20c82b%40sessionmgr4001&vid=1&hid
=4104

Cho, J., Laschinger, H., & Wong, C. (2006). Workplace empowerment, work
engagement and organizational commitment of the new graduate nurses. *Nursing
Leadership, 19,* 43–60 doi: 10.12927/cjnl.2006.18368

Chow, S. K. Y., & Wong, F. K. Y. (2010). Health-related quality of life in patients

undergoing peritoneal dialysis: Effects of a nurse-led case management

programme. *Journal of Advanced Nursing, 66*, 1780–1792.

doi:10.1111/j.1365-2648.2010.05324.x

Chuang, Y., Chung, M., & Liu, W. (2013). Case management knowledge and

preparedness among public health nurses. *The Journal of Nursing Research, 21*,

289–296. doi:10.1097/jnr.0000000000000005

College and Association of Registered Nurses of Alberta. (2008). *Registered nurse roles*

that facilitate continuity of care. Edmonton, AB: Author.

College and Association of Registered Nurses of Alberta. (2011). *Seniors and health*

aging: A position statement. Edmonton, AB: Author.

Conti, R. M. (1996). Nurse case manager roles: Implications for practice and education.

Nurse Administration Quarterly, 21(1), 67–80. Retrieved from http://ovidsp.tx.ov

id.com. qe2a-proxy.mun.ca/sp-3.18.0b/ovidweb.cgi?WebLinkF rameset=1&S=O

KFMFPBKIPD DKF BENCJKKBJCIFBLAA00&returnUrl=ovidweb.cgi%3fMa

in%2bSearch%2bPage%3d1%26S%3dOKFMFPBKIPDDKFBENCJKKBJCIFB

LAA00&directlink=http%3a%2f%2fgraphics.tx.ovid.com%2fovftpdfs%2fFPDD

NCJCKBBEIP00%2ffs047%2fovft%2flive%2fgv039%2f00006216%2f00006216

-199602110-00011.pdf &filename=Nurse+Case+ Manager+Roles%3a+Implicati

ons+for+Practice+and+Education.&navigation_links=NavLinks.S.sh.22.1&link_

from=S.sh.22%7c1&pdf_key=FPDDNCJCKBBEIP00&pdf_index=/fs047/ovft/li

ve/gv039/00006216/00006216-199602110-00011&D=ovft& link_set= S.sh.22

|1|sl_10|resultSet |S.sh.22.2 3|0

Corbin, J., & Strauss, A. (2008). *Basics of qualitative research: Techniques and procedures for developing grounded theory*. Thousand Oaks, CA: Sage.

Cunningham, B., Kizziar, B. K., Wilson, P., & Zander, K. (2012). CM experts: Hospitals need ED case managers now more than ever. *Hospital Case Management, 20*(10), 145–156. Retrieved from http://www.ahcmedia.com/articles/77549-cm-experts-hospitals-need-ed-case-managers-now-more-than-ever

Davis, C. B., Cornman, C. B., Lane, M. J., & Patton, M. (2005). Person-centered planning training for consumer-directed care for the elderly and disabled. *Care Management Journals, 6*(3), 122–130. Retrieved from http://web.b.ebscohost.com.qe2a-proxy.mun.ca/ehost/pdfviewer/ pdfviewer?sid=12785b52-2288-4b13-aecd-0e61c1fd3448%40sessionmgr112&vid=1&hid=106

Dellasega, G., Gabbay, R., Durdock, K., & Martinez-King, N. (2009). An exploratory study of the orientation needs of experienced nurses. *The Journal of Continuing Education in Nursing, 40*, 311–316. doi:10.3928/00220124-20090623-04

Duke, C. (2005). The frail elderly community-based case management project. *Geriatric Nursing, 26*(2), 122–127. doi: 10.1016/j.gerinurse.2005.03.003

Dyess, S. M., & Sherman, R. O. (2009). The first year of practice: New graduate nurses' transition and learning needs. *The Journal of Continuing Education in Nursing, 40,* 403–410 doi:10.3928/00220124-20090824-03

Ellerton, M., & Gregor, F. (2003). A study of transition: The new nurse graduate at 3

   months. *The Journal of Continuing Education in Nursing, 34*(3), 103–107.

   Retrieved from http:// web.a.ebscohost.com.qe2a-proxy.mun.ca/ehost/pdfviewer/

   pdfviewer?sid=56e60907-408 9-47d2-a1b8-1e424ac074ec%40sessionmgr4003&

   vid=1&hid=4104

Etheridge, S. (2007). Learning to think like a nurse: Stories from new nurse graduates.

   Journal of Continuing Education in Nursing, 38(1), 24–30. Retrieved from

   http://web.b.ebscohost. com.qe2a-proxy.mun.ca/ehost/pdfviewer/pdfviewer?sid=f

   417cce 4-f02b-4686-ba83-c37 af722bef7%40sessionmgr105&vid=1&hid=124

Gallagher, L. (2012). The transitional journey of enrolled nurse to registered nurse: A

   review of the literature. *HNE Handover: For Nurses and Midwives, 5*(1), 21–23.

   Retrieved from http://journals.sfu.ca/hneh/index.php/hneh/article/view/89

Glaser, B., & Strauss, A. (1967). *The Discovery of Grounded Theory*. New York: Aldine

   Publishing.

Guba, E. G. (1981). Criteria for assessing the trustworthiness of naturalistic inquires.

