

Clinical Manager Perceptions of
New Nurse Preparation for Clinical Leadership

by

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ABSTRACT

Nurses are ideally positioned to lead the transformation of healthcare delivery in the United States, however they must be prepared to do so. The Institute of Medicine has called for nurses to become change agents and assume leadership positions across all levels in order to become full partners with physicians and other health care providers. While clinical leadership is a responsibility for all nurses, expectations for new nurse clinical leadership have not been well studied.

This study sought to determine the nursing leadership competencies clinical managers expect of new nurses in an acute care setting and to identify gaps between end-of-program nursing leadership competencies, as outlined in *The Essentials of Baccalaureate Education for Professional Nursing Practice*, with leadership competencies identified by clinical managers in an acute-care setting.

A single, bounded case study approach was used to collect data from nurse managers and assistant nurse managers at one acute care hospital. Data from intensive interviews, focus groups, and archival records were analyzed. Seven major themes related to clinical leadership emerged, including intentional learning, communication, professional practice, advocacy, teamwork, influencing practice, and systems thinking. Traits, mentoring, and generational differences emerged as secondary themes.

Data from this study revealed a developmental sequence for clinical leadership. Certain expectations identified as antecedent to clinical leadership emerged initially, whereas other aspects of clinical leadership, developed later in the career trajectory. It was clear that accomplishing nursing care tasks was a fundamental expectation for professional nursing practice. Communication, teamwork and advocacy are crucial

leadership competencies which help the new nurse to effectively manage time and provide safe, high-quality nursing care. As the new nurse continues to develop, systems thinking and influencing nursing practice emerge as significant expectations. Nurse managers have clear expectations for how new nurses should be prepared for clinical leadership. The degree to which clinical practice partners employing new nurses and academic nursing programs educating future nurses collaborate to establish expected outcomes is variable; however, academic-practice collaborations are crucial in developing educational standards for entry to practice in complex healthcare delivery systems.

DEDICATION

To my wife Jody, there are no words to express how much your support and encouragement has meant to me. To my children Davin, Ellery, Freya, and Zayda, thank-you for your patience and understanding for all of the times you heard “not right now, I have school work to do”. Truly, I could not have made this journey without you all.

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TABLE OF CONTENTS

	Page
LIST OF TABLES.....	ix
LIST OF FIGURES.....	x
CHAPTER	
1. INTRODUCTION	1
Problem Statement.....	3
Purpose of the Inquiry.....	4
Research Questions.....	4
Researcher Assumptions.....	4
Significance.....	5
Definition of Terms	8
Summary.....	9
2. REVIEW OF THE LITERATURE.....	10
From Novice to Expert	10
Complexity Science in Nursing and Healthcare	17
Leadership and Management.....	22
Summary.....	42
3. METHOD	45
Research Method Appropriateness	45
Case Study Design.....	46
Setting and Sample	50

CHAPTER	Page
Data Collection Procedures.....	52
Summary.....	59
4. FINDINGS AND DISCUSSION.....	60
Traits.....	62
Intentional Learning.....	65
Mentorship.....	69
Effective Communication.....	71
Professional Nursing Practice.....	77
Advocacy.....	83
Teamwork.....	86
Influencing Practice.....	91
Systems Thinking.....	96
Generational Differences.....	100
Nurse Manager Perceptions of the AACN Baccalaureate Essentials.....	105
Archival Documents.....	109
5. CONCLUSIONS AND RECOMMENDATIONS.....	112
Developing Clinical Leadership.....	113
The Role of Sensitizing Frameworks.....	119
Discussion Summary.....	123
Contribution to Nursing.....	125
Study Limitations.....	126

CHAPTER	Page
Future Research.....	127
REFERENCES	128

APPENDIX

A	AACN BACCALAUREATE ESSENTIALS	149
B	STUDY DIAGRAM.....	151
C	SHORT CONSENT TEMPLATE, INTENSIVE INTERVIEW	153
D	SHORT CONSENT TEMPLATE, FOCUS GROUP	155
E	PARTICIPANT DEMOGRAPHIC FORM.....	157
F	INTENSIVE INTERVIEW PROTOCOL	159
G	FOCUS GROUP PROTOCOL	161
H	AACN BACCALAUREATE ESSENTIALS FOCUS GROUP FORM.	164
I	THEME DEVELOPMENT MIND MAP.....	169
J	INSTITUTIONAL REVIEW BOARD, ASU.....	171
K	INSTITUTIONAL REVIEW BOARD, STUDY SITE	173

LIST OF TABLES

Table	Page
1. From Novice to Expert	12
2. Complex Adaptive Systems in Healthcare	20
3. Contrasting Differences in Leadership/Management	24
4. Study Propositions.....	49
5. Participant Demographics	60
6. Traits	62
7. Intentional Learning	66
8. Mentorship	69
9. Effective Communication	73
10. Professional Nursing Practice	79
11. Advocacy	84
12. Teamwork	86
13. Influencing Practice	93
14. System Thinking	98
15. Generational Differences	101
16. AACN Baccalaureate Essential II Findings	106
17. AACN Baccalaureate Essential IX Findings	108

LIST OF FIGURES

Figure	Page
1. Feedback Loops in Complex Healthcare Systems	33
2. Developmental Sequence for Clinical Leadership	62

CHAPTER 1

INTRODUCTION

The Institute of Medicine (IOM) report *The Future of Nursing: Leading Change, Advancing Health* offers several recommendations for the role of nursing in the transformation of health care delivery in the United States (Institute of Medicine (IOM), 2011). Included in the recommendations is a call for nurses to become change agents and assume leadership positions across all levels in order to become full partners with physicians and other health care providers (IOM, 2011). The challenges facing many health care systems may create significant barriers to nurses seeking to meet the recommendations set forth by the IOM. This is especially true of nurses who are entering into professional practice for the first time. According to the Health Resources and Services Administration (HRSA), over the next 13 years there is expected to be a net growth of 1,089,500 RN Full Time Equivalencies (FTEs), resulting in a national RN workforce of 3,895,600 FTEs by 2030 (U.S. Department of Health and Human Services & Health Resources and Services Administration, 2017). New nurses are ideally positioned to lead the transformation of health care delivery in the United States; however, they must be prepared to do so.

Health care systems are facing challenges for service reimbursement, grappling with changing patient demographics and struggling to meet rising expectations from stakeholders (Arend, Tsang-Quinn, Levine, & Thomas, 2012; IOM, 2011). Quality measures indicate the current status quo of health care delivery is simply not sustainable (Anderson et al., 2014; Clarke, 2013). The provision of high-quality health care depends, to a great extent, on building and maintaining a well-educated nursing workforce

(American Association of Colleges of Nursing, 2015; National Advisory Council on Nurse Education and Practice, 2010). Education has a positive impact on registered nurses (RN's) professional practice, which has been linked to lower mortality rates and better patient outcomes (Aiken, 2014; Blegen, Goode, Park, Vaughn, & Spetz, 2013). Nursing education has evolved from a model of apprentice-based training to one of high academic rigor in an attempt to meet the changing landscape of health care delivery. More recently, emphasis is placed on how to prepare new nurses for professional practice and how to equip new nurses to manage the complex care needs of patients and families. An emerging body of research indicates that a gap between academic nursing preparation and the expectations of clinical practice does exist (K. A. Cook, Marienau, Wildgust, Gerbasi, & Watkins, 2013; Spector et al., 2015; A. C. Wolff, Regan, Pesut, & Black, 2010; Wright, 2014), however these studies do not comprehensively examine new nurse preparation for clinical leadership in nursing practice.

Clinical leadership is a professional practice responsibility for all nurses. Early descriptions of clinical leadership were founded on expert nursing practice (Harper, 1995; Lett, 2002). More recently, Chavez and Yoder (2015) suggested that a clinical leader is any staff nurse who influences the healthcare team and facilitates individual and team efforts to accomplish mutual clinical objectives. Clinical leadership can then be seen as any activity through which the nurse improves the safety and quality of healthcare (Démeh & Rosengren, 2015). Clinical leaders are present in significant numbers across all practice environments, however they may not consider themselves leaders because they equate leadership with power or a position, rather than a way of thinking or being (Clark, 2008).

Strong evidence exists which links the overall quality of practice environments with patient safety, outcomes and nurse recruitment and retention (Dyess & Sherman, 2011; Wong, 2015; Wong, Cummings, & Ducharme, 2013). Creating high quality practice environments is essential, particularly in acute care settings where approximately 57% of Registered Nurses are employed (Budden, Zhong, Moulton, & Cimiotti, 2013). Preparing nurses to lead in their practice is essential in meeting these quality outcomes. Increasing the clinical leadership skills of new nurses improves their ability to identify clinically-related problems, instigate innovative change, and evaluate outcomes (Kilger, Lacey, Olney, Cox & O'Neil, 2010). Professional work environments which promote strong nursing practice through collaboration, team work and autonomous decision making through the efforts of both administrative leadership and the clinical leadership of nurses are more closely linked to positive patient outcomes (Wong, 2015).

Problem Statement

Nursing leadership is a component of most nursing curricula as accrediting agencies and other related organizations have developed core competencies and standards around the development of nursing leadership (AACN, 2008; Cronenwett et al., 2007; National League for Nursing, 2012). Gaps between new nurses' academic preparation and the expectations of employing agencies have been identified in the literature. There is little information available that specifically explicates the nursing leadership competencies that employing agencies expect as graduate nurses enter into clinical practice for the first time.

Purpose of the Inquiry

The purpose of this study was to evaluate the extent to which end-of-program nursing leadership competencies are congruent with the expectations of clinical agencies employing new nurses, as perceived by clinical nurse managers.

Research Questions

Research Question #1

What nursing leadership competencies do clinical managers identify as essential preparation for new nurses?

Specific Aim. To determine the nursing leadership competencies clinical managers expect of new nurses in an acute care setting.

Research Questions #2.

How do clinical nurse leaders' expectations of nursing leadership competencies differ from end of program competencies as outlined in *The Essentials of Baccalaureate Education for Professional Nursing Practice*?

Specific Aim. To identify gaps between end-of-program nursing leadership competencies, as outlined in *The Essentials of Baccalaureate Education for Professional Nursing Practice*, with leadership competencies identified by clinical managers in an acute-care setting.

Researcher Assumptions

Engaging in reflexivity about assumptions holds particular significance throughout qualitative data analysis (Charmaz, 2014). It is the researcher's own adaptivity, creativity, sensitivity and skill in applying verification strategies which determines the reliability and validity of an emerging study (Morse, Barrett, Mayan,

Olson, & Spiers, 2002). Identification of the personal assumptions researchers bring to the study is one critical step in this process (Creswell, 2007). As an educator, I have designed and delivered undergraduate coursework on nursing leadership. It is my belief that leadership knowledge, skills and abilities are vital to one's professional nursing practice. The degree to which leadership is fostered can differ significantly between nursing programs and among faculty within the same program. There is a clear distinction between leadership and management, however they are not mutually exclusive, but often are used interchangeably in nursing education and practice. I recognize that my colleagues in education and practice may not regard nursing leadership competencies in the same way I do. This familiarity with nursing leadership and leadership competency development may bias my views and prevent me from realizing certain aspects of my research findings. Throughout the study, I maintained a journal about my beliefs of competency development in nursing leadership and discussed any biases or assumptions with my research chair to maintain awareness of my potential biases. Merriam and Tisdell (2016) note that awareness and articulation of personal bias allows for greater perspective which enhances the accuracy of the researcher's observations and interpretations.

Significance

This educational research is significant because it addresses the academic-practice gap of nursing leadership readiness in professional practice. The demanding role of future nurses will require an increased knowledge base and mastery of core competencies that will allow for the clinical leadership supportive of highly complex patient care needs across multiple settings, in collaboration with the inter-professional health care team

(American Organization of Nurse Executives, 2008). Perhaps more importantly, building leadership capacity will allow nurses to take a prominent role in catalyzing systems-level change, leveraging innovation to design more efficient and effective models of healthcare delivery, and transforming healthcare to meet the needs and expectations of current and future consumers (Folan et al., 2012; Institute of Medicine (IOM), 2011; Scott & Miles, 2013). Employers expect that new nurses will be well prepared to assume a professional practice role within dynamic and complex health care delivery systems. The public has a right to expect high quality care from registered nurses who demonstrate clinical competence throughout their careers. Substantial human and financial resources are dedicated to curricular redesign and innovative best practice approaches to teaching and learning in nursing. Current and future needs of employers and the academic preparation of nurses must be brought into closer alignment to adequately prepare new nurses for the realities of the workplace (American Organization of Nurse Executives, 2008; P. E. Benner, 2010; Ekström & Idvall, 2015; Everett-Thomas et al., 2014; Lima, Newall, Kinney, Jordan, & Hamilton, 2014; Numminen et al., 2014; A. C. Wolff et al., 2010; Wright, 2014). This is particularly true of preparation for nursing leadership, an area not widely studied in the literature.

The American Association of Colleges of Nursing (AACN) is a national organization which works to establish quality standards for nursing education programs, influences the work of professional nurses in improving healthcare, and promotes public support for nursing education, practice and research (“American Association of Colleges of Nursing (AACN) > About AACN > Who We Are,” n.d.). The AACN’s *Essentials of Baccalaureate Education for Professional Nursing Practice* (AACN, 2008) addressed

recommendations from nursing educators, clinicians, executive leaders and research scientists to establish a framework for developing and assessing nursing curricula. AACN Baccalaureate Essential II focused on basic organizational systems leadership for quality care and safety. Essential IX described generalist nursing practice, which included the knowledge, skills and attitudes that contribute to improved patient outcomes. To lead effectively, graduates of nursing programs must be prepared to practice within the microsystem of complex, dynamic health care delivery systems. This requires creativity, effective leadership and communication skills to work within inter-professional teams across a multitude of settings (AACN, 2008).

While the research linking nursing leadership to clinical outcomes is far from complete, studies have demonstrated the impact of leadership in transforming work environments and promote high-quality patient care (Wong, 2015). Team leadership, communication and facilitating organizational change have emerged as important areas for nursing leadership development (Severinsson & Holm, 2012). Leaders are expected to facilitate positive change in practice environments. All nurses must prepare for the leadership competencies required to influence outcomes in complex healthcare delivery systems (AACN, 2008; IOM, 2011; Institute of Medicine (U.S.) et al., 2016). Errors, adverse patient events, mortality and patient satisfaction can be linked to nursing leadership. It is vital, therefore, that new nurses are well prepared to lead (Wong, 2015; Wong et al., 2013).

There is no doubt that health care is becoming increasingly complex. Patient demographics are rapidly changing as the population ages, becomes increasingly diverse and sicker over time. Patients are discharged from acute care facilities at a rapid pace,

returning home to manage their care. Looming retirements will lead to a shortage of experienced nurses and abundance of novice nurses in many health care organizations (McMenamin, 2014). Recent estimates note that between 210,000-400,000 premature deaths occur annually from preventable harm and there is concern that these estimates may grow with the proportional increase of novice nurses in health care delivery systems (James, 2013). As the context for patient care and professional nursing practice continues to shift, academically preparing new nurses to be responsive to the changing needs of health care delivery systems is imperative.

Definition of Terms

Clinical leader refers to any staff nurse who influences the healthcare team and facilitates individual and team efforts to accomplish mutual clinical objectives (Chávez & Yoder, 2015).

Clinical leadership is the process through which nurses positively influence healthcare services, nursing care, quality, safety, and professionalism within healthcare delivery systems (Démeh & Rosengren, 2015).

Clinical Nurse Manager is a term used to define a clinically-based administrator who is positioned in a formal leadership role between the front-line employees and the senior leadership staff, and who has day-to-day responsibility for the operations of a specific patient care unit (Rundio & Wilson, 2013).

Competence is a holistic term referring to a nurse's overall capacity for- or command of pertinent knowledge, skills and abilities which are developmental, impermanent and context-dependent (Pijl-Zieber, Barton, Konkin, Awosoga, & Caine, 2014)

Competency denotes knowledge, skills, abilities and values, which are expected to be integrated into practice (Pijl-Zieber et al., 2014).

Leader is the term for an individual who acts in ways which influence outcomes (Mary Uhl-Bien & Marion, 2008)

Leadership is a complex and interactive dynamic through which adaptive outcomes such as adaptability, creativity, innovation and learning emerge (Uhl-Bien & Marion, 2008).

New nurse is the term for nurse who has graduated within the previous 3 months and is entering into registered nursing practice for the first time.

Summary

While there is an emerging body of research examining the gap between academic preparation and preparedness for professional practice, nursing leadership has not been a primary focus (Lima et al., 2014; Numminen et al., 2014; Theisen & Sandau, 2013; A. C. Wolff et al., 2010; Wright, 2014). This research is novel as it specifically addresses the new nurse preparation for leadership in the professional practice environment. Findings of this research may inform curricular redesign in nursing programs as well as open additional dialogue among academic-practice partners. In addition, this research contributes to the national dialogue on preparing nurses to lead patient care, become positive change agents and work to optimize patient-care outcomes through inter-professional practice. Gaining a better understanding of how new nurses are academically prepared in contrast with how employers need new nurses to be prepared establishes a shared understanding from which academic and practice partners can work collaboratively to transform nursing education and practice.

CHAPTER 2

REVIEW OF THE LITERATURE

Imported concepts, according to Sandelowski and Barroso (2007), are concepts or ideas which the researcher borrows from existing theoretical and empirical literature to organize and integrate research findings. The selection of these concepts is based on the researcher's knowledge of and sensitization to relevant frameworks and theories (Sandelowski & Barroso, 2007, p. 204). Sensitizing concepts or frameworks provide an orientation to or world-view for the research with clear linkages to conceptual underpinnings, and provide the researcher with a place to begin the inquiry and analysis without determining its content (Charmaz, 2014; Sandelowskii, 1993) The sensitizing frameworks for this research included Patricia Benner's From Novice to Expert (Benner, 1982, 2001), Complexity Science, and Complexity Leadership Theory.

From Novice to Expert

Benner's From Novice to Expert Theory (2001) is one framework with which to examine clinical practice and the knowledge that nurses possess. The two types of knowledge Benner describes are practical knowledge and theoretical knowledge. "Knowledge development in a practice discipline consists of extending practical knowledge (know-how) through theory-based scientific investigations and through the charting of the existent 'know how' developed through clinical practice of that discipline" (Benner 2001 p.3).

Benner looked to philosophers such as Kuhn (1970) and Polanyi (1958) who note that "knowing how" and "knowing that" are 2 types of distinct knowledge. Specifically, skill performance and the fact that one cannot always account for "knowing how" with

regard to common activities (riding a bike, for example); differs from theoretical explanation, or “knowing that”, a method by which one comes to know by establishing causal relationships between events. One may “know how” (skill performance) before “knowing that” (having a theoretical explanation for the performance of the skill), which Polanyi (1958) described as the “unspecifiable knowledge of a skill”. For new nurses, the opposite may also be true, that is, the new nurse may have theoretical knowledge, but does not yet have sufficient experience or context to be able to apply the knowledge effectively in clinical practice.

Building upon the Dreyfus Model of Skill Acquisition (Benner, 2004; Dreyfus & Dreyfus, 2004; Dreyfus, 2004; Dreyfus & Dreyfus, 1980), Benner conducted interviews and observations with 21 pairs of nurses, the goal of which was to uncover characteristic differences between a novice and an expert. Additional interviews and observations were conducted to characterize clinical performance at various stages of skill acquisition (Benner, 2001). The five levels identified include novice, advanced beginner, competent, proficient and expert as depicted in Table 1.

Benner’s use of interviews and observations to develop exemplar cases to examine the relationships between practice, knowledge and skill level have been generalized to several aspects of professional nursing practice. These aspects include (a) clinical practice (Burket et al., 2010; Whyte et al., 2012); (b) nursing residency programs (AACN, 2001; Meyer Bratt, 2013; Remillard, 2013); (c) clinical judgment (Benner, 2004; Tanner, 2006); and (d) nursing education (Larew, Lessans, Spunt, Foster, & Covington, 2006; Lasater, 2007; Nielsen, Noone, Voss, & Mathews, 2013). The universal

aspects of skill acquisition are not limited to one particular area or context of nursing practice; rather levels of skill are identified across nursing as a whole.

Typically, new graduates are not expected to have nursing experience beyond that of their academic preparation. According to Benner (2001), both academic faculty and new graduates themselves would consider this initial level of skill as entry to practice at the novice level. The challenge in preparing new nurses for professional practice is the increasing demand by the clinical practice sector for better-prepared nurses ready to engage in nursing practice at the advanced beginner or competent level (Ashton, 2015; Numminen et al., 2014; Spector et al., 2015; A. C. Wolff et al., 2010). Gubrud-Howe and Schlosser (2008) discussed challenges with traditional models of clinical education, noting that relying on random access opportunities made it difficult to plan meaningful clinical learning experiences for students. Without access to intentionally designed, high-quality learning opportunities, students may fail to progress as anticipated on the Novice-to-Expert continuum, compounding the growing education-practice gap (Benner, 2001; Benner, Sutphen, Leonard, Day, & Schulman, 2010). This study utilizes From Novice to Expert (Benner, 2001) as one sensitizing framework through which to examine how new graduate nurses are academically prepared as leaders, in contrast to what the clinical agencies employing the new graduates are expecting.

Table 1
From Novice to Expert

Skill Level	Performance Characteristics
Novice	Lacks situational experience Learns about situations according to objective characteristics using context-free rules. Behaviors and actions are guided by rules.
Advanced Beginner	Exhibits “marginally acceptable performance”. Has enough experience with actual situations to begin taking note of the significant and recurring components of a situation.
Competent	Actions are seen in terms of long-range goals and characteristics of a situation are distinguished into what is important and not important (prioritization). Can sufficiently adapt and manage situations but lacks the speed and proficiency of a more experience nurse.
Proficient	Views situations as a whole, rather than separate parts. Through deep understanding of situations, experience begins to guide practice. Aspects of situations are not actively thought out but come naturally to the nurse. Recognizes “normal” versus “abnormal” aspects of a situation and begins to consider fewer plausible options based on the context of the individual situation and clinical experience. Practices at a competent level when a more analytical or problem-solving approach is needed.
Expert	Has an intuitive grasp of situations and no longer relies on rules to guide actions, however, analytic problem solving is used to adapt in unfamiliar or uncertain situations. Accurately focuses in on key aspects of situations. Demonstrates deep understanding through clinical wisdom and Is flexible and adaptive in clinical practice.

Note. Data for From Novice to Expert from Benner (2001).

Novice Nursing Practice

The novice nurse, according to Benner (2001), possessed little to no experience of the situations in which they are expected to perform. Throughout their pre-licensure training, nursing students experienced many types of learning experiences to develop their theoretical knowledge and skill of nursing practice. This included being taught “context free” rules to guide them in their emerging clinical practice (Benner, 2001, p.21). These rules are recognized and applied, in the absence of experience in nursing

practice, to guide nursing practice at the novice level. Performance progressed to a “marginally acceptable” level only after the novice has had considerable experience in the practice environment (Benner, Tanner, & Chesla, 2009). Experience in applying rules over time allows the novice to begin to gain a sense of salience and insight into particular situations (Benner, Sutphen, Leonard, Day, & Schulman, 2010). The challenge for nursing education is how to enhance and extend student learning by creating transformative learning experiences allowing students to apply theoretical knowledge in the practice setting.

Benner and colleagues noted that nursing students and new nurses needed to learn the simpler aspects of situations before being able to manage more complex and uncertain clinical situations (Benner, Hooper-Kyriakidis, Stannard, 2011, p.2). The authors presented clinical reasoning as a form of practical reasoning which included habits of thoughts and action, and domains of practice for acute and critical care nursing. Habits of thought and action were styles of practice, thought or action whereas the domains of practice were organized as situations organized by clinical goals or concerns (Benner et al., 2011). Habits of thought and action, according to Benner et.al (2011) included problem identification, problem solving, and anticipation and prevention of potential problems. Domains of practice included managing physiologic functions, using skilled knowledge to manage a crisis, providing comfort measures, caring for families, preventing hazards, decision-making at end-of-life, communicating and improving teamwork, promoting quality and safety, and engaging in the skilled know-how of clinical and moral leadership (Benner et al., 2011).

Relational and clinical leadership, according to Benner (2011, p. 449-450), allowed nurses to intervene in “difficult or confusing situations on the patient’s behalf”. Relational leadership skills dealt primarily with inter-personal actions, which, while not unique to nursing, do provide a foundation for nurses to develop expert clinical leadership skills (Benner et al., 2011). Clinical leadership skills were developed over time, most often after task-related skills were mastered and the nurse noticed a gap at some point during the situation (Benner et al., 2011). Evidence also suggested that nurses often emerged as a clinical leader as a particular situation demanded in order to meet patient care needs (Benner et al., 2011, p. 450). Informal leaders emerged through their power to influence clinical situations and team members through “authoritative knowledge” rather than a formal role or position of power (Benner et al., 2011, p. 451). Coaching and mentoring by expert nurses allowed new nurses to develop and refine clinical leadership skills leading to more skillful patient care, and the detection and prevention of potential complications (Benner et al., 2011). As new nurses developed clinical leadership, mentors provided less support, which allowed new nurses to practice clinical leadership more independently (Benner et al., 2011). With an overarching aim of improving the quality of care, clinical leadership development was seen as an ongoing process as nursing roles continue to change over time.

Transitioning to Professional Practice

As the complex demands of health care evolve and the shortage of registered nurses impacts care delivery, redesigning nursing education has become imperative (AACN, 2014; Benner et al., 2010; IOM, 2011). Examples of educational transformation include the: (a) creation of nursing education consortiums to support evidence-based

curricular redesign (Gaines & Spencer, 2013; Tanner, Gubrud-Howe, & Shores, 2008), (b) use of simulation to extend clinical learning and enhance nursing clinical judgment (Cant & Cooper, 2010; Foronda, Liu, & Bauman, 2013; Hayden, Smiley, Alexander, Kardong-Edgren, & Jeffries, 2014; Lasater, 2007), (c) development of concept-based and competency-based curricula to support teaching for a sense of salience (Nielsen, 2013; Pijl-Zieber, Barton, Konkin, Awosoga, & Caine, 2014), and (d) creation of academic-practice partnerships to provide students with better hands-on clinical experiences (Malloch & Porter-O'Grady, 2011; Niederhauser, MacIntyre, Garner, Teel, & Murray, 2010; Tuohy, 2011). While these efforts support student learning while in nursing school, the transition to professional practice in complex healthcare delivery systems continues to be a challenge for many new graduates (Letourneau & Fater, 2015).

