DEFINING NURSE LEADERSHIP: NURSES' PERCEPTIONS OF NURSE
LEADERSHIP AND THE CONDITIONS THAT INFLUENCE ITS DEVELOPMENT

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ABSTRACT

Megan Parpart Williams: Defining Nurse Leadership: Nurses' Perceptions of Nurse
Leadership and the Conditions that Influence its Development
(Under the direction of Janice Anderson)

In this era of technologic and scientific advancement, the aging population, and the
shift from illness and treatment to wellness and prevention, the multitude of calls for nurses
to lead is shining the spotlight on the significant work of all nurses. However, the phrase
"nurse leadership" is defined and used in a variety of ways in the literature. Conceptual
clarity about nurse leadership and nurse leadership development in the context of nursing and
health care is needed to provide an empirical direction for future research and theory
development. Transparency is needed in this area so nurse leadership is utilized as a
legitimate vehicle for advancing health care and the nursing profession. This study
contributes to both academic and practice environments current understanding of nurse
leadership. Using nurses' viewpoints this qualitative study sought to explore the concept of
nurse leadership in today's health care environment and the conditions that influence
leadership development. A literature review on nurse leadership was conducted. Qualitative
methodology was employed to study fifteen registered nurses' perceptions of nurse
leadership. Data analysis yielded seven themes: confidence; leading by example; risk taking;
"you have potential"; resource person; "prove myself"; and sticking out. Nurse leadership
can be broadly defined as the process by which nurses, individually or collectively,
intentionally influence their patients, colleagues, and settings both internal and external to
health care to improve the practice of nursing with the aim of safe patient care.

I dedicate this dissertation to all nurses who are leading each and every day by taking action where they are. And to my husband Durward, for loving me more every day and being a constant source of encouragement and support throughout this journey. This would not have been possible without you.

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LIST OF ABBREVIATIONS

AACN   American Association of Colleges of Nursing

ANA   American Nurses Association

ADN   Associate Degree Nurses

BSN   Bachelor of Science in Nursing

CINAHL   Cumulative Index to Nursing and Allied Health Literature

H-PEPSS   Health Professional Education in Patient Safety Survey

HRSA   Health Resources and Services Administration

IOM   Institute of Medicine

LGBT   Lesbian, Gay, Bisexual, and Transgender

LPI   Leadership Practices Inventory

NCNA   North Carolina Nurses Association

NLN   National League for Nursing

MSN   Masters of Science in Nursing

QSEN   Quality and Safety Education for Nurses

RN   Registered Nurses

RWJF   Robert Wood Johnson Foundation

SNCL   Staff Nurse Clinical Leadership

S-LPI   Student Leadership Practices Inventory

WHO   World Health Organization

CHAPTER 1: INTRODUCTION

Introduction to the Problem

The health care industry is under intense scrutiny and experiencing rapid change. The impact of health care errors has been well documented by the Institute of Medicine (IOM) through the Quality Chasm series (2000, 2001, 2003). *Keeping Patients Safe* (2003) laid the foundation for the current focus on improving patient safety, emphasizing that nursing leadership is essential to achieving safety goals. The World Health Organization (WHO) estimates that in developed countries as many as 1 in 10 patients are harmed while receiving hospital care (WHO, 2014). They estimate that these harms have an economic cost of as much as $19 billion annually, due to additional hospitalizations, litigation costs, infections acquired in the hospital, disability, lost productivity and medical expenses (WHO, 2014). In 2008, the federal government instituted new Medicare payment rules that would penalize organizations demonstrating poor performance on eight nursing-sensitive indicators. For the first time, hospital payment was tied to the quality of care provided by the nursing workforce.

As the largest component of the health care workforce in the United States (U.S.), nurses need to be leading critical conversation about reducing healthcare errors (Rotheschild et al., 2006). The nursing profession is described as forming a "strong, secure safety net for consumers of healthcare" (Bargagliotti & Lancaster, 2007, p. 156). According to Fardellone et al. (2014) "nurses are guided by immediacy, take measures to understand situations, deal with complex situations, manage multiple tasks, meet patient and family needs, and negotiate and collaborate with the health care team" (p. 507). Nurses must seize the opportunity to be

empowered leaders in America's health care industry. When health care organizations do not put patients at the forefront, health care reform efforts may not be as effective. Nurse leadership can play an important role in health care reform. At its core, nurse leadership is a vehicle for accomplishing the multidimensional work of health care. Nurse leadership is about aligning the organization of health care around common goals and working collaboratively to make today's health care environment safe.

In 2008, the American Association of Colleges of Nursing (AACN) identified patient safety as the second priority in their list of nine essentials for baccalaureate education for professional nursing practice. The AACN explained that a baccalaureate nurse should be able to: demonstrate leadership skills to effectively implement patient safety and quality improvement initiatives within the context of the Interprofessional team (AACN, 2008). From a pedagogical standpoint, health care leadership scholarship has helped increase health care provider awareness, shaped national health policies, provided theoretically driven work, and produced texts for undergraduate and graduate students (Scott, 2010). However, more standardized tools are needed to develop nurses to be effective leaders in a variety of contexts and situations. Specifically, concentrated leadership preparation that is focused on the unique strengths of the nursing profession is warranted. Unfortunately, there is a deficit in the amount of concentrated leadership preparation available in undergraduate and graduate nursing programs specifically, and researchers believe that nurses would benefit from leadership preparation specifically suited for them (Dyess, Sherman, Pratt, & Chiang-Hanisko, 2016).

The nursing profession could be considered to be at a "tipping point" (Gladwell, 2000) related to leadership and patient safety. Representing the largest healthcare workforce,

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"nurses must begin to utilize the potential power they possess" (Altieri & Elgin 1994, p. 75). In this era of technologic and scientific advancement, the aging population, and the shift in focus from illness and treatment to wellness and prevention, the profession of nursing continues to be confronted with calls both internally and externally to the profession for all nurses to lead. Addressing the unique and complex attributes of the health care industry will require significant alterations in the health care workforce culture and in the preparation of future nurses to embrace the role of leader. It is imperative for the profession of nursing to embrace the identity of nurse leader and prepare all nurses to be empowered leaders on every team, in every health care environment and on behalf of every patient.

Background of the Study

The 2010 Institute of Medicine (IOM) Report, *Future of Nursing: Leading Change, Advancing Health* is the result of a joint collaboration between the Robert Wood Johnson Foundation (RWJF) and the IOM and is "intended to support efforts to improve the health of the U.S. population through the contributions nurses can make to the delivery of care" (IOM, 2010, p. 4). The report's eight recommendations are centered on four key messages:

- Nurses should practice to the full extent of their education and training.

- Nurses should achieve higher levels of training through an improved education system that promotes seamless academic progression.

- Nurses should be full partners with physicians and other health professionals in redesigning health care in the United States.

- Effective workforce planning and policy-making require better data collection and improved information infrastructure.

The committee issued eight recommendations based these four key messages. Two of the eight recommendations are specifically focused on nurse leadership: "expand opportunities for nurses to lead and diffuse collaborative improvement efforts", and "prepare and enable nurses to lead change to advance health. Nurses, nursing education programs, and nursing associations should prepare the nursing workforce to assume leadership positions across all levels, while public, private, and governmental health care decision makers should ensure that leadership positions are available to and filled by nurses" (IOM, 2010, p.14).

The Committee on the Robert Wood Johnson Foundation in partnership with the Institute of Medicine published the Future of Nursing: Leading Change, Advancing Health (2010) report that emphasized the need for strong nursing leadership to improve patient safety outcomes and that it is now time for the nursing profession to enhance its leadership role in health care redesign.

> Although the public is not used to viewing nurses as leaders, and not all nurses begin their career with thoughts of becoming a leader, all nurses must be leaders in the design, implementation, and evaluation of, as well as advocacy for, the ongoing reforms to the system that will be needed. Additionally, nurses will need leadership skills and competencies to act as full partners with physicians and other health professionals in redesign and reform efforts across the health care system (IOM, 2010, p. 221).

This study will focus on Registered Nurses (RN) and defines nursing: as the protection, promotion, and optimization of health and abilities, prevention of illness and injury, alleviation of suffering through the diagnosis and treatment of human response, and advocacy in the care of individuals, families, communities, and populations (American Nurses Association, 2010, p. 1). There are six essential features of professional nursing:

- Provision of a caring relationship that facilitates health and healing,

- Attention to the range of human experiences and responses to health and illness

within the physical and social environments,

- Integration of objective data with knowledge gained from an appreciation of the patient or group's subjective experience,

- Application of scientific knowledge to the process of diagnosis and treatment through the use of judgment and critical thinking,

- Advancement of professional nursing knowledge through scholarly inquiry, and

- Influence on social and public policy to promote social justice (ANA, 2010, p. 29).

Nursing education leading to licensure as a registered nurse is achieved in several different ways, and in approximately twenty-five hundred pre-licensure schools of nursing in the United States (National Council of State Boards of Nursing, 2007). Although there is only one licensing examination, the NCLEX-RN examination developed by the National Council of State Boards of Nursing, each school of nursing develops its' own curriculum and course of study to prepare nursing students within certain accreditation guidelines (AACN, 2008). Despite differences in pre-licensure programs and educational curricula, all graduates of these schools are expected to function in a similar role within the healthcare settings that employ them. Very few facilities differentiate the role of the entry-level registered nurse based on educational level and all are expected to provide safe, high quality care (Chernomas, et al., 2010, Grossman & Valiga, 2012). Recent nursing graduate indicate that leadership education is needed as part of their preparation for entry into the workforce (Candela & Bowles, 2008). Nursing education appears to be lagging behind in the domain of leadership development, with many schools focusing on clinical practice and management, but inadequately embracing the concept of nurse leadership and nurse leadership development (Manfredi & Valiga, 1990; DeYoung, 2009; Curtis, de Vries, & Sheerin, 2011).

Nurse leaders today need new knowledge and skills to be prepared for the challenges of leading in highly technical, collaborative, interprofessional environments. There is little evidence to support the effectiveness of teaching strategies utilized in many entry-level nursing programs (Holmes, 2011). "At a time when health care delivery systems and models of care are changing radically, we need much more research into the best ways to prepare nurses for new roles, competencies and responsibilities" (Holmes, 2011, p. 38). Interprofessional teams and coordination of care across the illness trajectory will be key components of every health system. According to Poter-O'Grady (2011) interprofessional health care environments should take "the full responsibility for leading and coordinating efforts that identify problems related to waste, care improvement, tracking quality improvement, and achieving established goals" (p. 35). It is time for transformation of our paradigms about nursing leadership and for "moving from teaching about leadership to developing leaders" who will lead and coordinate care in today's interprofessional health care environments (Cleeter, 2011, p. 283).

Nursing is a diverse profession that encompasses multiple overlapping roles, including: delivering care; coordinating care; ensuring safety and quality; developing and managing health care systems; educating and conducting research. As a result nurses must be involved in decision-making about how to identify, respond and improve the delivery of care. According to Moloney (1979), accountability for professional practice implies that nurses must "broaden their view of what responsible leadership entails" (p. 3). The current transformation of the healthcare industry into integrated healthcare networks makes the role of nurse leader development more complex, requiring clinical, organizational, sociocultural and political knowledge and skills. Leadership is increasingly seen as a skill that should not

be solely the role of individuals at the top of any organization, but instead something that is embraced by staff at all levels (Hartley & Allison, 2000; Grossman & Valiga, 2012).

The image of nursing is subject to historic preconceptions, gender references and biases, and the perception of the nurse as "following orders". But nursing is not a series of routine, habitual, technical skills to be learned, instructed to perform, and repeated day after day, year after year. Being a full partner means that nurses must be empowered to speak up and take on more responsibility and accountability; "it requires nursing to move out of the shadows of other disciplines and join the discussion" (Wyatt, 2012, p. 565). Though the concept of nurse leadership is addressed in the nursing literature, it is primarily focused on administrators who work within health care systems with varying sizes and patient populations. For nurses accustomed to the traditional hierarchical structure in health care and the new nurse ready to begin his or her career, the call for nurse leadership at every level is transformational and requires nurse educators to reform the way we think, act and teach future nurse leaders. This presented the question, what is nurse leadership in today's health care environment and how is it defined and developed?

Statement of the Problem

The phrase "nurse leadership" is a phrase with varied operationalization that makes it difficult to define. Though the concept of nurse leadership is found in the nursing literature, it is primarily focused on formal leadership roles and no universally accepted definition exists (Grossman & Valiga, 2012). Chief nursing officer, director of nursing, nurse manager, nursing supervisor, and charge nurse are some of the formal roles associated with nurse leadership (Sherman, Schwarzkopf & Kiger, 2011). The phrase "nurse leadership" is also used to describe activities nurses engage in to affect change such as quality improvement projects, advocating for patients, families and the nursing profession, and participating in

health care governance. Nurse leadership is one way that the nature of nurse involvement in different health care organizational structures is conceptualized. There is a lack of research on how individual nurses see themselves as leaders. Therefore, it is critical to examine the concept of leadership from their perspective.

With the significant changes that both have occurred and are expected to occur in health care, it is important to shift the discussion to the equally important concept that "nurse leader" is not a job title and nurse leadership at all levels will improve patient safety in health care. Hutchinson and Jackson (2013) recommend a critical review of transformational leadership, the dominant leadership theory in nursing literature, to better speak to the contemporary interpretation of nurse leadership. Calls for nurse leadership combined with growing national attention on the need to better utilize the nursing workforce have given the phrase "nurse leadership" more significance.

At the same time, nurse leadership is a concept that has not been fully developed by the nursing profession and has not been fully integrated into nursing curricula, practice, and by extension, professional identity. In addition, without an understanding of how nurses view nurse leadership and the conditions that influence its development, it is difficult to identify and address leadership development needs and the impact of nurse leadership on safe patient care. Conceptual clarity about nurse leadership and nurse leadership development in the context of nursing and health care is needed to provide an empirical direction for future research and theory development that can advance the science of leadership research in nursing. This study contributes to both academic and practice environments current understanding of nurse leadership. Transparency is needed in this area so nurse leadership is utilized as a legitimate vehicle for advancing health care and the nursing profession.

Purpose of the Study

The purpose of this qualitative research study is to explore the concept of nurse leadership from nurses' perceptions within the context of today's healthcare environment among a sample of 15 Registered Nurses (RNs), in North Carolina. Additionally, this study sought to identify what influences the development of nurse leadership. Qualitative inquiry was appropriate for the study, as it allowed the identification of beliefs, concerns and shared experiences (Creswell, 1998, 2003) among registered nurses as factors affecting leadership development.

The qualitative study included a two-phased research design with an online Qualtrics ™ survey in phase I and individual semi-structured interviews with a purposive sample of 15 participants in phase II. Magilvy and Thomas (2009) describe that in qualitative research the meaning of data is generated through questions asked in interviews. The goal of this interpretive qualitative approach was to produce a rich description of the concept of nurse leadership through narrative interview data.

Research Questions

The research questions for this study were grounded in the values of the nursing profession and based upon findings from the literature. The questions were initially designed around participants' self-knowledge of leadership, nurse leadership, nursing values and nurses' perception of today's health care environment. Additionally, the questions were structured to reveal a deeper understanding of what fosters and inhibits nurse leadership development. Such information would be beneficial to educators as they explore the concept of nurse leadership in developing curricula to build nurse leadership capacity. The specific research questions to be answered are:

1. What are the essential elements of nurse leadership?

2. What key language, actions and values demonstrate nurse leadership?

3. In what ways do nurses consider nurse leadership essential in today's health care environment?

   a. How is this different from previous perspectives?

   b. How is this similar to previous perspectives?

4. What influences the development of nurse leadership?

   a. How do gender, race/ethnicity, age, and sexual orientation influence the development of nurse leadership?

   b. What additional social factors emerge to influence the development of nurse leadership?

Theoretical Framework

This qualitative research study employed interpretive paradigm, Hollander's (1964) emergent leadership theory and the concept of expert power to guide the exploration of nurse leadership in today's health care environment and what influences the development of nurse leadership.

Interpretive Paradigm

Glesne (2006) describes the interpretive paradigm as having a "research goal of interpreting the social world from the perspective of those who are actors in that social world" (p. 8). The research participant is the expert and there is no one correct interpretation of reality. This research study will employ the perspectives of several members of the same social group (i.e. Registered Nurses) about the same phenomena (i.e. nurse leadership) in order to "begin to say something about cultural patterns of thought or action for that group" (Glense, 2006, p. 8). The interpretive paradigm (Table 1) seeks to explore, observe, ask

questions with an open mindset, look for patterns, and the writing will be descriptive in nature.

Table 1. Predispositions of Interpretivist Approaches to Research (Adapted from Glense, 2011, p. 9)

Assumptions	*Research Approach*
▪ Reality is socially constructed ▪ Variables are complex, interwoven and difficult to measure *Research Purposes* ▪ Contextualization ▪ Understanding ▪ Interpretation	▪ May result in hypotheses and theory ▪ Researcher as instrument ▪ Inductive ▪ Searches for patterns ▪ Descriptive write-up *Research Role* ▪ Personal involvement ▪ Empathic understanding

Emergent Leadership

Emergent leaders are described as "group members who exert significant influence over other members of the group, although no formal authority has been vested in them" (De Souza & Klein, 1995, p. 476). There are two major patterns that distinguish how an individual achieves legitimacy as a leader (Hollander, 1964). Emergent leaders gain legitimacy informally from the acceptance and support of other team members (De Souza & Klein, 1995; Hollander, 1964, 1978). In contrast, formal leaders gain legitimacy by formal appointment rather than from team member support (De Souza & Klein, 1995; Hollander, 1964, 1978). Despite the original source of legitimacy, the maintenance of leadership for both emergent and formal leaders is dependent upon relationships (De Souza & Klein, 1995; Hollander, 1964, 1978).

Expert Power

Expert power originally described by french and raven (1959; n.d.) is the basis for collaboration and for advocacy in a variety of health care contexts and it provides nurses with considerable credibility to speak out on health care issues.

Expert power denotes that a person or group of persons or organization of persons determines or affects what another person or group or organization will do. It is the power derived from having more information or skill in a given area than do most other people. Expert power comes from the individual's authority, which has been granted to the person through expertise in a subject or through a position that the individual holds in the organization and is derived from expertise, skill, or knowledge (Stevenson, 2006).

Nurses, as both providers and consumers of health care, often have the best view of the health care challenges facing providers and patients and the very real impact of problems within the health care system, such as access to care and healthy work environments. By demonstrating their expert power, nurses establish credibility and trust from others both internal and external to the health care organization (Stevenson, 2006).

Definitions of Key Terms

The following key terms have been defined for the purposes of understanding specific and crucial vocabulary within this research study.

Clinical Leader: A clinician who is an expert in their field, and who, because they are approachable, effective communicators and empowered, are able to act as a role model, motivating others by matching their values and beliefs about nursing and care to their practice (Stanley, 2006, p. 111).

Emergent Leader: group members who exert significant influence over other members of the group although now formal authority has been vested in the (Schneier and Goktepe, 1983).

Formal Nurse Leader: Formal nurse leaders are responsible for nursing practice and quality of care among frontline nurses or nurses in a single unit, department, or health care system—as well as overseeing all personnel and budget matters and creating an environment that supports professional practice and employee engagement (Cipriano, 2014).

Informal Nurse Leader: Informal leaders in nursing are often nurses with a high level of clinical competency who are recognized as experts. This type of leader influences the group, comes from the team, and is chosen by the team, but does not hold an assigned position of authority within the health care organization (Krueger, 2014).

Interprofessional: a group of individuals from different disciplines working and communicating with each other individuals. In the Interprofessional learning environment each member provides his/her knowledge, skills, and attitudes to augment and support the contributions of others (Hall and Weaver, 2001).

Leadership Development: refers to almost every form of growth or stage of development in the life cycle that promotes, encourages, and assists in one's leadership potential. This includes learning activities that are both formal and structured as well as those that are informal and unstructured. Therefore, leadership development is a continuous learning process that spans an entire lifetime; where knowledge and experience builds and allows for even more advanced learning and growth (Brungardt, 1997, p.83).

Nursing: Nursing is the protection, promotion, and optimization of health and abilities, prevention of illness and injury, alleviation of suffering through the diagnosis and treatment of human response, and advocacy in the care of individuals, families, communities, and populations (American Nurses Association, 2011, pg. 1).

Patient Safety: The reduction of risk of unnecessary harm associated with health care to an acceptable minimum (Hibbert, et al., 2009, p. 19).

Significance of the Study

Nurses are the single largest group of healthcare providers in the nation, with approximately 3.1 million registered nurses in the United States (HRSA, 2010). They are the profession on the frontlines of patient care and play a major role in patient safety and quality

improvement. Because of their number and proximity to patient care, nurses have the potential to be leaders at all levels of patient care and in every health care setting.

Nursing Science and Research

Understanding the experiences of Registered Nurses in today's health care environment and what influences the development of nurse leadership contributes to the advancement of nursing science. This study contributes to the emerging literature on the experiences of nurses and what influences nurse leadership development. The understanding of these experiences contributes to theory development by further describing the nature of the impact of nurses in health care. In addition, the study contributes to the understanding of the impact of leadership development on nurses' personal and professional quality of life. The results of this study provide a foundation for future research that provides conceptual transparency and potential research instruments that measure the impact of nurse leadership on Registered Nurses and the effects of nurse leadership development on Registered Nurses.

Nursing Practice

Starting at the registered nurse level, this study seeks to explore nurse leadership through the perspective of contemporary registered nurses in the state of North Carolina. With increased transparency around this concept, nurses may gain a better understanding of what it means to be a nurse leader and be able to grow their abilities in this area. This growth area directly aligns with the IOM Future of Nursing Report and could increase the awareness of nurses as equal partners in health care (IOM, 2010). In addition, the findings of this research study could help in the design of nurse professional development programs for all levels of nurses. This study may be helpful for health care organizations to use in creating supportive organizational structures and providing more appropriate professional development opportunities to nurses with varying levels of experience. This may help with

future nurse retention and nurse job satisfaction efforts. Additionally, as the number of new graduate nurse transition programs continue to increase, findings from this research can contribute to their design, implementation, and evaluation to promote a focus on nurse leadership.