   Educational Communication and Technology Journal, 29, 75–92. Retrieved from

   http://www.clemson.edu/ces/cedar/images/1/1a/3-Guba-Trustworthiness-1981.pdf

Halfer, D., & Graf, E. (2006). Graduate nurse perceptions of work experience. *Nurse

   Economics, 24*(3), 150–155. Retrieved from http://web.b.ebscohost.com.qe2a-pro

   xy.mun.ca/ehost/pd fviewer /pdfviewer?sid=8530db3c-c64a-43c3-997a-bd87846

   f3e6c%40sessionmgr103&v id=1&hid=124

Hammer, B. J. (2001). Community-based case management for positive outcomes. *Geriatric Nursing, 22*, 271–275. doi:10.1067/mgn.2001.119479

Hogan, T. D. (2005). The impact of staff case manager-case management supervisor relationship on job satisfaction and retention of RN case managers. *Lippincott's Case Management, 10*(5), 246–253. Retrieved from http://ovidsp.tx.ovid.com.qe2 a-proxy.mun.ca/sp-3.18.0b/ovidweb.cgi?QS2=434f4e1a73d37e8c54ea12160ae19 8c5cedd8c2fc6da6a6533b3a1f8d82b6a435bd3c6a8ec5768d9ab864a27571b55f07 bdf80e3439df9b40cfcad214298b0855f835df55b86eb11cd7ac4b43ab6706a323b4 aab38c199398a80c8266df0a11512e156d9a7aeb2b48808c6bffd6ee4a86611108f1a 93d335c12d095a14a3fbe862f73e938b83a2d4569c088592e7e57f7eecd960387f5c 53cac76da623771034c9f8ef16eb1f2b2465b299204dafa69df6a5e02fc30d9b09023 73c1cc98c6ed97a8ff0b2b562839cf681dd17be80ab4ca584cd1fbfaa3ef92be6e142 2996fc126851ff156d11d922d40354b8e636d4aee077f72d25c200d26f52647212fc 1341e877f14f3b291f93

Hollander, M. J., Chappell, N., Prince, M. J., & Shapiro, E. (2007). Providing care and support for an aging population: Briefing note on key policy issues. *Healthcare Quarterly, 10*, 34–45. doi:10.12927/hcq.2007.18923

Holmes, C. A., & Phil, M. (1990). Alternatives to natural science foundations for nursing. *International Journal of Nursing Studies, 27*, 187–198. doi:10.1016/0020-7489(90)90034-G

House of Commons. (2012). *Chronic diseases related to aging and health promotion and diseases prevention.* Ottawa, ON: Author.

Huber, D. L. (2002). The diversity of case management models. *Lippincott's Case*

Management, 7, 212 –220. Retrieved from http://ovidsp.tx.ovid.com.qe2a-proxy.

mun.ca/sp-3.18.0b/ovidweb.cgi?QS2=434f4e1a73d37e8c1b4a447f0f0a848d3d26

a5c8019134b85c7d43a4e8796af11d8f94f7a48f0e6d30b3484e193391df43f45e666

4d6f7ee5cdf80db7650b042b676ffbacce886f08217ea904e3779703663d9c0c6beee

28020e90585fa9769ce81e9efdaa453f14cfa1fdd2f858eb074d7ecf7819e6a4b8a300

bfa6023c37af7cdebd118fc5939225a5d9265f0b7c67c2a14d30b2f3a7d242ad0ef14

ebc8b70e8360988bdae55b0dbd064215eefd74d42b7f682037ce6fdecfe1097c4d38

25b6a3ecdeb7ad34360a8e3a7992dcfb5e9cf04964b9b6b2a43b16df233560ea7816

7775ff4735f9b83bec31b971f58b46283ace27cd4bb8c29d7035474b96069f5b539e

a974d114e2f

Jamison, M., Ross, V., Hornberger, C., & Morse, V. (1999). Implementation of the care

coordinator role: A grounded theory approach. *Journal of Professional Nursing,*

15, 356–363. doi:10.1016/S8755-7223(99)80066-0

Janes, B., Beck, D., & Denny, A. (2002). *Joint Program Evaluation Committee Report of*

the Survey Results: Employers and Graduates, Class 2000. St. Johns, NF:

Memorial University of Newfoundland Bachelor of Nursing (Collaborative)

Program.

Jennings-Sanders, A., & Anderson., E. T. (2003). Older women with breast cancer:

Perceptions of the effectiveness of nurse case managers. *Nursing Outlook, 51,*

108–114. doi:10.1016/S0029-6553(03)00083-6

Johansson, B. C. (2002). Case management stress: Strategies to lessen the load. *Care Management 8*(5), 16–18.

Joo, J. Y., & Huber, D. L. (2013). An integrative review of nurse-led community-based case management effectiveness. *International Council of Nurses, 61,* 14–24. doi:10.1111/inr.12068

Keeling, A. W., & Bigbee, J. L. (2005). The history of advanced nursing practice in the United States. In Hamric, A. B, Spross, J. A., & Hanson, C. M. (Eds.), *Advanced nursing practice: An integrative approach* (pp.1–21) Philadelphia, PA: W. B. Saunders.