There is strong research which suggests that nurse residency programs (NRPs) are successful in successfully transitioning novice nurses into professional practice while reducing the traditionally high turnover rate of new nurses (Lin, Viscardi, & McHugh, 2014; Warren, Perkins, & Greene, 2018). There is no mandate for healthcare systems to implement NRPs. For those systems which do implement NRPs, resources and capacity for implementation can vary greatly (Spector, 2015). A multi-site study by the National Council of State Boards of Nursing (Spector et al., 2015) found that new nurse clinical competence and retention were significantly better for NRPs. The NRP's included a formal, integrated program with administrative support; a 9-12 month formal preceptorship; educational content on patient safety, clinical reasoning, effective communication, evidence-based practice; teamwork; and quality improvement. In addition, the programs included time for new nurses to integrate new learning into

practice and receive preceptor feedback; time for preceptors and new nurses to connect and develop a positive relationship; and customization for new nurses learning specialty content based on their area of practice. Nurses in a high-support NRP demonstrated higher competence and significantly lower turnover than new nurses in low-support NRPs (Spector et al., 2015).

Organization-wide implementation of an evidence-based, supportive, sustainable NRP model can help to successfully transition new nurses into professional practice. While there is strong evidence for NRPs, significant barriers do exist including a misalignment between pre-licensure education and the curricular content of NRPs, leading to both gaps and redundancy. Bringing academic and practice partners together to collaborate on academic curricula, NRP curricula, preceptor development, and teaching/learning strategies for preceptors and hospital-based educators can help optimize the NRP-based learning (Letourneau & Fater, 2015; Spector et al., 2015; Warren et al., 2018).

Complexity Science in Nursing and Healthcare

Complexity science provides a framework through which to explore and better understand human interaction through the study of dynamic behaviors of interacting, interdependent, adaptive agents responding to environmental influences (Lalley & Clouthier, 2017; Mary Uhl-Bien & Marion, 2008). The foundational underpinnings of complexity science were derived from many disciplines including systems thinking and complex adaptive systems, mathematics, biology, physics, and social sciences (Crowell, 2011; Weberg, 2012). Patterns of behavior and action unfold in irregular but often similar ways (Tetenbaum, 1998). The lens of complexity science shifts the understanding of

systems from a more predictable, linear, and mechanistic view to one in which order is emergent and unpredictable.

Complex adaptive systems (CAS) are non-linear, interactive systems which adapt to dynamic environments (Uhl-Bien & Marion, 2008). At the core, a CAS is comprised of a population of diverse agents interconnected through a system of networks. These agents are dynamic, autonomous, interactive and adaptive. There is no global control, rather agents interact and influence one another at the local level and order is emergent, rather than hierarchical (Chillers, 2002; Olson, 2001). The overall behavior of the system, therefore, is the result of the numerous moment-to-moment decisions made by the agents interacting at all levels (Crowell, 2011). Olson (2001, p.14) described these interactions as “transformative exchanges” whereby when one agent changes, signals (communication, information, materials) are sent to nearby agents who, in turn, respond in the local environment. This pattern continues as more agents continue to receive and respond to the changes.

As a sensitizing concept, Complexity Science assisted in maintaining researcher sensitization to the CAS conditions which impact how, when and why new nurse leadership emerges within a defined system. Notarnicola et al. (2017) described nursing, and nursing practice, as a complex adaptive system . The authors identified both antecedents and consequences of CAS through the lens of nursing. According to Walker & Avant (2005), antecedents are events or occurrences which must occur prior to the manifestation of the concept of interest. Consequences are the events or occurrences which manifest as a result of the concept of interest. Antecedents of the nursing CAS identified by Notarnicola et al. (2017) included the nursing care process, complex care

environments, complex problems, leadership and management practices, and operational dysfunctions. Consequences, or outcomes, of the nursing CAS included cognitive diversities, decision-making processes, streams of information, and integrated care. The CAS framework helps to provide new context for the delivery of nursing care within complex healthcare delivery systems. Perspectives which consider the CAS framework are necessary for explaining the nearly infinite, dynamic connections, communication, and interactions between and among the parts of healthcare systems (Nugus et al., 2010). Table 2 presents CAS properties with healthcare-related examples.

Systems thinking provides the framework for understanding the feedback loops within the self-regulating system (Uhl-Bien & Marion, 2008). Positive feedback loops promote dynamic instability, pushing the system closer to the edge of chaos whereas the negative feedback loops pull the system back to a state of equilibrium (Goldstein, 2008; Stacey, 2007). This push-pull dynamic allows the system to move towards and be held at the edge of chaos where the potential for the emergence of new, adaptive patterns is the greatest (Goldstein, 2008; Mennin, 2010). Concepts of complexity science have been integrated into the broader view of natural systems through the framework of complex adaptive systems (CAS).

Table 2
Complex Adaptive Systems in Healthcare

Properties of the CAS	Healthcare Example
A CAS consists of multiple interactive, interdependent agents.	In the Emergency Department (ED), clinicians from numerous disciplines practice collaboratively as an inter-professional team. Professional norms, scope of practice, clinical responsibilities, and professional networks all differ between each clinician.
Agent rules are not homogeneous, therefore interactions between agents may produce unpredictable results.	One critical care nurse may approach a sudden change in a patient's condition much differently than another nurse with the very same patient. Variances in education, experience and clinical wisdom influence how the nurse will act in a situation.
As agents within the system gain experience, learning emerges, and system-wide change is influenced.	A nurse may attend a conference, gaining new knowledge which is brought back to the nurse's clinical unit. The nurse may share information and influence local and systematic change.
The environment influences the CAS. Agents adapt in response to environmental influences and new behavioral patterns emerge.	As changes in regulatory requirements or organizational service delivery demands unfold, agents will adapt to meet these new demands. Conversely, agents may lead a research study, the results of which influence the internal and external environments.
The CAS is an open, non-linear system with no single point of control.	Outcomes on a nursing unit or within an organization cannot be controlled, however outcomes can be influenced. Nurses are ideally positioned to influence outcomes through the use of clinical leadership.

Note. Data for Complex Adaptive Systems in Healthcare from (Mahajan, Islam, Schwartz, & Cannesson, 2017; Porter-O'Grady & Malloch, 2016; Pype et al., 2017).

Mahajan, Islam, Schwartz, & Cannesson (2017) demonstrated that acute care facilities are not simple mechanistic factories but are composed of numerous sub-systems which function as a CAS. In their work with perioperative care, Mahajan et al. (2017) identified the following principles: defining the system and identifying the agents operating within the system boundaries, increasing the overall organizational power, reinforcing integrators, creating feedback loops, and building leadership capacity. For an inpatient acute care unit, the boundary spans from admission through discharge and may include transfer across various nursing care units. Agents interacting within a typical

inpatient unit include nurses, physicians, nurse practitioners, pharmacists, nursing assistants, therapists, care managers, environmental services, volunteers, patients and family members.

Increasing organizational power, according to Mahajan et al. (2017), means distributing resources needed to effectively solve problems broadly and removing the constraints which prevent agents from using resources for problem solving. Integrators within the system are agents identified not by role, title or a position of power, but by their ability to harness organizational power to solve problems presented by other agents. Creating feedback loops allows for the flow of vital information over time and across physical space to minimize uncertainty in the healthcare delivery system. In their discussion of perioperative care, Mahajan et al. (2017) identified increased complication rates and readmissions as two areas amenable to better coordination and communication among patient care teams. Redefining the system and work context reduced transitions in care by having the same team evaluate the patient pre-operatively and care for the patient post-operatively, thereby contributing to reductions in complications and readmission rates (Mahajan et al., 2017).

Building and reinforcing leadership allows agents within a system to utilize organizational power to influence system behavior (Mahajan et al., 2017). Nursing care is delivered in relationships by practitioners who engage in multifaceted interactions, whereby the power influencing the interaction (i.e.: leadership) comes from the interaction itself (Lalley & Clouthier, 2017; M. Uhl-Bien, 2007). The adaptive leadership framework, rooted in complexity science, has recently been applied to healthcare delivery systems to understand healthcare staff behaviors which organize and support patients and

families as they are met with and adapt to change (Bailey et al., 2012). Benner (2009) noted that the functioning of inter-professional teams assumes relational qualities and timing depending on the demands of the situation; interactions within a particular situation reflect emerging needs, changing styles and patterns of interactions within the social group. As healthcare systems continue to evolve and increase in complexity, it is vital that new nurses are well prepared for effective leadership. New contexts for nursing leadership need to be identified and explored.

Leadership and Management

The concepts of leadership and management are often used interchangeably and, while not mutually exclusive, there are important distinctions. Northouse (2007) recognized that leadership is a process similar to management in several ways. Both involve influence, entail working with others, and are focused on accomplishing goals. Simonet and Tett (2013) argue that leadership and management functions are complex, somewhat independent and largely intersecting processes which are not necessarily at the opposite ends of a spectrum. Leadership and management are complementary functions, sharing certain similarities while offering attributes that the other may lack, creating a “shared foundation for performance” (Simonet and Tett, 2013).

By definition, management is an “organizational position and function” (Porter-O’Grady & Malloch, 2016). Management is considered to be a formal position with authority given to the individual manager by the hierarchical organizational administration (Porter-O’Grady & Malloch, 2016). This authority, or power, requires managers to have subordinates. The manager appraises the employee as to the nature of the work to be completed, provides orientation to the work and its impact on the

organization, reviews essential functions required for the work activity, and provides required trainings and performance appraisals (Simmons & Sharbrough, 2013).

Management is critical to the success of an organization's day-to-day operation. The ongoing attention to both leadership and management produces new ways of solving immediate problems so that new challenges can be met in the future (Yoder-Wise & Kowalski, 2006).

Porter-O'Grady and Malloch (2016) further differentiate management versus leadership noting that leadership has little relationship to the more traditional views of management. While leaders and managers have accountability for doing the right thing, and focusing the product, or results, of the work done; the roles assumed by nurse leaders and nurse managers can be quite different (Table 3). Leaders use evidence-based principles of communication, relationship building and interaction to engage others and influence outcomes (Porter-O'Grady & Malloch, 2016). While managers provide direction from a hierarchical position of power, leaders can be found at all ranks within an organization and leadership can be provided at any point within a system. Leadership, if exercised properly, can influence an entire system regardless of where the leader may be located as leaders leverage influence rather than control (Porter-O'Grady & Malloch, 2016). Clinical managers play a critical role in the success of new nurses. The leadership style of a nurse manager can significantly influence staff engagement, empowerment, and professional growth (Bormann & Abrahamson, 2014; Manning, 2016; Sveinsdóttir, Ragnarsdóttir, & Blöndal, 2016).

Theoretical Frameworks for Leadership

Theoretical and historical frameworks for leadership are presented in this section to provide context for roles and competencies of leaders, which are relevant to clinical managers' expectation for new nurses. There are numerous ways to describe leadership, many of which are dependent on the purposes to be served by leadership (Bass, Bass, & Bass, 2008). The application of Complexity Science concepts to social interactions within complex systems is challenging for traditional person-role centered leadership frameworks (Schwandt, 2008). Understanding multiple leadership perspectives broadens the understanding of social interaction within complex systems and the entanglement of complex systems dynamics and formal administrative systems and structures (Schwandt, 2008; M. Uhl-Bien, 2007).

Table 3
Contrasting Differences in Leader and Manager Characteristics

Leader	Manager
Emerge from the group	Appointed to a formal position
Inspires others to work towards a common goal	Influence and direct from a position of formal power
Goal of looking ahead and working for change	Goal of generating results; controlling and problem-solving
Focus on synthesis, inspiration, and motivation	Focus of organization, analysis, and implementation

Note. Data for Contracting Differences in Leader and Manager Characteristics from (Andriopoulos & Dawson, 2009; Porter-O'Grady & Malloch, 2016).

Leadership can be seen as a universal phenomenon, the study of which can be matched to the rise of civilization. Early principles of leadership extend back to Confucius and Lao-tzu in the 6th century B.C.E, detailing the responsibilities and proper

conduct of leaders (Bass, Bass, & Bass, 2008). The modern study of leadership began to evolve around the turn of the 20th century. The trait theory of leadership was one of the first approaches to systematically study leadership (Northouse, 2007). Trait theory was rooted in the identification of innate qualities and characteristics possessed by highly regarded socio-political leaders in an attempt to determine specific traits separating leaders from followers (Bass et al., 2008). Contemporary views of trait theory have shifted to focus on the impact traits have on effective leadership, including intelligence, self-confidence, determination, integrity and sociability (Northouse, 2007). While trait theory provides a clear picture of essential traits for effective leadership, the list of traits may be both innumerable and highly subjective (Bass et al., 2008). Furthermore, situational differences are not accounted for in the trait approach. Those who possess traits that make them leaders in one situation may not be leaders in other situations (Stogdill & Bass, 1981). Relational aspects of leadership are also discounted in the trait approach. While linkages have been made between specific traits and the leader, the impact of these traits on the work of individuals and groups within the organization is not well described (Northouse, 2007)

The style approach to leadership was first described in the 1940s, shifting the focus to what leaders do and how they act (Bass et al., 2008). This approach expanded the study of leadership to include actions of the leader towards their subordinates. Many studies have been done to determine which style of leadership is most effective in a given situation. In general, the style approach provides for a broad framework for assessing leadership as a behavior with both task-oriented and relation-oriented dimensions which shift depending on the situation (Northouse, 2007). The key to being an effective leader

rests on how the leader is able to balance these dimensions in various situations. Similar to trait theory, this theory does not address the relationship between how leaders' styles are associated with overall performance outcomes (Yukl, 2013). Northouse (2007) noted that many leadership development programs in the United States are founded primarily on a style approach. It is important to note that while this is considered a leadership theory, it is well suited to management and the work of managers as they engage in both task and relationship behaviors (Northouse, 2007).

The transactional leader attempts to guide followers to a goal by clarifying roles and task requirements through the initiation of structure (Andriopoulos and Dawson, 2010). There may be little to no consideration for the needs of the followers. Relationships are based on power where there is a high-power distance between the leader and follower. Kuhnert and Lewis (1987) cited that transactional leaders do exert influence as it is often simply just in the followers' best interest to do what the leader wishes. The relationship expressed in transactional leadership is based on two factors: constructive transactions, or contingent rewards; and corrective transactions, or management-by-exception (Bass et al., 2008). Contingent rewards include an exchange process whereby the leader provides something of value to the follower in exchange for satisfactorily completing a task or assignment. Conversely, management-by-exception involves corrective criticism and negative feedback (Northouse, 2007, p. 185) and may be either passive or active in nature, occurring only when the follower underperforms or fails to meet a goal. Transactional exchanges can often be seen in the interactions between managers and their subordinates.

Transformational leadership has been a highly researched approach to leadership since the 1980s. The emergence of transformational leadership represented a landmark shift in the field of leadership. This new approach introduced concepts of charismatic, visionary, inspirational, values-oriented and change-oriented leadership (Bryman, 1992). Transformational leadership, according to Northouse (2007), fits the need of today's work groups who need to be empowered and inspired in the face of uncertainty. It involves an exceptional form of influence which moves followers to accomplish more than what might generally be expected of them (Bass et al., 2008). Burns (Burns, 2010) attempted to link the role of leader and follower, distinguishing between leadership and power. Leadership, according to Burns (2010) differed from power in that it is inseparable from the followers' needs. Burns (2010) also distinguished between two types of leadership: transactional and transformational leadership. Transactional leadership is closely linked to the majority of leadership approaches in that it focuses on exchanges between leader and follower. Transformational leadership is the process by which the leader engages and establishes a connection with followers to raise motivation in an attempt to reach beyond the followers' potential.

Though transactional and transformational leadership may seem like opposing approaches to leadership, transactional leadership is situated within transformational leadership (Andriopoulos and Dawson, 2010, p. 197). Burns (1978) described a transformational leader as one who elevates the followers' level of consciousness regarding the importance of the identified goals and motivates the followers to rise above their own self-interests for the sake of the organization to address higher level organizational needs. Bass et al. (2008, p. 620-623) summarized four key factors in

transformational leadership: (a) charisma or idealized influence, which describes leaders who act as a role model with sound moral and ethical values; (b) inspirational motivation, or the communication of high expectations to followers so they may become part of the shared vision of the organization; (c) intellectual stimulation, which fosters creativity and innovation through challenging one's own beliefs and assumptions; and (d) individualized consideration, a supportive environment in which the follower can grow.

Unlike transactional leadership, which results in predicted outcomes, transformational leadership seeks to achieve results beyond what is expected. That is, followers are motivated to achieve more than what would usually be expected (Bass and Bass, 2008, p. 638). While the transformational leader is more relations-oriented than the charismatic or transactional leader, power continues to rest in the hands of the leader. Likewise, Yukl (1999) noted that the transformational leader may display a "heroic leadership" bias as emphasis is placed on the notion that it is the leader alone who moves followers to achieve extraordinary things.

Leading in Complex Systems

While transformational leadership has been widely discussed and adopted within nursing over the past two decades, new ways of thinking about leadership have begun to emerge (Hutchinson & Jackson, 2013). Leadership education in pre-licensure nursing programs faces immense challenges in preparing nurses with the abilities and drive to become effective clinical leaders (Buckwell-Nutt, Francis-Shama, & Kellett, 2014). Traditional approaches to teaching and learning have focused on the transfer of information from teacher to student in a pre-defined manner which has contributed to gaps between what is learned in the classroom and the demands of clinical practice

(Leigh, Rutherford, Wild, Cappleman, & Hynes, 2012; Tedesco-Schneck, 2013). Banning (2005) suggested that experiential learning approaches were most productive in helping students develop nursing leadership knowledge and skills which could be translated into clinical practice over time; however, in many nursing programs, leadership is not a primary focus until students are within months of graduation (Buckwell-Nutt et al., 2014). Universities are under increasing pressure to explicitly demonstrate how and when clinical leadership knowledge, skills, and attitudes are taught within the curriculum and show the alignment of content with professional practice standards (Leigh et al., 2012)

The American Association of Colleges of Nursing (AACN) *Essentials of Baccalaureate Education for Professional Nursing Practice* (2008) offers insight into the leadership competencies expected of a baccalaureate-prepared professional nurse. New and practicing nurses are expected to have a foundational knowledge of organizational and systems-level leadership including providing high-quality care, coordinating healthcare teams, communicating effectively with members of inter-professional care teams, promoting safety and quality through improvement processes, and participating in creative strategies to enable systems-level change (AACN, 2008). Traditional leadership theories no longer meet the needs of the evolving healthcare landscape, so nursing education faces an immense challenge in bridging the gap (Buckwell-Nutt et al., 2014; Uhl-Bien & Marion, 2008).

Complexity leadership is suggested as one path to move healthcare into the future. Complexity leadership is not simply a new way to lead, rather a new way of thinking that is vastly different from the more traditional linear, top-down, command-and-control approaches that pervade organizations (Crowell, 2011). Complexity leadership, according

to Crowell (2011), views the organization as a complex adaptive system (CAS) which is non-linear, dynamic, often unpredictable, and relationship-based. Change is a continuous process which can be described as an alteration of the current state and, in healthcare environments, is better understood from a complexity paradigm as compared to a linear paradigm (Porter-O'Grady & Malloch, 2016). Uhl-Bien, Marion and McKelvey (2007) proposed leadership, through a complexity lens, is seen not as a simple position of authority but as an emergent and interactive dynamic.

Complexity Leadership Theory (CLT) provides a framework that describes administrative leadership, adaptive leadership, enabling leadership and the enmeshment of the three roles (Mary Uhl-Bien & Marion, 2008). In CLT, concepts of leader and leadership must be differentiated. Leaders, according to Uhl-Bien and Marion (2007), are individuals who act in ways that influence a system and the outcomes of the system. Administrative leadership includes the actions of groups and individuals in formal managerial roles, which function to plan and coordinate organizational activities (Uhl-Bien, 2007). Adaptive leadership is described as “an emergent, interactive dynamic that is the primary source by which adaptive outcomes are produced (Uhl-Bien & Marion, 2008). Adaptive outcomes include creativity, innovation, learning, and enhanced responsiveness to uncertain or unpredictable situations (Uhl-Bien, 2007). Adaptive leadership occurs within and through emergent, informal dynamics throughout an organization (Heifetz & Linsky, 2002). Enabling leadership manages the complex relationship between administrative and adaptive leadership, including the conditions and environment within which adaptive leadership occurs (Uhl-Bien & Marion, 2008).

Adaptive Leadership

Adaptive leadership relies on interactive exchanges between individuals or groups, known as agents, within a system (Lichtenstein et al., 2006). The leadership emerges through struggles among agents over conflicting needs, ideas or preferences, resulting in alliances between or among people, ideas or technology and is the immediate source of change in an organization (Lichtenstein, et al., 2006; Uhl-Bien & Marion, 2008). Uhl-Bein and Marion (2008) noted that adaptive leadership is acknowledged as such when it has both significance and impact, including the potential usefulness of the new ideas or knowledge and the degree to which other agents might utilize the new ideas and knowledge. Bailey et al. (2012) noted that the adaptive leadership framework was particularly useful for developing, guiding and describing clinical leadership skills at the point of care. The adaptive leadership framework helped organize activities occurring in patient-provider encounters which co-produced better outcomes for patients (Bailey et al., 2012). Furthermore, this framework provided a lens through which to investigate nursing and leadership at the point of care. Adaptive leadership draws attention to the interactivity between and among providers, including the interaction with patients. Bailey et al. (2012) therefore argued for the application of adaptive leadership to explore questions and gain new perspectives about the working relationships between healthcare practitioners, patients and families.

Porter-O'Grady and Malloch (2016) noted that although relatively few nurses will ever assume a management role, all nurses are leaders: there is no one better than the

point-of-care nurse to identify opportunities for new ways to provide optimal patient care. As more pressure is placed on health care delivery systems, the need for change becomes more evident (Weberg, 2012). Complexity leadership allows for leadership at the spaces in between agents and formal leadership roles (Lichtenstein et al., 2006). Adaptive leadership allows nurses to become change agents, fostering conditions for health care systems to adapt, change and innovate (Crowell, 2011; Weberg, 2012). Crowell (2011) noted that in complexity leadership, the leader is embedded and fully part of the whole, leaders are in the flow of change and their ideas are no longer theirs alone. As a sensitizing concept, Adaptive Leadership helps maintain focus on the emergent conditions of clinical leadership expected of new, baccalaureate-prepared professional nurses.

Leadership Education

Pepin, Dubois, Girard, Tardif and Ha (2011) employed an interpretive phenomenological approach to explore the experience of learning and practicing clinical leadership with both nursing students and practicing nurses. In total, five distinct stages were identified by Pepin et al. (2011), each building on the previous stage of learning and development: awareness of nursing clinical leadership, integration of leadership into one's actions, active leadership, active leadership with the team, and embedded clinical leadership extended to the organizational level and beyond. The initial three stages were most closely linked to leadership preparation in the academic and clinical-learning environments. Pepin et al. (2011, p. 272) described clinical leadership as a professional competency, which “galvanizes the nurse to influence others for the continuous improvement of care, while simultaneously improving the care provided by the nurse”.

As nursing students progressed along their educational paths, little difference was noted in the leadership experiences of students in the final year of the program and graduate nurses in their first year of practice (Pepin et al., 2011). This raises the issue of providing sufficient opportunities to practice leadership as students begin to transition to professional practice (Cook & Leathard, 2004; O’Driscoll, Allan, & Smith, 2010; Pepin et al., 2011). Figure 1 illustrates the feedback loops between the nurse, inter-professional team, healthcare delivery system, and external environment.

Figure 1
Feedback Loops in Complex Healthcare Delivery Systems

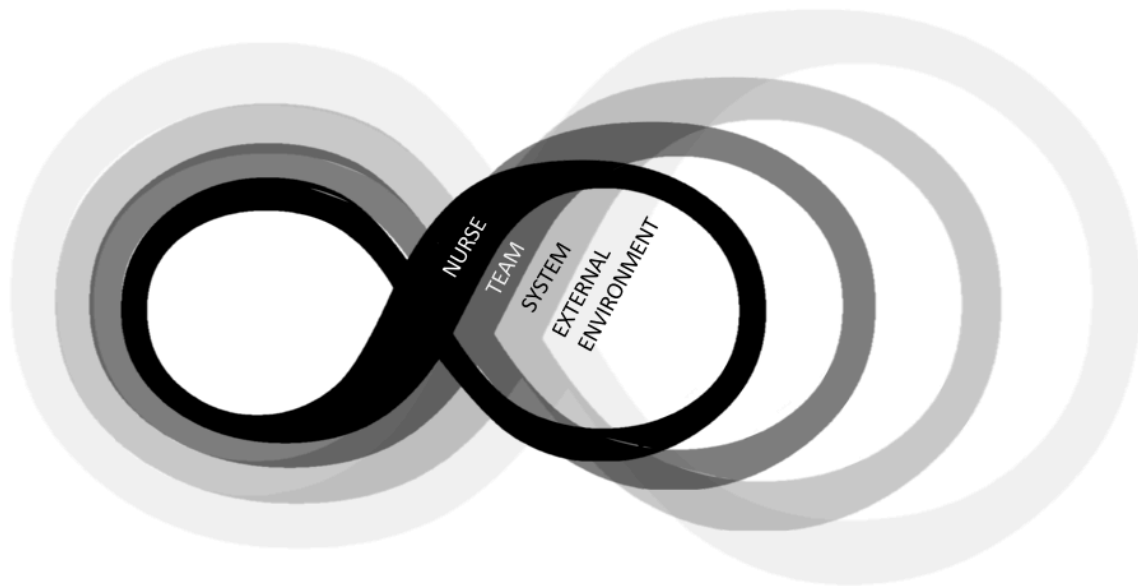


Figure 1. Diagram of non-linear feedback loops between the nurse, inter-professional team, healthcare delivery system, and the external environment. The loops illustrate the recursive and non-linear nature of feedback in complex systems. The spatial arrangement of the loops demonstrates the embeddedness and enmeshment of the nurse within the system. Overlapping loops indicate interconnections with and interactions between agents in the system. Note: Data for Feedback Loops in Complex Healthcare Delivery Systems from (Notarnicola et al., 2017; M. Uhl-Bien, 2007)

Purposeful design of student practice experiences can facilitate the achievement of leadership competencies. Galuska (2015) examined the use of a Dedicated Education Unit (DEU) in an academic-practice partnership to facilitate leadership-in-practice for

student nurses. Students were paired with nurse preceptors for 12-hour shifts in an end-of-program leadership course. Under the guidance of the preceptors, the students were provided with as many opportunities to practice leadership as possible, including: (a) communicating and collaborating with the inter-professional team, (b) leading discussions during inter-professional rounds, (c) delegation to assistive staff and (d) participating in shared governance activities (Galuska, 2015). The Student Leadership Practices Inventory (LPI) was used to collect data on student leadership behaviors. Students participating in the DEU experience showed a statistically significant improvement in the overall mean LPI score. The increase in the overall mean for the control group was not statistically significant (Galuska, 2015). Focus groups were used to uncover the perceptions of students and clinical instructors participating in the DEU experience. Data indicated that both students and clinical instructors reported the DEU to be a positive environment for student growth on leadership outcomes identified by the American Association of Colleges of Nursing (AACN, 2008), particularly in the areas of clinical, organizational, communication and relational competencies (Galuska, 2015). Generalizability of the findings may be limited beyond the setting of the DEU, however.