Health Care Organizations and Health Care Policy

The nurse leader has the unique power to influence both health care organizations and health care policy. The findings of this study may help to promote nurse leadership responsibilities across the health care system and explore potential hidden conflicts at the individual, interpersonal and organizational levels that can reveal structural factors that may play a critical role in nurse leadership development. It may help health care employers to better evaluate nurses in nursing leadership domains. This study's exploration of nurse leadership and the factors which influence its development could lead to improved quality and safety measures and contribute to a positive effect on overall patient outcomes. Since improvement in quality and safety measures is the desired goal of many national accountability measures, nurse leadership activities may align with the overall directives for health care reform.

Nursing Education

Many pre-licensure nursing programs have increased their emphasis on leadership and management, but often the work is completed in silos and confusing as the concepts of leadership and management are used interchangeably. The literature suggests that nursing education programs do not adequately prepare students with the leadership identity or skills needed to enter today's health care environment (DeYoung, 2009; Curtis, de Vries, & Sheerin, 2011). This research may improve nurse educators understanding of nurse leadership and what influences leadership development, and in turn may improve the

education and training needed for nurses to embrace the nurse leader identity and to effectively lead in today's health care environment. The contemporary perspective of this study may help colleges and universities design nursing education curricula and programs that prepare future nurses for a more realistic understanding of what it means to be a nurse leader.

<center>**Assumptions**</center>

In the conduct of this study, the researcher makes several assumptions. First, it is assumed that nurses and the profession of nursing hold the concept of leadership as a core value. The second assumption is that the IOM Future of Nursing Report's recommendations have been widely accepted and are viewed as a roadmap to transform the profession of nursing (IOM, 2010). Third, this study assumes that safe, accessible, high-quality, equitable healthcare cannot be achieved without exceptional care from healthcare's largest workforce. Given that research relied on participant's perspectives, the researcher assumes that the respondents answered truthfully and to the best of their knowledge. Fourth, the researcher assumes that nurses seek to provide safe patient care that leads to improved health outcomes and will apply lessons learned through this study to their respective practices.

<center>**The Researcher**</center>

I am a registered nurse with 18 years of clinical experience and 13 years of experience in nursing education. Of significance to this study, I served as President of the North Carolina Nurses Association (NCNA) from 2013-2015. In this role, I was responsible for working with the CEO, board, staff, membership and the community at-large to further the organizations mission. I am a member of the NCNA and the National League for Nursing (NLN). At the present time, I am a faculty member at the University of North Carolina at Chapel Hill where I teach in the undergraduate nursing program and am the faculty advisor

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for the Association of Nursing Students, the pre-professional organization for pre-licensed nursing students.

Organization of the Dissertation

This qualitative study is organized into five chapters. Chapter 1 is an introduction to the study. This chapter provides an introduction to the problem followed by a description of the background of the study, a statement of the problem and purpose of the study; key definitions are provided for the reader along with the assumptions of the study and positionality of the researcher. The four research questions are described here as well as the significance of the study. A brief description of the methodology used is included in Chapter 1 as well. Chapter 2 presents a review of the literature associated with nurse leadership: defining nurse leadership, predicting nurse leadership, nurse leadership development, and nurse leadership effectiveness. Questions emerged following my review of the literature concerning the underexplored role of gender, age, race, and sexual orientation in the study of nurse leadership. The review of the literature focusing on nurse leadership from within the field of nursing will provide the foundation and direction for the research study.

Chapter 3 details the research design, the target population, sampling method, and other procedures employed in this research study. Rationale for utilizing these approaches is provided as well as a description of the methods for data collection and analysis. Chapter 4 will outline the analysis of the data, the findings and results related to the research questions. Chapter 5 will provide a summary and general discussion of the results, as well as a discussion of the results as it relates to the literature. Implications for nursing education and practice are provided and recommendations for future research.

CHAPTER 2: REVIEW OF THE LITERATURE

Introduction

The previous chapter provided an overview of the research study. The purpose of the following literature review is to unpack the relevant literature, "show command of the subject area and understanding of the problem" and effectively evaluate the literature in relation to the study (Hart, 1998, p. 13). Nurse leadership at all levels across contemporary health care contexts was the general inquiry for the study. The researcher acknowledges that the expansive topic of leadership is both multifaceted and complex and therefore the review of the literature will focus on nurse leadership from within the field of nursing to provide the foundation and direction for the research study. The research discussed in this section reinforced the need for continued research in the area of nurse leadership. Chapter 2 examines the literature in more detail.

The Changing Role of the Nurse

According to the Health Resources and Services Administration (HRSA) there are 3.1 million registered nurses in the United States. The job of a registered nurse has become increasingly complex in recent years. Nurses today are expected to be competent care providers (meeting the holistic needs of each patient, family or community), as well as health care leaders (mentoring, coaching and empowering their colleagues, other health care team members and their patients to thrive in the complex health care environment.) Health care systems and health care payers are shifting away from a focus on volume to a focus on value and improving health outcomes through population health. There are new emerging roles for

nurses that will call for new skills in care coordination and transitions in care, optimizing care through a focus on patient safety and evidenced-based practice.

Nurse leadership is needed to meet the increased demands placed on the health care system, including the rapidly growing population of older adults. "Nurses' clinical knowledge and presence across all care settings will likely make them primarily responsible for navigating interactions between patients and providers along the continuum of care" (Fraher, E., Spetz, J., & Naylor, M., 2015, p.5). Competition among providers continues to restrict licensure and scope of practice in many states. The answer to the national call for all citizens to have access to high-quality, patient-centered care is a health care system where all health care professionals practice at the top of their license and the leadership capacity of nursing is advanced (Fraher, E., Spetz, J., & Naylor, M., 2015; Hassmiller, 2011).

"Leadership" in Nursing

Leadership has been studied by many disciplines. The oldest leadership theories explored traits, or a set of specific characteristics that if they are shown, an individual was recognized as a leader (Bass, 1990; Grohar-Murray, 2003). Contemporary leadership theories have shifted the paradigm to explore multiple influences on leadership: leader, condition/context, and follower (Grossman & Valiga, 2009, p. 3). "Because of the elusiveness of leadership, its various meanings, and its dependence on the situation or discipline, it is important to examine this concept within the framework of each discipline" (Altieri & Elgin, 1994, p. 76). Therefore, the following review of the literature on nurse leadership examined the research that has been done within the field of nursing.

The last two reviews on nursing leadership research were published for the years 1966-1983 by McClosky and Molen (1987) and 1983-1993 by Altieri and Elgin (1994). McClosky and Molen (1987) reviewed 58 articles and using content analysis of the research

identified four areas to categorize nursing leadership research. The first category was defining leadership and early research on leadership that concentrated on descriptions of founding nurse leaders that were each influential and contributed substantially to development of professional nursing. The second category was predicting leadership that examined the qualities that indicate the potential for nurse leadership. The third category was leadership development in order to "know what leadership skills are needed in various situations" and career advancement (McClosky & Molen, 1987, p. 183). The fourth and final category was leadership effectiveness and was divided into academic and practice contexts.

Altieri and Elgin (1994) picked up where McClosky and Molen (1984) finished and wanted to investigate and analyze the nursing leadership research literature, but also wanted to examine what new insights had been discovered and if the recent research utilized McClosky and Molen's (1984) recommendations. Altieri and Elgin (1994) utilized three of the four categories of nursing leadership research: predicting leadership, leadership development and leadership effectiveness. Altieri and Elgin (1994) reviewed 33 articles and found that the majority of the research centered on formal leaders and they recommended further research in the following areas: the relationship between leaders and followers; comparison studies of leaders in multiple settings, and further analysis of the relationship between potential leaders and mentors; continuing education and networking in leadership development. Altieri and Elgin (1994) encouraged more qualitative research to reflect the values, and experiences of nurse leaders.

The method for this review of the literature incorporated a computer and manual search for the years 1995-2015 using Cumulative Index to Nursing and Allied Health Literature (CINAHL), Academic Search Primer, Cochrane Library and Web of Science.

Resources were accessed mainly through the University of North Carolina at Chapel Hill library website. Inclusion criteria were as follows: published research conducted in the United States, written in English, and relevant to nurse leadership. Exclusion criteria included published or non-published theses and dissertations, published research conducted outside the Unites States. Search terms included: nursing (nursing OR nurse OR nurses) and su (subject) leadership. In addition, the results were cross-referenced with articles cited in several reviews of nursing leadership research (Cummings et al., 2008; Wong & Cummings, 2015) and manually searched the reference lists of publications reviewed (Figure 1).
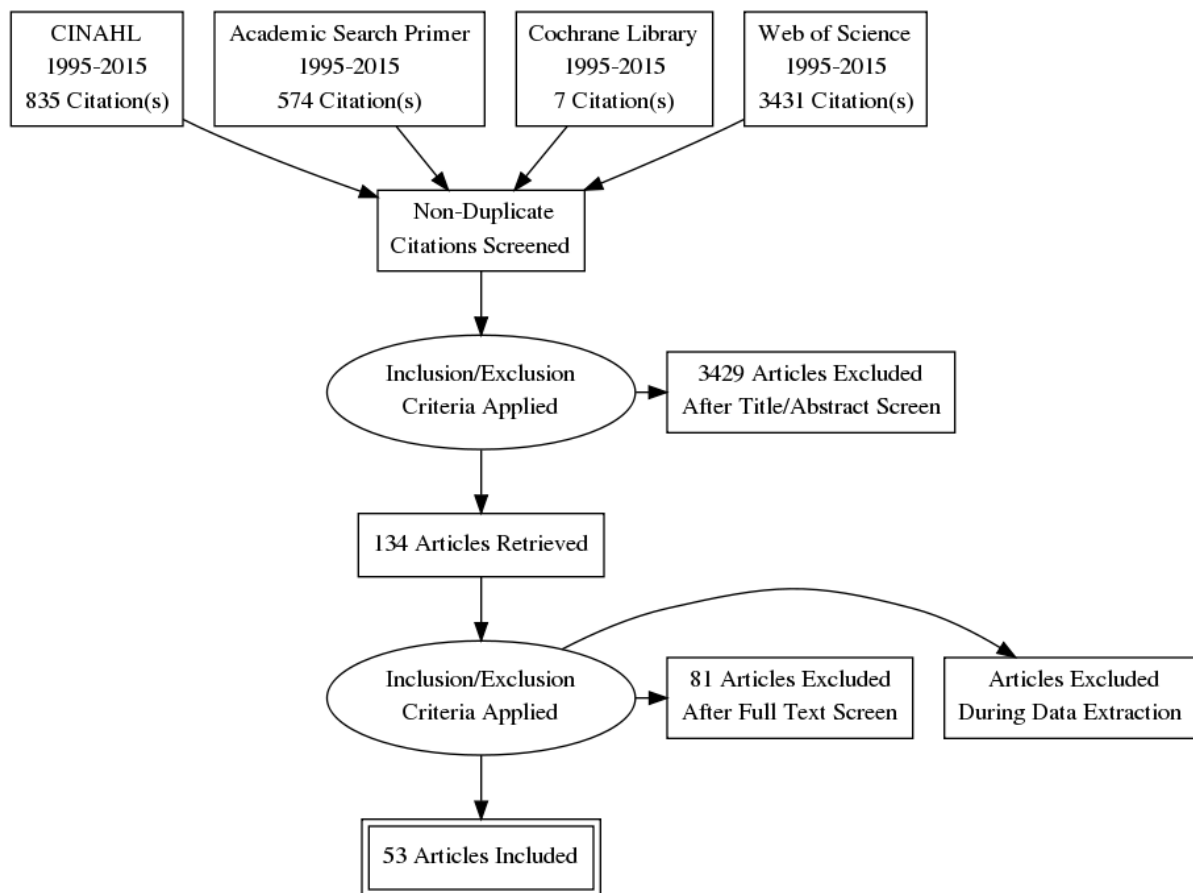
Figure 1. Search Strategy

Using these criteria, 53 studies were identified, reviewed, and categorized into four groupings as identified by McClosky and Molen (1984): *defining leadership, predicting leadership, leadership development, and leadership effectiveness*. The four categories are one strategy to organize the research in this area into meaningful classifications for analysis, the categories are not mutually exclusive, but each article will be discussed under only one category. The identification and description of the four key areas of the literature review (Figure 2) frame the concept of nurse leadership.
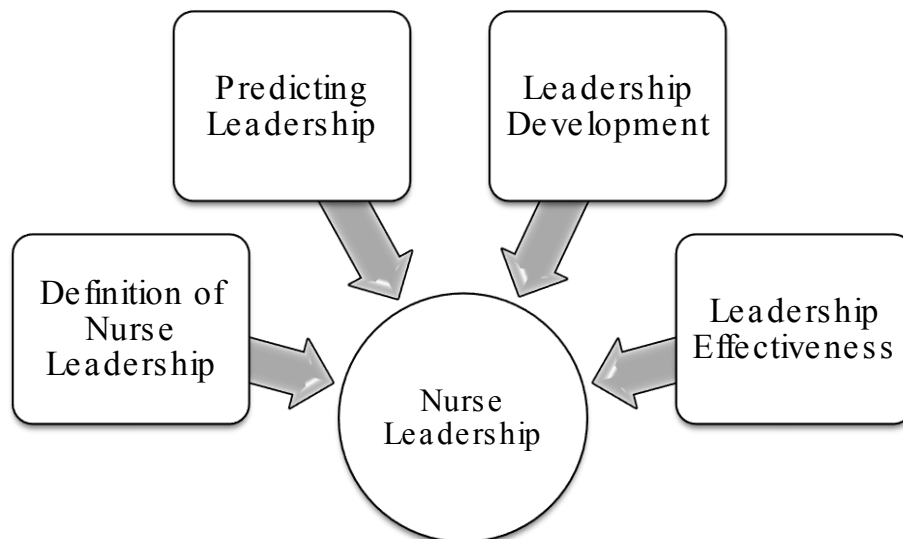
Figure 2. Four Categories of the Conceptual Literature Review as Identified by Mcclosky and Molen (1984)

Defining Nurse Leadership

Although many nursing professionals have discussed the importance of nurse leadership, they have not defined nurse leadership or educated nurses how to establish a culture of nurse leadership. The concept of nurse leadership is continually advanced as a key component for both the success of patient care and the professionalism of nurses. Since the publication of the IOM report in 2010, the increased attention on the phrase "nurse leadership" has saturated journals, textbooks, websites and various forums on health care

within and outside of nursing. One area of consensus among the literature is that nurse leaders can be found in various roles and contexts internal and external to health care (e.g. hospitals, education, policy, research, etc.) including more traditional formal leadership roles (e.g. management and administration) (Cutcliffe & Cleary, 2015). While there are some nurses who see nurse leadership as formal administrative roles, others view nurse leadership as any opportunity to contribute to the decision-making process. Either way, nurse leadership capacity is underdeveloped. With the spotlight on nursing leadership, many hospitals, health care organizations, and professional organizations have developed programs, workshops, continuing education, institutes and centers that focus on nurse leadership.

McClosky and Molen (1984) define leadership as "the process of influencing people to accomplish goals, whereas management is moving an organization toward achievement of its goals" (p. 178). Leadership has also been defined by profiling nurses who were in positions of leadership and/or influential in the development and advancement of the profession of nursing. Nurse leadership is often characterized in terms of the behaviors and personal qualities demonstrated by nurse leaders. A dictionary definition for *nurse leadership* provides a basic definition for the individual terms *nurse* and *leadership* that lack the essence of the concept in its entirety. The online Merriam-Webster Dictionary defined *nurse* as "a person who is trained to care for sick or injured people and who usually works in a hospital or doctor's office" (Nurse, 2016). *Leadership* is defined as "a position as a leader of a group, organization, etc.; the time when a person holds the position of leader; the power or ability to lead other people" (Leadership, 2016).

Kerfoot (2003) described the nursing workforce as a well-educated, motivated group of people that need learning opportunities to become effective leaders. "Top-down autocratic

leadership doesn't have a place in nursing and health care" (Kerfoot, 2003, p. 149). Instead, she recommends a leader as learner and leader as teacher approach that is in opposition to the command and control leadership styles. An environment where all knowledge is valued and shared with the goal of continual improvement to provide high quality, optimal health care to every patient (Kerfoot, 2003).

Nurse leadership may also be more about the role of the nurse as a driving force to reach a specific objective. Nurse leaders are patient advocates who often have to be the voice of the patient or family in an effort to achieve better outcomes. Gilster and Dalessandro (2009) define leadership as "the art of influencing and engaging colleagues to serve collaboratively toward a shared vision" (p. 32). Nurse leadership is an important component of patient care success which required nurses to be included and engaged in the decisions that are made which affect patients. The use of the term engaging is significant, as leadership is more than influence. It is also about action and the willingness for those who follow (i.e. nurses, patients, health care professionals, families, external and internal stakeholders) to do the work to achieve the vision of the leader. Initially, followers can be cautious to invest themselves. In time, to be truly successful, followers must also be included and engaged. Once invested, they believe and share in the leader's vision, bringing with them their own contributions. Eventually, leaders and followers become a cohesive team utilizing a "collective approach" (Gilster & Dalessandro, 2009, p. 32). They work together to strengthen and modify the vision over time, ensuring that the vision becomes truly realized (Gilster & Dalessandro, 2009). Nurse leadership is really a collective effort that empowers nurses. Kouzes and Posner (2002) suggest that leadership is not found only at the top or highest levels of the organization, but that leadership requires fostering opportunities for

development. Traditionally, health care organizations are organized with a top-down and physician led structure where nurses are often overlooked in the decision-making process. This hierarchical structure is anchored in formal leadership positions, which makes it challenging for nurses to emerge as leaders.

Nurse leaders seek to make improvements as change agents without a formal role. Nurses have significant influence on patient outcomes and other nurses. Nurse leaders differ from other leaders because of the emphasis on the nurse "assuming responsibility for influencing and improving the practice environment" (Curtis, de Vries and Sheerin, 2011, p. 307). The significance of nursing knowledge that is derived from nursing education and practice is unique and instrumental to the development nurse leadership compared to general leadership definitions (Curtis, et al., 2011). Chavez and Yoder (2014) carried out a concept analysis of staff nurse clinical leadership (SNCL) role to differentiate it from other types of leadership in the nursing profession. SNCL is defined as staff nurses without formal leadership roles who exert significant influence over other individuals in the health care team to accomplish shared clinical objectives.

Malby (1998) identified the term clinical leadership to mean the leadership qualities of staff nurses at the point of care and to shine the spotlight on the leadership potential within all nurses that are "…delivering complex care, to an increasingly demanding population in an environment of increasingly tighter resources" and to invest in their development as leaders (p. 41). Malby (1998) was critical of the tendency to force differentiation among nurses as clinical vs. non-clinical, asking "is it possible for a nurse…to be anything but clinical?" and suggested that "the more we try to make clinical the property of only those nurses actually doing clinical care all the time, the more we are endangering the nursing contribution at other

levels of the organization" (p. 41). Malby (1998) proposed that if nurses are to lead, then new emphasis on professional identity, working beyond hierarchy, managing conflict, valuing, and working with diversity, exploring possibilities, and questioning traditions and assumptions are critical skills for nurses to develop to meet the demands of an increasingly complex health care system.

Formal vs. Informal Nurse Leaders

Even today, there is still confusion about the relationship between nurse leadership and nurse management. While the literature points to the fact that "Registered Nurses (RNs) have a strong background to be managers of patient care" the challenge is that "most RNs then attempt to manage people as they have patient care" (Laurent, 2000, p. 84 & 85). Leadership and management skills are different; while managers generally focus on maintaining the current status, leaders challenge legacy thinking. A formal job title on its own does not make a nurse leader.

Within most organizations, the registered nurse with years of clinical experience that advances to formal leadership positions by appointment or promotion. Cutcliffe & Cleary (2015) suggest that there is a disconnect between the optimal picture as seen in the relevant literature and what occurs in today's health care environments where decisions about promotion into administrative or managerial positions are being made by non-nurse health care executives. It is clearly important to conduct research on not just the easy questions that relate to nurse leadership, but challenge the profession to ask the difficult questions about the value of experience and the lack of diversity in formal nurse leadership positions and bring these issues into the consciousness of the nursing community.

Predicting Leadership

Who are the current nurse leaders and what made them leaders? Are there particular skills, traits, abilities, experience, or behaviors that lead to nurse leadership? Is nurse leadership…predictable? Do early career nurses see themselves as leader? Health care organizations are facing greater change, more competition, and more uncertainty than ever. They need the right leaders in place – at all levels – to guide them into the future. To execute on their strategies, health care organizations need nurse leaders who can not only manage patient care complexities, but also inspire and engage colleagues across health care disciplines. Unfortunately, simple measures of experience (e.g., time in previous role) used in many recruiting and promotion processes simply do not work as predictors of future success. And worse – hiring or promotion based only on demonstrated nursing experience may overlook other high-potential nurse leaders in the current nursing workforce, and ignores the demographic shift of our aging nurse workforce. Nurse leaders across all contexts will have to be identified and developed from among many non-traditional avenues.

Sherman (2005) studied early career nurses in Florida and utilized three focus groups of nurses who were not currently in formal leadership roles. The focus group sessions were conducted use a ConCensus process. This process uses a neutral facilitator and the ConCensus software package to all participants the opportunity to identify the critical factors of importance in response to each question. Factors were prioritized by the focus group and group results were immediately available on a computer screen. All focus groups were asked the same nine questions (Table 2).

Table 2. Focus Group Questions (Sherman, 2005)

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Focus Group Questions

1) What are the major role responsibilities of nursing leaders today?
2) What feedback do you hear about nursing leadership positions from current nursing leaders?
3) What incentives would be there for you in a nursing leadership position?
4) What would you fear most about taking a nursing leadership position?
5) What would the ideal nursing leadership role look like?
6) What essential values are needed to ground the practice of nursing leadership?
7) What contributions could you make in a nursing leadership role?
8) What type of support would you need to move into a nursing leadership position?
9) What qualities would you look for in a mentor?

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The study included a total of 48 registered nurses ranging from 22 years of age to 42 years of age with a median of 7years of nursing experience. Sherman's study informed this research project's focus on "types of support" received to become a nurse leader. There was a concern about the level of support that the early career nurses would need to move into a formal leadership role. Mentorship, education about being a leader, self-confidence, family support and elimination of barriers to move up into nursing leadership positions were all key types of support that participants felt they needed (Sherman, 2005). The challenge for the health care decision makers will be to understand the values, beliefs and career drivers of every nurse and to redesign leadership roles for nurses to best accommodate their needs and improve patient care.