Keffer, M. J. (1997). Ethical decisions with limited resources: How is that possible? *Nursing Case Management, 2*(2), 8–9. Retrieved from http://ovidsp.tx.ovid.com. qe2a-proxy.mun.ca/sp-3.18.0b/ovidweb.cgi?WebLinkFrameset=1&S=OKFMFP BKIPDDKF BENCJKKBJCIFBLAA00&returnUrl=ovidweb.cgi%3fMain%2bSe arch%2bPage%3d1%26S%3dOKFMFPBKIPDDKFBENCJKKBJCIFBLAA00& directlink=http%3a%2f%2fgraphics.tx.ovid.com%2fovftpdfs%2fFPDDNCJCKB BEIP00%2ffs047%2fovft%2flive%2fgv038%2f00063148%2f00063148-199709 000-00004.pdf&filename=Ethical+ Decisions+With+Limited+Resources+HOW +IS+That+Possible%3f.&navigation_links=NavLinks.S.sh.39.1&link_from=S.sh. 39%7c1&pdf_key=FPDDNCJCKBBEIP00&pdf_index=/fs047/ovft/live/gv038/0 0063148/00063148-199709000-00004&D=ovft&link _set=S.sh. 39| 1|sl_10|result Set|S.sh.39.40|0

Kneafsey, R., Long, A., Reid, G., & Hulme, C. (2004). Learning and performing care

management: Experiences of a newly formed interdisciplinary, assessment

andrehabilitation team. *Learning in Health and Social Care, 3*, 129–140.

doi:10.1111/j.1473-6861.2004.00069.x

Kodner, D. (2009). All together now: A conceptual exploration of integrated care. *Health

Care Quarterly, 13,* 6–16. Retrieved from http://www.albertahealthservices.ca/

Publicati ons/ahs-pub-hc-quarterly.pdf

Lamb, G. (1992). Conceptual and methodological issues in nurse case management

research. *Advances in Nursing Science*, *15*(2), 16–24. Retrieved from

http://ovidsp.tx.ovid.com.qe 2a-proxy.mun.ca/sp-3.18.0b/ovidweb.cgi?WebLink

Frameset =1&S=HGEKFPCGPHD DNFLBNCJKGDIBMEOFAA00&returnUrl

=ovidweb.cgi%3fMain%2bSearch%2bPage%3d1%26S%3dHGEKFP CGPHDD

NFLBNCJKGDIBMEOFAA00&directlink=http%3a%2f%2fgraphics.tx.ovid.com

%2fovftpdfs%2fFPDDNCIBGDLBPH00%2ffs047%2fovft%2flive%2fgv038%2f

00012272%2f00012272-199212000-000 04.pdf&filename=Conceptual+and+met

hodological+issues+in+nurse+case+management+research.&navigation_links=N

avLinks.S.sh.27.1&link_from=S.sh.27%7c1&pdf_key=FPDDNCIBGDLBPH00

&pdf_index=/fs047/ovft/live/gv038/00012272/00012272-199212 000-00004&D

=ovft& link_set=S.sh.27|1|sl_10|resultSet|S.sh.27.28|0

Lancero, A. W., & Gerber, R. M. (1995). Comparing work satisfaction in two case

management models. *Nursing Management, 26*(11), 45–48. Retrieved from

http://ovidsp.tx.ovid.com. qe2a-proxy.mun.ca/sp-3.18.0b/ovidweb.cgi?WebLink

Frameset=1&S=OKFMFPBKIPD DKFBENCJKKBJCIFBLAA00&returnUrl=o

vidweb.cgi%3fMain%2bSearch%2bPage%3d1%26S%3dOKFMFPBKIPDDKFB

ENCJKKBJCIFBLAA00&directlink=http%3a%2f%2fgraphics.tx.ovid.com%2fo

vftpdfs%2fFPDDNCJCKBBEIP00%2ffs047%2fovft%2flive%2fgv039%2f00006

247%2f00006247-199511000-00010.pdf&filename=Comparing+ Work+Satisf

action+in+Two+Case+Management+Models.&navigation_links=NavLinks.S.sh.4

1.1&link_from=S.sh.41%7c1&pdf_key=FPDDNCJCKBBEIP00&pdf_index=/fs0

47/ovft/live/gv039/00006247/00006247-199511000-00010&D=ovft&link_set=s

.sh.41|1| sl_10|resultSet|S.sh.41.42|0

Lincoln, Y. S., & Guba, E. A. (1985). *Naturalistic Inquiry.* Beverly Hills, CA: Sage.

Lloyd, P. (2013). *Perceptions of the male millennial baccalaureate nursing student*

(Order No. 3598473). Available from ProQuest Dissertations & Theses Global.

(1459234781). Retrieved from http://search.proquest.com/docview/1459234781?

accountid=12378

MacDonald, M., Schreiber, R., & Davis, L. (2005). *Exploring new roles for advanced*

nursing practice. Ottawa, ON: Canadian Nurses Association.

McGeehan, S. K., & Applebaum, R. (2007). The evolving role of care management in

integrated models of care. *Care Management Journals, 8*, 64–70.

doi: http://dx.doi.org/10.1891/152109807780845591

McLaughlin, K., Miller, J. M., & Wooten, C. (1999). Ethical dilemmas in critical care:

Nurse case managers' perspective. *Critical Care Nursing Quarterly, 22*, 51–64.

doi:10.1097/00002727-199911000-00009

McWilliam, C. L., Stewart, M., Vingilis, E., Hoch, J., Ward-Griffin, C., Donner, A.,…

Anderson, K. (2004). Flexible client-driven in home case management: An option

to consider. *Care Management Journals, 5*(2), 73–86. Retrieved from http://web.

b.ebscoho st.com.qe2a-proxy.mun.ca/ehost/pdfviewer/pdfviewer?s id=7cb0 95e3-

a600-49ca-92 5c-d0e464d528f3%40sessionmgr120&vid=1&hid=106

Moffat, M. (2014). Reducing moral distress in case managers. *Professional Case

Management,19*, 173–186. doi:10.1097/NCM.0000000000000039

Morse, J. (2001). *Using Grounded Theory in Nursing*. Springer Publishing Co. Inc.