Morrow (2015) critically reviewed the literature on leadership curricula in nursing education to develop a gap analysis. The underlying theme among articles was the use of active learning strategies to facilitate the development of leadership knowledge, skills and abilities including reflective activities, team-based learning, inter-professional activities, organizational partnerships and curricular redesign (Morrow, 2015). Notable gaps in leadership education included development of leadership competencies at the organization level, classroom teaching/learning activities aimed at integrating leadership

competencies and development of leadership competencies among students from diverse backgrounds (Morrow, 2015). One potentially significant barrier to new nurse leadership development identified was a lack of understanding among staff nurses about professional practice competencies and recommendations from organizations such as the Institute of Medicine (Folan et al., 2012; IOM, 2011; Morrow, 2015).

Academic-Practice Gap

Numminen et al. (2014) used a cross-sectional, comparative design to examine new graduate competence as assessed by nursing faculty ($n=86$) and clinical unit managers ($n=141$). Using the Nurse Competency Scale (NCS), a 73-item instrument based on Benner's Novice to Expert (Benner, 2001), nursing faculty consistently rated novice nurses' competency to a significantly higher level ($p<.001$) than clinical managers across all competency domains. The most significant differences were related to new graduate developmental and evaluation tasks, coaching activities, utilizing evidence-based knowledge and areas where a comprehensive view of the situation were needed (Numminen et al., 2014).

Significant differences have also been demonstrated in perceptions of preparedness between clinical leaders and graduate nurses (Wright, 2014). The 36-item Nursing Practice Readiness Tool ($\alpha=.986$) was used to quantify differences in perceptions of preparation for practice. This tool was developed to capture new graduate performance across 36 competencies, including AACN Baccalaureate Essentials and QSEN competencies (Virkstis, Jaggi, & Shkuda, 2009). Across all areas, clinical leaders reported scores significantly lower ($p<.001$) than graduate nurses, including clinical knowledge, critical thinking, communication, professionalism and management of

responsibilities (Wright, 2014). Overall, nursing faculty, clinical leaders and graduate nurses perceived the greatest opportunities for growth to be delegation, conflict resolution, anticipation of risk or complication, time management, and prioritization (Wright, 2014).

Using qualitative interviews, Ancheta (2013) explored areas of concern with graduate nurses ($n=10$), nursing managers ($n=20$) and nurse educators ($n=21$). All three participant groups agreed lack of clinical skills was of concern to them. Managers and educators acknowledged graduate nurse basic competency as novice practitioners, however they identified a lack in critical thinking skills. Managers were the only group that felt the new graduates lacked sufficient leadership skills to practice independently and required more training in areas such as coordinating care and calling providers (Ancheta, 2013). Walker et al. (2013) further explained that new nurses are often presented with interpersonal conflicts but lack sufficient experience and skill to effectively manage them. Seventy percent of managers indicated new nurses lack leadership preparation, with 50% of managers indicating additional training on professionalism, communication, accountability, and understanding regulatory standards was needed (Walker et al., 2013). Modern nursing practice includes a series of complex and highly specialized cares, which require both theoretical knowledge and practical skills, however there is no strong agreement on what constitutes clinical leadership for practicing nurses (Brown, Dewing, & Crookes, 2016; Henderson, 2002).

Rather than directly identifying gaps in preparedness to practice, Wolff et al. (2010) explored the meaning of new graduate readiness for practice. A total of 150 nurses from the practice, regulatory, and education sectors were brought together to participate

in a series of focus groups to define readiness for practice and describe factors that influence readiness (Wolff et al., 2010). Findings from the focus groups demonstrated mixed ideas about what readiness to practice should be. Readiness, as described by study participants, is possessing a generalist foundation with some degree of job-specific capabilities including: (a) providing safe client care; (b) keeping up with current practice and future possibilities; and (c) possessing a balance of doing, knowing and thinking (Wolff et al., 2010). Divergent perspectives, particularly among the education and practice sectors, can create significant barriers between nurses newly entering into practice and those working alongside them as mentors and colleagues.

The research on readiness to practice has important implications for nursing education. One theme consistent throughout the literature is a gap in academic preparation and readiness for professional practice. This gap is not limited to technical skills; rather it includes other aspects such as clinical judgment, communication and leadership. Research findings suggest nursing educators and managers have differing views on readiness for entry to professional practice (Numminen et al., 2014; Oermann, Poole-Dawkins, Alvarez, Foster, & O'Sullivan, 2010; Wolff et al., 2010). Numminen et al. (2014) proposed that educators may assess competency as the ability to pass the licensure examination and enter into generalist practice. Managers' assessments, however, may be based on more specific unit-based needs.

Workforce shortages, financial constraints, shifts in healthcare delivery, higher patient acuity, advances in technology and research and health policy all influence the successful preparation, transition, integration and retention of new graduates (Wolff, Pesut, & Regan, 2010). Educating nursing students and facilitating the transition to

professional practice is a complex process. Moving away from shared accountabilities in the academic and practice sectors, it has become less clear who plays what role in preparing nurses for professional practice (Wolff et al., 2010). Shifting the current academic-practice culture to value multiple perspectives can help to strengthen partnerships and create a shared vision for how new nurses should be prepared as they transition to professional practice.

Competencies for Novice Nursing Practice

Nursing leadership is becoming increasingly more important as healthcare delivery systems evolve at a rapid rate. Novice graduate nurses are assuming both formal and informal leadership positions more rapidly than ever before, requiring better leadership education prior to entering the nursing workforce (Candela & Bowles, 2008). The Institute of Medicine's *Future of Nursing* report called for nurses to be prepared to practice nursing leadership at all levels (IOM, 2011). While leadership competencies have been identified by accreditation agencies and professional organizations, the degree to which they have been integrated throughout nursing curricula is questionable. Stanley and Stanley (2018) found that the concept of clinical leadership is a relatively new term and a clear definition does not yet exist. A lack of a clear definition of clinical leadership may be a contributing factor in the malalignment between academic preparation and clinical practice. Candela and Bowles (2008) noted that, in undergraduate nursing programs, leadership is often seen as an end-of-program concept. Integration of leadership concepts and competencies across the curriculum allows students to augment their leadership knowledge, skills and abilities over time and before transitioning to professional practice (Candela & Bowles, 2008).

Healthcare consumers have a right to expect registered nurses to exhibit professional competence (Bazarko et al., 2013). Competence, as defined by the American Nurses' Association is "an expected and measurable level of nursing performance that integrates knowledge, skills, abilities and judgment that is based on established scientific knowledge and expectations for nursing practice" (American Nurses Association, 2010). Development of competencies essential for professional nursing practice begins as students enter into academic nursing preparation. Professional organizations and accrediting agencies such as the National League for Nursing and American Association of Colleges of Nursing serve to establish and implement quality standards for nursing education (AACN, 2008; National League for Nursing, n.d.).

The AACN's *Essentials of Baccalaureate Education for Professional Nurses* (AACN, 2008) provide key curricular elements and a framework for scaffolding the baccalaureate-nursing curriculum. First introduced in 1998, *Essentials of Baccalaureate Education for Professional Nurses* provided a set of competency standards to enhance the provision of safe, high-quality nursing care (AACN, 2008). The current Essentials document is a revised document which was developed through a national consensus-building process with leaders and experts from academic programs and clinical practice (AACN, 2008). This work addressed stakeholder recommendations as well as the Institute of Medicine's proposals for the core knowledge necessary of all healthcare providers (American Association of Colleges of Nursing (AACN), 2008; Greiner, Knebel, Institute of Medicine (U.S.), & Institute of Medicine (U.S.), 2003). According to the AACN (2008), achievement of these Essentials enables graduates to enter into the profession of nursing and practice within complex health care delivery systems to design,

provide, manage and coordinate care (AACN, 2008). In total, there are nine Essentials within the document (see Appendix A):

- I. Liberal Education for Baccalaureate Generalist Nursing Practice
- II. Basic Organizational and Systems Leadership for Quality Care and Patient Safety
- III. Scholarship for Evidence-Based Practice
- IV. Information Management and Application of Patient Care Technology
- V. Healthcare Policy, Finance and Regulatory Environments
- VI. Interprofessional Communication and Collaboration for Improving Patient Health Outcomes
- VII. Clinical Prevention and Population Health
- VIII. Professionalism and Professional Values
- IX. Baccalaureate Generalist Practice

AACN Essential II specifically addressed leadership outcomes expected of graduates of baccalaureate nursing programs. Organizational and systems leadership, quality improvement and patient safety were identified critical elements for facilitating high-quality nursing care (AACN, 2008). As such, expected leadership outcomes were identified to guide nursing education programs in preparing student nurses for the demands of working in complex healthcare delivery systems. Basic nursing leadership, according to the AACN (2008) included being able to effectively communicate and work in inter-professional teams, utilizing principles of quality science to positively influence patient care, implementing principles of patient safety to create a safe environment for care delivery, coordinating and directing care in a variety of settings, and being aware of complex organizational systems and structures. Essential II established a framework with

which baccalaureate nursing programs were able to begin preparing students for new ways of thinking about, providing, and leading health care.

AACN Essential IX focuses on expectations of baccalaureate level generalist nursing practice. Baccalaureate generalist practice, according to the AACN (2008), included providing direct and indirect care, assuming a professional nursing identity, advocating for patients and the nursing profession, and designing, coordinating and managing care. Essential IX integrates knowledge, skills and attitudes identified in Essentials I-VIII into the nursing care of individuals, families, groups and populations across a multitude of practice settings (AACN, 2008). Essential IX incorporates knowledge related to: (a) health, wellness, illness and disease management across the lifespan; (b) providing care to individuals, groups and populations from diverse backgrounds; (c) working with the inter-professional team to support patients with chronic healthcare needs; and (d) integrating new knowledge into practice through self-evaluation and life-long learning. Essential IX provides a framework through which baccalaureate nursing programs were able to prepare nurses to provide compassionate nursing care informed by the best available scientific evidence.

Essential VI highlights the role of inter-professional education in promoting effective collaboration and communication among members of the healthcare team (AACN, 2008). Essential VI incorporates knowledge, skills, and abilities related to: (a) understanding roles, scope of practice, and perspectives of other non-RN healthcare professionals; (b) building inter- and intra-professional communication and collaboration skills; (c) demonstrating effective teambuilding strategies; and (d) advocating for safe, high quality patient care as a member of the inter-professional team. While Essential VI specifically

calls out interprofessional communication and collaboration, Essentials II and IX demonstrate some overlap with Essential VI regard to communication, collaboration, coordination of the care team, delegation, building a culture of safety, promoting/providing high quality care, and engaging in systematic change. Professional roles, relationship building with team members, contributing the nursing perspective, and team building were all unique to Essential VI. The Essentials used in the focus group sessions were limited to Essentials II and IV.

The AACN (2008) called on baccalaureate nursing programs to provide opportunities for clinical practice which would foster the development of the nine Essentials. Clinical learning, according to the AACN (2008, p. 33) should focus on “developing and refining the knowledge and skills necessary to manage care as part of an inter-professional team”. The overarching goal of clinical learning, as guided by the AACN Essentials, was to more fully develop the role of the baccalaureate generalist nurse as a provider of care, designer/manager/coordinator of care and a member of a professional practice (AACN, 2008). It is imperative that nursing programs design opportunities for significant learning to ensure graduates are able to attain the outcomes listed in the Essentials and integrate the skills into their own professional practices (AACN, 2008).

Summary

Benner’s From Novice to Expert provides a lens for understanding how skill acquisition unfolds over time for nurses (Benner, 2001). The AACN’s Essentials of Baccalaureate Education for Professional Nursing Practice (AACN, 2008) provide an educational framework for the preparation of professional nurses, outlining the expected outcomes for graduates of baccalaureate nursing programs. Scientific advances in

healthcare, changing patient demographics, emerging healthcare technologies and changes in healthcare delivery require new ways of thinking and providing nursing care. Building new nurse leadership capacity may have important implications for the delivery of safe, high-quality nursing care in complex healthcare delivery systems. Complexity Leadership Theory (CLT) describes the dynamics through which adaptive outcomes emerge, generating adaptive and creative change, and knowledge (Uhl-Bien & Marion, 2008). To exhibit significance and have an impact, adaptive leadership must be embedded within the context of the complex adaptive system (Uhl-Bien & Marion, 2008). Adaptive leadership provides a framework with which to examine the clinical leadership of the nurse in complex healthcare delivery systems (Uhl-Bien & Marion, 2008, p. 214).

Preparing nursing students for entry to professional practice is challenging, particularly when navigating the complex and often segmented sectors of academia and practice. Research indicates that new nurses, academic faculty and nurse managers have divergent views of readiness for professional practice. There is a paucity of research which examines academic preparation of new graduates in the area of leadership. The literature indicates that efforts are being made to enhance leadership education in nursing programs; however, the introduction of leadership concepts is fragmented and often relegated to the end of the program of study (Galuska, 2015; Morrow, 2015; Pepin et al., 2011). Nursing leadership, as a practice competency, can have a positive impact on patient care outcomes and the environment of care (Severinsson & Holm, 2012; Wong, 2015; Wong et al., 2013). Uncovering the expectations for and emergence of adaptive

clinical leadership of nurses working in complex healthcare delivery systems is critical in promoting high-quality, safe nursing care.

CHAPTER 3

METHOD

This research study used qualitative methods with a bounded case-study approach. The purpose of this study was to identify gaps between end-of-program nursing graduate leadership competencies and the expectations of clinical nurse managers in agencies employing new nurses. The contents of this chapter include rationale or justification of the research method and design. Congruence between the research approach and research goals is explicated. This chapter also includes a description of the research sample, ethical considerations, data collection methods and issues of trustworthiness.

Research Method Appropriateness

Qualitative research, according to Bloomberg and Volpe (2012, p. 27), is well suited to promote “a deep understanding of a social setting or activity as viewed from the perspective of the research participants” with a focus on exploration, discovery and description. Denzin and Lincoln (2005) assert that qualitative research involves an interpretive and naturalistic approach whereby the researcher undertakes an emic point of view in an attempt to make sense of phenomena in terms of the meanings people bring to them. The researcher uses an emerging qualitative approach to inquiry and inductive data analysis which produces patterns or themes (Creswell, 2007). The re-presentation of the findings, through a report or other media, includes the voice of the participants, reflexivity of the researcher and a complex, rich description and interpretation of the problem under study (Creswell, 2007).

The design of qualitative studies remain open and emergent, collecting and analyzing data in a recursive fashion with the researcher becoming the instrument for data collection (Bloomberg & Volpe, 2012). The qualitative researcher does not attempt to generalize findings, rather the researcher seeks to explain transferability of findings to other like contexts (Bloomberg & Volpe, 2012). A qualitative approach was chosen for this study to uncover the unique perspectives of the participants and provide a thick description of nurse manager perceptions of new nurse leadership preparation in the acute care setting.

Case Study Design

A case study design should be considered, according to Yin (2009), when the focus of the inquiry is to answer questions of “how” or “why”, the researcher cannot manipulate the behaviors of research participants, the researcher seeks to uncover contextual data relevant to the phenomenon of interest, or the boundaries between the context and the phenomenon itself are unclear. Case study research provides an in-depth description and analysis of a bounded system through multiple data sources over time (Creswell, 2007; Stake, 1995; Yin, 2009). Merriam (2009) writes that data analysis is rich in the context of the setting in which the case presents itself. This approach can provide a multi-perspective analysis of the phenomenon (McAndrew & Warne, 2005). Single case studies are used to further explore a theory and are particularly useful for gaining access to a phenomenon which has been previously inaccessible (McAndrew & Warne, 2005). One rationale for using a single case design, according to Yin (2009, p. 48) is to examine the “representative” or “typical” case. The objective is to capture a routine occurrence or everyday situation, illuminating common experiences of the average person or

organization (Yin, 2009). This allows the researcher to focus on a single unit of analysis. Generalizability is not the ultimate goal of case study research, rather the intention is the concept of transferability of findings to similar cases or contexts (Yin, 2009).

A single, bounded case study design was chosen for this study. Identifying the bounded system helps to define the case as a single, unique unit of analysis (Simons, 2009). For this study, one acute care hospital was selected as the bounded system.

Yin (2009) offers five rationales for selecting a single case study where the case represents: (a) the critical case in testing theory, (b) an extreme or unique case that is rare yet worthy of documenting, (c) a representative or typical case which captures the circumstances of a situation or experience, (d) a revelatory case which analyzes a phenomenon previously inaccessible to social science inquiry, and (e) a longitudinal case studying a case at multiple points in time. This research study represents the representative perceptions of nurse managers in one acute care hospital. Findings from this study are assumed to be informative about experiences from the average acute care hospital employing new nurses (Yin, 2009). By using a single, bounded case study design, existing theoretical assumptions about new nurse preparation for leadership were explored while analyzing new relationships which emerged from the data. The components of this case study include the study questions, propositions, unit of analysis, the logical linking of data to the propositions and the criteria for interpreting the research findings. The research design for this study links the data to be collected to the research questions of the study. A discussion of each of the components of the case study design follows.

Research Questions

The research questions for this study included:

1. What nursing leadership competencies do clinical managers identify as essential preparation for new nurses?
2. How do clinical nurse leaders' expectations of nursing leadership competencies differ from end of program competencies as outlined in *The Essentials of Baccalaureate Education for Professional Nursing Practice*?

Research Propositions

Propositions, according to Yin (2009) are declarative statements which direct the researcher's attention to something that ought to be examined in the scope of the study. Propositions are more specific applications of the research questions, providing further depth and detail on the study (Yin, 2009). Study propositions directed the researcher's attention to factors that should be included within the scope of this study (Table 4).

Logical linking of the data to the propositions provided a framework for data analysis. Awareness of the techniques linking the collected data to the study propositions helped to guide the process of data collection, including individual interviews, focus group interviews and organizational (archival) records. The review of literature provided strong input into proposition development as the researcher considered how previous researchers designed and conducted studies, and interpreted key findings (Runeson, Host, Rainer, & Regnell, 2012).

The research propositions (RPs) were closely linked with the sensitizing frameworks, highlighting ideas for the researcher's attention. Benner's *From Novice to Expert* (2001) directed the researcher's attention to skill acquisition over time, during

formal pre-licensure education and post-graduation as a new nurse (RP1, RP3).

Preparation for clinical leadership was linked closely to all three sensitizing concepts, focusing the researcher on the relational, clinical, and adaptive aspects of new nurse clinical leadership (RP 2).

Table 4
Study Propositions

Research Question	Research Propositions
RQ1. What nursing leadership competencies do clinical managers identify as essential preparation for new nurses?	RP1. An academic-practice gap exists. RP2. Nurses must be prepared for clinical leadership competencies required to influence outcomes in healthcare delivery systems.
RQ2. How do clinical nurse leaders' expectations of nursing leadership competencies differ from end of program competencies as outlined in <i>The Essentials of Baccalaureate Education for Professional Nursing Practice</i> ?	RP3. Skill acquisition occurs over time. RP4. The AACN Baccalaureate Essentials provide a framework for building the leadership capacity of nursing students.

Unit of Analysis

Identifying the unit of analysis is the third and final component of defining the case or cases in a study (Yin, 2009). The unit of analysis is the major entity or entities in the study including individuals, groups, artifacts, geographically bounded areas and social interactions (Trochim, Donnelly, & Arora, 2016). Clearly defining the unit(s) of analysis by particular “spatial, temporal or other concrete boundaries” helps to define or bound the case (Yin, 2009, p. 32). The units of analysis for this study included acute-care nurse managers and assistant nurse managers in one acute care facility, archival records from the organization, and the AACN Baccalaureate Essentials.

Overview of the Research Approach

The research approach for this study is detailed below. A diagram of the research approach is included in Appendix B. For this study, multiple sources of data were used to

provide perspective and insight into clinical manager perceptions of new nurse preparation for leadership. Data collection began with in-depth, individual interviews to determine the nursing leadership competencies clinical managers expect of new nurses in an acute care setting. Archival documents were collected for review and included a job description for a new nurse, initial skills validation and preceptor evaluation forms. The archival documents provided additional context for the single case study. Finally, focus groups were conducted to identify gaps between end-of-program nursing leadership competencies, as outlined in *The Essentials of Baccalaureate Education for Professional Nursing Practice*, with leadership competencies identified by clinical managers in an acute-care setting.

Setting and Sample

The research setting is comprised of the physical, social and cultural space in which the researcher conducts a study. In qualitative research, the researcher studies participants in their natural setting (Bhattacharya, 2012). The setting for this research was one acute care hospital in the Pacific Northwest of the United States. This site was selected because of the high number of new nurses hired into the organization over the past five years. System-wide, 300-400 new nurses have been hired into to fill acute care (inpatient, outpatient, and ambulatory) nursing vacancies in the past five years.

Population and Sample

For this study, the population included nurse managers (NM) and assistant nurse managers (ANM). This single case study was bounded to include NMs and ANMs of acute care units who are responsible for hiring and evaluating new nurses. Inclusion criteria included NMs and ANMs who had hired at least two new graduate nurses within

the past one year. This criterion was selected to ensure participants had recent experience in working with newly graduated nurses. Exclusion criteria included NMs and ANMs from non-acute care, outpatient settings. A researcher designed demographic tool was used to collect data from the intensive interview participants.

Participant Recruitment

Once IRB approval for the study was obtained, recruitment of participants began with a presentation to the research site's leadership team to introduce the study and help gain initial access to participants. Communication with the sample prior to consent included an information sheet, shown in Appendix C, which was provided in an email message describing the individual interview purpose, time commitment, risks and benefits to participating in this study. Interested participants then contacted the researcher directly to establish a meeting time and place for the interview. Determination of the participant's eligibility was reviewed prior to scheduling an interview. Interviews were scheduled as participants contacted the researcher. The sample size for the intensive interviews was a total of 11 participants.

The researcher met with the research leadership team to pre-schedule times and locations for the focus groups that would be most convenient for NMs and ANMs. A second communication was sent following the individual intensive interviews inviting prospective participants to join in a focus group session (see Appendix D). As with the intensive interviews, determination of the participant's eligibility was reviewed prior to scheduling participants in a focus group. The sample size for the focus groups was a total of 12 NMs and ANMs. Participation in the intensive interviews was not a pre-requisite for participation in a focus group.

Data Collection Procedures

The use of multiple sources of data allows the researcher to investigate a phenomenon of interest in depth and from multiple perspectives (Creswell, 2007). These converging lines of inquiry help to both triangulate and corroborate the data. All data collected for this research study was entered into a secure research database by the researcher. The use of a database aids the researcher in organization but also serves to increase the reliability of the study findings (Yin, 2009).

Demographic information. Demographic data were collected about the clinical managers (see Appendix E) following each intensive interview. Variables included clinical manager age, years in practice, years in nursing management, years in current position, highest academic degree obtained and the average number of new nurses hired into the clinical manager's unit annually.

Contextual information. Documents provide a major form of data, allowing the researcher to review information that informs the interview process (Charmaz, 2014). Extant documents, according to Charmaz (2014), are official documents created to reflect shared definitions concerning a topic, the power to enforce the definitions and a frame with which to convince the reader of their verity. Copies of new nurse job description(s), initial skills validation and preceptor evaluation forms were obtained and uploaded into the research database.

Perceptual information. Perceptual data were collected through a series of one-on-one intensive interviews and focus groups. Data collection procedures for each method is discussed below.

Intensive individual interviews. Qualitative research relies on informational, intensive and investigative interviewing strategies. Charmaz (2014) described intensive interviews as gently guided conversations which explore a person's substantive experience with the topic of interest. The intensive approach emphasizes the understanding of the participant's perspective and experience (Charmaz, 2014). Intensive interviews were used to collect data to inform research question #1. Each interview was 30-60 minutes in duration and utilized a semi-structured format. An interview protocol was used to guide the intensive interviews (see Appendix F). The researcher was the interviewer for each intensive interview. All interviews were digitally audio recorded and transcribed for verification.

Focus groups. Following individual interviews, single-category focus groups were used to collect additional perceptual data. The goal of focus groups, according to Krueger and Casey (2015) is to explore perceptions, feelings and thinking about issues ideas and opportunities of people across groups. The focus group setting allows ideas to emerge from the group which are greater than the sum of the participants' individual perspectives (Krueger & Casey, 2015). Focus groups were held in a private location to ensure privacy. Each focus group lasted between 60-90 minutes and facilitated additional discussion of the essential leadership competencies contrasted with end-of-program leadership competencies. Participants were given copies of Baccalaureate Essential II and IX (see appendix G) with instructions to indicate which elements they perceived as: (a) highly important or essential, (b) ideal but not essential, or (c) not required or not useful for new nurse leadership. Quantitative data were entered into IBM SPSS® Statistics version 24. Descriptive statistics, including mean and standard deviation, were calculated. A focus

group protocol was used in moderating each focus group session (Appendix H). The researcher was the moderator for each focus group session. Audio from each focus group session was digitally recorded and transcribed for analysis.