A priority for nurses currently in formal leadership roles must be empowering "other nurses to act, produce, create and excel" (Sovie, 1987, p. 17). Nurses are highly skilled and highly knowledgeable professionals who expect to participate in the decisions that impact nursing practice. Manion (2014) suggests that there are three influential aspects of leadership that an individual can use to "assess your likely success as a leader" (p. 321). The first is the

time span evidenced by your thoughts and actions. The second is the degree to which you are comfortable with complexity and ambiguity and finally the degree to which you take a proactive stance in the world. Manion (2014) illustrates the time limited perspective is the example of a staff nurse who notices that this is the third shift that a necessary supply was not stocked. The nurse takes no action. And, the missing supply problem goes on week after week. The idea is that some people only focus on the here and now. The opposite of short-term orientation to time is that successful leaders "are those who see well into the future" (Manion, 2104, p. 322). The second attribute is the ability of the individual to deal with complexity and ambiguity. Leaders reflect on what happens and why disruptions occur, evaluate if there is anything that could be done differently next time, seek feedback, and make changes as appropriate. The final leadership attribute is proactivity. "A proactive individual is one who is not only future oriented, as already described, but also take deliberate and intentional action based on that awareness" (Manion, 2014, p. 323). These potential leaders are always doing an environmental scan looking for opportunities.

Manion (2014) recommends that nurses do a brief self-assessment using the following questions:

- Time span – "Where is my primary focus? In the here-and-now, or do I think about the future and what I am doing to create a new reality for myself?" "Am I satisfied with getting things accomplished today or do I consciously think about how they prepare me for a different future?" "Do I even know how I want things to be different in the future?" "Do I take action today that is future oriented or do I tell myself…I will worry about tomorrow when it gets here?"

- Complexity – "What is the level of complexity that I deal with every day? Am I focused

on a patient or two, an entire department, or a service?" "Am I comfortable with uncertainty or do I prefer predictability and stability?" "How frustrated do I become when my plans for the day go awry because of unforeseen circumstances?" "Am I comfortable and willing to 'roll with the punches' or do I like things concrete and defined?"

- Proactivity – "To what degree am I a self-starter? Or do I wait to be told to do things or let others take the lead?" "Am I simply reacting to the events around me or do I take deliberate action to change the way thing are?" "Do I see challenges as opportunities or do I use them as excuses for why something cannot be done or cannot be better?"

Leaders must have knowledge in his/her area of expertise. Leaders must have conviction of their beliefs. Leaders are goal-oriented. Leaders have good communication skills, and leaders are lifelong learners (Miracle, 2002). These are the attributes of a leader, and Miracle (2002) argues that nurses possess all of these qualities. Patients and families look to nurses for knowledge and insight into their health and wellness. Nurses have a conviction for caring for others, placing others before ourselves. Nurses are exceptional at prioritization and establishing short and long-term goals that are realistic, measureable, person-centered and time oriented. Nurses are taught to be therapeutic communicators, and this involves listening and detection of non-verbal cues. Kelly, Wicker and Gerkin (2014) identified that nurses that excel in their clinical positions are promoted to formal leadership roles without any additional training or education, instead "informally learn from each other and adopt leadership practices based on situational circumstances" (p. 159).

Nurses are lifelong learners with many nurses advancing their education through informal and formal continuing education programs. Nurse that pursue advanced education

were identified as having higher Leadership Practices Inventory (LPI) scores (Kouzes and Posner, 2002) and utilized transformational leadership practices. (Kelly, Wicker and Gerkin, 2014). The majority of states require continuing education hours to renew your license to practice nursing. Given the educational preparation and role complexity, it would seem imperative for nurses to value leadership as a fundamental principle of the profession, but nurses need guided development to see their own potential.

Fardellone, Musil, Smith and Click (2014) examined the leadership behaviors of clinical staff nurses "the change agents who transform the patient experience" (p. 507) and specifically focused on the clinical ladder program for nurses. Clinical ladder programs are designed within health care systems to promote and recognize excellence in nursing practice.

> These programs also focus on being a role model and challenging and
> encouraging younger colleagues to participate in continuing professional education,
> certification, organizational membership, leadership, community service, committees,
> mentorships, coaching, and research activities (p 508).

The study involved 102 nurses ranging in age from 24-66. The samples were predominantly female (96%), had a baccalaureate degree (86%), or were enrolled in a master's program (24%). The participant's leadership behaviors were assessed using the Leadership Practices Inventory (LPI) (Kouzes & Posner, 2002). The LPI is a 30-item survey that measures the frequency of leadership behaviors using a 10-point Likert-type scale. Higher scores represent behaviors that are used most often and lower scores represent areas for improvement (Kouzes & Posner, 2002).

The LPI has five subscales:

- ➢ Modeling the way

- ➢ Inspiring a shared vision

- ➢ Challenging the process

- ➢ Enabling others to act

- ➢ Encouraging the heart

The participant's highest response was the subscale of "enabling others to act." The leadership behavior "enabling others to act" is illustrated as fostering collaboration and building group strength. The participants least common response was "inspiring a shared vision," which encourages others to imagine future possibilities and share recommendations for the future (Kouzes & Posner, 2002). Fardellone, Musil, Smith and Click (2014) also found that nurses with more experience had a deficit in leadership behaviors and would benefit from leadership development.

In a study to identify and describe the competencies needed by nurse educators to be leaders, Patterson and Krouse (2015) interviewed 15 leaders in nursing education who held formal leadership positions (i.e. Dean, Director) and also leaders of professional nursing organizations (National League for Nursing, American Association of Colleges of Nursing, Sigma Theta Tau International). Within the context of a foundation in nursing education and scholarship, four competencies and task statements were identified from the interview data analysis and interpretation (Table 3). The study highlighted that "all faculty have the potential to become leaders" and with the aging academic workforce there is a critical need for current formal leaders to foster the professional development of others "one leads best by creating opportunities for others to lead" (Patterson & Krouse, 2015, p. 81-82).

Table 3. Core Competencies for Leaders in Nursing Education with Task Statements (Patterson and Krouse, 2015)

Core Competencies for Leaders in Nursing Education with Task Statements	
Articulate and promote a vision for nursing education	- Envision the possibilities for nursing education - Challenge the status quo and assumptions by taking risks - Think and plan strategically - Advance innovative ideas - Create an environment for change
Function as a steward for the organization and nursing education	- Scan the higher education, professional, and health care environments for data to inform strategic planning - Develop systems to collect, manage, and interpret data for informed decision-making - Make the challenging and difficult decisions - Influence constituents to support and advance nursing education - Engage in succession planning for self and others in the organization
Embrace professional values in context of higher education	- Function in an ethical manner - Demonstrate accountability to self and others through actions and decisions - Promote a safe environment - Maintain credibility as a nurse faculty
Develop and nurture relationships	- Communicate respectfully and compassionately - Serve as a role model for advancing nursing education - Mentor students and colleagues within and outside individuals own organization - Create a mutual environment with others (administration, colleagues, peers, students) - Advocate for colleagues, peers, students - Recognize and support innovation

Leadership Development

The demand to advance the competence and value of leadership in the nursing profession has never been more imperative than it is today. The IOM report (2010) recommends that all professional nursing organizations include increasing capacity for leadership development as a part of their organizational mission and strategic priorities. The report highlights professional organizations that are already offering leadership development programs, including the American Nurses Association, American Association of Colleges of Nursing, National League for Nursing, American Organization of Nurse Executives, American Academy of Nursing, and the National Coalition of Ethnic Minority Nurse Associations (IOM, 2010) (Appendix F). These nurse leadership development programs have been created to increase nurse leadership activities. A consistent framework for nurse leadership development does not currently exist. In addition to the professional organizations leadership development programs, healthcare organizations have created professional development that focuses on building leadership capacity, but without a clear guiding framework or definition of nurse leadership (Scott & Miles, 2013). Nurse leadership requires a well-educated workforce. The IOM (2010) report recommended increasing the number of nurses with a baccalaureate to 80% by 2020.

Scott & Miles (2013) call for a shift in the paradigm of the role of a nurse, "such that leadership is seen as a dimension of practice for all nurses…in doing so, leadership identity development would be seen as a part of becoming an expert nurse" (p. 77). In an effort to prepare future nurses with the knowledge, skills and attitudes necessary to improve patient care, the multi-phase project, Quality and Safety Education for Nurses (QSEN) has explored and made recommendations to evaluate and enhance the nursing education on the topics of quality and safety. Scott & Miles (2013) advocate for "parallel work to be done to outline

educational content, objectives, and effective pedagogy for advancing leadership development in nursing students at all levels" (p. 78).

Baccalaureate pre-licensure nursing programs are an important foundation for developing nurse leaders. "It is critical to expose students to leadership development during their formative years of nursing education to assure graduates' maximum impact on the profession and health care outcomes. Central to building effective leadership skills is self-development" (Waite, Mckinney, Smith-Glasgow, & Meloy, 2014, p. 282). Nurse leadership in nursing curricula cannot be defined by one class or even one course; rather, teaching the knowledge, skills and attitudes related to nurse leadership involve integrative and Interprofessional learning experiences throughout the curriculum. Developing curriculum with practice partners so that students can engage with and learn from nurses in a variety of contexts across the continuum of care.

Morrow (2015) synthesized the state of the science of leadership curriculum in baccalaureate pre-licensure nursing education programs from 2008-2013. Five teaching strategy themes were identified in the literature: reflection, peer learning, interdisciplinary teams, curricular reform, and organizational partnerships. In addition five stages were examined in the review of the literature: leadership awareness, leadership integration, active leadership with patients, families and colleagues, active leadership: interdisciplinary teams, and embedded leadership at the organizational level. The review exposed four main gaps in leadership curriculum in baccalaureate pre-licensure nursing education programs: few strategies included students in organizational level activities, minimal study of classroom specific strategies, minimal incorporation of technology, and the majority of the students in the studies reviewed were white females. Morrow (2015) recommended that baccalaureate

pre-licensure nursing education programs: increase student involvement in health care organizational quality improvement project and policy development, and incorporate more simulation.

Faculty at the University of Maryland developed the "Leadership Competence for the New Millennium". The project involved the development of an innovative curriculum in leadership development for both RN-BSN and RN-MSN students. A unique aspect of the course was the establishment of an advisory panel for the course of stakeholders from public and private health care sectors, and academics. The advisory panel identified the following core knowledge areas: economics and financial management of health care delivery systems and managed care; knowledge of technology, patient safety, resource management, and business or administrative practices; organizational theory and change theory; types of leadership styles; roles of gender and diversity in nursing leadership and responsibility to the profession. The essential individual skills identified by the panel were: interpersonal skills (e.g., conflict resolution, team skills, and delegation; communication skills; organizational navigation (networking, collaboration, partnerships, and influencing); crisis management; time management; adoption of an appropriate leadership style. The elective course involved didactic sessions, group consultations, self-assessment, and mentorship. The student evaluations of the course were positive and the faculty decided to recommend that it be a required course and available for practicing nurses as a continuing education course in leadership development (Heller et. al, 2004).

Waite and McKinney (2015) using the Kouzes and Posner (1998) Student Leadership Practices Inventory (S-LPI) in a pre-post survey design to examine students leadership attributes pre-post participation in an 18-month undergraduate leadership program. The

research identified a need for cascade leadership development to support student's own learning and instill foundational knowledge critical to their leadership journey. The leadership development program involved six one-credit courses that students took each quarter during their junior and senior year. The faculty employed role play activities; cultural autobiographies; individual professional development plans; leadership briefs; fishbowl exercises; team building exercises; round table debates; guest speakers; mind-mapping; building a network; cross-cultural interviews; team service projects; media clips; leadership and diversity panels; small group discussions; simulation and standardized patient cases; team presentations; reflective practice and writing; and active discussions about case studies on power, oppression, privilege, and leadership in healthcare.

The Student Leadership Practices Inventory (S-LPI) is a 30-item behavioral statement, self-report assessment that focuses on Kouzes and Posner's five exemplary leadership practices: model the way; inspire a shared vision; challenge the process; enable others to act and encourage the heart (Waite and McKinney, 2015, p. 2). The findings reported indicated that the mean from study participants self-reported scores on the pre-post S-LPI improved and students scored highest in the area of enabling others to act and lowest in modeling the way. The study identified that scaffolded leadership development programs best support students engagement and early career goals (Waite and McKinney, 2015).

Waite et al. (2014) reported on a unique, authentic leadership course. Key learning objectives for the authentic leadership course were for students to develop consciousness of self, personal character, and self-efficacy; increase ability to manage personal emotions; gain a greater understanding of cultural factors that shape leadership values and decisions; understand the importance of personal branding as a leader; identify their own personal

values, traits, and goals and define a personal leadership style; enhance understanding about

the importance of self-regulation and learning, and understand the differences between being

a manager and leader.

Table 4. Student Competencies for Authentic Leadership Course (Waite et al., 2014)

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Student Competencies for Authentic Leadership Course

a. Establish the process of creating a learning community that would minimize discomfort during group engagement;
b. Debate and define critical leadership characteristics;
c. Gain increased appreciation for diversity while developing leadership competencies;
d. Learn to communicate with purpose;
e. Gain knowledge about how to use mind mapping strategies;
f. Demonstrate personal management of professional behaviors;
g. Discuss and defend difference between begin a manager and leader;
h. Develop and make an oral presentation of their personal branding statement;
i. Have intellectual discourse on how to build authentic leadership within themselves;
j. Conduct self-analysis of personal leadership characteristics;
k. Identify and strengthen self-regulation to promote academic success.

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"Developing leadership skills, rather than only learning the facts about them, required

a level of personal engagement, risk-taking, and interaction" (Waite et al., 2014, p. 285). The

course was grounded in critical pedagogy and moved away from teacher-centered education

strategies to learner-centered education strategies. Faculty served as a guide for students

using a social justice orientation inherent in critical pedagogy to empower students to

"challenge the status quo, become advocates for change, and assume proactive leadership

roles in developing new approaches to nursing education, professional practice and health

care delivery" (Waite et al., 2014, p. 290). Waite et al. (2014) recommend that nurse

leadership education and experiences should be embedded earlier and ongoing throughout

the curriculum and not wait until the final semester of an undergraduate education program

"leaving little time for students to internalize important concepts and practice related skills" (p. 290). In addition, they recommend that authentic leadership and critical pedagogy can provide a framework for Interprofessional education.

In addition to integrating leadership throughout the curriculum, nursing students need to spend less time in observational roles and more time practicing leadership skills. In one study of nursing students, Kling (2010), shared an innovative experiential clinical leadership project that involved senior nursing students in the role of nurse leader and nurse educator, serving as clinical mentors for sophomore nursing students during clinicals. The senior students assisted the sophomore students with time management, prioritization, and documentation. In addition, the senior students applied leadership concepts by leading pre and post conference sessions and giving feedback to the sophomore students. In a separate study virtual simulation was used to teach leadership styles to students in a master's program in nursing education. Virtual simulation in this study was referred to as synchronous, Web-based, multiplayer clinical environments using avatars to practice the art of a specialty. A pre-post test design was used to evaluate students prior to engaging with the virtual simulation exercises and immediately following completion. The student learning outcomes of the simulation were a) recognize different leadership styles and b) demonstrate conflict resolution. The students demonstrated statistically significant improvement in cognitive knowledge following the virtual simulation exercises (Foronda, Budhathoki, and Salani, 2014).

Other health care organizations have utilized simulation in addition to traditional workshop or leadership courses provided. In the quality improvement project described by Clark and Yoder-Wise (2005) the simulation scenario involved one participant in the role of

charge nurse, one participant in the role of a novice bedside nurse and one participant in the role of an anxious parent. The authors found that simulation enabled the development of leadership skills, self-efficacy and confidence. The simulation provided a safe setting to apply cognitive knowledge into a clinical leadership situation (Clark & Yoder-Wise, 2005).

Once nurses have graduated from nursing school, the demand for nurse leadership skills in clinical practice becomes alarmingly clear. Many nurses are transitioned into the role of charge nurse within six months to a year after graduation. Charge nurses represent the role of an individual who makes certain that a team on a given shift accomplishes its work and that issues related to work flow and competence are addressed in a timely manner (Clark and Yoder-Wise, 2015). In addition, the admission, discharge and transfer process is a focal point of the charge nurse role (Sherman, 2005). In one study of charge nurses, Sherman (2005) reviewed the impact of a 1-day workshop for charge nurse both on patient care delivery and the financial benefit for the health care organization. The four critical skills needed by charge nurses today were identified as communication, supervision and delegation, conflict management and team building and were the focus for the workshop.

Georges (2004) article highlights the call for developing African American nursing leaders and recommends membership in both racial and ethnic professional organizations and specialty professional organizations to develop leadership potential. The author provides the example of the New York Black Nurses Association, a chapter of the National Black Nurses Association and the annual community service programs that are coordinated by the membership. "Through these experiences member/potential leaders have an opportunity to display their leadership abilities and develop their leadership skills" (Georges, 2004, p. 171). In addition, Georges (2004) describes working with community-based organizations (i.e.

local community boards, and home owners associations) to build relationships and improve the health of communities.

Using a sequential mixed methods design Hill, Del Favero, and Ropers-Huilman (2005) studied the role of mentoring in the development of African American nurses who have achieved leadership positions in baccalaureate and graduate nursing programs. The study involved 10 African American nurses leaders and utilized the Mentoring Experiences Survey (MES), adapted from the Jeanne Madison's Mentoring Survey (1994) and the Mentoring Interview designed by the investigator. The results aligned with previous research Levinson (1996) that indicated that having a mentor is crucial to adult development in their realization of a dream and most of the mentors were at least 10 years older and often developed during graduate school. The mentor-mentee relationships were mostly formed through having common interests, lasted at least 5 years, and the majority of the participants indicated that their relationships with their mentors have not ended. "Many of the nurse leaders in this study spoke fondly of their mentors and continue to consult with them on certain issues" (Hill, Del Favero, & Ropers-Huilman, 2005, p. 354). The study also found that mentoring does play a role in the development of African American nurse leaders and that both same-race and cross-race mentoring relationships had an impact on both personal and professional growth.

In one study of registered nurses in Florida, Denker, et al. (2015) used exploratory descriptive research to examine nursing leadership and succession planning from the perspective of emerging and current nurse leaders in the State of Florida. 90% of the study participants were female, and 71% were older than 50 years of age. 75% of the participant's reports that nurses are absent in policy making, lack a unified voice and are not seen, as

major revenue generators are barriers to leadership. Survey respondents identified communication as the top competency need by the nurse today.

Dunham & Fisher (1990), as well as Murphy & DeBack (1991) conducted studies to explore the characteristics of "traits" of nurses in hospital leadership positions. Their research had comparable conclusions that nurses in leadership positions were visionary, credible, enabling, willing to serve as role models, and change agents. Meighan (1990) also studied leadership characteristics but with staff nurses and identified a similar list of traits. Fardellone, et al. (2014) examined the leadership behaviors of clinical staff nurses "…the change agents who transform the patient experience" (p. 507). The staff nurses completed the Leadership Practice Inventory (LPI) (Kouzes & Posner, 2002) and "enabling others to act" was the most frequent leadership behavior identified by the study participants. The research also identified the "educational gap of leadership training" and a need to evaluate the barriers staff nurses experience that inhibit them from "leading their patients to better health outcomes" (p. 511). Parse (1997) described leaders as individuals committed to a vision, willing to engage in discourse, and respectful of others.

Upenieks (2002) conducted a qualitative, descriptive study using Kanter's theory of organizational behavior to better understand the types of organizational structures that support nurse leaders in their role. The sample population for the study included selecting only nurse leaders in identified formal roles (i.e. managerial, director, or executive role). In addition to validating the importance of the structures of Kanter's theory (formal/informal power, opportunity, resources, information) three emerging categories were identified. The first was central beliefs-core principles and value system guiding leadership style. Of the nurse leaders interviewed for the study, 81% identified "passion for nursing" as a guiding

principle. One leader stated, "Passion for nursing involves the intimate relationships you have with patients that you get only through being their nurse" (Upenieks, 2002, p. 630). The second was business orientation-using quantitative data in decision-making. The third was collaborative teamwork-cooperative effort and synergy by nurses, physicians, and ancillary personnel to achieve excellence in-patient care delivery.

Stanley (2006) sought to identify who clinical leaders are and to critically analyze the experience of being a clinical leader. The research identified that clinical leaders demonstrated: clinical competence and knowledge, effective communication, decision-making, empowerment, openness, and role modeling. Stanley argued that a new definition of clinical leadership would clarify the concept and support more effective leadership development for frontline staff. The new definition of clinical leadership authored following this research stated that "a clinician is an expert in their field, and who, because they are approachable, effective communicators and empowered, are able to act as a role model, motivating others by matching their values and beliefs about nursing and care to their practice" (Stanley, 2006, p. 111).

Anderson, Issel & McDaniel (2003) using complexity science as a framework, explored the relationship between management practices (communication patterns, participation in decision making, leadership behaviors, and formalization) and resident outcomes (prevalence of aggressive behavior, restraint use, complications of immobility, and fractures) in 164 nursing homes. Using traditional and accepted views of management, many believe that such conditions call for authoritarian management in which the rules are clear and the manager's job is to be sure that they are followed. The results of this study, however, suggest that a different type of management is required for better outcomes, confirming the

theory that effective management practices are those that support self-organization (Anderson, Issel & McDaniel, 2003).

Allen & Vital-Nolen (2005) provide an example of how transformational leadership impacts patient care. Through redefining nursing care that focused on empowerment and consideration of both professional and personal values the researchers found an increase in nurse job satisfaction "where nurses feel they make a difference" (Allen & Vitale-Nolen, 2005, p. 277). In nursing, the most significant tools for transformational leaders are one's self-awareness, self-development and trust in followers (Barker, 2006).