National Case Management Network. (2009). Canadian standards of practice for case

management. Toronto: Author.

Novak, D. (1998). Nurse case managers' opinions of their role. *Nursing Case

Management, 3*(6), 231–237 Retrieved from http://ovidsp.tx.ovid.com.qe2a-prox

y.mun.ca/sp-3.18.0b/ovidweb.cgi?WebLinkFrameset=1&S=OKFMFPBKIPDDK

FBENCJKKBJCIFBLAA00&returnUrl=ovidweb.cgi%3fMain%2bSearch%2bPa

ge%3d1%26S%3dOKFMFPBKIPDDKFBENCJKKBJCIFBLAA00&directlink=

http%3a%2f%2fgraphics.tx.ovid.com%2fovftpdfs%2fFPDDNCJCKBBEIP00%2f

fs047%2fovft%2flive%2fgv038%2f00063148%2f00063148-199811000-00002.p

df&filename=Nurse+Case+Managers%27+ Opinions+of+Their+ Role.&navigatio

n_links=NavLinks.S.sh.43.1&link_from=S.sh.43%7c1&pdf_key=FPDDNCJCKB

BEIP00&pdf_index=/fs047/ovft/live/gv038/00063148/00063148-199811000-000

02&D=ovft&link_set=S.sh.43|1|sl_10|resultSet|S.sh.43.44|0

O'Donnell, L. T. (2007). Ethical dilemmas among nurses as they transition to hospital

case management: Implications for organizational ethics, part 2. *Professional*

Case Management, 12, 219–231. doi:10.1097/01.PCAMA.0000282909.36285.ba

Park, E. J., Huber, D. L., & Tahan, H. A. (2009). The evidence base for case management

practice. *Western Journal of Nursing Research, 31,* 693–714.

doi:10.1177/0193945909332912

Parse, R. R. (1999). Nursing science: The transformation of practice. *Journal of*

Advanced Nursing, 30, 1383–1387. doi:10.1046/j.1365-2648.1999.01234.x

Porter, S. (2010). Fundamental patterns of knowing in nursing: The challenge of

evidenced-based practice. *Advances in Nursing Science, 33*, 3–14.

doi:10.1097/ANS.0b013e3181c9d5eb.

Randall, G. E. (2007). Competition, organizational change, and conflict: The changing

role of case managers in Ontario's homecare system. *Care Management Journals,*

8, 2–7. doi:http://dx.doi.org/10.1891/152109807780494096

Registered Nurses Association of Ontario. (2003). *The value of registered nurses as case*

managers. Ontario: Author.

Sargent, P., Boaden, R., Roland, M. (2008). How many patients can community matrons

successfully case manage? *Journal of Nurse Management, 16*(1) 38–46.

doi:10.1111/j.1365-2934.2007.00785.x

Schmitt, N. (2005). Role transition from caregiver to case manager, part 1. *Lippincott's*

Case Management, 10(6), 294–302. Retrieved from http://ovidsp.tx.ovid.com.qe2

a-proxy.mun.ca/sp-3.18.0b/ovidweb.cgi?WebLinkFrameset=1&S=OKFMFPBKI

PDDKF BENCJKKBJCIFBLAA00&returnUrl=ovidweb.cgi%3f%26Full% bTex

t%3dL%257cS.sh.50.51%257c0%257c00129234-200511000-00010%26S%3dO

KFMFPBKIPDDKFBENCJKKBJCIFBLAA00&directlink=http%3a%2f%2fgrap

hics.tx.ovid.com%2fovftpdfs%2fFPDDNCJCKBBEIP00%2ffs046%2fovft%2fliv

e%2fgv023%2f00129234%2f00129234-200511000-00010.pdf&filename=Role+

Transition+From+Caregiver+to+Case+Manager%2c+Part+1.&pdf_key=FPDDN

CJCKBBEIP00&pdf_index=/fs046/ovft/live/gv023/00129234/00129234-200511

000-00010

Schmitt, N. (2006). Role transition from caregiver to case manager, part 2. *Lippincott's*

Case Management, 11(1), 37–46. Retrieved from http://ovidsp.tx.ovid.com.qe2a-

proxy.mun. ca/sp-3.18.0b/ovidweb.cgi?WebLinkFrameset=1&S=OKFMFPBKIP

DDKFBENCJKK BJCIFBLAA00&returnUrl=ovidweb.cgi%3f%26Full%2bText

%3dL%257cS.sh.60.61%257c0%257c00129234-200601000-00007%26S%3dO

KFMFPBKIPDDKFBENCJKKBJC IFBLAA00&directlink=http%3a%2f%2fgra

phics.tx.ovid.com%2fovftpdfs%2fFPDDNCJCKBBEIP00%2ffs047%2fovft%2fli

ve%2fgv024%2f00129234%2f00129234-200601000 -00007.pdf&filename=Role

+Transition+From+Caregiver+to+Case+Manager-Part +II.&pdf_key=FPDDNCJ

CKBBEIP00&pdf_index=/fs047/ovft/live/gv024/00129234/00129234-20060100

0-00007

Smith, A. C. (2011). Role ambiguity and role conflict in nurse case managers: An

integrative review. *Professional Case Management, 16*, 182–196.

doi:10.1097/NCM.0b013e318218845b

Smith, A., MacKay, S., & McCulloch, K. (2013). Case management: Developing practice

through action research. *British Journal of Community Nursing, 18*, 452–458.

doi:10.12968/bjcn.2013.18.9.452

Statistics Canada. (2012). *The Canadian population in 2011: Age and sex.* Ottawa, ON:

Author.