Data Handling Procedures

Steps were taken to maximize the confidentiality of participants and security of the data. Data were not linked in any way to the participants.

Hard copy documents. Some documents, including contextual information, consent forms, confidentiality agreements and demographic data were received in hard-copy format. These documents were scanned and saved on an encrypted, password-protected computer. The original copies were placed in a folder and secured in a locked file cabinet in the researcher's office. Only the researcher had access to these documents.

Intensive interview and focus group data. The digitally recorded audio files from the interviews were downloaded onto an encrypted, password-protected computer and the files securely sent for transcription. Once transcribed, all files from interviews were sorted and stored in distinct folders on a password-secured, encrypted computer. Backup files were also created on a secure, encrypted data server. Each transcript was uploaded into Dedoose™ for data analysis.

Data analysis. Qualitative research is often non-linear and emergent in nature. All aspects of data collection and analysis were monitored such that the techniques used maintain congruence with the selected research approach. Gathering rich data provides the researcher with a strong foundation for developing a strong analysis (Charmaz, 2014). Geertz (1973) described this as seeking thick description. This thick description is built

through multiple sources of data including documents and archival records, interviews and field notes (Charmaz, 2014).

Coding is used to categorize segments of data and define what the data are about (Charmaz, 2014). The coding process shows how the researcher selects and sorts data in the analytical process and is the vital link between data collection and the emergent explanation of the data (Charmaz, 2014). Initial coding is the first step in reviewing and analyzing data. Initial coding, according to Charmaz (2014, p. 109) involves studying data fragments closely for their “analytic import”. Initial codes constructed as the researcher actively names, defines and labels the data stem from the researcher’s own actions and understandings of the phenomenon of interest (Charmaz, 2014). Focused coding is then used to analyze larger amounts of data through the exploration of the most significant and/or most frequently occurring initial codes. This requires the researcher to make decisions about which initial codes make the best analytic sense to categorize data and allow themes to emerge (Charmaz, 2014). This categorical aggregation, according to Stake (1995), allows the researcher to view a collection of data instances from which issue-relevant meanings emerge.

Data analysis for this study began by reading each transcript while simultaneously listening to the corresponding audio recording to verify accuracy. Using qualitative content analysis, data were coded line-by-line within each transcript. Once codes were applied multiple times, working definitions were crafted to ensure accuracy in code application within and across transcripts. Through this iterative approach to data analysis, ideas emerging from the data were reconfirmed through new data and definitions were modified as needed. Peer review and debriefing (Morse, 2015) were used throughout data

analysis to prevent bias and aid in the conceptual development of codes and themes. After coding was complete, codes were organized into conceptual groupings and themes emerged. A mind map was created and refined to visualize and refine conceptual groupings (Appendix I). Similarities and differences were analyzed amongst the sources of data to ensure integration of the findings, including the expectations and experiences of nurse managers and organizational expectations from the archival data.

Protection of Human Subjects

Approval to conduct this study was received from the Arizona State University Institutional Review Board (IRB) and the research site IRB. The researcher took steps to minimize risk and ensure anonymity of participants throughout both strands of the study. The data collected for this study did not identify whether subjects were part of any vulnerable population. There was no more than minimal risk involved in participating in the individual interviews and focus groups. Data collection took place in a conference room on the campus of the hospital, providing a private, convenient location for participants. This allowed for the participant to be responsive to the researcher's questions in a comfortable, familiar setting while maintaining confidentiality.

At the beginning of each individual interview and focus group session, an information sheet describing the nature and the purpose of the study, including risks and incentives, was distributed to participants. Participants had the opportunity to withdraw from participation at that time or at any point during the interview or focus group. Please see Appendices H and I for additional detail. At the start of the focus group sessions, each participant was asked to sign a confidentiality statement to ensure all participant responses remained confidential following the conclusion of the session.

Issues of Trustworthiness

Trustworthiness is a critical aspect of all qualitative research. In quantitative research, the terms *reliability* and *validity* are most often used to denote standards indicating good and credible research (Bloomberg & Volpe, 2012). Qualitative research, however is characterized by an evolving dialogue as to the most appropriate and acceptable terminology (Bloomberg & Volpe, 2012). Lincoln and Guba (1985) suggested utilizing terms which are distinct to the traditional qualitative research paradigm including credibility, dependability and transferability.

Credibility. Approaches to enhancing credibility of the study began with being self-aware of the researcher role. Throughout the study, a journal was maintained to document and reflect upon beliefs of competency development in nursing leadership. Awareness of biases or assumptions were discussed with my research chairperson. Merriam and Tisdell (2016) note that awareness and articulation of personal bias allows for greater perspective, which enhances the accuracy of the researcher's observations and interpretations.

Peer review and debriefing (Morse, 2015) were used throughout data analysis to identify bias and aid in the conceptual development of codes and themes. An ongoing review of the data with the dissertation committee co-chair provided the researcher with crucial feedback which enhanced the researcher's insight into data analysis and any potential assumptions or biased views. The peer review also ensured that the emerging themes were firmly grounded in the data, thereby enhancing credibility and maintaining trustworthiness.

An audit trail was maintained as to improve the overall trustworthiness of this research study. The audit trail provides a record of the study which enable the researcher to reconstruct steps of the study and, if needed, justify any changes that may have taken place (Rodgers, 2012). Field notes were taken at each individual interview and at each focus group. Field notes were limited in scope and not included in data analysis. Memoing was also used throughout data analysis; memos were recorded electronically in the research database.

Dependability. Dependability, in qualitative research, acknowledges that the context of research is ever changing and open to variation and, as such, the researcher must be conscious of any changes causing a drift from the initial research design and proposal (Jensen, 2012). Dependability for this study was authenticated with the dissertation co-chair following through and reviewing the research design throughout data analysis. Additionally, all methods of data collection and analysis were reviewed with the dissertation committee to determine and maintain dependability and confirmability.

Transferability. In qualitative research, transferability implies that the research findings can be applied or “transferred” to contexts and situations beyond that of the research study itself (Jensen, 2008). The usefulness and applicability of research findings allow for a study to demonstrate transferability. To increase transferability, Jensen (2008) suggests that researchers should focus on the contextual boundaries of the results and how closely the participants are linked to the context under investigation. The research report for this study includes specific contextual data which will enhance transferability to similar contexts and populations.

Summary

There were two aims for this qualitative study. The first aim was to determine the nursing leadership competencies that clinical managers expect of new nurses. The second aim was to compare end-of-program nursing leadership competencies, as outlined in *The Essentials of Baccalaureate Education for Professional Nursing Practice* with leadership competencies identified by clinical managers. A case study design using a single, bounded case was chosen for this study.

This chapter included description of the research setting and the process by which the sample was selected, including inclusion and exclusion criteria. The sample size consisted of 11 NMs and ANMs for the intensive interviews and 12 total NMs and ANMs for the two focus groups. The setting for data collection was selected for participant convenience and to maintain confidentiality. The process of data collection and analysis, including the use of qualitative analysis software were discussed. Issues of trustworthiness were explicated, including the role of the dissertation committee in establishing and maintaining dependability, credibility and transferability.

CHAPTER 4

FINDINGS AND DISCUSSION

A total of 11 nurse managers and assistant nurse managers participated in the individual interviews. (see Table 5). The average length of time in nursing practice was 25.3 years. The majority (64%) of participants were masters prepared and had been in a management role for an average of 11.2 years. No participants held academic affiliations as faculty or instructors with any school of nursing. The average number of nurses that the participants had hired into each unit was 6.3, ranging from 1 to 13.

Table 5
Participant Demographics for Intensive Interviews

Demographics	Range Min Max	Mean
Age (Years)	27 63	47.5
Length of Time as an RN (Years)	5.5 41	25.3
Time in Management Role (Years)	2.5 31	11.2
Length of Time in Current Role (Years)	.75 8	2.4
Number of New Nurses Hired to Unit Annually	2 13	6.3
	n	%
Highest Academic Degree		
Baccalaureate Degree	4	46
Master's Degree	7	64
Academic Affiliations		
Yes	0	0
No	11	100

A total of 12 participants took part in the focus interviews. Two separate interview sessions were held. Participation in the intensive interviews was not a pre-requisite for participation in a focus group. Data from the focus groups helped to further develop themes identified in the intensive interviews. Focus group data informed research

questions #2, providing insight into how nurse managers perceive the AACN *Baccalaureate Essentials*.

Archival documents including the new nurse position description, initial skills validation, and weekly preceptor evaluation were reviewed after themes were developed. The review of documents provided insight into the consistency between organizational expectations and the expectations of nurse managers. Findings from the intensive interviews, focus groups, and archival document review are integrated in Chapter 4 by theme.

Seven major themes related to clinical leadership emerged through data analysis, including: (a) intentional learning, (b) communication, (c) professional practice, (d) advocacy, (e) teamwork, (f) influencing practice, and (g) systems thinking. Issues of generational differences, mentorship and desired traits also emerged as important topics for participants and are discussed in this chapter. Findings from the intensive interviews, focus groups and archival documents were synthesized for each theme in table format. Sub-themes presented include nurse manager expectations for new nurse leadership and their experiences of new nurse leadership. A developmental sequence for new nurse clinical leadership was identified in the data (Figure 2). Findings are presented according to the developmental sequence, including: (a) influences on clinical leadership, (b) foundations for clinical leadership, and (c) expectations for clinical leadership in practice.

Figure 2
Developmental Sequence of Clinical Leadership

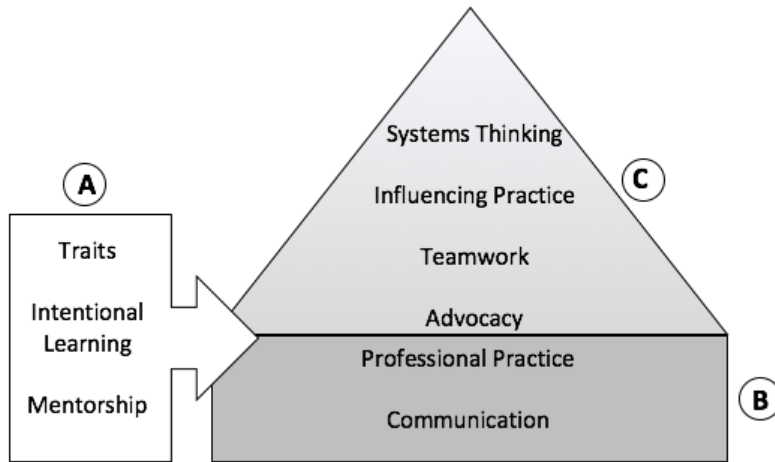


Figure 2 Diagram of the developmental sequence of clinical leadership for new nurses, including influences on clinical leadership (A), foundations for clinical leadership (B), and expectations for new nurse clinical leadership (C). Expectations for clinical leadership are listed according to the developmental sequence over time, read from bottom to top.

Traits

While knowledge, skills and abilities are important, participants perceived inherent traits exhibited by new nurses as important as managers looked for these traits beginning with the employment interview (Table 6).

Table 6
Traits

General Expectations	<p>“When I interview, and I hire people, I'm looking more for those soft skills that you can't teach. So, I can teach IVs; I can teach numerous skills, but the tasks of hard-working, compassionate, kind – those more behaviors, I think, are really hard to teach, and sometimes impossible.” (Participant 9).</p> <p>“I can teach you the clinical. I cannot teach you the core value of being humble and approachable and assuming the best intent of everybody, and flexible. Those things are inherent. I don't know how to teach those. I think you can foster them. I think you can put people in a positive environment where loved and they can blossom into that, but I don't know that I know how to teach them.” (Participant 3).</p>	
Trait	Expected	Observed
Assertive	<p>“We want very strong individuals, people that during their interview don't come across as being arrogant. More of the fact that they understand where their limitations are, their assertive.” (Participant 8).</p>	<p>“I see that a lot with delegating, figuring out how to be assertive, if they're not an assertive person, and advocating for their patients. Usually, the advocating for their patient comes up the fastest, because they want to</p>

		<p>make sure the patient gets the best thing that they need.” (Participant 8).</p> <p>“The nurse didn’t speak up, had great insight and great suggestions in the way of the nutritional support that the patient needed or potentially could have benefitted from – the head and neck patient – and it was like; well, what do you think? It was kind of pooh-pooed by the provider and she said; oh okay and kind of backed down versus, well you know I’ve read about this or I know this or I’ve seen this.” (Participant 6).</p>
Confident	<p>“I guess confidence, but not being over confident where you just blindly go down the wrong path of not asking the questions you need to ask, if you don’t know something, you need to feel confident to ask.”(Participant 6).</p> <p>“Somebody who is competent, knows themselves, knows what they can do, make a decision based on what they have, and not to be afraid to make a decision.” (FG Participant 2a).</p>	<p>“There are times when they come as overconfident and then fail to ask when they should be asking. So, I’ve found that to be a problem.” (FG Participant 3b).</p> <p>“[some new nurses come] with false confidence.” (Participant 1b).</p> <p>“They are competent to take care of a patient; they just don’t know it. That’s what’s holding them. A couple times, I just had to go to the coffee shop, get little presents, flowers – She would be standing in the corner crying. “You did great! Here’s a little box of chocolates to put a smile on your face.” They don’t have the confidence to go in a room and apply themselves.” (FG Participant 2a)</p>
Humble	<p>“Well, for our nurses on a newer nurse side, exceptional leadership would be being humble, being approachable, being professional... it’s a dance between understanding that ‘look what I was able to do’ and also ‘LOOK WHAT I WAS ABLE TO DO!’.(Participant 3).</p>	<p>“Because if you always have that humble belief that – and ability to say I’m in an area that is out of my understanding and I need help, and asking for help, those are the people that do much better than the people that are always presenting themselves like I know everything and I’m doing everything right.” (Participant 8).</p>

Data revealed that assertiveness, confidence in one’s self and an awareness of one’s own limitations are traits that nurse managers expect to see develop in new nurses.

Assertiveness and confidence emerged as two areas that were particularly challenging for

new nurses. While assertiveness was expected, participants noted that new nurses often lack assertiveness which could negatively impact communication, teamwork and patient advocacy. Participants expected new nurses to have confidence in their emerging professional role, knowledge and skills. Over-confidence and a lack of confidence were two concerns which emerged through the data. Nurses may enter into professional practice with an over-confidence or false-confidence in their knowledge, skills and abilities while others may be competent new nurses but lack confidence to truly apply their full range of knowledge and skills. Confidence in working with others and in performing technical skills was included on the preceptor weekly evaluation form.

For participants, one aspect of exceptional leadership was being humble. Participants connected humility to self-advocacy when new nurses acknowledged that there was a gap in understanding and actively sought out help.

Participants acknowledged that, while clinical skills and abilities are important, those can be taught. Personality characteristics or traits were more challenging to change. Chen and Hsu (2015) noted that the “good” nurses conveyed concern for their patients by effectively attending to their wellbeing, however, traits which exemplify a “good” nurse cannot be taught in the classroom. Catlett and Lovan (2011) found that being a “good” nurse and doing the right thing were influenced by four categories, including a nurse’s personal traits, technical skills, work environment, and caring behaviors. It was suggested that nurses were more likely to do the right thing in practice if they had personality traits which supported their behaviors, including caring, patience, responsibility, honesty, selflessness, and dependability (Catlett & Lovan, 2011).

Participants indicated they looked for new nurse to be: (a) assertive, but not aggressive; (b) confident, but not over confident in their knowledge, skills and abilities; and (c) humble, approaching new situations with a sense of humility. Assertiveness was seen as important in promoting good communication, teamwork and self-advocacy. Participants wanted new nurses to feel as though they could speak up and make their voices heard in order to advocate, lead care and lead the team. Having new nurses that were confident in their knowledge, skills and abilities was important to participants. Overconfidence was a major concern as this could lead new nurses to not seek out help or ask questions when needed, resulting in poor patient outcomes. If new nurses lack confidence in their abilities, they may be challenged in moving forward and growing as a professional. Fry and MacGregor (2014) found that self-confidence is an important factor in sustaining a nurse's clinical reasoning and problem-solving skills and can be influenced by internal and external factors. Education, experience and interaction with peers including informally debriefing after action is taken, can profoundly impact the self-confidence of a new nurse (Fry & MacGregor, 2014). Chen et al. (2017) found that simulation may offer hands-on experience to support new nurses through the first year of practice and suggest nurse educators and healthcare administrators continue to seek out practical strategies to support new nurses.

Intentional Learning

Intentional learning was defined as the process of deliberate learning from experiences, including mistakes, over time. There was evidence which indicated that nurse managers viewed intentional learning as an important influence of new nurse role development. Data indicated that learning from experience and sharing knowledge with

others contributed to clinical leadership development through intentional learning (see Table 7). New nurses were expected to challenge themselves and learn from mistakes. Overall, new nurses were eager and open to new learning and professional role development. Even one year after entering into practice, new nurses were continuing to learn skills. Intentional learning was not specifically included as part of any of the archival documents reviewed.

There was recognition, that while new nurses do grow over time, some may be impatient and look to progress very quickly. Some new nurses were very eager to “jump ahead” of where participants perceived their skills and abilities to be. Some participants voiced concern that the new nurses may “not know what they don’t know” and that rushing ahead negatively impacts the “clinical piece that makes them [new nurses] great”. Other participants noted that when new nurses push ahead too quickly, their skills don’t develop as fully and they [the new nurses] aren’t “absorbed”, or enculturated, into the unit.

Table 7
Intentional Learning

Subthemes	Expected	Observed
Learning from experiences	<p>“...it’s to not be afraid to make mistakes but committed to learn from them from them in what you’d do differently next time, because the fear of failure is paralyzing.” (Participant 6).</p> <p>“I want them to always be challenging themselves. I want them to be seeking opportunities to take care of more and more acute patients. So, part of that is always gathering knowledge.” (Participant 7).</p>	Some of the strengths I see them bringing their willingness to learn, their willingness to grow.” (Participant 8).
Being patient	“But, really, to try to teach that all in four years, and then you come out, and you’re a novice, and you begin	“Sometimes I worry a little bit that they are almost jumping ahead and they don’t know what they don’t know. So, that is the

	<p>to work on the floor and get your skills down, all of this stuff that you've taught me about these other leadership – these higher-skilled leadership issues – I'm not going to remember most of them anyway because I'm too busy learning those new skills. And, time management – you've got to get your time management down, or you're not going to survive as a nurse. And so, those are the kind of things that – most of the time, we recognize that those take even up to three years to be able to build to that level where you're not considered a novice anymore. So, we're teaching all this information, which is not bad. It's just not going to be put in practice for a while." (FG Participant 1a).</p>	<p>part I think that makes me a little bit anxious that they are willing to jump in that quickly." (Participant 5).</p> <p>"They think they are ready for leadership sooner than I think they are ready many of the times. They are prepared, I think very well, but they aren't patient to let their skills develop and to let them absorb into the unit. They just want to move forward really, really fast, and they think that they are quite capable. And in some ways they are, but I think that they are not quite ready." (Participant 2).</p>
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Learning from experiences and being patient with the professional role development as a new nurse were identified as important aspects of intentional learning, as described by participants. Mollman and Candela (2017) noted that, while nurse educators constantly work to better prepare new nurses, there still exists a gap in preparation for practice. Preparing nursing students to be intentional learners may be helpful in bridging the academic-practice gap, allowing new nurses to practice more effectively in complex, changing healthcare systems (Mollman & Candela, 2017). Intentional learning, according to Lee, Rooney and Parada (2014), occurs when individuals recognize a gap in understanding, relate learning to everyday experiences through problem solving, and activate metacognitive processes in the course of learning. Lee et al. (2014, p. 95) related intentional learning to systems thinking, whereby learners externalize their thinking, making more abstract thinking explicit as to reflect upon their knowledge and self-identify gaps, assume ownership of learning, and develop systemic perspectives. Knowledge gained through intentional learning is deeper, better integrated,

more valued, and can be applied more readily in new situations (Cholbi, 2007). New nurses who are intentional learners are willing to seek out the knowledge and skills required for professional formation which can positively impact patient care and outcomes (Knight, Tait, & Yorke, 2006; Mollman & Candela, 2017). Nurse educators must continue to generate and test learning experiences which foster intentional learning in nursing students (Davis, Taylor, & Reyes, 2014; Mollman & Candela, 2017).

Benner (2001) described new nurses in the first year of practice as advanced beginners, not yet at a competent stage of practice, but with enough experience to demonstrate an acceptable practice. Development requires experience in actual situations where new nurses begin to recognize particular, or salient aspects of a situation (Benner, 2001). Entering into practice for the first time, new nurses may lack the ability to effectively prioritize. Situations and interactions are so new that little information can be taken in (Benner, 2001). Pushing ahead too quickly may pose a challenge for new nurses as much of the preceptorship focuses on integrating salient points of nursing practice and developing clinical reasoning (Benner, 2001; Benner et al., 2010). Nurse Residency Programs (NRPs) have been suggested as one possible way to support new nurses in the transition to professional practice (Benner et al., 2010; IOM, 2011; Institute of Medicine (U.S.) et al., 2016).

NRPs are training programs designed to develop clinical and professional competencies for new nurses as they enter into professional practice after graduation (Letourneau & Fater, 2015). The goal of an NRP is to provide new nurses with opportunities to build skills in the practice setting to facilitate the transition from student to professional nurse including adapting to complex care environments, and responding

to challenges facing nurses and healthcare professionals (Bratt & Felzer, 2011; Meyer Bratt, 2013). Research has indicated that NRPs can have a positive impact on new nurse job satisfaction, retention, clinical decision-making, decreased work-related stress, clinical leadership and overall confidence in skills and abilities (Bratt & Felzer, 2011, 2012; Goode, Lynn, McElroy, Bednash, & Murray, 2013; Olson-Sitki, Wendler, & Forbes, 2012). Evidence suggests that NRPs are increasingly important for assisting new nurses in the transition from student nurse to professional nurse in acute care settings. Nurse educators and nursing leaders must continue to work together to design, implement and evaluate high-quality NRPs to support new nurses.

Mentorship

Providing strong mentorship helps to foster professional growth and leadership capacity for new nurses. Intentional selection of formal preceptors who exhibit sound leadership characteristics was important as this helped foster similar values and behaviors in new nurses. Informal mentorship can prove to be quite beneficial, fostering a “safe space” where new nurses could ask questions and seek advice (Table 8).

Table 8
Mentorship

Expected	Observed
<p>“I think having the selection of your preceptor so those experienced nurses who are good at leadership, and who are good at fostering those behaviors in individuals are really important, and I think sometimes managers get in these schedule ruts where they’re like, “I’ll just stick them with this person. It’s not ideal, but that’s how my schedule is going to work right now.” And, that can be so harmful to a new – especially a new graduate nurse.” (Participant 9).</p> <p>“I think that they need that support and even it was somebody who’d</p>	<p>“I felt that she [a newer staff nurse] demonstrated great leadership potential, rather than just taking it to somebody else and saying, “This is what I decided to handle it,” or even just walking away and not doing anything. But she took that new nurse and said, “What I saw was not okay, and you should know that, and that is not the way you should be treated,” so mentoring a younger nurse as well.” (Participant 7).</p>

<p>been through it to help say; hey, this is what I've learned. This is what didn't work well, and this is what worked well if it's helpful for you, and to share that ...and I think people would benefit from that, that buddy where you have the safe place to be...I've met two recently and then one that asked if I would help mentor, just be a mentor and not related to their supervisor or anything. I think some of them just don't have that leadership, that mentorship, that preceptor." (Participant 6).</p>	
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New nurses often face a myriad of challenges as they transition to practice in complex healthcare delivery systems. Many experience frustration and a lack of confidence when faced with stressful, challenging work environments which can lead to role strain, moral distress, and leaving the nursing profession all together (Chen & Lou, 2014; Duchscher, 2009). Shacklock and Brunetto (2012) noted that stress experienced by new nurses may be the result of poor relationships with peers and managers, perceived lack of reward or recognition, and lack of support from the organization. Benner (2001) noted that most new nurses enter into clinical practice as a novice or advanced beginner and strong efforts must be made to support and guide new nurses as they learn to apply theoretical knowledge to actual clinical experiences. Proficient and expert nurses must continue to grow and expand their wisdom and guidance to assist the novice nurse as they transition to professional practice and build a professional practice. While preceptorship and mentorship are often used interchangeably, they are not one and the same. Sorrell and Cangelosi (2016) thoughtfully delineated the roles of preceptor versus mentor. The preceptor role, according to Sorrell and Cangelosi (2016) included the designated, formal

role designed to assist the novice nurse in transitioning to professional practice during a time-limited orientation phase, whereas the mentor role was seen as more fluid, involuntary, mutually beneficial, holistically focused and long lasting.

Walker-Reed (2016) noted that a mentor could support novice nurses through communicating new ideas, building networks, connecting with resources, and empowering technical and intellectual competencies. Tiew, Koh, Creedy and Tam (2017) found psychosocial support, psychological empowerment through coaching, and consideration of generational diversity were critical factors to consider. Chen and Lou (2014) cited strong evidence in support of mentorship for new nurses to reduce attrition from the nursing profession, reduce financial losses due to turnover, and reduce cases of malpractice and negligence. Stepping back further into the transition to professional practice, Thompson, Docherty and Duffy (2017) found that strong mentorship for nursing students in their final clinical placement before graduation supported student independence and sense of belonging in the nursing profession. Students with more negative experiences of mentorship cited a lack of regular feedback, lower levels of independence and confidence, and felt overall unprepared for the transition to clinical practice (Thomson et al., 2017). Strong mentorship and supportive work environments, whether for nursing students at the end-of-program or for new nurses, are essential for successful transition to professional practice.