Leadership Effectiveness

The nursing profession must now "ensure that the potential for leadership capacity is advanced through incorporation of leadership development at every level of nursing education and practice in both the academic and clinical environments" (Porter-O'Grady, 2011, p.33). Allen (1998) interviewed a small sample of nurses in formal leadership positions to identify what they believed influenced the development of their leadership characteristics, skills, and expertise. The five themes that emerged from the interviews included self-confidence, innate leader qualities/tendencies, progression of experiences and success, influence of significant people, and personal life factors. The "cornerstone characteristic essential for leadership development" was self-confidence (Allen, 1998, p. 4). The author summarized four strategies for leadership development: reinforcing self-confidence, acting as role models and mentors, creating opportunities for progressive experiences and successes, and fostering continuous learning. In another study, the following six themes emerged as challenges to leadership development specific to healthcare organizations: Industry lag, representativeness, professional conflicts, time constraints, technical hurdles, and financial constraints (McAlearnery, 2006)

In a recent systematic review of 24 quantitative research studies on nursing leadership, the authors sought answers to the following two questions (1) what factors contribute to leadership in nursing? and (2) how effective are educational interventions in developing leadership behaviors among nurses? Using content analysis the researchers identified four categories: behaviors and practices, traits and characteristics, context and practice settings, and leader participation in educational activities. It was evident that previous leadership experience was a significant factor for nursing leaders, but this review and research since has not yet identified if there are explicit previous leadership experiences that were more influential than others in developing leaders (Cummings et al., 2008).

Curtis, de Vries & Sheerin (2011) found that primary degrees in nursing do not develop nurses for leadership to the extent needed in today's complex and evolving 21st century healthcare landscape. Eight leadership competencies likely to be essential in 2020 include: (i) a global perspective regarding healthcare and nursing issues, (ii) technology skills, (iii) expert decision-making skills rooted in empirical science, (iv) the ability to create organizational cultures that permeate quality healthcare and patient/worker safety, (v) understanding and appropriately intervening in political processes, (vi) highly developed collaborative and team building skills, (vii) the ability to balance authenticity and performance expectations, (viii) and being able to envision and proactively adapt to a healthcare system characterized by rapid change (Huston, 2008).

Leadership skills should be taught throughout the undergraduate curriculum in order to best prepare new graduates for the transition to early career nurses (Jones & Sackett, 2009; Scott & Miles, 2013; Kent et al., 2015) Therefore, it will be necessary to reform how we have been preparing new nurses in both classroom and clinical settings. "It is time to

purposefully move from teaching about leadership to developing leaders…this in itself will

require a transformation of our paradigms about leadership in nursing education" (Cleeter,

2011, p. 283). In addition, the Cummings, et al. (2008) study recommended "…leadership

qualities can be developed through specific and dedicated educational activities." (p. 247)

According to Wilmoth & Shapiro (2014) "the nursing profession and healthcare

systems are wasting precious time and human capitol, not to mention other resources, by

failing to begin the intentional development of nurses as leaders at the beginning of their

careers" (p. 335). Kent et al. (2015) examined the effects of a senior practicum and

leadership course on nursing student's confidence in speaking up for patient safety. The

study utilized the Health Professional Education in Patient Safety Survey (H-PEPSS)

(Ginsburg et al., 2010). The researchers recommended, "…reinforcing leadership skills,

effective communication, conflict resolution, and creating a culture of safety is a top priority

in nursing education. This reinforcement increases students' confidence and makes them

more likely to become an advocate for patient safety" (Kent et al., 2015, p. S14).

In 2000, the IOM of the National Academies of Science published *To Err is Human:*

Building a Safer Health System. The report was eye-opening and created immense media

attention on medical errors and the alarming rates of deaths from medical errors each year.

Over the last decade, the prevalence and economic impact of patient safety errors have

finally received the attention warranted. Wong (2015) explains:

> The continuing economic pressures, health and safety risks associated with stressful
> and overloaded work environments, workforce shortages and the impending
> retirement of a large cohort of nurse leaders mean that attention must be directed to
> both understanding and developing what is effective nursing leadership and how it is
> connected to patient outcomes in order to ensure care practices are cost effective
> while improving patient outcomes (Wong, 2010, p. 275).

Wong & Cummings (2007) describe their findings of a systematic review of studies that examine the relationship between nurse leadership and patient outcomes. Positive associations between nurse leadership and reduced adverse events were found. In another study, the researchers examine the impact of senior nursing leaders and managers on patient safety in hospitals and community health services (Stewart & Usher, 2010). Using semi-structured interviews and thematic analyses, the results of the study suggested that it is important that organizations empower nursing leaders and managers, that leadership approaches need to take an increased patient focus into account, and that leaders need to be aware of the challenging work situation of most frontline nurses to improve patient safety outcomes.

According to the IOM (2000), nurses are the "instrumental leaders" most likely to intercept and prevent medical mistakes "by catching, correcting, and removing underlying causes of suboptimal care processes" (Kliger, et al, 2009, p. 611). Houser (2003) used a mixed-method design to explore contemporary nursing care environments and the contextual factors that influence delivery of nursing care. The qualitative focus group interviews were analyzed using constant-comparison and six themes emerged: leadership, teamwork, resources, staff stability, expertise, and workload. With regards to leadership effectiveness study participants described communication skills, offering encouragement, defining expectations, and problem solving as the most desirable leadership behaviors. The study concluded that there is a relationship between the context of nursing care and the outcomes of that care.

In 2005, RWJF's desire to enhance quality and safety education led to the funding of a multiyear project to develop a nursing school curriculum on quality and safety and teaching

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nursing faculty to include these issues in nursing education, known as *Quality and Safety Education for Nurses (QSEN).* The project has identified core quality and safety competencies and integrated them in curricula with the aim of preparing future nurses with the knowledge, skills, and attitudes needed to engage in improvement efforts. Now, in its fourth and final phase, *QSEN* continues to promote innovation in quality and safety education, develop graduate faculty expertise in these areas, and generate tools—such as textbooks, accreditation and certification standards, licensure exams, and continued competence requirements—that will magnify nursing's role in health care transformation (Cronenwett et al., 2007).

In 2008, the AACN identified patient safety as the second priority in their list of nine essentials for baccalaureate education for professional nursing practice. Hendricks, Cope, & Baum (2015) describe the extent to which future nurse leaders intuitively acknowledge patient safety as part of their leadership role. A content analysis to search for quality and safety terminology was conducted on 146 essay responses to a question about the nurse leader role in today's healthcare environment. At an operational level: nurses collaborate with other disciplines, work within a set of professional standards (ANA Code of Ethics), monitor patient status, advocate on behalf of patients and delegate to health care workers in a variety of care settings. Patient safety as a core component of a nurse leader's role and is often overlooked. The research identified a new nursing model where safety is central to leadership. "What nurses should understand is that each episode of nursing care is an opportunity for safety and minimizing risk and improving outcomes, thus having an effect on overall quality of care" (Hendricks, Cope, & Baum, 2015, p. 76). For example, a nurse might note that the supply of preoperative antibiotics often is depleted, so these medications are

frequently unavailable to be given to patients in accordance with the Institute for Healthcare

Improvement's (IHI) protocol to reduce surgical site infections. The nurse should identify

and report the problem and then collaborate with members of the healthcare team to design

and implement a plan that ensures that preoperative antibiotics are available to be

administered.

Ahern and McDonald (2002) found that even when nurses have a professional

obligation to know and to advocate for patient safety, they often hesitate due to the traditional

hierarchical structure in health care. Kent et al. (2014) showed that a reinforcing leadership

skills, effective communication, conflict resolution and creating a culture of safety improved

nursing students confidence and in turn their confidence to advocate for patient safety. Kent

et al. (2014) remain concerned that "the idea of not questioning an authority figure could be

ingrained throughout the educational process…this is a dangerous belief because it could

lead to a fatal patient outcome without anyone coming forward on that patient's behalf"

(Kent et al., 2014, p. S14). Influences such as culture, education and home environment have

some influence on nurses confidence to go against the traditional hierarchical structure in

health care and that nurses silence is still an issue that demands further research and dialogue

in today's healthcare environment (Garon, 2012). By defining nurse leadership, a stronger

nurse leader identity will position nurses to lead within interprofessional teams in a complex

health care system positioned for change in the 21st century.

Discussion

In comparing McCloskey and Molen's (1984) and Altieri and Elgin (1994)'s, this

review of the nursing leadership research literature included 53 research reports and that

indicates a continued interest in the area of research in the nursing literature. The majority of

articles focus on leadership development, which is a shift from the previous two reviews of

the literature, indicating that nurses are concerned with exploring professional development opportunities. Research in this area will continue to evolve as nurses are called on to lead across health care settings and the need for broad changes to the development of nurse leadership at the beginning of a nurse's career becomes a priority.

This study reflects on the current literature of nurse leadership and found four areas that the research has addressed: (a) defining nurse leadership; (b) predicting nurse leadership; (c) nurse leadership development and (d) nurse leadership effectiveness. Nurse leadership may be the basis for health care improvement in the future. Specific nurse leadership activities are defined in a variety of ways in the literature. Traditionally, nurse leadership consists of formal roles where nurses are given additional responsibilities outside of the staff-nursing role.

Nurse leadership research is beginning to examine nurse leadership through informal roles. This perspective of nurse leadership comes from within the grassroots level where nurses are considered experts on their unit or within their specialty area. Nurse leadership go through a development process where they gain credibility and recognition for their nursing proficiency. The literature suggests a study of nurse leadership that focuses on its definition and how nurse leadership is supported. This current body of literature shaped the research questions and provides background for understanding the information provided by the study participants. It is important now to focus on the nurse's perspective and ask them to define nurse leadership and describe what fostered and/or inhibited their own nurse leadership development.

CHAPTER 3: METHODOLOGY

Introduction

The purposes of this qualitative study were to describe and find meaning in nurse leadership perceptions within the context of today's healthcare environment among a sample of 15 Registered Nurses, in the Triangle Region of the North Carolina Nurses Association. Chapter 3 focuses on the methodology used, and describes the design and procedures used to accomplish the study goals. The chapter describes and presents rationale for the following: selection of the qualitative paradigm; participant selection criteria; human subject protection; data collection and analysis; and limitations.

The following four research questions guided the investigation of nurse leadership:

1. What are the essential elements of nurse leadership?

2. What key language, actions and values demonstrate nurse leadership?

3. In what ways do nurses consider nurse leadership essential in today's health care environment?

    a. How is this different from previous perspectives?

    b. How is this similar to previous perspectives?

4. What influences the development of nurse leadership?

    a. How do gender, race/ethnicity, age, and sexual orientation influence the development of nurse leadership?

    b. What additional social factors emerge to influence the development of nurse leadership?

Research Design

Qualitative Research

Merriam (1998) identified five characteristics that are common across all forms of qualitative research. First, qualitative research is the study of understanding how individuals make sense of the experiences they have in the world. "It is assumed that meaning is embedded in people's experiences and that this meaning is mediated through the investigator's own perceptions"(Merriam, 1998, p. 6). Second, the researcher serves as the responsive and adaptable human instrument for data collection and analysis. Third, most qualitative research involves some form of fieldwork. Fourth, in contrast to finding data to match an existing theory, qualitative researchers begin the research process without a theory to guide the investigation. "Qualitative researchers build toward theory from observations and intutitive understandings gained" (Merriam, 1998, p. 7). Finally, the final research project is a culmination of the researchers descriptions of the context, the participants involved, the data is likely to come from the participants own words or the researchers own observations to support the findings of the study (Merriam, 1998). Since health care environments are structurally and functionally complex, a means to understand the dynamics involved in nurse leadership is to explore and examine commonalities and distinctive features. This goal can be accomplished by soliciting information from diverse group of registered nurses working in diverse contexts in today's health care environments.

As this study seeks to understand and explore the conditions that influence nurse leadership development, a process that is both complicated and contextual, it calls for a research paradigm that accounts for these interrelated elements. According to Altieri & Elgin (1994) the concept of leadership remains difficult to measure, the qualitative method can capture personal values, experiences, and influences that cannot be obtained with quantitative

methodology. Qualitative research has emerged within the nursing research community as research that is "relevant and congruent with the perspective and goals of nursing" (Sandelowski, 1986, p. 27). As little is known about the phenomenon of nurse leadership and the conditions that influence its development, a holistic understanding of events, situations, perspectives of the individuals involved make qualitative paradigm the most appropriate for this study (Creswell, 1998, 2003; Merriam, 1998; Vaismoradi, Turunen & Bondas, 2013).

Table 5 adapted from Johnson (2004) and Sandelowski (2000) outlines the key differences between the quantitative and qualitative approaches.

Table 5. Key Differences Between Quantitative and Qualitative Approaches (Adapted from Johnson (2004) and Sandelowski (2000))

	Quantitative	**Qualitative**
Scientific Method	Deductive reasoning; researcher tests hypotheses with data collected	Inductive reasoning; researcher generates information or theory from data collected
View of Human Behavior	Behavior is regular and predictable	Behavior is fluid, dynamic, situational, social, contextual and personal
Common Research Objectives	Description, explanation, and prediction	Description, exploration, and discovery
Focus	Testing specific hypotheses or theories	Examining the breadth and depth of phenomena
Data Collection	Based on precise measurement, used validated instruments	Researcher is the data collection tool; methods include observation, interviews, artifacts, and field notes
Data Analysis	Statistical relationships	Patterns or themes; "data-near"
Findings	Generalizable	Particularistic, holistic; transferrable by the reader

Hammersley and Atkinson (1995) describe the qualitative research design as a "reflexive process operating through every stage of the project" (p. 24). The qualitative approach allows for a clear description of the phenomenon from the participants' perspectives (Magilvy & Thomas, 2009). "Qualitative researchers tend to ask how x plays a role in causing y, what the process is that connects x and y" (Maxwell, 2005, p. 23). Thus, accessing the perspectives of nurses about the phenomena of nurse leadership can begin to say something about patterns of thought, collectively agreed upon, and divided notions of what is occurring for the whole nursing profession. The phrase "nursing perspective" refers to those stances taken by nursing leaders that are informed by their professional training or experiences and used in their daily practice.

Creswell (2003) describes the researcher as the instrument to discover participants' perspectives of their worlds. It is also the role of the researcher in qualitative inquiry to provide sufficient description to enable the reader to determine whether the findings resonate to their particular context. A descriptive form provides a comprehensive summary of an event and produces data as described by the participants (Sandelowski, 2000, 2010). Researchers conducting qualitative studies seek descriptive validity (Sandelowski, 2000, 2010).

Data collection will be through semi-structured interviews and data analysis will utilize thematic analysis. It is important for the research to accurately describe the nurses' perspective on nurse leadership in today's health care environment and how nurse leadership is developed. The research purpose and the research questions for this study guided the selection of the qualitative paradigm.

Participants and Sampling

"Whenever you have a choice about when and where to observe, who to talk to, or what information sources to focus on, you are faced with a sampling decision." (Maxwell, 1996, p. 69) By taking into account the researchers relationship with the study participants, the feasibility of data collection, validity concerns and ethics, the decision was made to use a purposive sampling strategy to facilitate this research. Purposive sampling is a strategy that focuses on specific settings, persons, or events in order to provide important information that cannot be obtain from other choices. The sample for this study involves registered nurses in North Carolina who have a minimum of one year of nursing experience. The research was limited to the members of the North Carolina Nurses Association (NCNA), Triangle Region.

The North Carolina Nurses Association (NCNA) was founded in 1902 by a group of nurses under the leadership of Mary Lewis Wyche. The association pursued legislation that would make North Carolina the first state in the union to legalize registration of nurses and this became known as the Nursing Practice Act of 1903. Today, the North Carolina Nurses Association has a membership of over 5,000 nurses in all eight regions and is the leading professional organization all registered nurses in North Carolina (About NCNA, n.d.). The NCNA Triangle Region is the largest region and includes 1500 registered nurses in the following 11 counties: Person, Granville, Vance, Franklin, Orange, Durham, Wake, Johnston, Chatham, Lee and Northern Moore (NCNA Regions, n.d.) Below are the demographic data provided by the North Carolina Nurses Association for the Triangle Region:

- 73% female members, 6% male members and 20% not reported

- 10% African American, 1% American Indian, 1.5% Pacific Islander, 36% Caucasian, 1% Hispanic, and 10% not reported

- 1.5% Diploma Nurses, 9% Associate Degree Nurses (ADN), 24% Bachelor of Science in Nursing (BSN), 30% Master of Science in Nursing (in nursing and other combined), 7% Doctorate (in nursing and other combined)

The state of North Carolina has 104,663 registered nurses and of those sixty-six percent are staff nurses and sixteen percent are nurse executives, supervisors, managers, educators or researchers ("Licensure Statistics", 2017). Over half of all nurses in North Carolina work in a hospital, and 21% of all nurses work in an acute care context. According to the North Carolina Board of Nursing RN Ethnicity Statistics the number of registered nurses that identify as a minority is disproportionally low: 3% Asian, 12% African American, and 1% Hispanic. While 82% of all registered nurses in the state are Caucasian. In North Carolina, 92% of nurses identified as female and only 8% as male. There are 39% of registered nurses with an Associate degree, 35% with a Baccalaureate degree, 9% with a Master's degree and only 1% with a Doctorate in nursing ("Licensure Statistics", 2017).

Inclusion criteria included registered nurses in the state of North Carolina with a minimum of one year of experience. There are no restrictions with regard to gender, race, ethnicity or sexual orientation. All study participants were able to read and write in English. Participants were recruited to include variation in years of experience, health care setting, gender, race, sexual orientation, geographic location, and education. The nurses' perception of events determined what constitutes nurse leadership and what influences its development, as these experiences are individual and unique to each nurse. This broad approach aims to

capture the experiences and perspective of the phenomenon of nurse leadership from diverse roles and contexts throughout the profession.

Guba and Lincoln (1989) describe maximum variation as a type of purposive sampling where the purpose is to ensure that the conclusions sufficiently represent the entire range of variation. Maximum variation sampling is best achieved by "defining the dimensions of variation in the population that are most relevant to your study and systematically selecting individuals… that represent the most important possible variations of these dimensions" (Maxwell, 1996, p. 71-72). A disadvantage of maximum variation sampling is that you will have less data about any particular kind of case or individual within the study.

Maximum variation sampling allows for the identification of significant common patterns that occur within that variation. Therefore, in order to capture the multiple contextual realities for nurses, it is important to ensure that both male and female, experienced and inexperienced, diverse age range, white and non-white, and rural and urban nurses were included in this study. In addition, acute vs. non-acute practice setting was identified as a variation of the participant sample. The sample was selected to provide the most comprehensive data possible from a diverse population of registered nurses. Figures 2-4 demonstrate that the study participants' diversity of gender, race, and education was comparable to both the members of the NCNA Triangle Region and to the Registered Nurse population in the state of North Carolina.
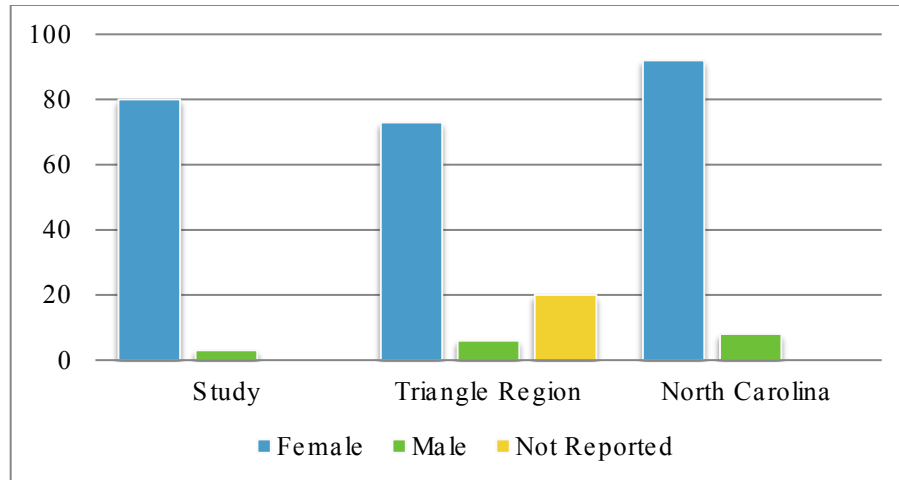
Figure 3. Phase II Participants Gender Compared to NCNA Triangle Region and State of North Carolina Registered Nurse Population

	African America	Caucasion	Hispanic	Asian
North Carolina	12	82	1	3
Triangle Region	10	36	1	1
Study	7	87	7	7
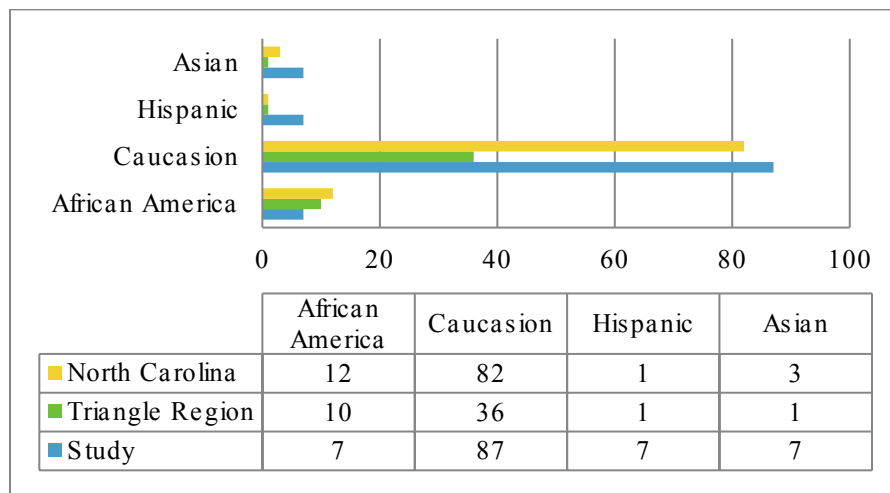
Figure 4. Phase II Participants Race/Ethnicity Compared to NCNA Triangle Region and State of North Carolina Registered Nurse Population
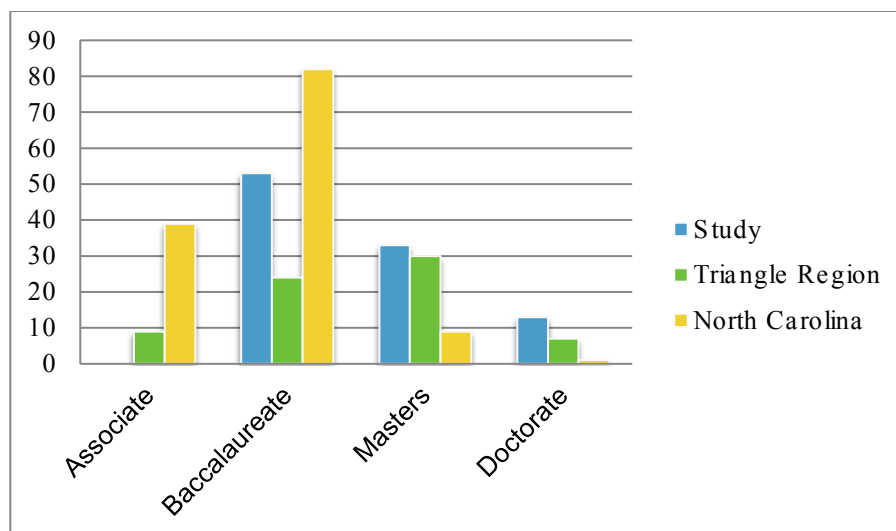
Figure 5. Phase II Participants Educational Background Compared to NCNA Triangle Region and State of North Carolina Registered Nurse Population

Human Subjects Protection

The University of North Carolina at Chapel Hill Institutional Review Board exempted this study from ethics review (Appendix B). Once it was determined that the inclusion criteria were met through the online Qualtrics ™ survey, individual interviews were arranged to provide privacy and comfort to the participants. Study participants voluntarily participated on their own time. At the start of each interview, participants were informed of the purpose of the study, the voluntary nature of participation, participants' right to confidentiality, and the risks and benefits associated with participation in the study. Participants were able to withdraw from the study at any time without explanation or consequence. However, no participants withdrew from the study or stopped the interview. Participants received a $25 Amazon gift card as compensation for his/her participation in this study. The gift cards were emailed to each participant at the completion of all interviews and after all transcripts were reviewed for accuracy and clarity. The participants were thanked for their participation (Appendix F).