Streubert, H. J., & Carpenter, D. R. (2011a). Ethical considerations in qualitative

research. In H. J. Streubert & D. R. Carpenter (Eds.), *Qualitative research in*

nursing: Advancing the humanistic imperative (pp. 56–71). Philadelphia, PA:

Lippincott Williams & Wilkins.

Streubert, H. J., & Carpenter, D. R. (2011b). Grounded theory as method. In H. J.

Streubert & D. R. Carpenter (Eds.), *Qualitative research in nursing: Advancing*

the humanistic imperative (pp. 123–139). Philadelphia, PA: Lippincott Williams

& Wilkins.

Sutherland, D., & Hayter, M. (2009). Structured review: Evaluating the effectiveness of

nurse case managers in improving health outcomes in three major chronic

diseases. *Journal of Clinical Nursing, 18,* 2978–2992. doi:10.1111/j.1365-

2702.2009.02900.x

Tahan, H. A., & Campagna, V. (2010). Case management roles and functions across

various settings and professional disciplines. *Professional Case Management, 15*,

245–277. doi:10.1097/NCM.0b013e3181e94452.

Tahan, H. A., & Flarey, D. L. (1998). Nurse managers: A support system for nurse case

managers. *Nursing Case Management, 3*(5), 216–219. Retrieved from http://ovid

sp.tx.ovidsp.tx.ovid.com.qe2a-proxy.mun.ca/sp-3.18.0b/ovidweb.cgi?WebLinkFr

amest et=1&S= OKFMFPBKIPDDKFBENCJKKBJCIFBLAA00&returnUrl=ovi

dweb.cgi%3fMain%2bSearch%2bPage%3d1%26S%3dOKFMFPBKIPDDKFBE

NCJKKBJCIFBLAA00&directlink=http%3a%2f%2fgraphics.tx.ovid.com%2fovf

tpdfs%2fFPDDNCJCKBBEIP00%2ffs047%2fovft%2flive%2fgv038%2f0006314

8%2f00063148-199809000-00007.pdf &file na me=Nurse+Managers%3a+ A+Su

pport+System+for+Nurse+Case+Managers.&navigation_links=NavLinks.S.sh.65.

1&link_from=S.sh.65%7c1&pdf_key=FPDDNCJCKBBEIP00&pdf_index=/fs04

7/ovft/live/gv038/00063148/00063148-199809000-00007&D=ovft&link_set=S.s

h.65|1|sl_10|resultSet|S.sh.65.66|0

Terra, S. M. (2007). An evidence-based approach to case management model selection

for an acute care facility: Is there really a preferred model? *Professional Case

Management, 12*, 148–157. doi:10.1097/01.PCAMA.0000271365.01171.b6

Thornicroft, G. (1991). The concept of case management for long-term mental illness.

International Review of Psychiatry, 3, 125–132. doi:10.1192/bjp.181.1.17

Tonges, M. C. (1998). Job design for nurse case managers: Intended and unintended

effects on satisfaction and well-being. *Nurse Case Management, 3*(1), 11–25.

Retrieved from http://ovidsp.tx.ovid.com.qe2a-proxy.mun.ca/sp-3.18.0b/ovidweb

.cgi?We bLinkFrameset=1&S=OKFMFPBKIPDDKFBENCJKKBJCIFBLAA00

&returnUrl=ovidweb.cgi%3fMain%2bSearch%2bPage%3d1%26S%3dOKFMFP

BKIPDDKFBENCJKKBJCIFBLAA00&directlink=http%3a%2f%2fgraphics.tx.o

vid.com%2fovftpdfs%2fFPDDNCJCKBBEIP00%2ffs047%2fovft%2flive%2fgv0

39%2f00063148%2f00063148-1998010 00-00004.pdf&filename=Job+Design +f

or+Nurse+Case+Managers+Intended+and+Unint ended+Effects+on+Satisfaction

+and+Well-Being.&navigation_links=NavLinks.S.sh.67.1&link_from=S.sh.67%

7c1&pdf_key=FPDDNCJCKBBEIP00&pdf_index=/fs047/ovft/live/gv039/00063

148/00063148-199801000-00004&D=ovft&link_set=S.sh.67|1|sl_10|resultSet|S.s

h.67.68|0

Walsh, C. (2009). Preceptors, mentors help CMs learn the way around. *Hospital Case

Management, 17*(11), 166, 171–172. Retrieved from http://www.lexisnexis.com.q

e2a-proxy.mun.ca/hottopics/lnacademic/?v erb=sr&csi=365639&sr=HEADLINE(

Preceptors%2C+mentors+help+CMs+learn+the+way+around)%2BAND%2BDA

TE%2BIS%2B2009

Waterman, H., Waters, K., & Awenat, Y. (1996). The introduction of case management

on a rehabilitation floor. *Journal of Advanced Nursing, 24,* 960–967.