Effective Communication

Effective communication was defined as the successful, purposeful transmission of specific information, spoken or written, between new nurses and other members of the inter-professional team. Communicating with physicians, in particular, was perceived as

an essential skill for new nurses (Table 9). New nurses are expected to work with physicians as part of the inter-professional healthcare team. Data indicated that communicating with a physician can be an intimidating experience for new nurses. Participants noted that the new nurses may not feel empowered to ask questions, make their voice heard and be part of the solution or decision-making process.

Giving and receiving feedback emerged as an important aspect of effective communication for new nurses. Participants expected feedback to be reflected upon and incorporated into nursing practice, however not everyone reacted the same to receiving feedback. New nurses who were not accepting of feedback presented a difficult challenge to the participants.

Data suggested that it was important for new nurses to actively listen, have confidence in having difficult conversations with others, and make their voices heard. Participants expected new nurses to have tough conversations when patient safety was in question. Listening for understanding, rather than listening to respond, emerged as a component of effective communication. Speaking up was seen as a challenge for many new nurses. Participants noted that, because they are fresh out of school, new nurses may not feel empowered to speak, assuming a passive role and deferring to others with more perceived expertise.

Elements of effective communication were noted throughout archival documents. New nurses were rated weekly on customer service and interpersonal skills, including accepting feedback, making eye contact and easily conversing with patients and members of the inter-professional care team. Standardized communication was also included on the weekly evaluation form. New nurses were expected to use an evidence-based

communication framework for change-of-shift report. The Situation Background Assessment Recommendation (SBAR) communication was included on the initial skills validation form. The skills validation form also highlighted prompt, effective communication with physicians and inter-professional team members as well as addressing language barriers through the use of interpretive services. Reporting pertinent data to other health team members was identified as a core job function on the new nurse job description. Participating in peer review and providing clear, meaningful feedback were acknowledged as core functions for structural empowerment within the organization.

Table 9
Effective Communication

Subthemes	Expected	Observed
Communicating with Providers	I would love to see newer nurses being able to look at a physician as a team member, and even asking them questions and having them educate them.” (Participant 7).	“I think that newer nurses are intimidated with physicians. They don’t have the confidence to speak on the same level with the physician. And even if they understand what best practice is, they may not feel empowered to say, “Can we talk about this plan?” (Participant 7).
Giving and Receiving Feedback	<p>“Giving and taking feedback, very important, being able to direct, don’t dance around it, just say what you mean, and a lot of people can’t or don’t do it.” (Participant 1).</p> <p>“I expect nurses to come with the whole open to new learning – they’re usually very open to feedback. They want feedback. They need feedback – good and bad.” (FG Participant 4b).</p>	“So, when I met with her I thought that there would be some acknowledgement or understanding that yes, she’s challenged – no clue. So when we went over some of the things, she just sat there. I don’t even know if I really got through to her because there’s no self-perception that there is anything lacking. So, how do you reach a person like that? I don’t know.” (Participant 2).
Having crucial conversations	“If you don’t have those kinds of leadership type skills, being comfortable and confident enough to have those tough conversations with individuals –	“[She] really took it upon herself – I mean all on her own – to really lead her team, not only by example but I guess in that recognition, a reward and recognition for the practice that we expect as far as hand

	then again, yeah, it could negatively impact the patient.” (Participant 9).	hygiene goes and coming up with fun ways to recognize and then also those tough conversations with accountability.” (Participant 6).
Listening	<p>“I’d say the ability to, how am I going to say this – listen without having the answer before responding.” (Participant 6).</p> <p>“I think in looking a future leaders, we need to not only help them learn to listen carefully, filter and decipher what is important information versus fluff – but also how to analyze, problem-solve, and then articulate it – to any audience – and to write about it.” (Participant 10).</p>	<p>So, you may have somebody – a newer nurse who’s very good at listening, but that same nurse may not be as good at trying to direct a conversation if that’s the need...</p> <p>the other side of that is that you may have somebody who is so driven to gather information that they won’t listen to some of those more subtle things that happen within a conversation.” (FG Participant 1a)</p>
Speaking up		<p>“You know, I still think sometimes they take the passive role” (Participant 9).</p> <p>“I’ve seen it out here with ideas of patient education. And as a newer nurse she had a great idea, really had a great idea as far as patient education because the resource wasn’t – it really isn’t up to fifth grade level or second grade level or whatever – and she was concerned that the patients might not understand but she wasn’t speaking up to her colleagues. It was like; no, that’s a great idea.” (Participant 6).</p> <p>“A lot of times, they come out of school and they don’t feel like they have that empowerment. They don’t feel like they have that right to speak up.” (FG Participant 4a).</p> <p>You know, when you're a nurse you're terrified of making mistakes. You want to do your absolute best, but the nurses with experience are who you listen to, and you do what they say even if you don't necessarily agree with it. Or, maybe it's not the best thing to do for the patient.” (Participant 9).</p>

Discussion

Effective communication was a fundamental expectation of new nurses. Clear linkages emerged between effective communication and advocacy, teamwork, and influencing nursing practice. Communication was an expectation for all new nurses as discussed by participants and as outlined on the new nurse job description, initial skills validation and weekly preceptor form. Furthermore, communication cut across multiple AACN Essentials, indicating that communication is considered an essential competency for new nurses in all practice settings.

Communicating with physicians was identified as a challenge for new nurses in the acute care setting. Effective communication is crucial in order to provide efficient, comprehensive patient-centered care (Elligson, 2002; Reeves, Lewin, Espin, & Zwarenstein, 2010). There is evidence which suggests poor communication among healthcare professionals negatively impacts patient outcomes (Zwarenstein, Rice, Gotlib-Conn, Kenaszchuk, & Reeves, 2013). In their research, Matziou et al. (2014) found that physicians and nurses did not share common perspectives on communication and collaboration. Unresolved tensions and historical power-oriented hierarchies tended to influence interpersonal interactions and, when met with conflict, physicians and nurses tended to ignore the conflict rather than working to resolve it (Matziou et al., 2014). Kaitelidou (2012) noted that a lack of inter-professional education and educational differences between healthcare professions often created a barrier to effective communication. In clinical practice, physicians and nurses must value effective communication and collaboratively work to develop and implement inter-professional teamwork interventions to foster better communication and collaboration (Matziou,

2014). Academic institutions must also consider how to address gaps in health professions education in order to facilitate better inter-professional communication and collaboration.

Communication involves the creation of meaning during which patients and healthcare practitioners exchange information; this two-way process involves expression and reception so the message and responsibilities of those involved are understood (The Joint Commission, 2010). Giving and receiving feedback, actively listening, making one's voice heard and engaging in crucial conversations were identified as essential skills for effective communication. It is important that these skills begin to develop as nurses are in school and are further developed once in practice. Nurses are faced with several barriers to effective communication including pressures from a heavy workload, lack of support, conflicts among/between staff, fear of making others distressed by asking difficult questions, lacking the skills to initiate crucial conversations, or difficulty coping with challenging reactions or strong emotions (Bramhall, 2014). The AACN includes communication as a core competency expected of new nurses, including written and verbal communication, documentation, conflict resolution, and inter-professional communication (AACN, 2008). As nursing faculty prepare students to enter into professional practice, core communication competencies should be identified and teaching-learning activities should be designed to allow students to practice and achieve competency. Komeratat and Oumtanee (2009) found that once in practice, mentorship could be particularly helpful for new nurses as they could receive advice while encountering challenging situations around communication in the workplace.

Professional Nursing Practice

Professional practice, ranging from being on time and completing tasks to professional development and upholding practice standards, emerged as a foundational expectation of new nurses. According to the American Nurses Association (American Nurses Association, 2015), professional nursing practice is defined by six major characteristics whereby the nurse: (a) fosters a caring relationship for healing, (b) attends to the full range of human experiences and responses to health and illness, (c) integrates objective data with the patient's subjective experience, (d) applies scientific knowledge through the use of clinical reasoning, (e) advances nursing knowledge through scholarship, and (f) influences policy to promote social justice.

Engaging in evidence-based practice (EBP) surfaced as a major expectation of new nurses (Table 10). In general, participants acknowledged that new nurses seem to be well versed in seeking out, appraising and integrating new evidence into nursing practice. Participants acknowledged changes in practice over time, specifically that many of the “more seasoned” nurses were never prepared for EBP in the same way new nurses have been. This could present challenges to new nurses as some of the “old guard” [nurses who have several years of experience in the profession] could be resistant to new information presented by the much less experienced new nurses. Incorporating evidence-based nursing practices was highlighted as a core job function on the new nurse job description as new nurses were expected to utilize best evidence to guide practice decisions including care plan development and performing interventions.

Maintaining an ethical practice, including integrity and respect, was uncovered as an important facet of a professional practice. In particular, participants discussed the role

of the nurse in navigating ethical challenges including end-of-life care and decision-making. Maintaining professional standards of excellence, privacy and confidentiality were indicated as core leadership expectations on the new nurse job description. Respect for peers and not compromising one's beliefs also emerged as expectations for new nurses. Accomplishing one's duties as assigned is also a significant part of a professional nursing practice. Participants expected that new nurses should be able to effectively manage their time to accomplish expected nursing tasks, however new nurses were not expected to keep pace with the more experienced nursing staff. Becoming overwhelmed with managing the workload was identified as a common challenge for new nurses.

In general, there was agreement that non-technical skills and character traits were important considerations when hiring new nurses and that the more technical nursing skills could be taught. Some participants voiced that, while other skills could be taught over time, it was important that new nurses came prepared to be able to perform common technical skills such as IV catheter insertion and Foley catheter insertion. The initial skills validation form was heavily oriented to performance of psychomotor skills such as completing head-to-toe and focused physical examinations, performing basic interventions, and using common diagnostic and interventional medical equipment. The weekly preceptor evaluation form included general expectations of professional practice including completing routine skills, displaying a positive attitude, and maintaining accurate and timely documentation.

Maintaining a healthy work-life balance was identified as a challenge for many new nurses. Participants noted that new nurses have been immersed in a highly-competitive academic environment and the transition to practice can be difficult. Some new nurses

continued to push themselves, picking up extra shifts and placing extraordinarily high expectations on themselves in order to “get ahead” which contributed to feelings of being “burned out”. New nurses were expected to work effectively under pressure and assume accountability for their work. New nurses were expected to take regular breaks and lunches as indicated on the weekly preceptor evaluation.

Table 10
Professional Nursing Practice

Subthemes	Expected	Observed
Using an Evidence-Based Practice (EBP)	“So, learning, bringing back to the unit, sharing their experiences, I see that as being an informal leader, having that opportunity to comfortably share best practice.” (Participant 1).	“They are very good at – they are very well groomed in evidence-based practice and they want to know the ins and outs and whys and wherefores. They know how to use technology to find their answers, and so they aren’t like us old nurses who aren’t used to all this stuff.” (Participant 2). “Initially, they may be so focused on tasks and things like that they may not think about evidence base for change, and that’s something that has a culture within our environment that we teach them.” (FG Participant 5b).
Engaging in ethical practice	“End-of-life care – what does that mean and kind of ethical dilemma – considering the ethical piece and wrapping around also to the shared decision-making. So, what are the patient’s goals?” (Participant 6). “Clinical-judgement, accountability, maximize health independence, quality of life, that kind of stuff. I wouldn’t consider someone who didn’t have those values or skills.” (FG Participant 1b).	

<p>Accomplishing tasks</p>	<p>“They have not only assigned education on the computer, but they have papers and orientation things they have to fill out. There are checklists that are important to people like JCHAO who accredit the hospital and to people like me to make sure I am doing all the right things. I want your feedback, but I want you to get the work done. I expect them to get their work done.” (Participant 3).</p> <p>“I think that the expectation when you walk in the door is so much about skills that some of this stuff that isn’t really very valuable to you until six months to a year down the road is not as valuable because it doesn’t help you live through the shift, and I think that focusing more on skills – how do you get an IV in, how do you get a Foley in, how do you manage five patients on a day shift – I think that kind of stuff is still so important from the moment you walk in the door that the nice-to-haves don’t help a lot until further down the road.” (Participant 6b).</p> <p>“They still need to be learning their tasks, even at a year.” (FG Participant 1a).</p>	<p>“We’ve had a couple of times where some of the new graduate nurses get overwhelmed very quickly, and that can be displayed in numerous different ways. Sometimes it’s like frazzled and panicking unnecessary, which then kind of creates tension between the nurse and the patient, or the staff and the nurse, or so forth So, we try to keep it a very nice, relaxing environment, but I think when you’re new, the littlest thing can be, you know, huge.” (Participant 9).</p>
<p>Balancing work/life demands</p>	<p>“I think they’ve been focusing on their school for so long that now they’re like oh they can keep going and everything. I’m like, you know, you need to – yeah. You can’t just put your all in – you can put it all into work, but you have to have that balance where you can –you know go home and forget about and trying to get them, they want to pick up extra shifts a lot, and you know, so that mentality of you need to keep a balance between the two.” (Participant 8).</p>	<p>“We tend to hire in this age where you have so many nurses coming out and so few position – you tend to hire the valedictorians, the best of the best, and so, there’s some unrealistic expectations they put on themselves that we usually have to overcome with them. So, the first time that they go to them and let them know that they did something wrong, they are horrified instead of like, no, that means you are normal” (Participant 3).</p>

Evidence-based practice can be defined as a “life-long problem-solving approach to the delivery of health care that integrates the best evidence from well-designed studies and integrates it with a patient’s preferences, values and the clinician’s expertise which includes evidence gathered from patient data” (Melnyk, Gallagher-Ford, Long, & Fineout-Overholt, 2014). Participants largely agreed that new nurses were well versed at seeking out, appraising and integrating the best available evidence into practice. As EBP continues to be at the forefront of nursing practice, nursing faculty will need to continue embedding EBP into clinical and classroom teaching-learning activities.

Blackman and Giles (2017) found that graduating nursing student ability to understand and apply EBP in clinical practice could be predicted by eight variables including: (a) the ability to analyze, critique and synthesize research; (b) the ability to apply the mechanics of research; (c) the capacity for clinical practice improvement; (d) the ability to communicate research findings effectively; (e) having witnessed EBP in practice; (f) past knowledge of EBP studies; (g) past qualifications in addition to the forthcoming degree in nursing; and (h) age, where younger students were more likely to be confident with clinical practice improvement activities as compared to older students. Integrating EBP-based learning activities throughout the curriculum can promote nursing students’ successful engagement with clinical improvement programs as students and subsequently as newly graduated nurses entering into professional practice (Blackman and Giles, 2017).

The American Nurses Association (ANA) *Nursing Scope and Standards of Practice* (2015) addresses six standards of professional nursing practice which describe a competent level of nursing care as demonstrated by and through the nursing process. The

Scope and Standards of Practice includes an additional 11 standards of professional performance which competent level of professional behavior in nursing (ANA, 2015). All nurses, according to the ANA (2015) are expected to engage in professional role activities and are accountable for their own professional actions. The ANA *Code of Ethics for Nurses With Interpretive Statements* (ANA, 2015) explicates the ethical obligations of all registered nurses. It is clear that participants expected new nurses to assume the professional role and uphold the values concordant with professional nursing practice.

Participants discussed the role of the new nurse in ethical and shared decision making at the end-of-life. End-of-life care is a critical role for the RN and can present challenging ethical dilemmas, especially for new nurses. Communication can be particularly challenging for new nurses. Barrere and Durkin (2014) found that new nurses often found it difficult to find the right words to comfort patients and families near or at the end-of-life. Balancing technical competency and expressing compassion was hard as many new nurses were still working to master basic nursing skills while providing complex end-of-life care to patients (Barrere & Durkin, 2014). Maintaining a strong work-life balance was also highlighted as new nurses may not yet have the coping strategies and supports required to prevent stress and burnout when providing end-of-life care (Barrere & Durkin, 2014).

Maintaining a work-life balance can be challenging for all nurses. New nurses are particularly vulnerable to stress and burnout as they transition to the role of professional nurse (Boamah & Laschinger, 2016; Boamah, Read, & Spence Laschinger, 2017). Greenhaus, Collins and Shaw (2003) described work-life interference as an

incompatibility between the pressures and responsibilities from work and personal life. For nurses, this incompatibility can lead to increased rates of burnout, job dissatisfaction, and diminished quality of nursing care (Boamah & Laschinger, 2016; Burke & Greenglass, 2001; Grzywacz, Frone, Brewer, & Kovner, 2006; Yildirim & Aycan, 2008). Nurses with a heavier workload or who face under-staffing were more likely to experience burnout and emotional exhaustion (Boamah et al., 2017). Participants of this study noted that a drive to learn and grow can present challenges to physical energy as the new nurses frequently requested to work extra shifts to gain more experience. Research by Boamah et al. (2017) found that new nurses consistently reported high levels of stress and struggled to find a positive work-life balance due to heavy workloads, short staffing, and pressures of transitioning to the role of professional nurse. Creating empowering, supportive work environments is essential in fostering positive work-life balance for new nurses (Boamah & Laschinger, 2016; Boamah et al., 2017).

Advocacy

Advocacy refers to the work of the new nurse in supporting personal, professional, and patient care needs. Two specific types of advocacy emerged from the data including patient advocacy and self-advocacy (Table 11). Participants expected that all nurses would promote or advocate for the interests, health and safety of patients. This was observed as new nurses worked to uphold patient autonomy, providing the patient with choices to become involved in their own care. Patient advocacy was seen as an important foundational facet of leadership as new nurses worked to support patient needs and wishes. Participants saw leadership emerging as new nurses managed conflict to successfully advocate for their patients.

Self-advocacy, supporting one’s own needs or clinical judgments, emerged as another important aspect of advocacy. Participants expected that new nurses will stop and ask questions when patient care or safety is in question. New nurses who stop and take the time to ask questions were seen as exceptional. Not asking questions, or not asking the questions early enough was a common concern. Participants acknowledged that, while new nurses are generally strong patient advocates, self-advocacy can be more challenging. New nurses may feel as though they need to keep up with the pace of more experienced nurses and may not feel empowered to ask questions or advocate for their point-of-view. Advocacy can be seen as an expectation for new nurses as evidenced through the new nurse job description and weekly preceptor evaluation. Expectations of patient advocacy included escalating concerns over patient safety, when recognized. Expectations of self-advocacy included self-care and taking breaks and lunches, and seeking assistance from the preceptor as needed.

Table 11
Advocacy

Subthemes	Expected	Observed
Advocating for Patients	<p>“I would expect you to always advocate for the patient. As far as leadership goes, I feel like that is a leadership thing, being able to say, I’m gonna go against what somebody else might have to say, and say, This is what’s best for the patient.” (Participant 7).</p> <p>“I think that if you look at it from the lens of being an advocate for your patient – not leadership in its classical sense, as in leading other people, but being a leader as in advocating for your patient – that’s how I see new nurses should bring leadership to the table when they walk in the door...That’s what I would expect them to be able to bring in a leadership sense.” (FG Participant 6b).</p>	<p>“Well, they certainly are willing to get involved in making sure the patient gets what they need. They believe in autonomy and they believe patients have choices and they are very good at advocating for the patient in that respect.” (Participant 2).</p> <p>“I think advocate – and, going from that, advocating for self. Lots of times, a new nurse is just really timid and afraid to ask for any help, or ask a question, because they think, “Oh, they’re going to think I’m stupid. I just finished school and I don’t know anything. I should know, but I don’t.” So, I think advocating for patients – most of them are pretty good. They always step up for that, even beyond their little box they have</p>

		for themselves, but advocating for self – It's a little harder to get to do." (FG Participant 2a)
Advocating for Self	<p>"I think it's the courage to call out to stop the line if there's something that they have a question about that they need answered in order to feel safe about the care or doing our very best for a patient." (Participant 2).</p> <p>"You're gonna need help and know when to speak up and say hey, I need somebody to help and having the ability to know who to ask questions for. I think those are the expectations I have of the new grads that are coming in." (Participant 8).</p>	<p>"The ones that say they don't know something and ask the question are exceptional". (Participant 3).</p> <p>"The ones that don't ask questions, you're kind of worried about." (Participant 1).</p> <p>"Not asking enough questions, and not asking the question early enough." (Participant 3).</p> <p>"I think where I still see new nurses struggling is asking for help, and that was just brought up in a meeting not too long ago, about new grads feeling worthless because they can't keep up with the pace. They shouldn't be expected to keep up with the pace. They should be expected to ask for help and know what they need help with." (FG Participant 4a).</p>

Because of illness or disability, patient autonomy and self-determination is often diminished, requiring members of the healthcare team to work on behalf of the patient (Kalaitzidis & Jewell, 2015). The American Nurses Association's Scope and Standards of Practice requires nurses to protect patients, promote health and optimize abilities, aid in the prevention of injury and disease, ease suffering, work collaboratively with other members of the healthcare team and advocate for the care of individuals, families and communities (ANA, 2015). Participants of this study expected new nurses to be advocates for their patients. In general, the NMs and ANMs routinely observed new nurses acting as strong patient advocates. New nurses advocated for patients by using effective communication to articulate important information to other members of the healthcare team.

Self-advocacy was identified as an essential skill as new nurses enter into practice for the first time. Participants identified two key expectations for self-advocacy, including asking questions as needed and asking for help when needed. Self-advocacy was more challenging for new nurses. Data from this study indicate a gap between expected and observed self-advocacy behaviors. Asking questions and asking for help was the exception, rather than the standard. Pines et al. (2012) found that few nursing students feel empowered to advocate for themselves in challenging situations. Similarly, nursing students may not be prepared to instigate and meaningfully influence crucial self-advocacy conversations (Doherty, Landry, Pate, & Reid, 2016). Doherty et al. (2016) found that implementing a communication competency educational program significantly decreased nursing students' non-self-advocating beliefs and behaviors, measured with the 12-item Nurse Workplace Survey (NWS) scale. Establishing communication competencies in nursing education programs may help to strengthen self-advocacy behaviors as new nurses enter into practice.

Teamwork

Teamwork was defined as the collaborative and relational processes new nurses employ to provide safe, high-quality patient care. Teamwork was seen as an important leadership competency for new nurses (Table 12). Participants clearly expected new nurses to effectively delegate to certified nursing assistants (CNAs). This was particularly important to participants, noting that new nurses “can’t do it all” and need to engage and use their team as needed. One participant noted that effective delegation was leading in a way that makes people want to work with you. Delegation could be challenging, however, as new nurses initially tended to over- or under-delegate. Participants felt that

new nurses who previously worked as CNAs tended to delegate more effectively. Those without CNA experience tended to have more difficulty “letting things go” and delegating to other members of the team. New nurses were evaluated each week on their ability to delegate with prompting from their preceptor. Delegation was an essential core function of the new nurse as indicated on the weekly preceptor evaluation and new nurse job description.

New nurses were expected to be proactive in working with team members. It was also an expectation that new nurses would successfully build a “network of acquaintances” to foster mutually supportive relationships as part of the healthcare team. As part of the weekly preceptor form, new nurses were evaluated on their confidence in working with patients, families, physicians and other members of the inter-professional team.

Team leadership and facilitation emerged as important elements of effective teamwork. Participants expected new nurses to be able to lead the team, coordinate care from the bedside, and pull the team together to improve patient care. Participants acknowledged that team leadership can be challenging for a new nurse and takes time to develop. New nurses were evaluated on the ability to delegate and work as a team with colleagues as part of the initial skills validation form. The highly competitive nature of nursing school emerged as a concern for participants, noting the high, independent achievement expectations students have in nursing school may negatively impact how they integrate with the healthcare team upon entering into professional practice.

Table 12
Teamwork

Subthemes	Expected	Observed
Delegating effectively	<p>“So, as far as leading out there for sure delegation would be good, but also delegating in a way that makes people want to work for you.” (Participant 3).</p> <p>“Be a good delegator – somebody that could take a group, or look at a situation, and be able to delegate out the important pieces to the right individuals.” (FG Participant 4a).</p>	<p>“I think teamwork is pretty essential, and I love when I see teamwork between them, and everyone kind of working together to get the job done.” (Participant 9).</p> <p>“When they first start out, that’s one of the things they really struggle with. You usually have two ends of the spectrum. You usually have the people that say hey, this is great. I’m gonna delegate everything and not do it. You know have everybody do my work, or you have the other end of the spectrum where you have people that say I’m gonna do everything on my own. I very rarely have somebody that is in between and does it well first out of the gates, so that’s one of the things that when they first start, usually, they’re not very good at.” (Participant 8).</p> <p>“...they usually don’t come with the delegating tasks, and making connections is intuitive to individuals. It’s hard to teach that one.” (FG Participant 2b).</p>
Leading the team	<p>“We expect the nurse who’s in the room to be the leader of the activity in that room. So being very directive in a positive way, in a constructive way to getting the team that’s working together for that patient care working in the same direction and all on the same page and having things go smoothly. That’s the leadership skill I would be looking for in a new nurse as they were practicing.” (Participant 4).</p>	<p>“They lead. They are very good. I guess the only downside of that is they come into the job with the expectation that they are going to be able to lead, and they are going to – success is a very important word to this generation. They want to get the awards in school, so they have a list of the awards they’ve gotten. Everybody succeeds nowadays! And so they measure their success differently than previous generations did, I think.” (Participant 2).</p> <p>“The competition to get into [nursing] programs can become very stringent. So, you end up with a whole bunch of people in nursing school that are Type A. They don’t work well with other people. And then, all of a sudden, we thrust them into an environment where I need you to work with a team...I have to make it on my own, and I can’t rely on other people</p>

		because I've got to beat them out.' " (FG Participant 1a)
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Effective delegation and leading the team were two key areas of teamwork identified by participants. Delegation, according to the American Nurses Association (2015, p. 86) involves the transfer of responsibility for the performance of a task from one person to another while retaining accountability for the outcome. Participants of this study verified the need for effective delegation, but acknowledged that new nurses may not be well prepared for delegating to others as evidenced by under- or over-delegation. While delegation is critical to delivering high-quality care, research suggests t a gap in the delegation skills of new nurses which can contribute to unequal distribution of workload, insufficient supervision of delegates, and insufficient or missed care (Anthony & Vidal, 2010; Hasson, McKenna, & Keeney, 2013; O’Kane, 2012). Johnson et al (2015) examined the role of organizational culture on delegation, noting that on units with a culture of collaboration, Certified Nursing Assistants (CNAs) and RNs understood each other’s roles better and valued working together to deliver care. With a less collaborative unit culture, CNAs and RNs tended to work in parallel because of role confusion, ineffective communication, and poor delegation skills. According to Johnson et al. (2015) unit culture and effective communication play a significant role in influencing effective teamwork between RNs and CNAs.