Participant confidentiality was maintained throughout the research study. Identification numbers one through fifteen and pseudonyms were assigned to each participant. Transcription, coding, analysis, and reporting were completed using the participant's identification number or pseudonym only. Information linking each participant to his/her respective identification number and pseudonym was kept in a locked file cabinet in the researcher's office and was separated from the actual audiotaped, paper copies and recorded transcription files. All data and material gathered during the research process was kept in a secure location, and will be retained for 5 years by the researcher, then destroyed. Data stored on the computer was secure through password-protection and will be destroyed after 5 years.

Rubin and Rubin (2012) emphasize that the credibility of a qualitative research study depends on how well informed the study participants are regarding the established research questions. The study participants were all registered nurses with at least one year of experience and could be described as "encultured informants" (p.65), individuals who know the culture of professional nursing and were interested in sharing their experiences and perspectives with the researcher. Miles and Huberman (1994) explain that the researcher's expert knowledge and experience in the area of interest increases credibility. The researcher is a registered nurse with 18 years of professional experience and a clinical assistant professor at a school of nursing.

Data Collection and Analysis

The data collection for the study involved two phases, phase I involved nurse identification through an online Qualtrics ™ survey and phase II comprised of individual nurse interviews.

Phase I: Nurse Identification

With 1500 potential Registered Nurses across the Triangle Region, and the intent to conduct interviews to gain a deeper understanding of the phenomena of nurse leadership it was important to reach a manageable sample size that met the inclusion criteria. A recruitment email was sent to the members of the North Carolina Nurses Association (NCNA) Triangle Regional from the North Carolina Nurses Association (NCNA) Triangle Regional Director briefly describing the purpose of the study, the online Qualtrics ™ survey link, and the researcher's contact information (Appendix A). The recruitment email was sent to 1500 members of the Triangle Region of NCNA in early April 2016 and a reminder email was sent one week later. The online questionnaire was designed with the comprehensive set of guidelines for the design of online questionnaires as a framework (Lumsden, 2007). In addition, it was important to take both the major strengths and potential weaknesses of online surveys into consideration (Evans & Mathur, 2005). The structured aspect of the questions will increase the ability to compare and contrast responses and reduce interviewer effects (Patton, 2002). The online Qualtrics ™ survey (Appendix C) included questions asking participants to share their gender, race, ethnicity, and sexual orientation, years of experience as a Registered Nurse (RN), current job title, years in current position, place of residence, healthcare setting, highest level of education, and a their definition of nurse leadership.

The online survey (Appendix C) was created and administered on Qualtrics ™, a software package available through the University of North Carolina at Chapel Hill for conducting Internet-based surveys for the management of the distribution of the research questionnaire to study participants. The Qualtrics ™ survey (Appendix C) was developed to determine if participants met the inclusion criteria for the study, achieve maximum variation sampling, and to provide readers with additional context of the information obtained in the

study. The Qualtrics ™ survey was completed by 17.3% (258/1500) of the NCNA Triangle

Region membership (Table 6).

Table 6. Phase I Participant Characteristics (N = 258)

Characteristic	*n* (%)
Gender	
Male	14 (5)
Female	244 (95)
Racial/Ethnic Background	
Caucasian	206 (80)
African American	48 (19)
Asian	4 (2)
Hispanic	2 (1)
Not Hispanic	256 (99)
Sexual Orientation	
Lesbian or gay	7 (3)
Straight	251 (97)
Highest Nursing Education level	
Associate	16 (6)
Bachelor	80 (31)
Master	121 (47)
Doctorate	41 (16)
Practice Setting	
Hospital Inpatient	107 (60)
Non-hospital outpatient	16 (13)
Nursing Education	40 (20)
Other	45 (7)
Nursing Role	
Staff Nurse	230 (60)
Administration	22 (27)
Education	4 (13)
Age	
18-24	5 (2)
25-34	25 (10)
35-44	48 (19)
45-54	57 (22)
55-64	89 (34)
65 and over	34 (13)
Years of Experience in Nursing	
1-3 years	18 (7)
4-9 years	37 (14)
10-19 years	45 (17)
20-29 years	41 (16)
30-39 years	73 (28)
More than 40 years	44 (17)

At the end of the Qualtrics ™, survey, participants were asked to share their contact information if they were interested in participating in Phase II, face-to-face or telephone interviews. After the Qualtrics ™ survey closed, the results were downloaded into Microsoft Excel for Mac 2011 reviewed, and filtered for inclusion criteria and maximum variation. The Qualtrics ™ survey data was saved on the researcher's personal computer and only the researcher had access to the data. Data stored on the computer was secure through password-protection and will be destroyed after 5 years.

Phase II: Nurse Interviews

The selection of participants and access to these individuals is an important aspect of qualitative inquiry as it is the participants' perspectives that contribute to the understanding of the phenomenon under study. 108 out of 258 (42%) of the Phase I sample provided their contact information. The data was filtered using Microsoft Excel for Mac 2011 to achieve maximum variation and resulted in 15 registered nurses in the Phase II study sample who met the inclusion criteria, responded to an email request to be interviewed, consented to participate in this study, and were interviewed by the researcher. As stated by Magilvy and Thomas (2009), for a qualitative, descriptive study, a typical sample size could range from a few (i.e. 3) up to 20 participants. Twelve female (80%) and three male (20%), registered nurses with more than one year of nursing experience, ranging in age from 24-64 participated in the study. The participants represent a diverse sample of registered nurses practicing in a variety of settings in diverse health care environments with a wide range of years of experience (Table 7). Given the nature of this research it was essential to include representation from diverse professionals in this study.

This qualitative, descriptive study included 15 registered nurses. The participants varied in their current place of employment: hospital inpatient (10/66%), nurse educators

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(2/13%) and non-hospital outpatient (3/20%). Eight of the participants (53%) had earned a

bachelor's of science in nursing (BSN), five (33%) had earned a master's of science in

nursing (MSN) and two participants (13%) had earned a doctorate in nursing. The

participants were from the following counties: Wake, Durham, Orange, and Granville. The

study included one participant that self-identified as African-American, one participant that

identified as Asian, one participant that identified as Hispanic, and twelve self-identified as

Caucasian. In addition, two participants (13%) identified as Lesbian or gay and thirteen

participants (86%) identified as straight, that is, not gay. Table 7 provides details about the

phase II participant characteristics.

Table 7. Phase II Participant Characteristics (N = 15)

Characteristic	*n* (%)
Gender	
Male	3 (20)
Female	12 (80)
Racial/Ethnic Background	
Caucasian	13 (87)
African American	1 (7)
Asian	1 (7)
Hispanic	1 (7)
Not Hispanic	14 (93)
Sexual Orientation	
Lesbian or gay	2 (13)
Straight	13 (87)
Highest Nursing Education level	
Bachelor	8 (53)
Master	5 (33)
Doctorate	2 (13)
Practice Setting	
Hospital Inpatient	9 (60)
Non-hospital outpatient	2 (13)
Nursing Education	3 (20)
Other	1 (7)
Nursing Role	
Staff Nurse	9 (60)
Administration	4 (27)
Education	2 (13)
Age	
18-24	1 (7)

25-34	5 (33)
35-44	1 (7)
45-54	2 (13)
55-64	5 (33)
65 and over	1 (7)
Years of Experience in Nursing	
1-3 years	4 (27)
4-9 years	3 (20)
10-19 years	1 (7)
20-29 years	3 (20)
30-39 years	2 (13)
More than 40 years	1 (7)

The Qualtrics ™ survey participants that provided their contact information were sent an introductory email (Appendix D) inviting them to participate in the second phase of the study, the semi-structured in-person or telephone interview about nurse leadership and the conditions that influence its development. The participants were asked to provide dates and times based on their schedule and were asked to indicate if in-person or telephone interview was preferable. The researcher followed-up with all participants that responded to the introductory email and arrangements for the interview were made at a mutually agreeable time and place. Interviews occurred at either an agreed upon location or via telephone to ensure privacy and comfort of the participant.

Table 8. Matrix for Data Collection

Research Question(s)	Population Sampled	Method(s) of Data Collection	Method(s) of Triangulation

1. What are essential elements of leadership?
2. What key language, actions and values demonstrate nurse leadership?
3. In what ways do nurses consider leadership essential in today's health care environment
   a. How is this different from previous perspectives?
4. What influences the development of nurse leadership?
   a. How do gender, race/ethnicity, age, and sexual orientation influence the development of nurse leadership?
	Registered Nurses that were members of the Triangle Region of the North Carolina Nurses Association (NCNA) with more than 1 year of experience identified through maximum variation purposive sampling	Semi-Structured Interview	• Participant validation
			
			• Examination of information gleaned from the literature versus data gathered

      The study interviews took place between April-July 2016. A total of 15 participants were interviewed for the study and informational redundancy was achieved. Ten of the interviews occurred in conference rooms or offices at the participant's place of employment. One interview occurred at the participant's home. Two interviews were conducted at coffee shops at the participant's request and four interviews were conducted via telephone. Ward, Gott and Hoare (2015) explored telephone interviewing and found that the prominence of telephone use in contemporary society and the comfort with which participants expressed in using the telephone everyday made the telephone interviews a "user-friendly tool for semi

structured interviews" (p. 2780). The researcher identified that while most face-to-face settings were comfortable and conducive to discussion, the background noise was a challenge for the audio recording. To address this challenge in later interviews, the researcher made recommendations for interview locations to ensure that the environment would be comfortable, private and quiet. All of the interviews lasted between 45-90 minutes.

Interviews

Interviewing is one of the most common methods used in knowledge inquiry. This study utilizes a semi-structured interview format by "deciding in advance what ground is to be covered and what main questions are to be asked." (Drever, 1995, p. 1) Kallio, Pietila, and Johnson (2016) produced a framework for developing a qualitative semi-structured interview guide. The five phases are 1) identifying the prerequisites for using semi-structures interviews; 2) retrieving and using previous knowledge; 3) formulating the preliminary semi-structured interview guide; 4) pilot testing the interview guide; and 5) presenting the complete semi-structured interview guide.

Drever (1995) describes the starting point for developing an "interview schedule" should be the research questions, starting with a preamble that reminds the participant what they have agreed to and what the interview is about, then begin with more general questions first, avoiding any sequence where discussion of the first question can influence later answers, and finally ending with a "very open 'sweeper' question (pgs. 18-27). The nurse leadership interview questionnaire (Appendix E) included both prompts to encourage interviewees to answer and to ensure they say as much as they can or wish to and probes to get the interviewee to explain further.

According to Charmaz (2006), the use of a semi structured open-ended interview protocol gives thee researcher flexibility to follow up on participants' answers as needed

which also permits the participants to do most of the talking. The nurse leader interview questionnaire (Appendix E) asked participants to describe essential elements of leadership, key language, actions and values that demonstrate nurse leadership, the essential nature of nurse leadership in today's healthcare environment compared to previous perspectives, and identification of what influences the development of nurse leadership. The eight interview questions were designed to help understand the key issues and challenges registered nurses face in today's health care environment.

In the fourth phase of the framework proposed by Kallio et al. (2016) the semi-structured interview guide would be pilot tested. Using "expert assessment", the nurse leader interview questionnaire was pilot tested by two nurses that were not part of the study sample to assess for appropriateness and comprehensiveness of the questionnaire in relation to the aims and the subjects of the study. The researcher interviewed two expert nurses and the interviews were digitally recorded to simulate the real interview situation. Following the interviews, the researcher asked the expert nurses to provide feedback on the clarity and the order of the questions. Based on the feedback of the expert nurses, questions were revised to be more practical and to best elicit the participants varied perceptions and experiences (Kallio et al., 2016). The researcher considered Ward et al. (2015) practical considerations for qualitative interviewing by telephone and Drever (1995) chapter five on "Doing the Interview" to prepare. Interview sessions lasted approximately 45 to 60 minutes and technical methods used during the interviews were audiotape and digital recording.

The purpose of the research study was explained to all of the participants individually, along with potential risks and benefits. At the start of the study interview, all participants were thanked for their participation in the Qualtrics ™ survey, reminded of the

purpose of the study and verbally agreed to be audio recorded. Audio recording was done using Voice Notes 4.2 and were saved as MP3 files on the researcher's password protected computer. The researcher was responsible for ensuring that the computer was securely stored when not in use. Credibility was established through participant validation, a valid means to establish the findings and interpretations, during the interview session (Egon & Yvonna, 1989). The researcher would paraphrase and if something was unclear the researcher would stop and check with the participant for clarification. Towards the end of the interview, the participants' comments were summarized and read back in an effort to capture salient points. Finally, all participants were thanked for participating in the study. The MP3 files were sent by email to a professional transcriber.

All interviews were transcribed verbatim into Microsoft Word 2010 and sent back to the researcher within one week after the interviews were conducted. The transcriber was recommended by the UNC School of Education and was a reliable and confidential service. The contract and communication between the researcher and transcriber provided added confidence that the confidentiality and accuracy of the information was of upmost importance to the transcriber. Participant identification was removed prior to sharing the MP3 file. The researcher reviewed each transcript for accuracy before entering into data analysis (Magilvy & Thomas, 2009).

Table 9 below presents the research questions used to frame the study, and the interview questions utilized to address each of the research questions. During the research process, the questions presented in the table were often rephrased, and additional questions may have been asked depending upon the participants' need for clarification. Field notes were written to capture the researcher's observations during and after the interviews, and to

process the researcher's thoughts and reflections during data analysis.

Table 9. Guiding Interview Questions Asked to Address Each Research Question

Primary Research Question and Subsequent Questions	Interview Questions Asked to Address Research Question
1. What are essential elements of leadership?	• What are the essential elements of leadership? • Do you consider yourself to be a leader? Why or why not? • How do you define nurse leadership?
2. What key language, actions and values demonstrate nurse leadership?	• Can you tell me about your career as a nurse? • Where did you go to school? • Where did you work as a new grad? • Do nurses have a common language? • What are the common things that all nurses do? • What role does nursing education play in learning the knowledge, skills and attitudes? • What are the values of nursing? • How does that impact nursing practice or patient outcomes?
3. In what ways do nurses consider leadership essential in today's health care environment? a. How is this different from previous perspectives?	• Do you consider nurse leadership essential in today's healthcare environment? • In what ways is nurse leadership different in today's healthcare environment? In what ways is it the same?
4. What influences the development of nurse leadership? a. How do gender, race/ethnicity, age, and sexual orientation influence the development of nurse leadership?	• What influences the development of nurse leadership? • To what extent have you benefited from nurse leadership development? • Describe the type of support you have received? • Do you play a role in nurse leadership development? Why or why not? • What should be done in order to improve nurse leadership

	development?
	• How do gender, race/ethnicity, age, and/or sexual orientation influence the development of nurse leadership?
	• In what ways have your gender, race/ethnicity, age, and/or sexual orientation influenced you development as a nurse leader?

Data Analysis

Qualitative data analysis involves organizing and making sense of the data collection, filed notes, transcriptions, and codes. Data processing involves converting the data collected from the structured interview questionnaire into a format that can be easily analyzed (Yin, 2014). Kelly (2010) described two aims to the process of qualitative data analysis: identification of emerging and recurrent patterns or themes in the data and to move beyond the description to gain deeper meaning of the participants' experiences and may highlight new research questions. A theme captures something important about the data in relation to the research question (Braun & Clarke, 2006). It was important during the analysis of the transcripts of interview data to "consistently reflect on the data, work to organize it, and try to discover what the participants have said" (Glense, 2011, p. 188). Braun and Clarke (2006) describe the phases of thematic analysis (Table 10) as a method for identifying, analyzing and reporting patterns that extend across an entire interview or a set of interviews.

Table 10. Phases of Thematic Analysis

Phase	Description of the process
1. Familiarizing yourself with your data	Transcribing data, reading and re-reading the data and making notes about initial ideas
2. Generating initial codes	Coding interesting features of the data across the entire data set, collating data relevant to each code
3. Searching for themes	Collating codes into potential themes
4. Naming themes	Ongoing analysis to refine the specifics of each theme and the overall story the data set tells
5. Producing the report	Selection of examples, final analysis of selected examples; relating back to the research questions and literature

A total of 15 interviews were recorded and transcribed and each was approximately 21 pages in length. The 15 interviews yielded a total of 322 pages of data. Once the transcription was emailed back to the researcher, a hard copy was printed and organized in a binder by participant number to ensure data accessibility and then uploaded into the qualitative data analysis software program Atlas. TI 6.2. ATLAS. TI 6.2 was used to store and organize the full set of interview transcripts for efficiency and accuracy (Yin, 2014). While ATLAS. TI 6.2 benefits the researcher and made it easier to maintain accuracy and organization of the analysis process, it is not a replacement for the researcher's own analysis or interpretation. At the onset of analysis of the transcripts of interview data, the researcher read through each of the interviews, beginning to end and then reread line-by-line "to achieve immersion and obtain a sense of the whole" (Hsieh & Shannon, 2005, p. 1279). Initial codes

were derived by highlighting text, writing memos of first impressions, and underlining phrases. Knowledge generated from coding is based on the participants' unique perspective. Hsieh and Shannon (2005) state, "labels for codes emerge that are reflective of more than one key thought and then become the initial coding scheme" (p. 1279).

After open coding of five transcripts, preliminary codes were identified. Remaining transcripts were coded and the original five transcripts were re-coded, new codes were added if new data emerged that did not fit into existing codes. Dependability was determined by reviewing the transcript and analysis with an expert nurse, whose interpretations of the data were compared to the researchers for similarities and differences. Discrepancies were reviewed and clarified by returning to the transcripts for additional analysis. As another means of triangulation, the interpretation and analysis of the data began immediately upon receiving the first transcribed interview instead of waiting until all interviews were transcribed. Examining the interview transcripts over the entire course of the study illuminated reliability in certain findings and therefore increased the researcher confidence in the results.

The theoretically driven codes (Table 11) were labels that were derived as a result of reviewing the literature about nurse leadership, organizing research questions and predicting data that might emerge. The more specific coding categories and the research questions that prompted the data driven codes presented in Table 12 were developed from systematic coding which allowed for generation of themes to address the four research questions. After the process of coding, the researcher identified the final emergent themes and specific quotes were selected to illustrate an interpretive point. Transferability was enhanced through the participants' quotes. One priority for the researcher was to provide an accurate representation

of the participant's perspective. The themes were then reviewed to ensure that they captured

the details of all the coded transcripts. The themes were aligned that illustrated aspects of the

phenomenon meaningful in some new and useful way.

The research focused on establishing trust with each participant through transparency

of the researcher's positionality. Participants knew the researcher as an experienced nurse,

nurse educator and a former NCNA board member. Following identification of emergent

themes, the researcher examined the relationship among the concepts and connections

between the research questions and findings from the data. "Researchers seeking to describe

an experience or event select what they will describe and, in the process of featuring certain

aspects of it, begin to transform that experience or event" (Sandelowski, 2000, p. 335).

Table 11. Research Questions, Researcher's Assumptions, and Anticipated Theoretical Codes

Research Question	Researcher's Assumption	Anticipated Theoretical Code(s)
1. What are essential elements of nurse leadership?	Nurses do not consider themselves to be leaders and view those that lead as having a formal title.	Defining Nurse Leadership
2. What key language, actions and values demonstrate nurse leadership?	Nursing is a caring profession and all nurses say and do the same thing to "care" for patients.	Predicting Nurse Leadership
3. In what ways do nurses consider nurse leadership essential in today's health care environment? a. How is this different from previous perspectives?	Nurses are the largest healthcare workforce and have the most significant impact on patient outcomes. Previously, nurses are supervised and carry out orders from a physician.	Leadership Effectiveness

Research Question	Researcher's Assumption	Anticipated Theoretical Code(s)
4. What influences the development of nurse leadership? a. How do gender, race/ethnicity, age, and sexual orientation influence the development of nurse leadership?	Older nurses with the most experience are prompted to leadership positions. Men are often selected for opportunities to advance their nursing career, but minority nurses are often left behind. Nurses that identify as LGBT are closeted in healthcare.	Leadership Development

Table 12. Actual Codes Used to Analyze Data as Generated by Research Questions

Primary Research Question and Subsequent Questions	Actual Codes that Emerged from the Interviews
1. What are essential elements of nurse leadership?	• Descriptions of nurse leadership: Confidence & Risk Taking
2. What key language, actions and values demonstrate nurse leadership?	• Leading by example
3. In what ways do nurses consider nurse leadership essential in today's health care environment? a. How is this different from previous perspectives?	• Description of nurse leader as a resource and risk taker
4. What influences the development of nurse leadership? a. How do gender, race/ethnicity, age, and sexual orientation influence the development of nurse leadership?	• Description of leadership potential "you have potential" • Aspects that hinder and promote leadership development: "Prove myself" & "Sticking out"

Limitations

Several potential limitations or "potential weaknesses or problems with the study identified by the researcher" warrant discussion (Creswell, 2003, p. 207). First, although this study generated new knowledge, the small sample size and the single geographic region of the sample, the results from the research may have limited application. Hagman and Wutich (2016) identified that the small sample size in a maximum variation sampling study is a limitation, as it often requires more interviews to capture the views of participants with heterogeneous knowledge and opinions. In addition, the lack of researcher experience in qualitative research and gathering quality data may have created gaps in the transcript interview data needed for this particular topic.