doi:10.1111/j.1365-2648.1996.tb02932.x

Whelton, B. J. B. (2000). Nursing as a practical science: Some insights from classical

Aristotelian science. *Nursing Philosophy, 1*(1), 57–63. Retrieved from http://web.

a.ebsco host.com.qe2a-proxy.mun.ca/ehost/pdfviewer/pdfviewer?vid=44&sid=87

c347d5-e73f-4bb8-8993-2e05cf661204%40sessionmgr4005&hid=4104

White, J. (1995). Patterns of knowing: Review, critique, and update. *Advances in Nursing

Science, 17*(4), 73–86. Retrieved from http:// ovidsp.tx.ovid.com.qe2a-proxy.mun.

ca/sp-3.18.0b/ovidweb.cgi?QS2=434f4e1a 73d37e8c1b4a447f0f0a848db5e7a005

66e2dec1f9c61d0702f11a0abc0b10515358496cbec60852b0368a07c29334f21dc0
ed9ebb0fe8f7b1682fd94dc492dcc2006acea964d12c4f07ebdbfc50d3616fcd0204d
3078d62b502550d5e117b493aaa0ccf7a98a1252312662dc3dd0a2ec50fead78d0ea
c5f534da8cac2ad63bef5d15f88cee07dd1ef21d2d32485943c56bdb08b3352156c1
af23f69b9d6f014e8e83f5ad14a56948f3fecdfdea7f84aecf783f14625f38f4f044336
c079f2555cc9d9d3e99281780e386643236016492d6234c73672b2b374272b40706
772f7fac6694a719d8a05d20382c6dfca406719a552ef0f78349fee8a39bdeda8c4a5
6a57f57e

Yoshie, S., Saito, T., Takahashi, M., & Kai, I. (2008). Effect of work environment on

care manager's role ambiguity: An exploratory study in Japan. *Care Management*

Journals, 9, 113–121. doi:10.1891/1521-0987.9.3.113

Zander, K. (2002). Nursing case management in the 21st century: Intervening where

margin meets mission, *Nursing Administration Quarterly, 26*(5), 58–67. Retrieved

from http://we b.a.ebscohost.com.qe2a-proxy.mun.ca/ehost/pdfviewer/pdfviewer

?sid=90e1f 379-eaa4-461a-a134-4ff4bd08d727%40sessionmgr4005&vid=1&hid=

4106

Appendix A

Approval Letter

Kelly Kean
5816 1A Avenue
Edmonton, AB
T8H 0C9
780-660-5024
e26klk@mun.ca

Date

Name
Program Director for Supportive Living/Home Living
Alberta Health Services
10216 124 St.
Edmonton, AB
T5N 4A3

Dear Mr. or Mrs. Surname,

My name is Kelly Kean and I am a currently completing my Master of Nursing degree at Memorial University of Newfoundland. In partial fulfillment of my Masters Degree in Nursing, I am conducting a study about registered nurse (RN) case managers in the community setting. The research question I am trying to answer is: "What is the transition experience like for RNs new to case management in the community setting?" I am writing to obtain your approval to recruit RN new to case management within your program as participants for this study.

There is a vast amount of nursing literature related to the client and system benefits of case management, the roles and responsibilities of RN case managers, and job satisfaction among RN case managers. However, literature that explored what the transition experience is like for RNs new to case management in the community setting have not been identified. Through this study, I hope to advance nursing knowledge in this area and ultimately retain RN case managers in the community setting.

The target population for this study is RNs new to case management who have been working in the community setting for a minimum of 6 months to a maximum of 2 years. Participant recruitment will include a poster that will be distributed to RN case managers' offices throughout the various AHS community work settings. Furthermore, the poster will be emailed as an attachment to employees within Alberta Health Services (AHS). The poster will outline the purpose and significance of the research study as well as my name, status, and contact information. Participants will be asked a series of questions

related to their transition experience into their new role as a case manager. Data will be analyzed and communicated to the participants and the intended audiences, which include RN case managers, community health care administrators, nurse educators, and education administrators.

Throughout the entire study process, there will be strict adherence to the guidelines set out by Health Research Ethics Authority (HREA) to ensure all ethical factors are considered and treated appropriately. A research proposal has been submitted and approved by the HREA for this study. Upon your request, a copy of the research proposal will be provided for your review.

Please return a signed copy of this letter to my address, which will indicate your approval for the study. Thank you for reviewing this request.

Respectfully yours,

Kelly Kean, BN, RN.

Appendix B

Recruitment Poster

What is the Transition Experience like for RNs New to Case Management in the Community Setting?

My name is Kelly Kean and I am a Master of Nursing student at Memorial University of Newfoundland. I am conducting a research study to explore perceptions, thoughts, and feelings related to the transition experience for RNs new to case management in the community setting.

If you have been a RN Case Manager in the Community Setting for minimum of 6 months to a maximum of 2 years, I invite you to share your experiences while transitioning into your new role.

If you are interested in participating in this research study, please contact me at your earliest convenience. My office phone number is: **(780) 616 – 4840.** My home phone is: **(780) 660 – 5024.** My email address is **e26klk@mun.ca.**

Appendix C

Questions to Guide Interview

1. How long have you been a nurse?

2. How long have you been working as a RN case manager?

3. How long was your orientation when you began your role as a RN case manager?

4. In what areas did you work as a nurse before becoming a RN case manager?

5. Why did you decide to work as a RN case manager in the community?

6. Can you think back and describe to me what it was like when you started as a case manager in the community? Has it changed? If so, can you explain in what ways?