Being able to prioritize patient care needs and effectively manage one’s time are essential for successful delegation and supervision (Johnson et al., 2015). Academic and practice leaders must collaborate to optimize the current nursing curricula to include salient theoretical knowledge and practical opportunities for nursing students to delegate

and supervise (Magnusson et al., 2017). Providing new nurses with supportive learning spaces to continue to develop communication, leadership and self-awareness may facilitate increased confidence and competence with delegation and supervision (Magnusson et al., 2014).

Coordinating, integrating, and facilitating the activities of multiple members of the inter-professional team are essential facets of team leadership for nurses (Porter-O'Grady & Malloch, 2016). Findings from this study indicate that participants expect new nurses to be the leaders in the room, working to move the team forward to provide the best care possible for the patients. In nursing programs, students are trained to be responsible for nursing care, however the leadership role of the nurse isn't always clearly articulated (Ekström & Idvall, 2015). New nurses often struggle with being able to lead nursing care. Ekström and Idvall (2015) found that clinical leadership affected the quality of care provided and new nurses frequently experienced challenges as they transitioned to the role of leader. Novice nurses have difficulty prioritizing and effectively organizing nursing care, but are expected to lead others while unable to effectively manage their own provision of nursing care (Benner, 2001; Ekström & Idvall, 2015). Becoming a competent leader, according to Benner (2001), requires knowledge and experience specific to an organization which education alone cannot provide.

As healthcare systems continue to evolve and become increasingly complex, it becomes apparent that no single individual or professional discipline has the knowledge, skills and abilities to adequately address the multifaceted needs of patients and patient populations (Porter-O'Grady & Malloch, 2016). To deliver the best possible care, healthcare practitioners from diverse backgrounds with unique knowledge and skills must

work together in an effective and efficient manner. As new nurses begin to engage with the inter-professional team, their lack of confidence may compromise the delivery of high-quality care (Pfaff, Baxter, Jack, & Ploeg, 2014). Pfaff et al. (2014) found that team leadership improved for new nurses as they gain knowledge and experience with inter-professional collaboration, are provided with opportunities to collaborate, develop supportive relationships with care team members, and balance self-imposed expectations with the practice expectations of other healthcare professionals.

Influencing Practice

One definition of influence offered by the Merriam-Webster Dictionary (“Influence | Definition of Influence by Merriam-Webster,” n.d.) is “the act or power of producing an effect without apparent exertion of force or direct exercise of command”. Having influence over nursing practice was an important aspect of new nurse leadership; participants expected new nurses to begin influencing practice through formal and informal channels (Table 13). Each new nurse participated in a formal process or performance improvement project as part of the nurse residency program within the organization. It was expected that the knowledge gained would be shared with other staff on the new nurse’s unit to influence practice. It was also expected that new nurses would take part in unit-based specialty practice teams as part of the organization’s shared governance as indicated through the interview data and new nurse job description. Participants noted that many of the new nurses do actively engage in specialty practice teams and unit-based research projects. The ability to influence others was closely linked to the new nurse’s ability to effectively communicate and advocate for change.

Leading patient care, going beyond the routine tasks, was also identified as an important way in which new nurses influence nursing practice. Examples offered by participants included mentoring or coaching patients to reach health goals. Leading patient care was also linked to communication and teamwork as new nurses were expected to begin leading the care team, including delegation to Certified Nursing Assistants (CNAs). Leading patient care was reflected in the new nurse job description. New nurses were expected to develop, initiate and review plans of care reflecting a patient's changing condition and taking into consideration the patient's unique background and preferences. Being proactive in caring for patients and intervening appropriately in emergency situations were also included as core job functions.

Taking the initiative to work through problems and look for solutions was identified as an important facet of influencing nursing practice. Participants expected new nurses to be instigators of change by actively seeking solutions to problems and articulating a thoughtful solution when presenting the problem to the NMs and ANMs. There was consensus that new nurses should be seeking out resources to help answer questions but, over time, should work to become the resource to help others. Teaching and supporting others was a core job function as outlined on the new nurse job description.

Participants revealed that some new nurse preparation for leadership wasn't as practical as it could be. Additionally, some participants felt the foundational concepts of leadership, including communication and teamwork, were more important for new nurses than to the study of formal leadership or management roles, noting that patient care was a priority while other areas of leadership could develop over time. One participant offered that some nurses are very well prepared with leadership theory, however the application

of the theory to practice can be challenging, especially if the new nurses have not had time to practice leadership while in school.

Table 13
Influencing Nursing Practice

Subthemes	Expected	Observed
Leading through Informal pathways	<p>“A staff nurse that’s just leading in their profession – we’re all leaders in some way, shape, or form.” (Participant 6).</p> <p>“Someone who can influence someone else – the ability to influence others. Well, just as far as –to imply a leader sometimes implies that there’s a follower. So, the ability to have others – maybe not even “follow” as a shepherding thing, but just influencing their behaviors by how you lead, I guess, if that makes any sense.” (FG Participant 3a).</p>	<p>“We had opportunity with hand hygiene and really took it upon herself – I mean all on her own – to really lead her team, not only by example but I guess in that recognition, a reward and recognition for the practice that we expect as far as hand hygiene goes and coming up with fun ways to recognize and then also those tough conversations with accountability.”(Participant 6).</p>
Leading Through Formal pathways	<p>“They [new nurses] have to lead and complete a four step problem solving, so that’s more of getting them involved, teaching them how to build their leadership skills, and management skills, encouraging them. If somebody has an idea that comes forward, okay. This is a great idea. I will mentor you, but you’re the one that’s gonna need to lead this and make sure you see it through completion” (Participant 8).</p>	<p>“They like to get involved in – I guess we call them – extracurricular kinds of activities, not just coming to work, and doing their 12 hours, and leaving. They like to be involved in committees. They like to get extra training, for instance, SANE work or we have psychiatric committees. We have a committee for everything in our department.” (Participant 7).</p>
Leading the patient	<p>“When you’re a primary nurse, you’re leading. You are, you know, leading. You’re leading that patient through their day, and so forth.” (Participant 9).</p> <p>“I think even a nurse leading their team of patients through the day, or through the process of healthcare, and having to delegate to the CNAs and collaborate with all the different disciplines. In a certain sense, they can even be the leaders of</p>	<p>“I get super excited when I see my nurses are kind of leading their patient. So, they’re not taking the back-seat role, and just giving medications, and leaving the room, but are leading the patient through their stay.” (Participant 9).</p>

	their patients through the day.”(FG Participant 3a).	
Solving problems	“To move things forward, you have to be part of the solution.” (Participant 1).	“it was a newer nurse within his first year who came in to us and he said that the place where he was either a student or had worked briefly before us had a column in Epic that told them when the patient was needing to be revitalized. So, time the vital signs, because it is all set to policy anyways. I was like, that’s a fantastic idea and we made that happen.” (Participant 3).
Learning leadership	<p>“I expect them to understand what good leadership is. Transformational leadership and what not. That part of it, I think is taught in school. I don’t think that’s as important, in my view, for new grads that are coming out of the nursing field.” (Participant 8).</p> <p>“I think they need to know how to apply leadership concepts when they first come out because they need to be able to – like we talked about earlier – be able to be empowered, to ask for help, how to communicate. I think all of those things – how to make decisions appropriately. I think all of those come – as a new nurse; they need to know how to utilize those skills. I think they need to be able to demonstrate leadership and communication.” (FG Participant 4a).</p>	<p>“What I find is it’s not as, the leadership that they come with is not as practical as I’d like to see.”(Participant 1).</p> <p>“The other stuff comes later when they have an opportunity to be exposed to formal leadership and leading other people, but when they’re baby nurses, and really, they’re just more interested in, “How do I care for this individual patient, or four or five of them?” How do you foster the leadership of advocating for your patient? I think that takes some skill as well.” (FG Participant 6b).</p>

Influencing nursing practice emerged as a competency for new nurses. Nursing practice was influenced through formal and informal leadership opportunities, leading patient care and solving problems. To safely and effectively meet increasingly complex patient care needs in the acute care setting, nurses must be able to positively influence nursing practice. Recently updated scope and standards for Registered Nurse (RN)

practice calls for all RNs to be leaders within the nursing profession, working to advance nursing practice, influence policy and encourage change and innovation (American Nurses Association, 2015). Nurses must be prepared to generate new knowledge, develop new healthcare practices, and improve healthcare delivery (Thomas, Seifert, & Joyner, 2016). The Institute of Medicine (2011) called for expanded opportunities for nurses to lead and collaborate on improvement efforts in practice and education. Creating formal and informal pathways for new nurses to engage in leadership can positively influence practice and build leadership capacity.

Thomas et al. (2016) examined the change agency of the RN in seeking solutions to problems through the lens of innovation. Healthcare innovation, as defined by Thakur, Hsu and Fontenot (2012), includes those changes which help healthcare practitioners to focus on the patient by allowing healthcare practitioners to work “smarter, faster, better, and more cost effectively”. Blakeney et al. (2009) discussed barriers and facilitators of innovation, where innovation becomes more difficult in organizations with more top-down bureaucratic structures. Organizations with supportive leaders, innovation networks and dedicated time for problem solving can be conducive for supporting innovation (Blakeney et al., 2009). Nursing administrators must create opportunities for staff innovation in the acute care setting to foster creativity and stimulate intellectual problem solving (Boston-Fleischauer, 2016). Supporting time away from direct patient care may be one way to allow space for new nurses to be creative and innovative in their approach to problem solving (Altman & Rosa, 2015). Finally, Thakur et al. (2012) noted that supporting nurses in developing leadership traits associated with innovation may be an effective method to develop a culture where innovation can grow.

Participants acknowledged a gap in new nurse leadership preparation, noting that some aspects were not as “practical” or applicable as they might like. End-of-program leadership competencies have been established by accreditation agencies and professional organizations such as the American Association of Colleges of Nursing (AACN) and the National League for Nursing (NLN). The question that emerged was the degree to which the competencies have been integrated into nursing curricula. Candela and Bowles (2008) noted that, in undergraduate nursing programs, leadership is often seen as an end-of-program concept, isolated and reserved for the final academic term of study. True integration of leadership concepts and competencies across the curriculum allows students to augment their leadership knowledge, skills and abilities over time and before transitioning to professional practice (Candela & Bowles, 2008).

Systems Thinking

Systems thinking refers to the expansion of the new nurse’s thinking beyond individual, segmented tasks to the whole patient which, over time, allows the new nurse to see a broader context for nursing care and begin to influence systems-level change. An initial grasp of systems thinking emerged as being an important competency for new nurses (Table 14). Participants expected new nurses to actively lead for change by sharing knowledge of best practices and participating on unit-based councils. Through the nurse-residency program, each new nurse worked with hospital leaders to design, enact, and measure a process improvement project.

Participants also discussed how new nurses begin to see the whole patient. New nurses must be able to begin to put the pieces together and move beyond individual tasks. The initial skills validation form for the organization clearly outlined the essential skills

and interventions that a new nurse is expected to perform. Being able to perform skills was important to the participants, however, being able to move beyond a task-focused orientation was also valued. Moving past individual tasks or elements of care to an emerging understanding of the patient care context was an important step in the development of a professional nursing practice. The job description for a new nurse encompassed leading for change through the use of knowledge, innovation and quality improvement. Systems thinking was specifically highlighted as new nurses were expected to understand and articulate unit and organizational-level data regarding patient outcomes and how the nurse's work impacts patient outcomes. Strategic engagement, an awareness of strategic initiatives and how organizational strategies are operationalized, was included as an expectation in the new nurse job description.

While moving past the individual nursing tasks is important, the ability to situate knowledge gained in nursing school to clinical practice can be challenging to new nurses. Participants relayed that some new nurses were excellent at analyzing data and recalling facts, however the patient was easily missed in the midst of all the information. The new nurses were adept at meeting technical challenges, however they had more difficulty in navigating adaptive challenges. While this was seen as a hurdle, some participants felt that it was part of the natural growth and development of a new nurse over time. For those participants, having a more task-focused approach was acceptable; once the foundational tasks were mastered, the new nurse could then begin to look at the bigger picture.

Table 14
Systems Thinking

Subthemes	Expected	Observed
Leading for change	<p>“And to continually improve practice in your area, you need to be able to take on leadership of – because we’re – actually as part of the LEAN journey that we’re on as well is that we expect all employees to lead, to some degree, incremental improvement in areas.” (Participant 4).</p>	<p>“Some of ours are involved with the specialty practice teams and willing to do the research. If they see a problem, they seem to want to do the research and lead in that respect. They want to learn to do some of our lean project work and play advocate for change as far as nursing goes.” (Participant 5).</p>
Putting the pieces together	<p>“It’s a brand new job, how do you – you have to figure out the tasks, but once you connect it to the tasks really are making the human better, that’s where my perspective, how nurses show that they’re connecting the dots and that now I can look beyond just the tasks and start thinking about best practice and how to all of us do it, how do we do consistency in our care, those are all vitally important pieces to caring for individuals.” (Participant 1).</p>	<p>“I think probably that whole clinical aspect of seeing the patient in the midst of all of their intelligent understanding of all of that is something that they are not as prepared at. They are so good at analyzing all that stuff. And then in the middle of it there is the patient. It just feels like that is a piece that is missing.” (Participant 3).</p> <p>“‘Life smart.’ Your A students are book smart, but they don’t know how to apply that knowledge to the real-world situations, and they get stuck.” (FG Participant 4a).</p>
Moving beyond the tasks	<p>“Getting from ‘I’m doing my tasks’ to ‘I’m treating a human’ sometimes takes a leap and sometimes people don’t ever get there.</p>	<p>But those are the people I see who I recognize get it, this is what we’re here for, and they often then are very engaged in ‘what else can I do for the patient’. That’s when I see that glimmer of leadership.” (Participant 2).</p> <p>“They can paint a picture of every diagnosis and everything, but they don’t know what is going on with their patient. They do the tasks, but they can’t tell you why. It’s interesting. They don’t connect their intellectual knowledge with the practical knowledge of that patient there. That’s a gap.” (Participant 2).</p> <p>“ [thinking beyond the tasks] is something that doesn’t come right away. They’re too focused on all these other things first, which I think is okay. I think they should focus on them.” (FG Participant 2b).</p>

Systems thinking was an expectation of new nurses as they start to see the larger context for patient care and begin to lead for change within the larger healthcare system. Phillips, Stalter, Dolansky and Lopez (2016) developed a seven-phase process of learning to think and act and the systems level. In the Systems-level Awareness Model (Phillips et al., 2016) action is influenced by the systems-level behaviors of personal effort, reliance on authority, clinical reasoning and an awareness of interdependencies within the system. Systems thinking, as identified by the participants, was consistent with the first three phases of the Systems-level Awareness Model, starting with the application of knowledge to provide basic nursing care (Phillips et al., 2016).

New nurses were expected to think beyond the individual tasks at hand, beginning to see the full context of how sets of tasks related to the patient's care and how that care was situated within the entirety of the nurse's shift. Participants acknowledged that this emerging systems awareness developed over time, which is consistent with the Systems-level Awareness model (Phillips et al., 2016) and Benner's From Novice to Expert (2001). Phillips et al. (2016) argue that as education increases, critical reasoning and awareness of interdependencies also rise, facilitating progression of systems-level awareness. Nurses may possess a great deal of knowledge from their clinical experiences, however they may not be thinking in terms of systems beyond their individual patients. End-of-program competencies such as the AACN's Essentials of Baccalaureate Education for Professional Nursing Practice provide key curricular elements and a framework for scaffolding the baccalaureate-nursing curriculum. Baccalaureate Essential II specifically focuses on basic organizational and systems leadership for quality care and safety, shifting the focus to include the individual patient

situated within the complex healthcare delivery system. Linking end-of-program outcomes to high-quality teaching-learning activities in nursing programs can improve the progression of systems thinking of students and graduates (Phillips et al., 2016).

Transition-to-practice programs can also help new nurses develop systems thinking. Participants noted that each new nurse hired into the organization takes part in a nurse residency program. New nurses participate in process or performance improvement projects as part of the nurse residency program, which helps to give a broader systems-level perspective beyond a single patient or patient care unit. Supporting the system-level awareness of new nurses has broad reaching implications, including increasing awareness of complex system functions and the nurse's role and responsibilities within the system (Phillips et al., 2016). Systems thinking, at higher levels of the Systems-level Awareness Model, begins to emerge as new nurses begin to influence nursing practice within the organization.

Generational Differences

Generational differences of new nurses entering into practice as contrasted with the entry-to-practice experiences of the nurse managers emerged as a strong secondary theme in the data (Table 15). One difference the participants described is the perception that new nurses, particularly those of a younger age, are more focused on themselves and what the organization can do for their career. Advocating for one's self through asking questions and asking for help was an expectation of new nurses, however self-advocacy in the setting of an employment interview was a cause for concern among participants. Participants acknowledged that this was a difference they have seen over time. Some participants acknowledged that when they were starting out, it was expected that the new

nurse would “pay their dues” and take on the less desirable shifts. Participants also discussed the “butting up of traditions”, acknowledging changes in practices and expectations over time, including the idea of “service before self”, which can be hard for some more experienced nurses and managers to accept.

Being able to use healthcare informatics and integrate technology into one’s practice was also seen as a difference which has emerged over time with new nurses. Participants noted that most new nurses entered into practice well prepared to utilize healthcare informatics. New nurses also tended to be accomplished in seeking out information using technology and on-line resources. Using healthcare technology, including electronic health records (EHRs) was a core job function on the new nurse job description and was included on both the initial skills validation and weekly preceptor evaluation.

Table 15
Generational Differences

Subthemes	Expected	Observed
Expecting more	“There was a time where nurses always had to start a night shift and work their way down to day shift, and now there’s a change in that nurses will say, “This is what I’m willing to do. This is what I’m not willing to do.” (Participant 7).	. They come with a – even in interviews – what are you going to do for me? What’s available? What kind of research do you have? And the old nurse in me wants to say, ‘You can just be glad that I might hire you’.” (Participant 2). “What I’ll say are the typical millennials – smart – competent, sometimes a little stubborn – wanting to – progress very quickly through – level of promotional opportunities, levels within their role, probably – from my view – sooner than they’re ready to – and more aggressive about that than I’ve seen with graduating groups – I would say.” (Participant 10). “I think that’s very generational. Gen X and the baby boomers all would get a job and stay with it for years and years, and the Gen Yers and the ones younger than that all know that

		<p>they're very portable, so they expect portability." (FG Participant 6b).</p> <p>"Here's my two years; I'm going to do it here, then I'm going to move on to the next spot." I think there's a higher turnover with this generation than there used to be, and I think it's probably generational as well, but I think that's an expectation of their peer group." (FG Participant 1b).</p>
Using healthcare technology		<p>"I think also their ability to use technology, whether it's the EMR or different equipment or what have you. I think the new grads are miles ahead in their ability to adapt to change in our electronic world." (Participant 6).</p> <p>"...back in the old days [they] did these three-year programs and they spent all their time in the hospital, they learned to see patients. They weren't so worried about all of the other things. I see new nurses sitting at the computer by the hour sometimes where they would rather sit there and explore through technology all of the ins and outs of their patients' physiology, all of the labs.(Participant 2).</p>

Generational differences were highlighted throughout the findings, with participants discussing differing expectations between present-day new nurses contrasted with expectations from when participants were new nurses. Changes in how new nurses advocate for their own expectations of employment emerged as an important sub-theme in the data. While new nurses were expected to employ self- and patient advocacy in clinical practice, the expectation for how new nurses should advocate for their employment needs or preferences differed. Self-centeredness versus an "other-centeredness" with nurses from a younger generation advocating for employment needs was perceived negatively by many participants. The dissonance between expectations and experiences of employment-related self-advocacy versus clinical practice-related self-

advocacy may be related to several factors including differences in values, educational preparation and experience, and life experience.

The present generational cohort, Generation Y, born between the years 1981-2000 numbers approximately 78 million and, although this generation only comprised approximately 15% of the nursing workforce before 2014, their numbers are steadily increasing (Sherman, 2014). It is expected that Generation Y will comprise nearly 50% of the nursing workforce by 2020 (American Hospital Association, Committee on Performance Improvement, 2014). Generational diversity is changing the dynamics of the nursing workforce and can be seen as a challenge to be resisted or an opportunity to embrace. Each generation brings unique experiences and values to the workplace.

Healthcare organizations which leverage the differences and strengths of their employees can become more agile in transforming how healthcare is delivered as patient experiences and patient care outcomes are improved (American Hospital Association, Committee on Performance Improvement, 2014). Organizations which do not effectively manage a generationally diverse workforce experience higher employee turnover, increased costs related to recruitment, retention and training, lower patient satisfaction and worse patient-care outcomes (American Hospital Association, Committee on Performance Improvement, 2014).

While they share many similarities with other generational cohorts, Generation Y has two unique differences from previous generations: (a) Many have incorporated technology into nearly all aspects of their personal and professional lives, and (b) many expect organizational accommodation to unique employment needs and preferences (McCready, 2011). Expectations of accommodation have proven particularly challenging

for nurse managers as leadership and management techniques which may have worked with other groups may not prove beneficial with this generational cohort (McCready, 2011). Issues of workforce turnover continue to be problematic. Members of the Generation Y cohort are more likely to seek out new employment or educational opportunities when workplace expectations are not met, a unique difference from previous generations (Kovner, Brewer, Fatehi, & Katigbak, 2014; RWJF, 2012). When this generational cohort feels they are working in an area where they are not able to do what they came to nursing to do, they will more readily move on to an organization where the system supports their needs (St-Denis, 2016).

The challenge for nursing administration is to foster work environments which are supportive of generational diversity and models of professional practice that embrace significant differences and strengths. Collaboration, communication and teamwork clearly emerged as expectations for new nurses. Recognizing the knowledge new nurses bring in areas such as healthcare informatics, research, and evidence-based practice can be beneficial while at the same time acknowledging they are in the process of developing their clinical nursing practice (Andrews, 2013). Transition to practice also requires careful planning such that all new nurses are supported as team members as opposed to outsiders that must earn acceptance (Andrews, 2013). Developing a culture accepting of multiple perspectives which acknowledges the contributions of each team member is critical for building high-quality work environments, reducing the workforce turnover of new nurses, and decreasing burnout amongst all nursing staff (Andrews, 2013; Perlo et al., 2017).

Nurse Manager Perceptions of the AACN Baccalaureate Essentials

The focus groups provided additional depth and detail on nurse manager perceptions and impressions of the AACN Baccalaureate Essentials. Initial impressions of the Essentials focused on the broad scope of nursing education in light of evolving areas of specialized practice. In general, most agreed that there is an enormous amount of knowledge nurses must possess and trying to distill it all into essentials would be challenging. All participants acknowledged that the outcomes for Essentials II and IX were “highly important” or “essential” for new nurses. Some of the essentials, however, were seen as less important for new nurses just entering into practice and could be developed over time.

Outcomes 1,2,4,5,6,7,8 and 9 were perceived to be the most important for new nurse leadership (see Table 16). There were some differing expectations of how a new nurse should be prepared for leadership. Some participants felt nearly all of the outcomes were important for new nurses, while others felt the more “cognitive” or “theoretical” aspects were less important and not as essential for new nurses as they entered into practice. Being aware of complex systems, using improvement methods (including principles of quality improvement) to catalyze change, and participating in the development and implementation of systems-level change were seen as less vital for new nurse leadership. In general, participants expressed they did not expect new nurses to be prepared in these areas, however as they develop in their professional practice these areas would be important. In consideration of cost-effectiveness, however, new nurses should have a basic understanding that the “mission drives the money, not the other way around” (FG Participant 1a).

Table 16

AACN Baccalaureate Essential II: Basic Organizational and Systems Leadership for Quality Care and Patient Safety

AACN Baccalaureate Essential II Outcomes	Mean	S.D.
1 Apply leadership concepts, skills, and decision making	2.55	.498
2 Demonstrate leadership and communication skills	2.92	.289
3 Demonstrate an awareness of complex organizational systems	1.83	.577
4 Demonstrate a basic understanding of organizational structure	2.58	.515
5 Participate in quality and patient safety initiatives	2.67	.492
6 Apply concepts of quality and safety using structure, process, and outcome measures	2.50	.522
7 Promote factors that create a culture of safety and caring	2.92	.289
8 Promote achievement of safe and quality outcomes of care	2.83	.389
9 Apply quality improvement processes	2.58	.669
10 Use improvement methods	2.33	.492
11 Employ principles of quality improvement, healthcare policy, and cost-effectiveness	1.92	.289
12 Participate in the development and implementation	2.00	.739

Note: Participants scored outcomes on a scale of 1 (not required or applicable) to 3 (highly important or essential). The outcomes rated as being most important or essential (≥ 2.50) are shaded in grey.

Many of the outcomes for Essential IX were identified as highly important or essential for leadership, while others were perceived to be ideal but not necessary for clinical leadership. Outcomes 1,3,4,5,8,11,12 and 14 were perceived to be the most important for new nurse leadership (Table 17). Conducting comprehensive and focused assessments, communicating with all members of the healthcare team, delivering high-quality compassionate care, and creating a safe environment for care emerged as major expectations of new nurses.

Communication was seen as a foundational aspect of leadership as new nurses assumed a role within the healthcare team and began to educate patients and families. Demonstrating sound clinical judgment and creating a safe patient care environment were seen as core values. Some participants voiced that they would not hire someone who did not possess these skills or values. Participants discussed the complex nature of inpatient

nursing units and how decision-making could quickly move away from the patient. Keeping the patient in focus was highly valued and was felt to positively impact patient care and patient outcomes. Conversely, knowledge of genetics and genomics and complementary/alternative therapies and caring for patients with multiple functional problems were seen as unimportant for leadership. Outcomes such as emergency preparedness were seen as more organizationally-dependent, so new nurses wouldn't be expected to be prepared for those aspects before hire.