Second, because the participants of the sample group differed in terms of demographics, it is difficult to relate differences in perspective only to years of experience or potentially discount the effect of generational, gender, race/ethnicity or sexual orientation influences. However, since the study participants came from a variety of backgrounds and have practiced nursing in different contexts, it is reasonable to assume that the findings of this study will have relevance beyond this particular geographic region. Third, Merriam (2009) describes the researcher as the primary instrument for data collection and analysis in qualitative research. The researcher in this study acknowledges that the data analysis is limited to interpretation and could be inadvertently biased based on the researcher's experience as a Registered Nurse in North Carolina and as an elected leader in a professional nursing organization. Finally, researcher bias and misinterpretation of the participants' data were potential limitations. To address researcher bias, an interview guide (Appendix E) facilitated the interaction between the researcher and the participant. To address misrepresentation, member checking during the interview was implemented.

Summary

This chapter included a description of the methodology used in this study. The focus of this chapter was the (a) selection of the qualitative paradigm; (b) participant selection criteria; (c) human subject protection; (d) data collection and analysis; and (e) limitations. In this study, fifteen participants offered detailed accounts of their perspectives and experiences as registered nurses in a variety of health care contexts. Seven themes and definitions about nurse leadership and the development of nurse leadership emerged. Factors that influence the way in which gender, race, ethnicity, age and sexual orientation influence nurse leadership development are also discussed. The following chapter is a description of findings with a discussion of the findings related to the literature and implications for future research to follow.

CHAPTER 4: FINDINGS

Introduction

This is a qualitative study of 15 Registered Nurses that aims to explore the concept of nurse leadership in today's health care environment. Additionally, this study sought to identify the participants' individual perceptions about what fosters or inhibits the development of nurse leadership. The desired outcome was to develop a nurse-centered set of viewpoints about nurse leadership in order to embed this knowledge across curricula so that future nurses will be well prepared to lead. The findings in this chapter were analyzed from 15 semi-structured interviews that were conducted over a period of four months (April-July) during 2016. The analysis revealed important insights about registered nurse perceptions regarding nurse leadership. This chapter includes the presentation and analysis of the data collected and analyzed for the research questions.

Results Overview

The chapter is organized around the findings that emerged from investigation of the following four research questions:

1. What are the essential elements of nurse leadership?

2. What key language, actions and values demonstrate nurse leadership?

3. In what ways do nurses consider nurse leadership essential in today's health care environment?

   a. How is this different from previous perspectives?

   b. How is this similar to previous perspectives?

4. What influences the development of nurse leadership?

     a. How do gender, race/ethnicity, age, and sexual orientation influence the development of nurse leadership?

     b. What additional social factors emerge to influence the development of nurse leadership?

The demographic profile of the research participants (Table 13) is provided to illustrate their age, experience, education, work setting, gender, and race/ethnicity. Study participants were assigned a pseudonym to ensure confidentiality and provide for enhanced readability. Maximum variation purposive sampling yielded a group of participants that ranged in age from 24-64 years of age and included 3 male and 12 female participants. In addition, the sample included members of racially under-represented groups, and a member of the Lesbian, Gay, Bisexual, and Transgender (LGBT) community. Participants identified their sector of employment. A total of 10 were employed in hospital settings (66%), 2 were nurse educators (13%) and 3 were employed in non-hospital/outpatient settings (20%). Eight of the participants (53%) had earned a bachelor's of science in nursing (BSN), five (33%) had earned a master's of science in nursing (MSN) and two participants (13%) had earned a doctorate in nursing. The range of years as a nurse was from 2 years-more than 40 years. The participants were from the following counties: Wake, Durham, Orange, and Granville. The study included a relatively diverse group with one participant that self-identified as African-American, one participant that identified as Asian, twelve self-identified as Caucasian, and one participant identified as Hispanic. In addition, two participants (13%) identified as Lesbian or gay and thirteen participants (86%) identified as straight, that is, not gay. Demographic data were collected from the Phase I online Qualtrics ™ survey (Appendix C).

Table 13. Summary of Demographic Data

No.	Pseudonym	Age Range	Race/Ethnicity	Gender	Practice Setting	Education	Years of Practice as RN	Title
1	Nena	45-54	White/Hispanic	Female	Nursing Education	Doctorate	20-29 years	Nurse Educator
2	Ron	45-54	White/Not Hispanic	Male	Hospital Inpatient	Masters	20-29 years	OR Nurse Manager
3	Cathy	65 or over	White/Not Hispanic	Female	Nursing Education	Doctorate	More than 40 years	Professor
4	Rachel	35-44	White/Not Hispanic	Female	Hospital Inpatient	Masters	10-19 years	Clinical Nurse Specialist
5	Gene	55-64	White/Not Hispanic	Male	Nursing Education	Masters	More than 40 years	Director
6	Rose	55-64	White/Not Hispanic	Female	Non-hospital outpatient	Masters	30-39 years	Pediatric Nurse Practitioner
7	Ann	45-54	White/Not Hispanic	Female	Other	Bachelors	4-9 years	Oncology Nurse Navigator
8	Myra	55-64	White/Not Hispanic	Female	Hospital Inpatient	Bachelors	30-39 years	Clinical Nurse IV
9	Emily	18-24	White/Not Hispanic	Female	Hospital Inpatient	Bachelors	1-4 years	Clinical Nurse III
10	Faith	25-34	African American/Not Hispanic	Female	Hospital Inpatient	Bachelors	1-4 years	Clinical Nurse II

11	Wes	25-34	White/Not Hispanic	Male	Hospital Inpatient	Bachelors	4-9 years	Clinical Nurse III
12	Lexi	25-34	White/Not Hispanic	Female	Hospital Inpatient	Bachelors	1-3 years	Clinical Nurse II
13	Jenna	25-34	White/Not Hispanic	Female	Hospital Inpatient	Bachelors	4-9 years	Wound & Ostomy Specialist Nurse
14	Grace	25-34	Asian/Not Hispanic	Female	Non-hospital outpatient	Bachelors	1-4 years	Clinic Supervisor
15	Mary	55-64	White/Not Hispanic	Female	Hospital Inpatient	Masters	20-29 years	Nurse Manager

At the end of the phase I online Qualtrics ™ survey, the participants were asked to
provide their definition of nurse leadership. Whether or not they expressed during the
interviews that they identify as a nurse leader, all of the 15 participants were able to provide
their definition of nurse leadership. Table 14 details the responses of the participants when
asked to define nurse leadership.

Table 14. Phase I Definitions of Nurse Leadership

1	Nena	A nurse leader is a person who has the skills, knowledge, and passion to guide, mentor, provides a vision, listens, provides feedback when needed, engaged in difficult and critical conversations and do not have a worry to express her/himself. A leader is able to identify the best on every person and use that best for the goal the team wants to achieve. A leader is person that respects questions and have emotional intelligence. There are different types of leaders, but the two types that I like modeling the most are the transformational and the servant. On the transformational, I like to empower people, make them feel that they are an important contributor and made them feel that we want them to actively participate. We offer them opportunities to participate, create and develop educational programs, fro example. Leaders are able to think out of the box and know that they have to bring this up, as others may not reach broadness of mind.
2	Ron	The managing and directing of nursing practice to patients in a thorough and concise manner to provide safe and appropriate care by my direct reports in providing patient care that is completely satisfying to our patients.
3	Cathy	Leadership is the ability to envision a preferred or better future, communicate that vision to others with passion and clarity, engage and excite others to join you in making the vision become a reality, orchestrating change needed to achieve the vision, providing support to and helping to develop followers, and investing time, energy, expertise and passion to change your sphere of practice (whether that is as a staff nurse, a manager, a dean, a member of a professional organization, or whatever). Leadership is dreaming and doing.

4	Rachel	Nurse leadership is nurses who work in effective and professional ways to promote positive outcomes for patients and professional development of nurses. This may be part of their job description or above and beyond it.
5	Gene	Demonstrating the ability to direct nursing activities to reach a designated positive outcome.
6	Rose	A nurse who functions to her full scope of practice advocating for patients and the profession.
7	Ann	Taking control of my own practice. Working toward improving the quality of our processes to ensure patient access and care are optimized. Working toward autonomy in my position and for my colleagues. Working with confidence that my voice is important and deserves equal time in the decision making when care plans or treatment options are determined.
8	Myra	Guiding, helping and sharing the knowledge and experience with your colleagues to provide the best possible care to the patients, their families and your co-workers.
9	Emily	Nurse leadership is leading by example and inspiring others through your patient care.
10	Faith	One who is able to set an example; standard of care and practice
11	Wes	I intentionally keep the definition vague because nurse leadership is encompassing of many different roles. Each nurse has the ability to be a nurse leader in some capacity, regardless of how "seasoned" they are within the profession.
12	Lexi	A nurse who is serving as a role model for his/her patients, colleagues, and community. Nurse leadership can be in many forms. Nurses can be leaders in many ways, including as an educator for a community group (I.e. Girl Scouts), a nurse manager, a care coordinator, a

		nurse educator (at a college/university), a political advocate for the profession, etc. ...
13	Jenna	Nurse leadership is facilitating others to find their passion in nursing and then nurture it to grow.
14	Grace	Leadership contains more than just directing a plan of action. Nurse leadership requires team communication to collaborate on a plethora of issues to identify the ideal plan of care with positive patient outcomes.
15	Mary	A leader is someone who inspires others. Nurse leaders help others to do the right thing, even if it is hard (mentally or physically). They encourage and support others to be the best they can be. Nurse Leadership involves advocating for staff as well as patients. They have to understand rules and regulations, and translate why we have to do certain things a particular way. Nurse Leaders must have exceptional listening skills. They must think before they speak. They have to not let frustrations show. They have to hold staff accountable for their actions without hurting their confidence and self-esteem.

Thematic Findings

The findings were organized thematically in order to develop a comprehensive understanding of the phenomenon of nurse leadership and its relationship to building nurse leader capacity. It is critically important to recognize that even in the best attempt to allow the concepts to emerge from the data, I acknowledge that this study was informed by the review of the literature. Including, research of registered nurses in formal leadership roles (Allen, 1998) in which self-confidence, innate leader qualities, progression of experiences and successes, influence of significant people and personal life factors were identified as the

five dominant factors that influenced leadership development. It is notable that the role of gender/gender identity, race/ethnicity and age were not a part of the Allen (1998) study. By contrast, the sampling plan for this study was designed to maximize the chance of recruiting participants in diverse health care contexts, varying career levels, and gender, age, racial/ethnic and sexual orientation diversity.

After careful review of both phase I and phase II narrative data, seven themes were incorporated into the below categories and defined. Table 15 lists the seven themes that emerged from the data.

Table 15. Emergent Themes and Definitions

Theme	Definition
Confidence	The ability to know your own limitations and embrace the knowledge and skills of all members of the health care team
Leading by Example	A shared approach to the work of nursing that can set leading by example apart from mentoring.
Risk Taking	Challenging the status quo and your own ideas.
"You have potential"	The knowledge that each nurse has the capacity to improve nursing and patient care and has the support and encouragement of their colleagues.
Resource Person	Highly entrusted nurses that share specialized knowledge and expertise.
"Prove Myself"	Differences in age, race, sexual identity or gender often cause individuals to believe that they have to work harder than everyone else to prove that they are worthy of the position.
"Sticking Out"	Embracing your individuality and being comfortable with who you are even when you stand out from the crowd.

Confidence. Many of the participants discussed the concept of confidence as being aware of self-doubt about one's abilities or skills. Others who discussed *confidence* when asked about the essential elements of leadership focused on situations when they work with other members of the health care team. The participants suggested that *confidence* during collaboration with colleagues is a critical moment because nurse leaders are not only able to contribute to the decision-making, but also gain additional knowledge from other professions. Ann has been a nurse for 4 years; she identifies as a Caucasian female between the ages of 45-54. Ann was a teacher before she earned her bachelor's degree in nursing. She shared how she believes that confidence in knowing your own limitations and embracing the knowledge and skills of all members of the health care team is essential to nurse leadership:

> I think it has to be confidence in what you know but confidence in what you don't, as well. I think that makes a good leader, cause there's not someone in this whole hospital that should be confident that they know all they need to know…I think the best leaders know that there is so much to learn from every single person, whether that's a phlebotomist or a, you know, an intake coordinator…that's what I view as leadership.

> Mary who has worked as a staff nurse, travel nurse, and in positions of formal nursing leadership has her master's degree in nursing and identifies as a Caucasian female between the ages of 55-64 expressed that having the confidence to share or distribute leadership was fundamental for nurse leadership. She stated, "…being a leader is not necessarily doing everything and having to have it your way but being able to be open to other ideas." Jenna has been a nurse for 8 years and recently earned her specialty certification as a wound and ostomy nurse talked about how her confidence and respect for other roles grew during her "journey":

> I was really young when I started this. I don't know if I would have put eighteen-year-old me on a truck and let me save lives, my journey's been very long and I have learned so much through the different roles that I've had and through that I've learned

to appreciate each role from the EMT to the NA, I even did a little work in transcription, so I really learned to respect the whole team process and that everyone no matter who you are has their role and that has helped developed my confidence knowing we are all working toward the same goal of helping people.

Nena describes growing up in a very poor house and making a decision at a young age that she was going to be successful:

I remember I was eight years old and I said to myself, "I'm going to get out of here and I going to have my own house and I'm going to have my own profession". I knew there were going to be challenges you know, there are going to be big holes along the way that I have to figure out how to cross, but you know what, I had confidence that I was going to do it.

Ron, who identifies as a Caucasian male, has been a nurse for 25 years and is currently in a position of formal nurse leadership; reflected on how much confidence his father "deposited into his life". He said "I am an anticipator, my dad was a carpenter and I would always hold the wood for him as he was sawing it, and I learned that if I held it in a certain way that it would not pinch his bade. I have told him now that what I'm doing is exactly what you brought into my life many years ago to be aware of each situation and learn from it." Cathy who has her doctorate in nursing and identifies as over the age of 65, female and Caucasian has been a nurse for more than 40 years also remarked that although she does not remember specific conversations, that being confident was just an idea that was conveyed by her parents. She said "neither my father or mother finished high school, but they always had the attitude that you know you can do anything you want to do and think about what you want to do and what you want to be and how you want to contribute was just a conveyance of confidence. I was the first in my family to go to college."

Gene is a director in a large health care system and has been a nurse for more than 40 years. He identifies as a Caucasian male between the ages of 55-64. Gene shared how important it was for nurses to embrace their expert power as this instills confidence in our

patients. He said:

> I think it's important to self-articulate that, you know, "I'm an expert". There have been many times during my career working with patients that I could tell they were afraid, that I could say to them "I am an expert at this and I am going do everything I can to make sure this goes well" and you can just see people relax, but when you are an expert you should acknowledge that because it really has an impact on the patients confidence in you as well.

Lexi has been a nurse for four years and is currently working in a hospital was more ambivalent and expressed self-doubt "I think I am working towards being more confident and taking on leadership roles. At times, I still feel like a new grad and at other times I feel that I was successful in helping a colleague or the team to make decisions."

Leading by Example. Leading by example was discussed as both an essential element of nurse leadership and a key concept for nurse leadership development. The respondents who discussed this stated that nurse leadership was about leading by example with nurse colleagues and most often pointed to a shared approach to the work of nursing which can set leading by example apart from mentoring.

Myra has been a nurse for 30 years and was trained in South India discussed how she feels that it is not the job title that is essential to nurse leadership, but the actions of the individual:

> Its human nature to see somebody to follow, so the leader in nursing or any other place, we want to see what they do, what they say, and we can improve ourselves by following in their footsteps…so that is important in nursing because we are dealing with human life and when the leaders with their experience and their knowledge and education share that knowledge-as I told you-sharing that knowledge to care and cure. This helps growing nurses to be more effective nurses. If I get new information regarding a particular care then I share it with them. I remember my mother for that, she said to me like in English they have "Be in their shoes", so what happens is that she told me in our language that I should think if you are in their position, what will you do?

Emily has been a nurse for two years; she identifies as a Caucasian female between

the ages of 18-24. She values nurse leaders that lead by example. She said, "I think to be a leader…you need to lead by example first…not just saying it but actually doing it and showing that it can be done." Ron agreed and shared how he does not ask nurses to do anything he would not be willing to do. He said that nurse leaders are "somebody who your staff know [will] do the job that they're doing and do it well right alongside them." Ann who works as a nurse navigator in a cancer hospital expressed how continuing education could help nurses motivate their colleagues:

> I think that learning new things keeps your spark and passion for nursing. If you are interested in asking questions, then you are not stuck in your ways. As a result, you will share what you have learned with the nurses you work with and often that excitement will motivate them to ask questions and learn something new.

Risk Taking. When discussing *risk taking*, participants were referring to challenging the status quo and asking questions. Cathy who is highly regarded as an expert and leader in nursing education believes that nurses should be the drivers of change in health care today and that nurse leadership is found in those that speak up, advocated for change or encouraged others to support something new or different. Jenna expressed concern that not all nurses are comfortable taking risks and that because she is then she feels a responsibility to advocate for others. She said, "I speak up on the patient's behalf and for other nurses who are too afraid to speak up. I point out when things need to be done or what could be done more efficiently. Those are ways I see myself as a nurse leader. I don't wait to be shown what to do, if I see something that needs to be done I do it."

> Cathy summed it up why challenging assumptions is critical to nurse leadership:
> I think nurse leaders have to be willing to stand up and say, perhaps unpopular things or things that make people a little uncomfortable because its challenging the status quo and we all get real comfortable in the status quo. It's questioning the assumptions that underlie what we do and asking why are we doing it this way or could we do it that way instead or what would happen if?

Cathy also discussed challenging your own ideas and reflecting on the feedback of others. She stated:

Get things out there, and you know what, if people don't like what you have to say then, well you've taking a risk to put it out there, and its good to hear their feedback because maybe it challenges you to rethink what you've said, or reaffirm it.

Emily an early career nurse shared the idea of risk taking as part of the leadership development process:

For me to move toward a leadership role I had to step outside my comfort zone, open myself up to change and take a risk.

Nena is a nurse educator in a large federal health care system. She identifies as Hispanic and is between 45-54 years of age. Nena is passionate about nurses pursuing advanced degrees and has a doctorate in nursing. She describes risk taking as being a change agent: "to be a true leader you should be a change agent. You are willing to step outside the norm. You are not willing to go with the flow. You are willing to see a change through and be a change agent." Rose is an advanced practice nurse. She identifies as female and Caucasian and is between the ages of 55-64. Rose has been a nurse for 33 years. She shared how "frustration" with the status quo often influences nurses to take risks and take the initiative to be a change agent. She said "there are a number of things in my practice right now that are frustrating and I've been working on them but not really going anywhere with it, I think frustration in some form or another, stimulates a leader to say, 'Ok I gotta do something to change this."

"You have potential". "You have potential" is defined as the knowledge that each nurse has the capacity to improve nursing and patient care *and* has the support and encouragement of their colleagues. Gene is currently in a formal leadership role and feels that "talent recognition" is a high quality for nurse leadership. Nena agreed, "it's really

important for nurse leaders to try to create leaders. We're directly addressing nurses that have

skills, you know going to them, I say, "look you have potential". Ron agreed that

empowerment as a leader comes from encouragement from colleagues and recognition from

those in formal nurse leadership positions "to have leaders recognize you, motivates you to

be even better, but finding the right thing for the right person is real key too". Wes, who has

been a nurse for 6 years and identifies as a gay, Caucasian male between the ages of 25-34,

discussed that while he is not in a formal leadership role that he informally "encourages

people to get involved in different task forces". Nena describes using her role in a formal

leadership position to create opportunities for other nurses:

> I have one person right now is helping me do the whole curriculum for novice ED
> nurses. And he's a very quiet person, but what he did was more than extraordinary.
> Because the thing is when you are a leader, they know you are a leader, so they know
> that when I go to them and recommend to them that they try something they do it and
> their response is very positive.

> Cathy advocates for both nursing students and nurses to be encouraged to lead from

every vantage point and to "…really come to appreciate that you know "I can do this and I

should do this even if I'm not in that position of authority". Ron, who identifies as a

Caucasian male, started out in the military and has been a nurse for 25 years. He is currently

in a position of formal nurse leadership and agreed, "to have leaders recognize you,

motivates you to be even better". Gene discussed his first nurse manager's influence on him

"I've had some very key people, my very first nurse manager, who allowed me to do

different things and to spend time with her to learn certain skills of communication and

delegation". Mary described the need for all nurses to think about their next step:

> We need to talk about those things they could do to advance, whether its going back
> to school or whether it's being on a committee or getting certified or going up the
> clinical ladder. I encourage them to find their passion and say "lets work on that
> together."

Some of the participants felt that they best way to foster leadership potential is through a formal leadership position. If you have a formal nurse leader that is promoting and encouraging nurses to take on leadership roles from any position within the organization then that is going to facilitate the process of nurse leadership development. Ron commented that "to have somebody who is really gonna take you by the hand and push you and say 'you should try this, you should apply for this, you should submit this abstract" and Ann agreed "I've had nurses that really helped me identify what my strengths are and I do think that giving people the opportunity to kind of stretch their legs-cause there are some people that are never going to know, never gonna jump into leadership unless you kind of nudge the in that direction". Rachel practices in a hospital as a clinical nurse specialist. She identifies as a Caucasian female between the ages of 35-44 and she has been a nurse for 15 years. In her advance practice role, she often has the opportunity to encourage and support nurses "I tell them you've got to get on this committee or you've got to go back to school because you're going to be able to grow."