7. Did you have any expectations about the role of a RN case manager in the community? If so, how did you acquire these expectations? Did these expectations accurately reflect the role of a RN case manager?

8. What has helped facilitate your transition as a RN case manager in the community?

9. Have you experienced any barriers to fulfilling your role as a RN case manager in the community?

10. When did you begin to feel comfortable in your new role as a RN case manager in the community?

11. Have you ever encountered any ethical dilemmas while working as a RN case manager in the community? If so, how do you perceive you handled these dilemmas? What resources were available for you adequately manage these ethical dilemmas?

12. Do you feel perceive your job as stressful? If so, in what ways?

13. Did you anticipate these stressors prior to beginning your new role as a RN case manager in the community?

14. Did you learn any ways to deal with day-to-day stressors?

15. How would you describe your professional relationships with your clients and families? The interdisciplinary team?

16. How would you describe your job satisfaction?

17. Is there anything you can think of that would help you achieve better job satisfaction?

18. Overall, how would you describe your transition to case management in the community?

19. Is there anything else you would like to add?

Appendix D

Health Research Ethics Authority Approval for Research

Health Research
    Ethics Authority

Ethics Office
Suite 200, Eastern Trust Building
95 Bonaventure Avenue
St. John's, NL
A1B 2X5

August 13, 2013

Ms. Kelly Kean
5816 1A Avenue
Edmonton, AB
T6X)K8

Dear Ms. Kean

Reference #13.190

Re: The transition experience of Registered Nurses new to Case Management in the Community

Your application received an expedited review by a Sub-Committee of the Health Research Ethics Board and **full approval** was granted effective **August 13, 2013.**

This approval will lapse on **August 12, 2014**. It is your responsibility to ensure that the Ethics Renewal form is forwarded to the HREB office prior to the renewal date. *The information provided in this form must be current to the time of submission and submitted to the HREB not less than 30 nor more than 45 days of the anniversary of your approval date.* The Ethics Renewal form can be downloaded from the HREB website http://www.hrea.ca.

This is to confirm that the following documents have been reviewed and approved or acknowledged (as indicated):
- Application, approved
- Questions to Guide Interview, approved
- Revised consent form, dated August 12, 2013, approved
- Revised poster, approved

The Health Research Ethics Board advises THAT IF YOU DO NOT return the completed Ethics Renewal form prior to date of renewal:

- *Your ethics approval will lapse*
- *You will be required to stop research activity immediately*
- *You may not be permitted to restart the study until you reapply for and receive approval to undertake the study again*

Lapse in ethics approval may result in interruption or termination of funding

email: info@hrea.ca   Phone: 777-8949   FAX: 777-8776

It is <u>your responsibility to seek the necessary approval from the Regional Health Authority or other organization as appropriate</u>.

Modifications of the protocol/consent are not permitted without prior approval from the Health Research Ethics Board. Implementing changes in the protocol/consent without HREB approval may result in the approval of your research study being revoked, necessitating cessation of all related research activity. Request for modification to the protocol/consent must be outlined on an amendment form (available on the HREB website) and submitted to the HREB for review.

This research ethics board (the HREB) has reviewed and approved the research protocol and documentation as noted above for the study which is to be conducted by you as the qualified investigator named above at the specified site. This approval and the views of this Research Ethics Board have been documented in writing. In addition, please be advised that the Health Research Ethics Board currently operates according to *Tri-Council Policy Statement: Ethical Conduct for Research Involving Humans*; *ICH Guidance E6: Good Clinical Practice* and applicable laws and regulations. The membership of this research ethics board is constituted in compliance with the membership requirements for research ethics boards as defined by *Health Canada Food and Drug Regulations Division 5; Part C*

<u>Notwithstanding the approval of the HREB, the primary responsibility for the ethical conduct of the investigation remains with you.</u>

We wish you every success with your study.

Sincerely,

Patricia Grainger

Ms. P. Grainger
Vice-Chair Non-Clinical Trials
Health Research Ethics Board

C   VP Research c/o Office of Research, MUN
         VP Research c/o Patient Research Centre, Eastern Health
         HREB meeting date: August 22, 2013

email: info@hrea.ca   Phone: 777-8949   FAX: 777-8776

Appendix E

Northern Alberta Clinical Trials and Research Centre Administrative Approval for

Research

Alberta Health Services

AHS ADMINISTRATIVE APPROVAL FOR RESEARCH

Northern Alberta Clinical Trials and Research Centre
Research Administration
1800 College Plaza
8215 - 112 Street NW
Edmonton, AB T6G 2C8
www.nactrc.ca

NACTRC
The Northern Alberta Clinical Trials and Research Centre

Protocol Acronym: _____ **Protocol #:** _____ **REB #:** Pro00044036 **Ethics Approved:** Nov 24, 2013

Protocol Title:
The Transition Experience for Registered Nurses New to Case Management in the Community

Principal Investigator: Kelly Kean   **Funding Agency:** No Funding Agency
  Funding Type: Investigator-Initiated/No Funding
  Overhead Rate: 0%

AHS Operational Approvals:
18897:   Seniors Health - Edmonton Zone - Integrated Supportive Living

---

AHS Admin File #: 32351
Approved: Apr 23, 2014

Approved By: Ron Welch
  NACTRC Research Administration
  On Behalf of Alberta Health Services