Findings from the focus group revealed several linkages between the AACN Baccalaureate Essentials and expectations of nurse managers for new nurse leadership preparation. In general, there was consistency between Essentials which participants found most important and the themes which emerged from the intensive interviews. Leading for change, patient advocacy, and leading patient care have clear connections with Baccalaureate Essential II. Interestingly, there was a split in how participants perceived the importance of new nurses leading change through formal and informal pathways. Participating in unit-based change projects as part of the Nurse Residency Program (NRP) and/or Specialty Practice Teams was expected, however it was not anticipated that new nurses be prepared to participate in more complex, organizational change. Higher-level organizational and systems thinking were valued, but not essential at the onset and could be developed over time. Intentional learning becomes important as new nurses grow their professional practice and clinical leadership.

Table 17

AACN Baccalaureate Essential IX: Baccalaureate Generalist Nursing Practice

AACN Baccalaureate Essential IX Outcomes		Mean	S.D.
1	Conduct comprehensive and focused assessments	3.00	.000
2	Recognize the relationship of genetics and genomics	1.83	.718
3	Implement holistic, patient-centered care	2.58	.515
4	Communicate effectively	3.00	.000
5	Deliver compassionate, patient-centered, evidence-based care	3.00	.000
6	Implement patient and family care around EOL	2.25	.452
7	Provide appropriate patient teaching	2.42	.793
8	Implement evidence-based nursing interventions	2.50	.522
9	Monitor client outcomes	2.08	.900
10	Facilitate patient-centered transitions of care	2.42	.515
11	Provide nursing care based on evidence	2.92	.289
12	Create a safe care environment	3.00	.000
13	Revise the plan of care	2.42	.669
14	Demonstrate clinical judgment and accountability for patient outcomes	2.92	.289
15	Manage care to maximize health, independence, and quality of life	2.25	.754
16	Demonstrate the application of psychomotor skills	2.25	.754
17	Develop a beginning understanding of complementary and alternative modalities	1.83	.577
18	Spiritual beliefs and values	2.00	.426
19	Manage the interaction of multiple functional problems	1.83	.577
20	Understand one's role and participation in emergency preparedness	2.08	.900
21	Engage in caring and healing techniques	2.42	.515
22	Demonstrate tolerance for the ambiguity and unpredictability	2.33	.651

Note: Participants scored outcomes on a scale of 1 (not required or applicable) to 3 (highly important or essential). The outcomes rated as being most important or essential (≥ 2.50) are shaded in grey.

Safety and quality are important aspects of nursing leadership and intersect with generalist practice as new nurses provide care to patients and families. Ethical, evidence-based care and accomplishing the duties required of a professional nurse are foundational to professional nursing practice. This was reflected in the lower-scoring outcomes Essential IX as managers felt these areas were important in the delivery of high-quality nursing care, but not necessarily as part of one's nursing leadership; however, many of some outcomes emerged through the themes of systems thinking and professional nursing practice. Moving beyond the psychomotor tasks of nursing and accomplishing tasks are

clear expectations for new nurses. Managers anticipate that all nurses will accomplish their assigned work in a timely fashion, however for new nurses this may prove overwhelming. Designing and implementing programs to support new nurses through the transition from accomplished student to novice nurse is critical (Benner, 2001; Jewell, 2013).

Archival Documents

Archival documents including the new nurse position description (NPD), initial skills checkoff (ISC), and the preceptor weekly documentation form (PWD) were reviewed and findings integrated into the overall findings for each theme. There were several areas worthy of discussion where themes were not reflected within these archival records. The NPD provided a look at what would be expected, in general, of a new nurse applying for a position within the organization. The NPD contained the most comprehensive information of the three documents about expectations for new nurses. Elements of each theme, with the exception of advocacy and intentional learning were present in the document. Clearly, the focus for ISC was focused on the performance of psychomotor skills. Accomplishing tasks to promote safe, high-quality care is essential and a primary goal for nursing staff. Effective communication, delegation, and teamwork were also expectations indicated in the ISC. Finally, the PWD was used to evaluate new nurse performance over the first six weeks of practice on the unit. This document looked at a more holistic development of the new nurse over time. Elements of systems thinking, effective communication, accomplishing nursing tasks, teamwork, and building confidence were clearly present in the document.

While the archival documents were, in general, consistent with how nurse managers expected new nurses to be prepared for leadership, there were gaps between the expectations of managers and those reflected in the documents. It was clear from the managers that patient advocacy and self-advocacy are expectations of new nurses, however there was no language which specifically addressed advocacy in the documents. Given the impact that advocacy has on patient safety (American Nurses Association (ANA), 2015; Doherty et al., 2016; Kalaitzidis & Jewell, 2015), it was surprising to see it was not clearly addressed from the organizational perspective. Similarly, intentional learning was not represented on the archival documents. Managers expect new nurses to continue developing professionally, learning from experience and being patient with progress as they transition into the professional nursing role. As expectations for professional practice evolve, it is critical that organizational documents reflect current goals and expectations (Olson, 2001).

Summary

This chapter presented the seven major themes, three secondary themes and findings on nurse manager perceptions of the Essentials II and XI from the *Essentials of Baccalaureate Education for Professional Nursing Practice*. Findings were presented in accordance to the research questions. Data from intensive interviews, focus groups and a review of archival documents revealed the nursing leadership competencies clinical managers expect of new nurses in an acute care setting as well as the practical usefulness of end-of-program competencies related to nursing leadership. As is typical with qualitative case study research, extensive samples of participant quotes were included in

the research findings. Using the words of the participants serves to accurately represent the reality of the phenomenon of interest and situate the reader.

The primary finding of this study includes the seven areas of leadership nurse managers expect new nurses to be prepared for upon entry to practice: being an advocate, beginning to think about inter-related systems, communicating effectively, influencing nursing practice, upholding a professional nursing practice, being an intentional learner and effectively working in teams. Three secondary themes emerged from the data. Participants expressed that, while skills can be taught, there are several traits which influence new nurse leadership and practice. Some participants described seeking these traits out starting with the employment interview. Finally, the importance of formal and informal mentorship for new nurses was uncovered. Participants agreed that mentorship is essential for supporting the personal and professional growth of new nurses.

The second finding was the outcomes of AACN Essential II and IX that participants found most important for new nurse leadership. Focus group participants discussed the challenge of the broad scope of nursing and trying to provide a general nursing education which adequately prepares new nurses. The Essentials outcomes identified as most pertinent to new nurse leadership were, in general, consistent with the competencies identified through the intensive interviews.

CHAPTER 5

CONCLUSIONS AND RECOMMENDATIONS

The aims of this study were to: (a) determine the nursing leadership competencies clinical managers expect of new nurses in an acute care setting, and (b) identify gaps between end-of-program nursing leadership competencies, as outlined in *The Essentials of Baccalaureate Education for Professional Nursing Practice*, and leadership competencies identified by clinical managers in an acute-care setting. A single, bounded qualitative case study was used to accomplish the aims. Data from intensive interviews, focus group interviews, and archival documents were analyzed. Seven major themes and three secondary themes emerged from the intensive interview data. Analysis of the focus group data revealed nurse manager perceptions of Essentials II and IX of *The Essentials of Baccalaureate Education for Professional Nursing Practice*. Analysis across data sources revealed how managers expect new nurses to be prepared for leadership, how managers have experienced new nurse leadership, and gaps in academic preparation and organizational expectations for the emerging practice of new nurses.

Competence in leadership is critical for new nurses as healthcare delivery systems continue to evolve at a rapid rate. New, novice nurses are expected to be effective leaders in clinical practice which requires better leadership education before entering the nursing workforce (Candela & Bowles, 2008). The Institute of Medicine's *Future of Nursing* report called for nurses to be prepared to practice nursing leadership at all levels (Institute of Medicine (IOM), 2011). While leadership competencies have been identified by accreditation agencies and professional organizations, the degree to which they have been integrated throughout nursing curricula is questionable. Similarly, how managers expect

new nurses to be prepared for leadership can vary greatly. Perceptions of leader and leadership, manager and management are often used interchangeably and concepts of each may not be well understood by nursing students, practicing nurses, clinical leaders and administrators.

Developing Clinical Leadership

Data from this study revealed a developmental sequence for clinical leadership. Certain expectations can be viewed as antecedent to clinical leadership, whereas other aspects of clinical leadership, identified as less important by nurse managers, could be developed later in the career trajectory. This developmental sequencing is important for understanding how new nurse clinical leadership emerges in the acute care setting.

Antecedents to Clinical Leadership

Antecedents to clinical leadership are those expectations nurse managers have which are necessary for development of, but alone do not sufficiently constitute, clinical leadership. Benner et al. (2009) identified relational aspects of the new nurse as an advanced beginner transitioning to professional practice. The “socially embedded nature” of nursing knowledge serves to collect expertise and the power of multiple perspectives across the continuum of novice to expert practice, model skills within a socially-embedded group, share and shape a vision of professional excellence, and build trust and a sense of possibility (Benner, 2009, p. 235). Communication is essential for building and maintaining relationships in the social context of complex healthcare delivery systems. Personal traits and characteristics also influence new nurses to engage with patients, families, members of the inter-professional team, and nursing as a professional practice.

Effective communication.

Nurse managers expect that new nurses enter into professional practice prepared to communicate effectively. From an organizational lens, communication is a core function for the new nurse. Effective communication and giving and receiving feedback with all members of the healthcare team including patients, families, physicians and other licensed independent providers (LIPs), are clearly articulated expectations in documents from the organization. Leadership, according to Tourish (2014) is a fluid process which emerges, in part, from communicative interactions between actors in a system. Effective communication is not sufficient to stand alone as a discrete leadership skill. Leveraging a new nurse's communication skills and abilities to improve patient care is a precursor to clinical leadership.

Effective communication is necessary for advocacy, influencing nursing practice, and teamwork. Nurse managers expected and routinely observed strong patient advocacy behaviors from new nurses. Patient advocacy, however, rests on the new nurse's ability to clearly articulate important information, on behalf of the patient, to the healthcare team. Less effective communication can negatively impact patient care. Speaking up, asking questions, and asking for help can be challenging for new nurses. Self-advocacy behaviors can be linked to communication skills as well as personal traits including assertiveness, confidence and humility. New nurses who are assertive, confident in the role of professional nurse, ask questions, and admit gaps in knowledge are able to better advocate for their own needs as well as those of their patients. These findings are consistent with those of Doherty et al. (2016), who found that deficiencies in

communication skills and abilities negatively impacted new nurses' ability to adeptly participate in central patient and self-advocacy conversations.

To meet increasingly complex patient care needs in the acute care setting, new nurses must be able to influence professional practice. As such, new nurses must be seen as leaders, influencers, advocates and agents of change (Bondurant & Armstrong, 2016). Communication and teamwork are particularly important as new nurses lead patients through a hospital stay. Delegation is a complex process with both managerial and legal implications. Delegation effectively transfers the authority to perform a selected nursing task in a specific situation to a competent individual (Porter-O'Grady, Weberg, Mangold, & Malloch, 2019, p.464) and is an expectation for all professional nurses. Learning to delegate requires practice and preparation over time. While new nurses may be prepared with the theoretical principles of delegation, developing the relational aspects can be more challenging. Managers noted that "making connections" with others is often intuitive and can be hard to teach.

Teamwork is influenced by the new nurse's ability to effectively communicate with members of the inter-professional team. Team leadership can be challenging for a new nurse and takes time to develop as relationships are built with other members of the healthcare team. Unit culture can impact how new nurses are received on the unit, particularly if the new nurse is seen as over-confident or lacking assertiveness. Issues of under-delegation and over-delegation can arise when there is a lack of communication and the new nurse is not able to effectively utilize a "leadership voice". As Benner (2001) noted, novice nurses may have difficulty in organizing, prioritizing, and leading their

own nursing care, yet are expected to provide leadership to patients, families, and other members of the healthcare team.

Growth Over Time

Benner's From Novice to Expert (Benner, 2001) kept the researcher sensitized to skill acquisition over time. How nurses are prepared for nursing leadership throughout their education will impact their leadership in practice. Similarly, new nurses may continue to develop along the novice to expert continuum and some leadership skills, while perhaps not expected upon initial entry to practice, may be expected later as the new nurse grows their professional practice. Systems thinking was one area, while specifically addressed as an end-of-program competency in AACN Baccalaureate Essential II, that managers felt new nurses could develop over time.

Systems thinking, for nurse managers, included leading for change, putting the pieces together, and moving beyond tasks. At the most fundamental level, early systems thinking for new nurses included being able to see the broader impact of their nursing care on their patients. That is, seeing past a list of nursing tasks to be completed and recognizing that there is a person for whom they are providing care. Managers relayed challenges that new nurses experience as they sometimes struggle with connecting theoretical nursing knowledge with practical knowledge of the patient.

As novice nurses enter into clinical practice, they lack sufficient situational experience in clinical practice (Benner, 2001). Novice nurses learn from the most obvious and objective parts of a situation as they are not yet prepared to take in the subtler nuances. Similarly, nursing care is directed by a series of learned rules upon which the novice nurse relies. As novice nurses become more proficient and competent in the

professional role, they advance along the novice-to-expert continuum and begin to “put the pieces together” and see beyond the tasks to incorporate unique aspects of the patient into the nursing care provided. The provision of basic nursing care shifts to incorporate a beginning systems-level awareness based on limited experience and knowledge. This progression is a clear expectation of nurse managers. Progression towards systems-level analysis and decision-making, however, was not expected and could develop later in the nursing career.

This trajectory of developing, or not developing, systems thinking presents a unique challenge for new nurses. Nurse managers expect new nurses to lead for change, lead nursing practice, solve problems, and work effectively in teams. These expectations require higher-level awareness of systems. As new nurses interact with other members of the healthcare team, local change occurs which instigates learning and change. Expectations of systems thinking for the new nurse is limited to the clinical microsystem, a small group of people collaborating to provide care for a specific group of patients (IHI, n.d.).

Clearly, it is important that new nurses become competent leaders within the clinical microsystem. This leadership expectation is distinctly evidenced through the expectations of nurse managers as well as archival documents from the study site. There is a disconnect, however, between how nurse managers expect new nurses to be prepared for leadership within the microsystem and the broader meso and macro systems expectations as presented in AACN Baccalaureate Essential II. Managers relayed that higher-level systems thinking was not critically important upon entry to practice and could be developed later in a nurse’s career. AACN Baccalaureate Essential II

specifically outlines how graduates of nursing programs should be prepared for leadership in complex healthcare delivery systems. Basic nursing leadership, according to the AACN (2008) includes an awareness of complex systems, and the impact of power, policy, legislation, and regulatory guidelines on these systems. Essential II calls for nurses to be well prepared for leadership in the microsystem as well as the broader system within which the microsystem is situated.

This gap in expectations for how new nurses should be prepared is concerning. If the emerging systems thinking of new nurses is limited to the local microsystem level throughout the transitional period of nursing orientation, how does a broader understanding of healthcare systems develop? Data from intensive interviews indicate that expectations of nurse managers extend to the mesosystem and macro system. New nurses are expected to begin to influence nursing practice and lead change through informal and formal leadership opportunities. These expectations, while congruent with the AACN Baccalaureate Essentials, are not part of the initial skills validation checklist or weekly preceptor evaluation for new nurses. Additionally, while nurse managers expect that new nurses will lead for positive, impactful change, these are the same skills which managers felt could develop later in a nurse's career and were, therefore, less important to develop than some of the more practical skills associated with professional nursing practice.

Registered nurses are expected to have, at minimum, foundational knowledge of organizational and systems-level leadership which impacts advocating for and delivering safe, high-quality nursing care; effective communication and teamwork; and actively working to enable systems-level change. From the perspective of complexity science,

systems thinking can help nurses understand how nurses can affect change in alignment with larger systems processes to prevent errors, improve teamwork, enhance problem solving, and drive performance excellence initiatives (Dolansky & Moore, 2013). If higher-level systems thinking skills are not cultivated during the orientation period, when and how do they develop? In the absence of intentional attention to these skills during the orientation period, there is no clearly defined pathway forward for developing systems thinking for nurses. Without a broader systems-level perspective, a nurse's ability to effectively influence nursing practice and lead for positive change could negatively impacted.

The Role of Sensitizing Frameworks

In Chapter 2, three sensitizing frameworks were identified including Benner's From Novice to Expert, Complexity Science, and Complexity Leadership Theory. These frameworks provided a useful lens through which to understand the data. The sensitizing frameworks assisted in identifying key relationships among themes, including a developmental sequence for clinical leadership development and gaps in building capacity for systems-thinking for new nurses. The four research propositions outlined in Chapter 3 derived from these frameworks provided additional clarity as to the boundaries and scope of the study.

From Novice to Expert

Benner's From Novice to Expert framework (Benner, 2001) kept the researcher sensitized to skill acquisition over time. How nurses are prepared for nursing leadership throughout their nursing education impacts their leadership in practice as a new nurse. Similarly, nurses continue to develop along the novice to expert continuum and some of

the leadership skills, while perhaps not expected upon initial entry to practice, may be expected later as a new nurse grows his or her professional practice. The Novice to Expert framework provided a lens through which to better understand how intentional learning impacts new nurse leadership development. While intentional learning may not be a specific leadership behavior, self-directed learning over time helps to build leadership capacity and clinical excellence. Benner's work on the social embeddedness of nursing knowledge provided strong context for how new nurses enculturate into a practice environment, including the impact trust, mood, climate, and sense of possibility have on new nurse clinical leadership development. Many relational aspects of clinical leadership, including teamwork, lie between the systems and individual level of analysis, according to Benner (2009). Benner acknowledged that the function of the community of inter-professional practice assumed situated relational qualities depending on the demands and constraints of the day (Benner et al., 2002). This adaptive function of the community of practice provides a theoretical link between Benner's work and complexity science.

Complexity Science

Complexity science provides a framework through which to explore and understand human interaction and the behaviors of agents responding to internal and external influences on the system (Lalley & Clouthier, 2017; Uhl-Bien & Marion, 2008). Notarnicola et al. (2017) described nursing as a complex adaptive system and, as a sensitizing framework, helped the researcher to remain attentive to the dynamic nature of the acute care environment. More specifically, the CAS perspective provided a way to understand how diverse groups of people come together to interact and accomplish the

task at hand. As new nurses interact with other members of the healthcare team, local change occurs which instigates learning and change. Significant differences between new nurses and experienced nurses creates tension. This tension has the potential lead to adaptive change or accommodation, leading to new knowledge, ideas, and practices. Leading patient care, problem solving, and teamwork help the new nurse in working to overcome adaptive challenges in clinical practice.

The degree to which the new nurse is able to adapt is dependent, in part, on where they lie on the Novice to Expert continuum. The rules-based practice of the novice nurse is quite limited in scope and inflexible; as such, adapting to emergent situations can be challenging. The novice nurse has little experience with particular clinical situations and therefore relies on previously learned rules to guide clinical performance with little or no ability to adapt to the actual situation (Benner, 2001). The new nurse who advances along the continuum to the advanced beginner stage is able to relate salient aspects of the situation to prior experiences and become more adaptive in practice. This adaptiveness, in turn, allows the new nurse to become more agile in professional practice and begin to influence practice through problem solving and meeting the changing needs of the patient.

Complexity Leadership Theory

This framework reminded the researcher that every nurse has the capacity to lead in complex healthcare delivery systems. While new nurses do not have a formal, appointed leadership role, there are ways in which they lead through their professional practice. Adaptive leadership was used as a sensitizing concept within the CLT framework. Within the framework of adaptive leadership (Bailey et al., 2012) are two

categories of challenges nurses face: technical and adaptive challenges. Technical challenges are situations in which the problem and solution can be clearly defined and the nurse uses clinical reasoning to intervene. Adaptive challenges occur in situations where the solution may not be clear and the solution requires new learning and behavior change to work with, rather than against, the problem (Bailey et al., 2012). The adaptive leader engages others to embrace new opportunities and grapple with difficult problems (Lichtenstein et al., 2006). Linkages to adaptive leadership were identified through patient and self-advocacy, leading for change, leading patient care, problem solving, accomplishing tasks, learning from experiences, and leading the team.

The work of the nurse as an adaptive leader includes both relational aspects and complex systems thinking. The relational aspects of adaptive leadership are enacted through “interpersonal behavioral interactions”, including both verbal and non-verbal communication (Bailey et al., 2012). Effective communication provides a foundation for adaptive clinical leadership for new nurses. From a complex systems perspective, adaptive leadership provides insight into the nature of clinical leadership and how complex contextual interactions spread across healthcare delivery systems (Lichtenstein et al., 2006).

Complexity leadership theory extends current notions of leadership practice by focusing on micro-level actions across all organizational levels (Lichtenstein et al., 2006). In order to provide safe, high-quality nursing care, new nurses must be prepared practice at the microsystem level, which requires effective clinical leadership skills and communication to promote inter-professional collaboration and teamwork in a variety of settings (AACN, 2008). Having a higher-level system understanding of the healthcare

organization may help the new nurse influence change more effectively and efficiently. New nurses are expected to think beyond technical tasks to see the full context of how inter-related sets of tasks relate to the patient's care and how that care is situated within the course of the nurse's shift. Participants in this study acknowledged that this emerging systems awareness developed over time, which is consistent with the Systems-level Awareness model (Phillips et al., 2016) and Benner's From Novice to Expert (2001).

Discussion Summary

This study identifies how managers expect new nurses to be prepared for leadership in an emerging professional nursing practice. It was clear that accomplishing tasks, tasks expected of a professional nurse under the employ of the organization, was a fundamental expectation. These expectations can be overwhelming for new nurses who are just entering into the nursing profession. Communication, teamwork and advocacy become increasingly important as leadership competencies which help the new nurse to effectively manage his or her time and provide safe, high-quality nursing care. Communication emerged as an antecedent to clinical leadership. Effective communication is foundational for advocacy, influencing nursing practice, and teamwork.

The new nurse is expected to continue to grow, learn, and develop the professional practice role throughout the transitional period from student to professional nurse. Mentorship can have a powerful impact in supporting the new nurse through this challenging and often stressful period. New nurses are expected to learn from experience, including mistakes. For new nurses, admitting mistakes or gaps in knowledge can be especially difficult. Having a supportive formal preceptor and informal mentor may

provide direct and indirect pathways for the new nurse to access information, feedback, and support.

As the new nurse continues to develop, systems thinking and influencing nursing practice emerge as significant expectations. Throughout the transitional period of nursing orientation, it is expected that new nurses begin to move from a rules-based, task-oriented focus to a more holistic focus where decision-making and prioritization across multiple patients comes into focus as a leadership expectation. As new nurses gain experience and knowledge, it is expected that they will begin to seek out new opportunities for leadership, including taking an active role in leading patient care, leading the healthcare team, solving problems, and leading for positive change locally on the nursing unit. Over time, as the new, novice nurse advances to the more experienced advanced beginner or competent stage, the expectation becomes to work for change on a broader scale that impacts nursing care.

The Essentials of Baccalaureate Education for Professional Nursing Practice (AACN, 2008) provided a strong benchmark for nurse managers to consider in comparing how newly graduated nurses are prepared for leadership versus their own expectations for how new nurses should be prepared. In general, there was strong agreement that the Essentials II and IX reflected how new nurses should be prepared for leadership upon entry to practice. Data revealed that, while broad complex systems knowledge is important, new nurses can develop this over time. The perception of nurse managers was that, upon entry to practice, the focus is, and should be, on providing quality nursing care to patients at the microsystems level. This finding is important as it indicates there is a gap in how organizations support the ongoing development of systems

thinking for new nurses beyond the micro-level. Additional discussion around theoretical versus applied concepts related to leadership raises the issue of academic preparation for leadership practice. Students may not have sufficient time to apply newly gained leadership knowledge, skills, and abilities prior to graduation and entry to practice (Galuska, 2015; Morrow, 2015; Omoike, Stratton, Brooks, Ohlson, & Storfjell, 2011; Scott & Miles, 2013).

Contribution to Nursing

The findings of this study offer an interpretation of how managers expect new nurses to be prepared for leadership upon entry to practice. It has been well documented that leadership has a significant impact on patient care outcomes, quality of work environments, and retention of nurses in the workplace. What has been less understood is how new nurses should be prepared to lead, and what expectations nurse managers hiring new nurses have for leadership. Gaps in academic preparation for entry to practice have largely focused on the performance of psychomotor skills and clinical reasoning skills. Leadership has not been an area of focused research, despite the impact leadership has in clinical practice.

Findings of this study may offer some clarity around what is, or should be, expected of new nurses as they enter into practice. Nurse managers have clear expectations, which were uncovered through this study, for how new nurses should be prepared to lead. The degree to which clinical practice partners employing new nurses and academic nursing programs educating future nurses collaborate to establish expected outcomes is variable, however, academic-practice collaborations are crucial in developing educational standards for entry to practice in complex healthcare delivery

systems. Nurse managers offered their perceptions of Baccalaureate Essentials II and IX and the degree to which each meets expectations the managers have for preparation for leadership. While there was a high degree of concordance, there were gaps identified between expectations and end-of-program outcomes identified in the Essentials II and IX. Systems thinking beyond the micro-level was identified as a significant gap. This is concerning as the focus for new nurses in the orientation phase is largely limited to the clinical microsystem, as evidenced through interview data, the initial skills checklist, and the weekly preceptor evaluation. Without support to better understand complex healthcare systems at the meso and macro levels, the impact new nurses can have on system-wide change and innovation may be diminished.

Study Limitations

This single case study was bounded to include nurse managers and assistant nurse managers of acute care units who are responsible for hiring and evaluating new nurses. Despite strong efforts, recruiting participants for the intensive interviews proved to be challenging. In total, only 11 nurse managers and assistant nurse managers were recruited to participate in the intensive interviews.

The researcher conducted both the intensive interview sessions and the focus group sessions. While this may be a potential limitation, it could also be seen as a strength as emergent lines of questioning could be threaded into the interviews based on the researcher's prior knowledge. Despite these potential limitations, the researcher is confident the data are true and accurate within the limited scope of a single, bounded case study.