Myra described herself as a "quiet leader", but that "not everybody needs to shout at things to achieve it. You can do things that show your leadership. I think when leadership positions are appointed by your administration; it's a lot better of a feeling because I can do this because they believe in me. They have obviously seen things that I can do." Faith is bachelor's prepared early career nurse with 3 years of experience. She identifies as an African American female and works in a hospital. She described a time when her nurse manager was supportive and that support allowed her to step out and push herself to find out new things about herself:

> Yes, that was the very first person I went to, my manager and I was like "I have this idea" and she helped me develop it and asked "How do you want to direct it?" and I

thought about it and said "I'm thinking about doing a survey and I need your help to send it out" so I developed the survey and my nurse manager reviewed it and distributed it. She also told me that if I need to come in and do more research that I could go ahead and clock in so she was a big help to me in facilitating and getting my project out there and I was able to present the project to the hospital and they were very pleased and asked me to come and teach a class to other nurses about this and I was shocked because I wondered initially "Is this project really going to matter?" and now they want me to help teach this class? And for me is really sparked the knowledge that I can improve nursing and patient care and I had a lot of support, so if I can change a hospital wide policy that is so powerful.

Resource Person. Many of the participants discussed nurse leaders as a *resource person*. A *resource person* is a highly entrusted nurse that shares specialized knowledge and expertise. The participants discussed this both in relation to nurse-to-nurse and nurse-to-health care provider sharing of knowledge and expertise and with regards to their patients. Nena shared how nurses are the most trusted professionals and we have to be advocates. She said, "a resource person knows the right questions to ask at the right time". Emily discussed the confidence it takes to be a resource person:

> I think she, the nurse supervisor respected me, each time she approached me about something and I appreciated that and I felt like…she treated me like her peer. If you are someone who won't stand up for certain things, they are not going to come to you to ask what your thoughts are on different things, but being that person who is willing to speak up about things is important. Those are the nurses' even formal leaders are going to go to and say, "what do you think we should do?" It is an earned respect and you need that to be a true leader.

Myra described how her knowledge and expertise make her resourceful to other nurses and for other members of the health care team. She remarked "Do I see myself as a leader? Yes, I do because I think on the unit I am on of the nurses with the most experience. The new nurses tend to seek my assistance and the doctors seek me out on a regular basis as well. They know I know my work and I am happy to share it with them." Jenna prides herself on being resourceful and shared that by gaining additional knowledge in a specific area; she gained the respect of her peers and was identified as a resource person.

I have got the trust of my manager and my coworkers. I was the unit champion for "Skin and Wound" so that I could help our unit prevent them. I wanted to gain more knowledge so that I could be a resource for other staff, patients and families. I think my manager also played a role in pushing me in that direction, knowing that I could do it and encouraging me."

Ann, who describes her current role as one of being a full-time resource person also discussed being a *resource person* for her patients. "The nurse leader is influential because we know the patient and can anticipate the patients journey. For example, a young woman is pregnant and diagnosed with breast cancer, nurse leaders not only focus on the cancer diagnosis and treatment, but on getting the patient connected to the mother and babies program."

"Prove myself". Seeing oneself as a leader was a function of gender, race, life experience, and professional socialization. Differences in age, race, sexual identity or gender often cause individuals to believe that they have to work harder than everyone else to prove that they are worthy of the position. Three of the participants used the phrase *"prove myself"* when discussing age as a barrier to leadership development. Wes, who asked to serve on the diversity council, shared a situation when he had to advocate for younger nurses. He said:

> I think that I've proven myself, but I do that that people call me out for my age all the time, they're like "oh you're 26, oh I remember being young" and I'm like "well yeah I'm young, but I'm also a really good nurse and leader" and I think that needs to be respected. When I started on the diversity council, I was the youngest member and I still am…so the group on the diversity council tends to be pretty open-minded, but I find that when we were talking about age…ageism…people also think "Oh we should not discriminate against older nurses"…but it's easy to say "Oh those, you know, the new generation" or that "Millennials are all on their phones…and they don't have communication skills" and that's totally acceptable.

Mary, who currently serves in a formal leadership position, remarked about the the need for nurse leaders to stop associating age with experience:

> Often we associate age with experience. So our younger nurses with less experience, our older staff who have more years of experience…and when it comes to sitting at

the take with those two dynamics, you do see a challenge when you know younger nurses because they are perceived as having less experience don't feel as if they're being heard or our older nurses who have more experience feel as if they aren't being heard because they don't have the knowledge about the new technology or new research they just want to do their work and go home.

The participants shared how environmental conditions such as promotions, engagement in organizational activities and having supportive teams can enable successful nurse leaders. Rachel, who has her master's degree, describes a situation where she was the only nurse and only woman on a council that she considered "levels above a group that I shouldn't be sitting on" and how she felt intimated and did not engage during these meetings. She goes on to describe her experience:

> I didn't do a good job of making my knowledge and background valued, or seem essential to the work of that group. I'm not really sure if it was because I was a woman more so than I felt like my title wasn't you know my role in the organization wasn't high enough to sit at that table. I definitely felt like I had to prove myself and prove that I could be professional, that I would-that I could get the job done that I was smart enough to be there to do that kind of work.

Grace, who has been a nurse for four years and identifies as female and Asian American, currently works in a clinic and shared her experience "there are many barriers, for instance, when you are not given opportunities that you are capable of, some opportunities do not seem to be open to everyone. I think there should be more opportunities to engage and demonstrate your skills and knowledge."

"Sticking out". The participants all discussed the various ways that gender, race, ethnicity, age, and sexual orientation were influential in their identity formation as nurse leaders. The theme of "sticking out" is defined as embracing your individuality and being comfortable with who you are even when you stand out from the crowd. Nena, who is Hispanic, shared an experience of how inequities both constrained and enabled her self-perception as a leader. She explained that a colleague "was making fun of my talking, every

time I would talk, he would try and mimic me. I told him "what you're doing is wrong." It's difficult to lead when people believe that you are not qualified for the job you have. I feel that I have been able to use my education as leverage to build my confidence and be comfortable in my own skin."

Ron, identifies as male and is currently in a formal leadership position, stated that "male nurses years ago were often labeled as gay, but that doesn't seem to be the situation anymore." Two of the three male participants discussed how being a male in a predominately female profession has been advantageous to their careers. Gene has been a nurse for more than 40 years and remembers at the beginning of his career when there were very few male nurses and he says he felt "unique". He shared a situation in which because he was male he was hired:

> When I interviewed for the position, there was a really long waiting list to get into pediatrics…I got moved up to the top of the waiting list and was hired. I do think being male helped me in that situation. I certainly think early on in my career I was aware that adults were very leery of male nurses and the connotations around male nurses, so I went into pediatrics because they didn't care. I also think there are some pathways that are easier, I think it was easier to initially moving into leadership positions.

Wes discussed how his gender has helped foster his leadership development:

> As far as my career…I think that being a male has been extremely advantageous…since I am male I stick out and people know me more because I'm a male and so it's helped me foster my growth.

Findings by Research Question

This section summarizes the transcript interview data as it relates to the research questions that are foundational to this study. Table 16 illustrates the relationships between the themes and the research questions. A number of the themes overlapped research questions.

Table 16. Relationships between Themes and Research Questions

What are the essential elements of nurse leadership?	• Confidence • Risk Taking • Leading by Example
What key language, actions and values demonstrate nurse leadership?	• Confidence • Risk Taking • Leading by Example
In what ways do nurses consider nurse leadership essential in today's health care environment and how is this different from previous perspectives?	• Confidence • Risk Taking • Resource Person
What influences the development of nurse leadership and how do gender, race/ethnicity, age, and sexual orientation influence the development of nurse leadership?	• Leading by Example • "You have potential" • "Prove Myself"

Question 1: What are the essential elements of nurse leadership?

Each interview began with the participants being asked to identify the essential elements of nurse leadership. The elements that were shared in the interviews varied widely among the participants. The 12 essential elements of nurse leadership (Table 17) contain descriptors provided by the nurses who participated in the interviews. As the researcher reviewed the interviewed transcripts, these descriptors were repeatedly used to describe nurse leadership. Although it does not distinguish between formal and informal nurse leadership, it became apparent that the nurses identified these elements in themselves and in those

individuals they described as nurse leaders.

Table 17. Essential Elements of Nurse Leadership

▪ Integrity	▪ Professionalism
▪ Anticipative Skill	▪ Compassionate
▪ Vision	▪ Confidence
▪ Commitment	▪ Effective Communication
▪ Passion	▪ Approachable
▪ Risk Taking	▪ Team Player

Upon reflecting on being a leader, the participants were asked: "Do you consider yourself to be a leader? If yes, what makes you a leader and if no, why not?" Interestingly the response was mixed, with 10 out of the 15 participants (65%) seeing themselves as nurse leaders, and 3 out of 15 (20%) working towards being a nurse leader, while 2 out of 15 (13%) had mixed feelings about being a nurse leader. The following are quotes from some of the participants who see themselves as leaders.

Nena shared "Yes, I do see myself as a leader. My attitude, my clinical experience, my educational background has prepared me. I think leadership is about having a vision. I'm a leader because I know I make a difference." Ron commented that "probably the biggest things that I bring to the table for staff is a broad experience. I've done a lot in my career, so the experience I bring is unquestionable, but also my situational awareness and how I project myself as a leader." Wes identified himself as a leader among his colleagues both informally and formally. He said "I think of myself as a leader because on my particular unit, I've grown relatively quickly. I am the liaison for the assistive personnel so I do feel like I help lead them-we have meetings and they come to me with issues and I advocate for them. Nurses come to me with questions and they feel like I am a resource and informal leader on the unit. I'm also charge nurse a lot and that is a formal leadership role."

For others who have mixed views about leadership, they described their experience:

Lexi an early career nurse said 'I think I am working towards getting there. I have days where I do and there are times when I don't." Ann said, "I don't know necessarily that I'm a nurse leader. I think wherever I've been in my life whether it was in high school or when I was a teacher before I was a nurse, I think I'm an idea person. I would say that I have leadership qualities, but I've never been hired in a leadership or administrative position."

Question 2:What key language, actions and values demonstrate nurse leadership?

At the core, nurses work in patient care, so it was not surprising that the participants all described nurse leadership as caring for patients. Additionally, having the knowledge, skills, and expertise in patient care are characteristics of what it means to be a nurse leader. Participants were asked to reflect on the common language, actions and values demonstrate nurse leadership. Rose an advanced practice nurse noted, "I value that the patients seek my guidance and can feel confident in what I am telling them is to the best of my knowledge and that you care about them, I find that to be a leadership quality." Mary values the holistic care that nurses provide. She sees the nurse as a coordinator of care between the patient, their physicians and other health care providers.

Myra and others expressed how caring for patients motivated them to become nurse leaders. Myra explained that it is important for her to show compassion and respect for each patient. She said "I often stay late because I find it comforting at the end of the day to be there for my patients. I think it means a lot to them-they share that no one listens and they need to be heard and given reassurance. It is a great complement for a patient to ask "are you going to be my nurse tomorrow?" The patients want you to be there for them and I look forward to coming back."

Nena shared that helping people who for whatever reason could not help themselves

was why she wanted to become a nurse. "To be an advocate was something I always was drawn towards. The nurse can give the patient the skills to take better care of their health. That is powerful." Emily who has worked for two years in a hospital expressed her view on the importance of integrity and caring as a nurse:

> Doing the right thing when no one is watching you and going above and beyond. Doing little things that make a big difference, which is why I went into nursing, was to make people feel like they are being cared for during a really hard time in their life and just being there for them. I think that's something that I try to excel at is making that patient and family feel like they are getting the best care they can.

After being a nurse for over 40 years, Gene feels that nurses need to embrace the idea that we are leaders. For Gene, this means using a "language" of leadership and celebrating our role and not downplaying it:

> I think nurses need to embrace the fact that we're really good, we're phenomenal, and individual nurses have these great gifts and skills and need to let the world know, we need to do a better job across the board of being able to say "I'm the nurse and this is what I do" the idea of going into a patients room and saying "I'm your nurse and I'm the coordinator of your care and its my job to protect you and make sure you get the things you need.

Table 18 combines the identified values shared by the participants. This shows that there is consistency across how nursing values are articulated and demonstrated on a daily basis, regardless of their work setting.

Table 18. Key Nursing Values

▪ Integrity ▪ Advocacy ▪ Respect ▪ Caring	▪ Holistic ▪ Compassion ▪ Patient Safety ▪ Patient-Centered

Question 3: In what ways do nurses consider nurse leadership essential in today's

health care environment and how is this different from previous perspectives?

The nurse participants all remarked on the complexity of today's health care

environment and how that presented the nursing profession with new opportunities to lead.

The participants felt strongly that nurse leadership is across all areas including with patients,

families and other health care professionals and on the larger landscape of state, national and

global health policy issues. Cathy offered, "Nurses lead at the bedside of their patients, as

charge nurses and as CNO. All are important, but changing the status quo for policy

improvement affects the most people". One area that was exposed during discussions of

today's health care environment was participant's recognition of the importance of

professional organization involvement. The participants expressed how critically important it

was to stay relevant and that continuing education and encouragement to go back to school

was often found through involvement in a professional organization.

A number of the participants commented that the science of nursing was growing and

having a greater impact. Gene described an experience when the research authored by nurses

was used to change a hospital policy.

> I know there was one incidence a couple of years ago when we were working on a
> policy, it was a policy related to nasogastric tube placement, and when we went to the
> literature to research this particular topic, the best evidence was in the nursing
> research and it was contrary to the practice physicians wanted. We have some of the
> best gastrointestinal physicians here, but they were basing their practice of prior
> knowledge and experience and not research. So when the policy changed, I knew that
> would not have happened even 5 or 10 years ago.

Question 4: What influences the development of nurse leadership and how do gender, race/ethnicity, age, and sexual orientation influence the development of nurse leadership?

Registered nurses are now responsible for an even wider range of health care responsibilities and they do not function in a vacuum. In order to better understand nurse leadership and nurse leadership development it is necessary to understand the impact of internal and external influences. Participants also cited a variety of organizational conditions as empowering such as a nurse manager or supervisor support, opportunities to practice leadership, recognition, personal motivation, and educational experience as influential in their development as nurse leaders. A number of participants stated that a formal nurse leader played a key role in their development as a nurse leader. In addition, the influence that nurse colleagues have on each other was evident. The participants all mentioned at least one significant nurse that provided direction and served as a role model.

Another external influence that nurses perceived as empowering was having a culture of continuous improvement. Access to professional development opportunities is critical to nurse leadership development. Many of the study participants gave examples of formal leadership development programs through their employer, but most expressed a desire for more formal and informal leadership development programs to be available for nurses at all levels. Mary shared that before she completed her masters in nursing she did not have leadership training. She said "In nursing, there are in-services and workshops about practice, such as better pain management, but they don't actually say that the work that nurses do every day to manage their patients pain is nurse leadership." Participants often cited their educational experiences as being transformative. The experience of graduate school in particular was a turning point. Rose stated "I would say getting my MSN was a turning point

for me. My nurse practitioner residency was really where I started to feel like a professional and a leader."

Constraints to building nurse leadership are the absence of the conditions mentioned above. In addition, participants were asked to describe in what ways if any that their gender, race, ethnicity, age and/or sexual orientation has been a factor in their development as a nurse leader. All of the nurses tended to tell their story as if they were describing a linear progression of events. Both positive and negative events were perceived as important features of his or her identify formation as nurse leaders. The negative influences were often internal such as lack of confidence and external such as gender, race, and sexual orientation or age-related in the way other nurses perceived them. Racial and ethnic conflicts were described in several participants' development as leaders. Those conflicts were experienced in a variety of settings in terms of the belief and expectations of themselves and others. One of the male participants shared how racial, gender biases and LGBT discrimination can manifest on an institutional level when they are magnified through media. The lack of positive images of men, different races and those that identify as LGBT in nurse leadership positions is problematic. All 3 male participants described the influence of being male on nurse leadership development as a positive influence. Gene stated, "if you are a male in nursing, it's this underlying assumption that nobody really talks about, but well, if you're a male in a predominately female field, then you must be on the leadership track."

Summary

Analysis of the data revealed that nurse leadership is a widely defined, gendered and culturally dependent concept. Nurse leadership can be broadly defined as the process by which nurses, individually or collectively, intentionally influence their patients, colleagues, and settings both internal and external to health care to improve the practice of nursing with

the aim of safe patient care. Nurse leadership is an organizational and interpersonal concept. Seeing oneself as a nurse leader was a function of gender, age, race, ethnicity, sexual orientation and professional education.

Analysis of the narrative data identified seven themes: confidence; leading by example; risk taking; "you have potential"; resource person; "provide myself"; and sticking out. The participants described their perception of nurse leadership through their own experiences. They viewed confidence to work collaboratively and to engage with their peers, organizational leaders, health care team members, patients and families as an essential component of the nurse leadership experience. The ability to lead by example and have their peers and their patients trust them is of utmost importance. There are times that nurse leaders need to take risks to provide safe patient care and uphold the standards of care.

Participants' initial knowledge of nurse leadership came from colleagues who were role models early in their nursing careers. Participants often had their own feelings of emergent nurse leadership first during patient care experiences, and then by sharing their expert knowledge with other nurses. Feeling valued, acknowledged as a nurse leader and having opportunities to influence and improve patient care and the nursing profession was reflected as central to the concept of nurse leadership. Life long learning was considered to be important for continued leadership development. It was evident that many of the participants had experienced barriers to nurse leadership and nurse leadership development. These included exclusion from nurse leadership opportunities, lack of support from colleagues and underrepresentation. In addition, there were concerns expressed about discrimination, LGBT, and gender bias. Participants believed that nursing education and practice should empower nurses to lead and remove barriers to nurse leadership and nurse

leadership development.

Nurses have both formal and informal roles and lead within and outside of the health care setting. However, nurse leader roles are not clearly defined and supported by the organizational culture. By studying nurse leaders' experiences and belief of their leadership development, understanding can be gained about nurse leader identity formation and how nurse leadership affects professional growth and patient care. Nurse leadership is an interactive process of development that is influenced by relationships, opportunities and organizational factors.

CHAPTER 5: DISCUSSION

Introduction

The purpose of this qualitative study was to examine the concept of nurse leadership from nurses' perceptions. Additionally, this study sought to identify what fosters or inhibits the development of nurse leadership. The problem is that nurse leader roles are not clearly defined and supported by the organizational culture. Thus, little is known about the situations and circumstances that facilitate the emergence of and development of nurse leadership. This study addressed the problem of role definition by examining the experiences of registered nurses in their leadership development. This chapter will relate the study's findings to the existing literature and make recommendations. The findings have implications for nurses, health care organizations, health care policy makers, and college and university nurse education programs. Ideas for future research will be shared.

Maximum variation purposive sampling was utilized to identify 15 registered nurses. The participants had diverse roles as nurses throughout the Triangle Region of North Carolina. Data collection consisted of semi-structured interviews. Through thematic analysis, seven themes were created to present the data. These themes were confidence; leading by example; risk taking; "you have potential; resource person; "provide myself"; and sticking out. The University of North Carolina at Chapel Hill IRB approval was obtained before conducting this study.

Nurses are the single largest group of healthcare providers in the nation, with approximately 3.1 million registered nurses in the United States (HRSA, 2010). They are the

profession on the frontlines of patient care and play a major role in patient safety and quality improvement. Because of their number and proximity to patient care, nurses have the potential to be leaders at all levels of patient care and in every health care setting. Nurse leadership is used for a variety of purposes and desired outcomes in a variety of contexts in health care. Nurses' lead by sharing best practices, contributing to research and providing professional development with the desired outcome of improving patient care. Nurse leadership is supporting patients, students, nurses, health care professional colleagues, and health care organizations to reach targeted goals. Nurse leadership resides in nursing expertise. Nurses lead by facilitating collaboration, shared governance engagement and providing professional development and support to other nurses and health care providers.

Nurse leadership is used to develop policies and provide direction for local, state and national health care initiatives. Nurses lead by seeking to be positive change agents with widespread effect, considering the impact of decisions, leading by example, and maintaining the key values of nursing today's complex health care environment. Nurse leadership will be sustained by developing in all nurses the 12 essential elements of nursing leadership. Nurse leaders have integrity, anticipative skills, vision, commitment, and passion. Nurse leaders are risk takers, professional, compassionate, confident, effective communicators, approachable and team players. While nurse leaders develop the identity of a nurse leader in a variety of ways, formal nurse leaders and peer support are vital for all nurses to have equitable opportunity to develop their leadership skills in collaborative environments that embrace risk taking.

Findings Related to the Literature

This study reflected on the current literature of nurse leadership and found four areas that the research has addressed: (a) defining nurse leadership; (b) predicting nurse leadership; (c) nurse leadership development and (d) nurse leadership effectiveness. The findings and implications of this study are aligned with all four of these areas.

The primary purpose of health care is patient-centered care, yet as a nursing profession we continue to rank formal leaders higher in status than patient-care leaders. "For those who have been excluded from informal induction into leader like roles, such as women and people of color, recognition as a potential formal leader is a critical part of professional development" (Collay, 2011, p. 66). In understanding the concept of nurse leadership it was important to ask the participants if they see themselves as leaders and why. 10 out of the 15 participants (65%) saw themselves as nurse leaders, and 3 out of 15 (20%) were working towards being a nurse leader, while 2 out of 15 (13%) had mixed feelings about being a nurse leader. From these results the majority of the participants see themselves as leaders and others are working towards developing as a leader. This finding is significant in that it confirms that a diverse group of nurses in a variety of health care contexts do see themselves as leaders and challenges the previous research that nurse leadership is restricted to nurses in formal leadership roles. This study extends the definition of nurse leadership to include all nurses at all levels.

Participants reported that nurse leadership should be infused in the nursing education curriculum in both undergraduate and graduate programs. There was an expressed need for intentionality in development of nurse leaders at all levels. The study supported current research that recommends including leadership education throughout a baccalaureate pre-

licensure nursing program beginning in the first year and progressing throughout the entire program and into the workplace (Curtis, Sheerin, & de Vries, 2011). Sherman et al. (2011) and Sherman and Pross (2010) emphasize that nurses must take ownership for their personal and professional growth as nurse leaders and that organizational support and a healthy work environment is necessary for nurse leaders to succeed. The IOM (2010) report recommends that nurses achieve higher levels of education and be full partners with physicians and other health professionals. The study participants recognized the benefits of personal and professional development through life long learning.