Page 1 of 1

Appendix F

Budget

Supplies	Price
Paper (200 sheets/pack) x 10	$35.00
Pens (15/pack) x 2	$3.30
Ink (Black only)	$50.00
Batteries (AAA – for digital recorder)	$15.00
Envelopes	$5.00
Postage Stamps	$10.00
Total for Supplies	$118.30

Equipment	Price
Digital Recorder	$110.00
Computer	$0.00 (personal computer)
Multi Media Projector for Presentations	$0.00 (Obtained from Professional Development though AHS)
Travel	35.68cents/kilometer
Interview/Presentation Rooms	$0.00 (Scheduled through LRC at MUN and Professional Development though AHS)
Total for Equipment	$110.00 + Travel Costs based on Kilometers

This research study will be conducted to fulfill the requirements for the degree of Master of Nursing. Therefore, I will not be paid a salary.

Appendix G

Informed Consent Document

Consent to Take Part in Research

TITLE: The Transition Experience for Registered Nurses New to Case Management in the
Community

INVESTIGATOR(S): Ms. Kelly Lynn Kean

You have been invited to take part in a research study. Taking part in this study is voluntary. It is up to you to decide whether to be in the study or not. You can decide not to take part in the study. If you decide to take part, you are free to leave at any time.

Before you decide, you need to understand what the study is for, what risks you might take and what benefits you might receive. This consent form explains the study.

Please read this carefully. Take as much time as you like. If you like, take it home to think about for a while. Mark anything you do not understand, or want explained better. After you have read it, please ask questions about anything that is not clear.

The researchers will:

- discuss the study with you
- answer your questions
- keep confidential any information which could identify you personally
- be available during the study to deal with problems and answer questions

1. **Introduction/Background:**

    Case management is a role that is often filled by registered nurses (RNs) within community health as a means to improve and maintain the health of populations while controlling healthcare costs. There is a vast amount of nursing literature related to the client and system benefits of case management, the roles and responsibilities of RN case managers, and job satisfaction among RN case managers. However, literature that explored what the transition experience is like for RNs new to case management in the community setting have not been identified.

2. **Purpose of study:**

    The purpose of this research study is to answer the question: **"What is the transition experience like for RNs new to case management in the community**

setting?" By having an understanding of this transition experience, it is hoped that the new nursing knowledge will improve RN case managers' job satisfaction and ultimately retain this group of professionals.

3. Description of the study procedures:

You are being asked to participate in one digitally recorded interview that I will conduct at your convenience. The interview will last approximately 60 minutes. I will schedule a private and quiet conference room at your area of work. The interview will take place a scheduled day of work at a time of your convenience.

4. Length of time:

The interview will last approximately 60 minutes. Furthermore, if you choose to participate in the study, you are invited to a presentation of findings that will be held for participants during April 2014. You will be notified of the exact date. The presentation is expected to be 30 minutes.

5. Possible risks and discomforts:

There are no anticipated risks to your physical health. Should you experience a negative emotional reaction during or after the interview, please contact the Employee and Family Assistance Program at this provincial toll-free number: 1-877-273-3134. The provincial EFAP is a voluntary, confidential, short-term counseling and advisory service that is available to all employees within AHS, as well as their families, 24 hours a day. Furthermore, there will not be a financial burden if you choose to participate.

6. Benefits:

It is not known whether this study will benefit you.

7. Liability statement:

Signing this form gives us your consent to be in this study. It tells us that you understand the information about the research study. When you sign this form, you do not give up your legal rights. Researchers or agencies involved in this research study still have their legal and professional responsibilities.

8. What about my privacy and confidentiality?

Protecting your privacy is an important part of this study. Every effort to protect your privacy will be made. However it cannot be guaranteed. For example we may be required by law to allow access to research records.

When you sign this consent form you give us permission to

- **Collect information from you**
- **Share information with the people conducting the study**
- **Share information with the people responsible for protecting your safety**
- **Access to records**

The members of the research team will see study records that identify you by name.
Other people may need to <u>look</u> at the study records that identify you by name. This might include the research ethics board. You may ask to see the list of these people. They can look at your records only when supervised by a member of the research team.

<u>Use of your study information</u>
The research team will collect and use only the information they need for this research study.

This information will include your

- **Information from the interview**

Your name and contact information will be kept secure by the research team in Newfoundland and Labrador. It will not be shared with others without your permission. Your name will not appear in any report or article published as a result of this study.

Information collected for this study will kept for five years.

If you decide to withdraw from the study, the information collected up to that time will continue to be used by the research team. It may not be removed. This information will only be used for the purposes of this study.

Information collected and used by the research team will be stored on a password protected flash drive and will be kept in a locked filing cabinet in a locked office at the researcher's place of work. Kelly Kean–the researcher–is the person responsible for keeping it secure.

<u>Your access to records</u>

You may ask the investigator to see the information that has been collected about you.

9. **Questions or problems:**

   If you have any questions about taking part in this study, you can meet with the investigator who is in charge of the study at this institution. That person is:

   Principal Investigator's Name and Phone Number

   Kelly Lynn Kean
   Ph: 780-660-5024

Or you can talk to someone who is not involved with the study at all, but can advise you on your rights as a participant in a research study. This person can be reached through:

Ethics Office

Health Research Ethics Authority

709-777-6974 or by email at info@hrea.ca

After signing this consent you will be given a copy.