The three male study participants echoed the current literature that found the minority status of men in the profession provides them a gender advantage and as a result, nurses that identify as male are more often encouraged to assume formal leadership roles (Kellet, Gregory, & Evans , 2014). Considering the importance of broadening nurse leadership opportunities among all nurses, a deeper look at what fuels such gender-biased practices would be invaluable. As participants shared their own stories, they also revealed personal struggles that impacted their identify formation as a nurse leader. For some, experiences of discrimination were acute moments in their development. Germain and Cummings (2010) strongly support the need for all nurses to feel empowered in the work environment. Although this is not new information, this study identified that are opportunities to examine the factors that contribute to negative experiences in the work environment that impeded effective nurse leadership. Germain and Cummings (2010) also found that those in formal leadership positions significantly influenced nurses. This was evident in the findings of this study and expanded to include both formal and informal leaders, for all of the nurses described a positive influence by a nurse colleague.

Wong and Cummings (2013) examined the relationship between nurse leadership and patient outcomes. The findings document evidence of a positive relationship between leadership and successful patient outcomes. This study emphasized the need to continue to strengthen and develop nurse leaders who play a key advocacy role as leaders in order to effectively deliver safe patient care. The literature is congruent with what the nurse participants shared in relation to their role as advocate.

Implications

The results of the study point to several implications that may inform practice and education and more specifically, advocate for enhancing nurse leadership capacity.

Practice

The implications are practical applications for nurses and health care organizations. The following implications are made regarding nurse leadership: a) advance organizational support of nurses through inclusion and leadership in all decision-making processes, b) provide opportunities for nurses to work with nurses within and across health care contexts, c) promote organizational support of nurse leaders through encouraging all nurses to take on leadership roles from any position within the organization, d) promote development of the 12 essential elements of nurse leadership through educational advancement, e) encourage nurses to provide input in defining nurse leadership roles, f) provide clarity in role definitions that distinguish formal and informal nurse leadership roles and g) support professional organization membership. Professional nursing organizations and health care organizations will need to articulate the value of nurse leadership and help nurse leaders to carry out the responsibilities of the roles by supporting the economic value. This may also eliminate barriers to nurse leadership.

Education

Implications are made for nursing education programs to develop nurse leaders. The following implications are made regarding preparing novice and veteran nurses along the educational trajectory for nurse leadership: a) encourage and engage nurse faculty in nurse leadership identity development, (b) give opportunities for faculty and students to self-reflect on nurse leadership development, c) promote nurse leadership as the "umbrella concept" for curriculum design, d) develop and disseminate relevant pedagogical content knowledge for nurse leadership, (e) advance organizational support of nurse leaders through inclusion and leadership in curricular decision-making processes and (f) support professional organization membership.

Higher education leaders are responsible for ensuring continued professional support for nurse educators to engage in development of nurse leaders who will deliver safe patient care. Nursing education must achieve a balance between teaching nursing specific knowledge, skills and values while also developing the essential elements of leadership. A new curriculum paradigm for nursing education must be refocused toward a vision of the nurse as leader. "There must also be a commensurate philosophical commitment among faculty regarding the essential nature of meaningful leadership development as a vital programmatic outcome measure for nursing graduates, a willingness to explore new teaching strategies that foster active student engagement, and commensurate resources for faculty development and support in this important endeavor" (Waite et al,. 2014, p. 290).

Implications in Future Research

Further research on the concept of nurse leadership will deepen the understanding of the topic. One productive line of future inquiry would be to expand the subject pool to include a broader sample of leaders from across the United States. This may allow one to ascertain whether the findings were a regional phenomenon or more common to the nursing profession in the United States. An additional dimension might include a methodology that would allow for observation of the participants in their daily work, which could add depth to the understanding of the nurse leadership phenomena. Additional exploration of how formal leaders are selected or what criteria is used to determine who gets to lead would also add to the growing dialogue of the need for inclusivity.

Another area for further exploration would be the concept of nurse leadership acceptance within the health care organizational culture and structure and the extent to which the health care organizational culture and structure fosters or inhibits nurse leadership development. The following question might be a place to start. When a nurse thinks of him or herself as a nurse leader, will he or she then internalize the leadership, thus, taking on more leadership? One way that might assist future researchers in exploring nurse leadership roles is by taking the focus off "leadership" and engaging nurses in conversations about nursing practice and patient care in general. For some resistant nurses, "leadership" seems to be an uncertain title. If instead in future research nurses are asked questions about nursing practice and patient care – a subject to which nurses are passionate about– then dialogue among nurses may open enough to begin to explore their understanding of nursing expertise, power and leadership. Lastly, more research is needed regarding the impact of nurse leadership on patient outcomes and patient safety.

With regards to nursing education, future research is needed on the use of technology and simulation to promote nurse leadership development at the baccalaureate pre-licensure level. In addition, research that explores classroom and clinical teaching strategies for active learning including: evolving case studies, critical reflection, diverse student populations and multidisciplinary perspectives. A larger body of empirical research will add to our growing understanding of what nurse leadership is and how it can be developed to impact today's health care environment.

Conclusion

The purpose of this qualitative research study was to explore the concept of nurse leadership from nurses' perceptions within the context of today's healthcare environment among a sample of 15 Registered Nurses (RNs), in North Carolina. Additionally, this study sought to identify what influences the development of nurse leadership. The multitude of calls for nurses to lead is shining the spotlight on the significant work of nurses in health care. However, the phrase nurse leadership is defined and used in a variety of ways in the literature. This makes it challenging to view nurse leadership as a legitimate vehicle for advancing health care and the nursing profession.

Nurse leadership must begin at the outset of every nursing education program and continue throughout the career of every nurse. This research invites us to rethink our historical beliefs that what nurses do and what leaders do are different. Nurses lead every day by taking action where they are. Woods (2003) implores nurse educators to prepare students to "lead where they land" (p. 256). While the current landscape in health care requires the physician to be the patient-care leader, the expertise to lead patient-care lies in the nurse. The following quote is adapted from Elaine Wilmore's 2007 book Teacher Leadership and really

spoke to me prior to and during the work of this study. I have added the word *nurse* in place

of her use of the word *teacher* and the word *patients* in place of her use of the word *students*.

> When nurse is coupled with the word leader it recognizes the seminal role that bonds patients and nurses lives into a community of care while acknowledging the nurses power to make a difference.

> This study found that nurse leadership occurs with every patient, among peers and

colleagues, and both internal and external to health care. This study is the first to speak

directly to all nurses, using a nurses' voice and exploring the role of nurse leadership. Based

on the findings of this study, implications for practice and education and future research were

presented. The study results expand and enhance the existing scholarship on nurse leadership.

The results demonstrated that nurses recognize and acknowledge their leadership abilities

and desire to develop the leadership capacity in the profession. Building and sustaining nurse

leadership within and across health care will play a vital role in patient safety. Nurses and

others can reframe their work as professional, collaborative, and requiring leadership. I

firmly believe that cultivating a community of nurse leaders will make patients safer. This is

true for all nurses at every level of health care.

APPENDIX A: INTRODUCTORY EMAIL TO PARTICIPANTS

Subject: Please participate in an important study on Nurse Leadership

Dear Nursing Colleague,

My name is Megan Williams. I am a nurse and I am completing my doctorate in education at University of North Carolina at Chapel Hill. The title of my dissertation is, "Defining Nurse Leadership: Nurses' Perceptions of Nurse Leadership and the Conditions That Influence its Development." As a researcher, I am interested in your thoughts and opinions on nurse leadership and what influences leadership development in nursing.

The Qualtrics ™ survey will take approximately 10-15 minutes to complete. Your participation is completely voluntary, and the information you provide will be kept confidential. Results will be reported only in aggregate form; your name will never be associated with your data.

Please click on the link below to complete the survey.

https://unc.az1.qualtrics.com/SE/?SID=SV_dnFYkAbqFuxVrtH

If you have any questions about the research study or the survey itself, please contact Megan Williams mpwilliams@unc.edu. If you have any questions about your rights as a research participant, you may contact the University of North Carolina Institutional Review Board at (919) 966-3113 and mention study number 15-3375.

Thank you for your participation in this important study.

Sincerely,

Megan Williams, MSN, RN, FNP

The University of North Carolina at Chapel Hill

APPENDIX B: INSTITUTIONAL REVIEW BOARD APPROVAL

THE UNIVERSITY
of **NORTH CAROLINA**
at **CHAPEL HILL**

OFFICE OF HUMAN RESEARCH ETHICS
720 Martin Luther King, Jr. Blvd. Bldg. 385, 2nd Floor
CB #7097
Chapel Hill, NC 27599-7097 (919) 966-3113
Web site: ohre.unc.edu
Federalwide Assurance (FWA) #4801

To: Megan Williams

School of Education Deans Office

From: Office of Human Research Ethics

Date: 3/02/2016

RE: Notice of IRB Exemption
Exemption Category: 2.Survey, interview, public observation
Study #: 15-3375

Study Title: Defining Nurse Leadership: Nurses' Perceptions of Nurse Leadership and the Conditions that Influence its Development

This submission has been reviewed by the Office of Human Research Ethics and was determined to be exempt from further review according to the regulatory category cited above under 45 CFR 46.101(b).

Study Description:

Purpose: The purpose of this qualitative research study is to explore the concept of nurse leadership from the perspective of Registered Nurses (RNs) in North Carolina. This study seeks to capture how nurses conceptualize nurse leadership in today's healthcare environment and identify what influences the development of nurse leadership.

Participants: The participants for this case study will be selected using maximum variation purposive sampling. Since the research questions for this study focused on nurses' perceptions of the essential elements of nurse leadership and the conditions that affect its development, the identified case to illuminate this will be actively licensed Registered Nurses (RN) in North Carolina. There are no restrictions with regard to gender, race, or ethnicity. All study participants must be able to read and write in English. Professional networking with state nursing associations will assist in facilitating accessibility to a group of participants who will recruit other groups to participate.

Procedures (methods): Prior to recruitment, ethical approval will be obtained through the University IRB process (Appendix F). The email invitation will be sent to potential participants (Appendix A) and includes a paragraph covering the purpose of the study, a brief explanation of their role as a participant, and a brief outline of the time commitment when completing the study. To obtain qualitative data in answering the research questions, the data collection will occur in two phases. In the first phase, all potential study participants will complete a Qualtrics ™ online survey (Appendix C). The Qualtrics ™ survey (Appendix C) will include questions asking participants to share their gender, race, ethnicity, and sexual orientation, years of experience as a Registered Nurse (RN), current job title, years in current position, healthcare setting, highest level of education and a their definition of nurse leadership. The Qualtrics ™ survey (Appendix C) was developed to determine if participants met the criteria for the study, achieve maximum variation sampling, and to provide readers with additional context so they can determine to use of the information obtained in the study. In the second phase, the study participants will be interviewed either in person or via telephone using the semi structured nurse leadership interview questionnaire (Appendix D) containing open-ended questions. The nurse leader interview questionnaire (Appendix D) will ask participants to describe essential elements of leadership, key language, actions and values that demonstrate nurse leadership, the essential nature of nurse leadership in today's healthcare environment compared to previous perspectives, and identification of what influences the development of nurse leadership.

Investigator's Responsibilities:

If your study protocol changes in such a way that exempt status would no longer apply, you should contact the above IRB before making the changes. There is no need to inform the IRB about changes in study personnel. However, be aware that you are responsible for ensuring that all members of the research team who interact with subjects or their identifiable data complete the required human subjects training, typically completing the relevant CITI modules.

The IRB will maintain records for this study for 3 years, at which time you will be contacted about the status of the study.

The current data security level determination is Level II. Any changes in the data security level need to be discussed with the relevant IT official. If data security level II and III, consult with your IT official to develop a data security plan. Data security is ultimately the responsibility of the Principal Investigator.

Please be aware that approval may still be required from other relevant authorities or "gatekeepers" (e.g., school principals, facility directors, custodians of records), even though the project has determined to be exempt. .

CC:

Janice Anderson, School of Education Deans Office

APPENDIX C: ONLINE QUALTRICS ™ SURVEY

https://unc.az1.qualtrics.com/SE/?SID=SV_dnFYkAbqFuxVrtH

The Defining Nurse Leadership research study is being conducted by Megan Williams. The purpose of the study is to explore the concept of nurse leadership from the perspective of Registered Nurses (RN) in North Carolina.

The survey will take approximately 10-15 minutes to complete. You may skip any question you choose not to answer. Your participation is completely voluntary, and the information you provide will be kept confidential. Results will be reported only in aggregate form; your name will never be associated with your data.

If you have any questions about the research project or the survey itself, please contact Megan Williams, MSN, RN, FNP mpwilliams@unc.edu. If you have any questions about your rights as a research participant, you may contact the University of North Carolina Institutional Review Board at (919) 966-3113 and mention study number 15-3375.

1. What is your age?

    a. 18-24 years

    b. 25-34 years

    c. 35-44 years

    d. 45-54 years

    e. 55-64 years

    f. Age 65 or older

2. What is you gender?

    a. Male

    b. Female

3. Ethnicity.

    Please specify your ethnicity.
    a. Hispanic or Latino
    b. Not Hispanic or Latino

4. Race

   Please specify your race.
   a. American Indian or Alaska Native

   b. Asian

   c. Black or African American

   d. Native Hawaiian or Other Pacific Islander

   e. White

5. Do you think of yourself as ….?

   a. Lesbian or gay

   b. Straight, that is, not gay

   c. Bisexual

   d. Something else

   e. Don't know

6. By <u>something else</u>, do you mean that…?

   a. You are not straight, but identify with another label such as queer, trisexual, omnisexual, or pan-sexual

   b. You are transgender or transsexual

   c. You have not or are in the process of figuring out your sexuality

   d. You do not think of yourself as having a sexuality

   e. You personally reject all labels of yourself

   f. You mean something else

   What do you mean by something else? _____

7. Where is your primary place of residence?

    a. North Carolina

    b. Other state in the U.S.

    c. Canada

    d. Other nation

8. If North Carolina is your primary place of residence, which county do you currently live in? _____

9. How long have you been living there?

    a. Less than 5 years

    b. 6-10 years

    c. 11-19 years

    d. 20-29 years

    e. 30-39 years

    f. More than 40 years

    g. All of my life

10. How many years of experience as a Registered Nurse (RN) do you have?

    a. Less than 1 year

    b. 1-3 years

    c. 4-9 years

    d. 10-19 years

    e. 20-29 years

    f. 30-39 years

    g. More than 40 years

11. What is your current job title? _____

12. How many years of experience do you have in your current position?

    a. Less than 1 year

    b. 1-4 years

    c. 5-9 years

    d. 10-19 years

    e. 20-29 years

    f. 30-39 years

    g. More than 40 years

13. Identify your current employment setting.

    a. Hospital inpatient

    b. Hospital outpatient

    c. Non-hospital outpatient

    d. Correctional system

    e. Long-term care facility

    f. Home Healthcare

    g. Hospice

    h. Public Health

    i. School Health

    j. Nursing education

    k. Not active in nursing

    l. Other

14. Does your main nursing position involve providing direct care services to

   patients/families?

       a. Yes

       b. No

15. What is the highest degree or level of school you have completed? If currently enrolled,

   mark the previous grade or highest degree received.

       a. Associate degree

       b. Bachelor's degree

       c. Master's degree

       d. Doctorate

9. Please provide your definition of nurse leadership.

Thank you for participating in the Defining Nurse Leadership research study and for supporting my efforts in the research process. If you would be interested in participating in a follow-up interview for this study, enter your contact information below.

APPENDIX D: NURSE LEADERSHIP REQUEST FOR INTERVIEW

Subject: Request for Interview for Research Study

Dear Nursing Colleague,

My name is Megan Williams. I am a doctoral candidate in the Doctorate in Education program at the University of North Carolina at Chapel Hill School of Education. I am conducting a research study as part of the requirements of my degree in Education, and I would like to invite you to participate. The study title is "Defining Nurse Leadership: Nurses' Perceptions of Nurse Leadership and the Conditions that Influence its Development." This study is funded by the Alpha Alpha chapter of Sigma Theta Tau.

I am studying the concept of nurse leadership from the perspective of Registered Nurses (RNs) in North Carolina. Thank you for participating in the initial Qualtrics ™ online survey, and providing your contact information. I am contacting you now to arrange for a follow-up interview about your experiences as a Registered Nurse. In particular, we will discuss leadership, concepts and values of nursing, today's healthcare environment, and nurse leadership development. The meeting will take place at a mutually agreed upon time and place or by telephone, and should last about 60 minutes. The session interview will be audio taped so that I can accurately reflect on what is discussed. Members of the research team will only review the tapes. They will then be destroyed.

Participation is confidential. Study information will be kept in a secure location at the University of North Carolina at Chapel Hill. The results of the study may be published or presented at professional meetings, but your identity will not be revealed. This study has been reviewed by the Office of Human Research Ethics and was determined to be exempt from further review according to the regulatory category cited above under 45 CFR 46.101(b).

There are no costs associated with participating in this study. If you decide to participate in this study you will receive a twenty- five dollar ($25) Amazon gift card.

If you have questions, concerns or complaints regarding your participation in this research study or if you have any questions about your rights as a research subject, you should contact Megan Williams (phone) 919-623-3767 or (email) mpwilliams@unc.edu If a member of the research team cannot be reached or you want to talk to someone other than those working on the study, you may contact the University of North Carolina Institutional Review Board at 919-966-3113 and mention study number 15-3375.

Thank you for your consideration. **If you would like to participate, please respond to this email with 3 dates/times that are most convenient for you to participate in a 60-minute interview within the next 3 weeks.**

With kind regards,

Megan Williams, MSN, RN, FNP

APPENDIX E: NURSE LEADERSHIP INTERVIEW GUIDE

Participant ID: _____

Date, time and location of Interview: _____

Other observations noted:

_____
_____
_____

Hi, My name is Megan Williams. Thank you for participating in this research study. I am interested in looking at nurse leadership and what inhibits and fosters leadership development in nursing. To achieve this goal, I am asking nurses like yourself what you think about leadership, your own experiences as a leader and with leaders, you experience as a nurse and with nurses. The interview will last around 60 minutes. It is important to note that:

- You will have complete anonymity and all information will be kept confidential.

- There are no right or wrong answers to these questions. I only want to know what you think.

- You may stop the interview or withdraw from the research study at any time without explanation or consequence.

Section I: Leadership

1. What do you believe are the essential elements of leadership?

    a. Do you consider yourself to be a leader? Why or why not?
    b. Could you explain further or give examples?
    c. How does that play out in today's healthcare environment?
    d. Would you like to add anything else?

Section II: Concepts and Values of Nursing

2. What is the common language of nurses?

    a. Could you explain further or give examples?
    b. Can you talk more about your experience as a nurse?
    c. How does that impact nursing practice or patient outcomes?
    d. What role does nursing education play?
    e. Would you like to add anything else?

3. What are the common actions of nurses?

    a. Could you explain further or give examples?
    b. Can you talk more about your experience as a nurse?

    c. How does that impact nursing practice or patient outcomes?
    d. What role does nursing education play?
    e. Would you like to add anything else?

4. What key values of nursing demonstrate nurse leadership?

    a. Could you explain further or give examples?
    b. How does that impact nursing practice or patient outcomes?
    c. What role does nursing education play?
    d. Would you like to add anything else?

Section III: Today's Healthcare Environment

5. Why do nurses consider leadership essential in today's healthcare environment?
    a. Could you explain further or give examples?

6. In what ways is nursing leadership different in today's healthcare environment? In what ways is it the same?
    a. Would you like to add anything else?

Section IV: Nurse Leadership Development

7. What influences the development of nurse leadership?
    a. How would you describe nurse leadership development?

    b. What is your view of this?

    c. To what extent have you benefited from nurse leadership development?

    d. Describe the type of support you have received?

    e. Do you play a role in nurse leadership development? Why or why not?

    f. What role does nursing education play?
    g. Would you like to add anything else?

8. How do gender, race/ethnicity, and/or sexual orientation influence the development of nurse leadership?
    a. In what ways have your gender, race/ethnicity, and/or sexual orientation influenced you development as a nurse leader?

    b. What should be done in order to improve nurse leadership development?

    c. What role does nursing education play?
    d. Would you like to add anything else?

9. Would you like to expand on any of the questions that you were asked? If so, please feel free to do so.

APPENDIX E: NOTE OF APPRECIATION TO PARTICIPANTS

Subject: Thank you for your participation

Dear Nursing Colleague:

Thank you for participating in the *Defining Nurse Leadership: Nurses' Perceptions of Nurse Leadership and the Conditions that Influence its Development* research study. I appreciate your time in support of my efforts in the research process. If you have any questions, concerns, or further comments concerning the questionnaire items, please contact me at mpwilliams@unc.edu

Sincerely,

Megan Williams, MSN, RN, FNP

The University of North Carolina at Chapel Hill

APPENDIX F: NURSING ORGANIZATIONS

Organization	Year	Competencies
The American Organization of Nurse Executives (AONE)	2011	Five leadership domains: Communication and relationship building Knowledge of health care environment Leadership skills Professionalism Business Skills Emerging Nurse Leadership Institute
National Black Nurses Association	2010	Self-knowledge Interpersonal and communication effectiveness Inspiring and leading change
American Nurses Association (ANA)	2013	Leading Yourself Leading Others Leading the Organization
American Association of Nurse Practitioners		
National League for Nursing		Lead Leadership Development Program for Simulation Educators Executive Leadership in Nursing Education and Practice
North Carolina Nurses Association	2010	
Sigma Theta Tau International Honor Society of Nursing		*Nurse Faculty Leadership Academy* Individual leadership development Leading a team project to advance nursing education Expanded scope of influence within the academic institutions, the community, and the profession.

Minority Nurse Leadership Institute		Individual minority nurse leadership development. Advancing evidence-based nursing practice to address minority and community health challenges through leadership of team projects. Fellows' expanded scope of influence within their sponsoring institutions, the community, and the profession.
Society of Trauma Nurses	2016	Communication and Relationship Management Leadership Professionalism Knowledge of the Healthcare Environment Business Skills and Knowledge
International Council of Nursing Global Nursing Leadership Institute	2009	Learn how to understand their role in developing a workforce able to meet new challenges; contribute to strengthening health systems; and influence the development and implementation of policy at the international, national and local levels.

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