Future Research

While this study provides insight into managers' expectations of how new nurses should be prepared for leadership at entry to practice, there are many questions left unanswered. This study focused on nurse manager expectations of new nurse leadership in the acute care setting. One avenue for future leadership research would be to study multiple perspectives on leadership expectations from all members of the inter-professional healthcare team. In addition, current workforce data indicate that, while most new nurses enter into practice in an acute care setting, an increasing number of nurses are entering into practice in community-based settings (U.S. Department of Health and Human Services & Health Resources and Services Administration, 2017). Future research should examine new nurse leadership competencies in community-based settings as compared with those identified in the acute care setting.

This study did not specifically focus on inter-professional leadership competencies. While elements of inter-professional collaboration did emerge, designing future studies to examine new nurse leadership emerges in inter-professional teams may inform how new nurses can be prepared academically to collaborate and lead in high-functioning teams. Further exploration around how nurses develop systems thinking beyond the micro-level should be considered, including how nurses develop systems thinking and how organizations support the development of systems thinking.

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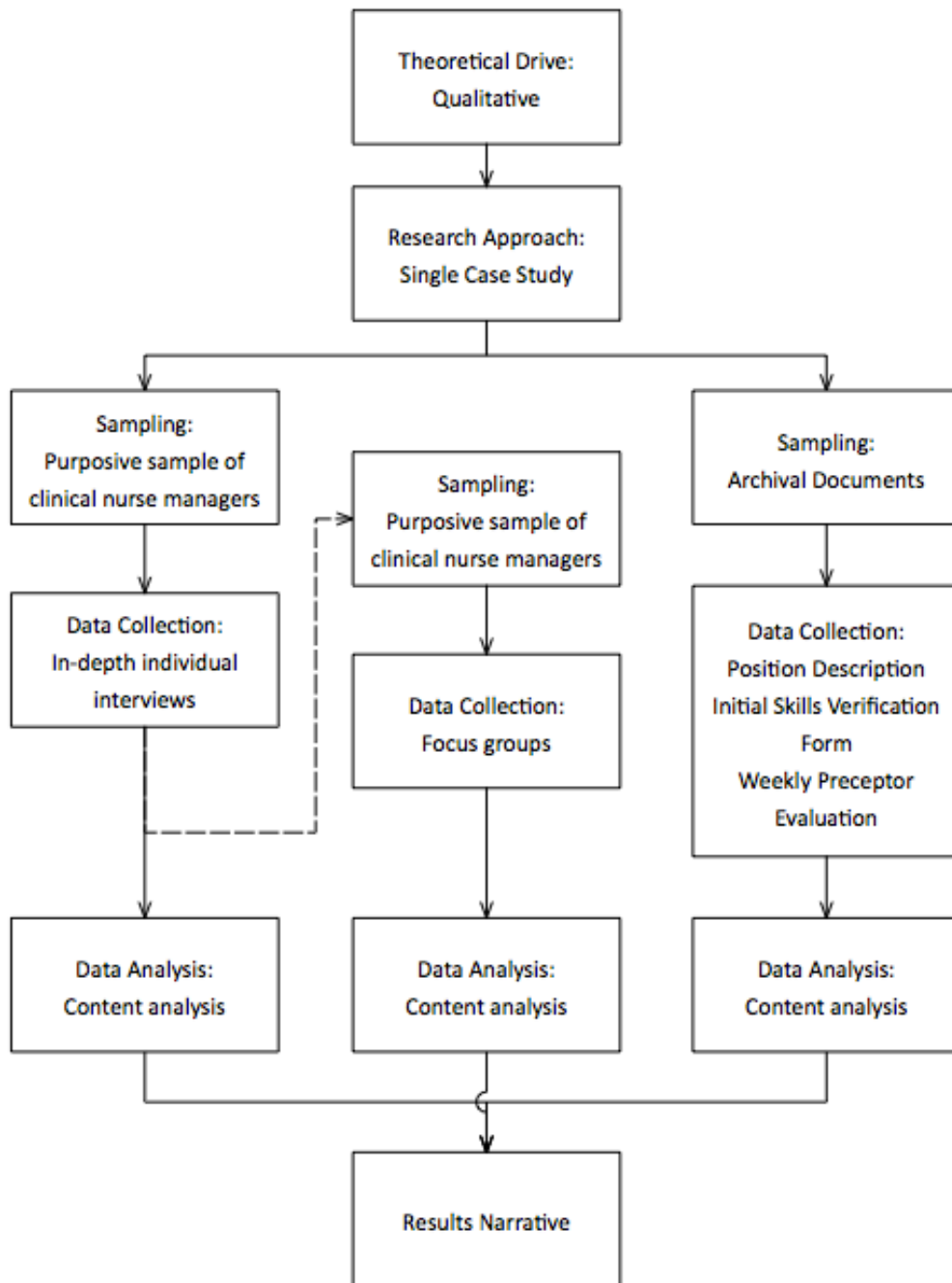
APPENDIX A

THE AACN ESSENTIALS FOR BACCALAUREATE EDUCATION
FOR PROFESSIONAL NURSING PRACTICE (AACN, 2008)

These essentials outline the end-of-program outcomes expected of graduates of baccalaureate nursing programs. Achievement of these nine essentials enables graduates to enter into practice within complex healthcare delivery systems and assume the professional roles of care provider, designer/coordinator/manager of care, and member of a professional practice (AACN, 2008). The nine Essentials include:

- I. Liberal Education for Baccalaureate Generalist Nursing Practice
 - A foundation of liberal education provides the basis for the education for- and practice of nurses.
- II. Basic Organizational and Systems Leadership for Quality Care and Patient Safety
 - Knowledge, skills, and abilities in leadership, patient safety, and quality science are essential for providing high-quality nursing care.
- III. Scholarship for Evidence-Based Practice
 - Nursing practice is founded upon the translation of best evidence into one's professional practice.
- IV. Information Management and Application of Patient Care Technology
 - Knowledge, skills, and abilities in informatics and patient care technologies are essential for delivering high-quality nursing care.
- V. Healthcare Policy, Finance and Regulatory Environments
 - Healthcare policy influences (directly and indirectly) the nature and function of healthcare delivery systems and are important aspects of professional nursing practice.
- VI. Interprofessional Communication and Collaboration for Improving Patient Health Outcomes
 - Effective communication and collaboration among healthcare professionals is essential for delivering safe, high-quality nursing care.
- VII. Clinical Prevention and Population Health
 - Health promotion and disease prevention at the individual and population levels are vital in improving population health.
- VIII. Professionalism and Professional Values
 - Professionalism in nursing, ethical principles, and issues of social justice are fundamental to professional nursing practice.
- IX. Baccalaureate Generalist Practice
 - The new, baccalaureate-prepared nurse is equipped to care for patients across the lifespan and across a broad range of healthcare delivery environments.
 - The new, baccalaureate-prepared nurse understands variations in care, increased complexity, and increased use of available resources necessary in caring for patients.

APPENDIX B
STUDY DIAGRAM



APPENDIX C
SHORT CONSENT TEMPLATE, INTENSIVE INTERVIEW

STUDY TITLE

I am a doctoral student under the direction of Dr. Pauline Komnenich in the PhD Program at the College of Nursing and Health Innovation at Arizona State University. I am conducting a research study to identify gaps between end-of-program nursing leadership competencies and the expectations of clinical agencies employing new nurses.

I am inviting your participation, which will involve a one-on-one interview lasting approximately 30-60 minutes. You have the right not to answer any question, and to stop participation at any time.

Your participation in this study is voluntary. If you choose not to participate or to withdraw from the study at any time, there will be no penalty.

You may or may not benefit from being in this study. However, by participating, you may help educators learn how to better prepare nurses for professional practice. There are no foreseeable risks or discomforts to your participation.

The interview will be digitally recorded (audio only). No identifying information will be recorded. Your responses will be anonymous. The results of this study may be used in reports, presentations, or publications but your name will not be used. Transcripts of the recorded audio may be shared with the PhD committee members for data analysis.

The interview will not be recorded without your permission. Please let me know if you do not want the interview to be recorded; you also can change your mind after the interview starts, just let me know.

If you have any questions concerning the research study, please contact the research team: Nick Miehl (814) 566-0154 nmiehl@asu.edu or Dr. Pauline Komnenich (602) 496-0861 paulina@asu.edu. If you have any questions about your rights as a subject/participant in this research, or if you feel you have been placed at risk, you can contact the Chair of the Human Subjects Institutional Review Board, through the ASU Office of Research Integrity and Assurance, at (480) 965-6788. Please let me know if you wish to be part of the study.

By signing below you are agreeing to be part of the study.

Name:

Signature:

Date:

APPENDIX D
SHORT CONSENT TEMPLATE, FOCUS GROUP

STUDY TITLE

I am a doctoral student under the direction of Dr. Pauline Komnenich in the PhD Program at the College of Nursing and Health Innovation at Arizona State University. I am conducting a research study to identify gaps between end-of-program nursing leadership competencies and the expectations of clinical agencies employing new nurses.

I am inviting your participation, which will involve a focus group lasting approximately 60-90 minutes. You have the right not to answer any question, and to stop participation at any time.

Your participation in this study is voluntary. If you choose not to participate or to withdraw from the study at any time, there will be no penalty.

You may or may not benefit from being in this study. However, by participating, you may help educators learn how to better prepare nurses for professional practice. There are no foreseeable risks or discomforts to your participation.

The interview will be digitally recorded (audio only). No identifying information will be recorded. Your responses will be anonymous. The results of this study may be used in reports, presentations, or publications but your name will not be used. Transcripts of the recorded audio may be shared with the PhD committee members for data analysis. Due to the nature of the focus group format, complete confidentiality cannot be guaranteed, however the names of participants mentioned during the focus group proceedings will not be used in any way.

The interview will not be recorded without your permission. Please let me know if you do not want the interview to be recorded; you also can change your mind after the interview starts, just let me know.

If you have any questions concerning the research study, please contact the research team at: Nick Miehl (814) 566-0154 nmiehl@asu.edu or Dr. Pauline Komnenich (602) 496-0861 paulina@asu.edu. If you have any questions about your rights as a subject/participant in this research, or if you feel you have been placed at risk, you can contact the Chair of the Human Subjects Institutional Review Board, through the ASU Office of Research Integrity and Assurance, at (480) 965-6788. Please let me know if you wish to be part of the study.

By signing below you are agreeing to be part of the study.

Name:

Signature:

Date:

APPENDIX E
PARTICIPANT DEMOGRAPHIC FORM

The following are some basic questions regarding your experience to help me gain more insight into the background of participants in this study. All the information you provide will be kept confidential and will not be shared with anyone else.

1. What is your current age in years?
2. How many years have you been a Registered Nurse (RN)?
3. How long have you been in a management role?
4. How long have you been in your current management position?
5. What is the highest academic degree that you have obtained?
6. In what year did you obtain your highest academic degree?
7. What is the average number of new nurses hired onto your unit annually?
8. Do you hold any academic affiliations in conjunction with your clinical role with this organization (i.e.: teaching for a nursing program)?

APPENDIX F
INTENSIVE INTERVIEW PROTOCOL

TITLE: Clinical Manager Perceptions of New Nurse Preparation for Leadership

Date/Time:
Participant #:
Informed Consent?

Notes for the interviewer:

Thank-you for your participation in this study. Your input is valuable in trying to better understand new nurse preparation for leadership. The purpose of this one-on-one interview is to determine the nursing leadership competencies clinical managers expect of new nurses in an acute care setting. This interview will last 30-60 minutes. I will be recording the interview with a digital audio recorder. All responses will remain confidential. Findings from this study will be disseminated through my doctoral dissertation as well as publication in a scholarly journal. This may include direct quotes or excerpts, which will be de-identified to maintain confidentiality. Do you have any questions before we begin?

Intensive Interview Questions:

1. Tell me a little bit about yourself and your background in nursing.
2. Talk to me about some of the strengths you see in new nurses as they join your team.
 - a. What gaps do you see?
 - b. Example
3. Take me back to a time when you were rounding on the unit and you noticed exceptional leadership from a new nurse. What did that look like to you?
4. Have you been in a situation where you might have liked to see better or different leadership from a new nurse? Tell me more...
5. In what ways do you see new nurses using leadership in their practice?
6. If I were a new nurse hired onto your unit, what leadership expectations would you have for me? How would I need to be prepared for leadership?
7. As a new nurse on your unit, how important would it be that I am prepared for leadership?
8. Is there anything else you would like to share?

Prompts:

Can you tell me again...

Can you give me an example?

How did you feel about that?

Tell me more...

Thank the participant for their time and discuss next steps of planning for the focus groups

APPENDIX G
FOCUS GROUP PROTOCOL

Date/Time:
of Participants:
Informed Consent?

Notes for the interviewer:

Thank-you all for your participation in this study. Your input is valuable in trying to better understand new nurse preparation for leadership. The purpose of this focus group is to identify gaps between end-of-program nursing leadership competencies and leadership competencies identified by clinical managers in an acute-care setting. This focus group will last approximately 90 minutes. I will be recording the session with a digital audio recorder. All responses will remain confidential. Findings from this study will be disseminated through my doctoral dissertation as well as publication in a scholarly journal. This may include direct quotes or excerpts, which will be de-identified to maintain confidentiality.

Ground Rules:

1. The goal is to have you do the talking and I would encourage everyone to participate.
2. There are no right or wrong answers. Everyone’s ideas and experiences are valuable. I anticipate a wide range of opinions and encourage you to share your thoughts.
3. In respect for one another, I ask that only one person speaks at a time and is permitted to finish his/her thoughts without interruption.
4. What is said in this room stays in this room. Your confidentiality is important and I want you to feel comfortable sharing.
5. I will be recording the audio from the focus group discussion. While I am capturing your thoughts and ideas on an audio recording, you will not be personally identified in any report and anonymity will be maintained.

Do you have any questions for me before we begin?

Opening Questions:

1. Tell us your area of nursing and something you enjoy when you aren’t busy working at the hospital.
2. What is the first thing that comes to your mind when you hear the word “leadership”?

Transition Questions: Findings from the intensive interviews will be presented

1. Do these accurately describe your expectations for new nurse leadership preparation? Please explain.
2. How do these findings compare to your experiences with new nurses?

Key Questions: AACN Baccalaureate Essential II will be presented. Participants will receive a printed copy of Essential II to review. The moderator will also read the document out loud.

1. What are your initial impressions of Essential II?
 - a. How do these outcomes match your expectations for new nurse preparation?
 - b. In what ways do these outcomes differ from your expectations?

Key Questions: AACN Baccalaureate Essential IX will be presented. Participants will receive a printed copy of Essential IX to review. The moderator will also read the document out loud.

2. What are your initial impressions of Essential IX?
 - a. How do these outcomes match your expectations for new nurse preparation?
 - b. In what ways do these outcomes differ from your expectations?
3. From your perspective, are the AACN Essentials relevant to new nurse professional practice (please explain)?
4. Specific to leadership, do you perceive a gap between academic preparation and preparedness for professional practice?
 - a. Do you have any suggestions for closing this gap?

Ending Questions:

1. Is there anything I missed during our time together? Is there anything we should have talked about but didn't?

Prompts:

Can you tell me again...

Can you give me an example?

How do you feel about that?

Tell me more...

Thank the participants for their time and discuss next steps of the research.

APPENDIX H
AACN BACCALAUREATE ESSENTIALS FOCUS GROUP FORM

Essential IX: Baccalaureate Generalist Nursing Practice

Instructions: Once you have read over the following statements, consider what is *essential for new nurse leadership*:

- Highly important or essential: place a star next to the number
- Ideal, but not absolutely essential: circle the number
- Not required or useful to new nurse leadership: cross out the number
- Not applicable to new nurse leadership: write NA next to the number

1. Conduct comprehensive and focused physical, behavioral, psychological, spiritual, socioeconomic, and environmental assessments of health and illness parameters in patients, using developmentally and culturally appropriate approaches.
2. Recognize the relationship of genetics and genomics to health, prevention, screening, diagnostics, prognostics, selection of treatment, and monitoring of treatment effectiveness, using a constructed pedigree from collected family history information as well as standardized symbols and terminology.
3. Implement holistic, patient-centered care that reflects an understanding of human growth and development, pathophysiology, pharmacology, medical management, and nursing management across the health-illness continuum, across the lifespan, and in all healthcare settings.
4. Communicate effectively with all members of the healthcare team, including the patient and the patient's support network.
5. Deliver compassionate, patient-centered, evidence-based care that respects patient and family preferences.
6. Implement patient and family care around resolution of end-of-life and palliative care issues, such as symptom management, support of rituals, and respect for patient and family preferences.
7. Provide appropriate patient teaching that reflects developmental stage, age, culture, spirituality, patient preferences, and health literacy considerations to foster patient engagement in their care.
8. Implement evidence-based nursing interventions as appropriate for managing the acute and chronic care of patients and promoting health across the lifespan.
9. Monitor client outcomes to evaluate the effectiveness of psychobiological interventions.
10. Facilitate patient-centered transitions of care, including discharge planning and ensuring the caregiver's knowledge of care requirements to promote safe care.

11. Provide nursing care based on evidence that contributes to safe and high quality patient outcomes within healthcare microsystems.
12. Create a safe care environment that results in high quality patient outcomes.
13. Revise the plan of care based on an ongoing evaluation of patient outcomes.
14. Demonstrate clinical judgment and accountability for patient outcomes when delegating to and supervising other members of the healthcare team.
15. Manage care to maximize health, independence, and quality of life for a group of individuals that approximates a beginning practitioner's workload
16. Demonstrate the application of psychomotor skills for the efficient, safe, and compassionate delivery of patient care.
17. Develop a beginning understanding of complementary and alternative modalities and their role in health care.
18. Develop an awareness of patients as well as healthcare professionals' spiritual beliefs and values and how those beliefs and values impact health care.
19. Manage the interaction of multiple functional problems affecting patients across the lifespan, including common geriatric syndromes.
20. Understand one's role and participation in emergency preparedness and disaster response with an awareness of environmental factors and the risks they pose to self and patients.
21. Engage in caring and healing techniques that promote a therapeutic nurse-patient relationship.
22. Demonstrate tolerance for the ambiguity and unpredictability of the world and its effect on the healthcare system as related to nursing practice.

Essential II: Basic Organizational and Systems Leadership for Quality Care and Patient Safety

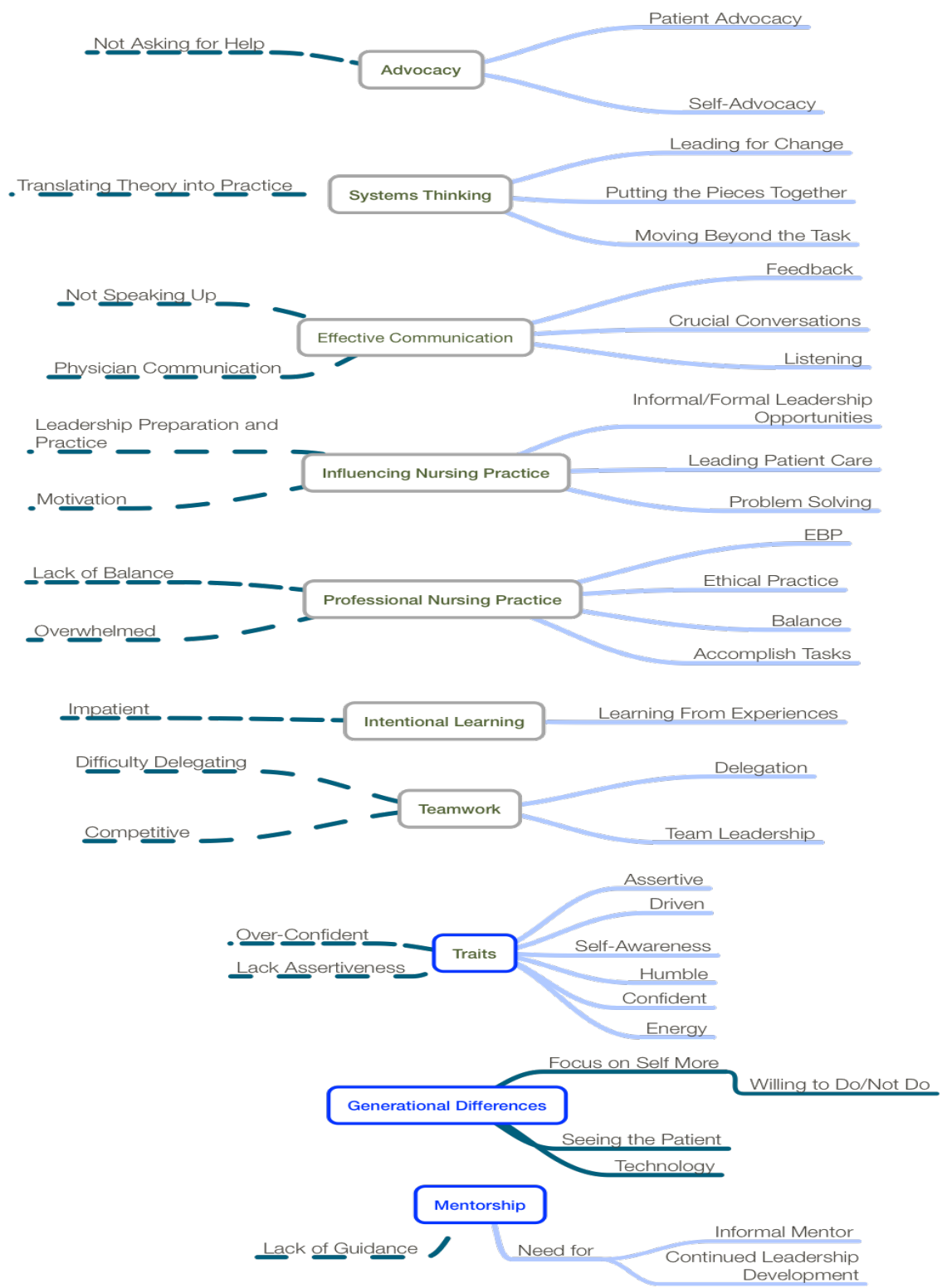
Instructions: Once you have read over the following statements, consider what is *essential for new nurse leadership*:

- Highly important or essential: place a star next to the number
- Ideal, but not absolutely essential: circle the number
- Not required or useful for new nurse leadership: cross out the number
- Not applicable to new nurse leadership: write NA next to the number

1. Apply leadership concepts, skills, and decision making in the provision of high quality nursing care, healthcare team coordination, and the oversight and accountability for care delivery in a variety of settings.
2. Demonstrate leadership and communication skills to effectively implement patient safety and quality improvement initiatives within the context of the inter-professional team.
3. Demonstrate an awareness of complex organizational systems.
4. Demonstrate a basic understanding of organizational structure, mission, vision, philosophy, and values.
5. Participate in quality and patient safety initiatives, recognizing that these are complex system issues, which involve individuals, families, groups, communities, populations, and other members of the healthcare team.
6. Apply concepts of quality and safety using structure, process, and outcome measures to identify clinical questions and describe the process of changing current practice.
7. Promote factors that create a culture of safety and caring.
8. Promote achievement of safe and quality outcomes of care for diverse populations.
9. Apply quality improvement processes to effectively implement patient safety initiatives and monitor performance measures, including nurse-sensitive indicators in the microsystem of care.
10. Use improvement methods, based on data from the outcomes of care processes, to design and test changes to continuously improve the quality and safety of health care.
11. Employ principles of quality improvement, healthcare policy, and cost-effectiveness to assist in the development and initiation of effective plans for the microsystem and/or system-wide practice improvements that will improve the quality of healthcare delivery.

12. Participate in the development and implementation of imaginative and creative strategies to enable systems to change.

APPENDIX I
THEME DEVELOPMENT MIND MAP



APPENDIX J
INSTITUTIONAL REVIEW BOARD, ARIZONA STATE UNIVERSITY

Pauline Komnenich
 CONHI - DNP
 602/496-0861
 paulina@asu.edu

Dear Pauline Komnenich:

On 6/7/2016 the ASU IRB reviewed the following protocol:

Type of Review:	Initial Study
Title:	Clinical Manager Perceptions of New Nurse Preparation for Leadership
Investigator:	Pauline Komnenich
IRB ID:	STUDY00004254
Funding:	None
Grant Title:	None
Grant ID:	None
Documents Reviewed:	<ul style="list-style-type: none"> • INTENSIVE INTERVIEW PROTOCOL.pdf, Category: Measures (Survey questions/Interview questions /interview guides/focus group questions); • Miehl CV 3_2016.pdf, Category: Vitaes/resumes of study team; • Focus Group Recruitment email (3).pdf, Category: Recruitment Materials; • Miehl HRP-503a-TEMPLATE_PROTOCOL_SocialBehavioralV02-10-15 v5 (4).docx, Category: IRB Protocol; • Recruitment Flyer (3).pdf, Category: Recruitment Materials; • Focus Group Confidentiality.pdf, Category: Participant materials (specific directions for them); • Short Consent Template%2C Focus Group (5).pdf, Category: Consent Form; • Miehl recruitment verbal-script.pdf, Category: Recruitment Materials; • FOCUS GROUP PROTOCOL.pdf, Category: Measures (Survey questions/Interview questions /interview guides/focus group questions); • Intensive Interview Recruitment email.pdf, Category: Recruitment Materials; • Demographic Form.pdf, Category: Measures (Survey questions/Interview questions /interview guides/focus group questions); • Short Consent Template, Intensive Interview.pdf, Category: Consent Form;

The IRB determined that the protocol is considered exempt pursuant to Federal Regulations 45CFR46 (2) Tests, surveys, interviews, or observation on 6/7/2016.

In conducting this protocol you are required to follow the requirements listed in the INVESTIGATOR MANUAL (HRP-103).

Sincerely, IRB Administrator

cc: Nickolaus Miehl

APPENDIX K
INSTITUTIONAL REVIEW BOARD, SALEM HEALTH

**Institutional Review Board (IRB)
Authorization Agreement**



SALEM HEALTH
An OHSU Partner

P.O. Box 14001
Salem, OR 97309-5014
IRB Phone (503) 814-2811

*Use this form when Salem Health IRB is waiving IRB oversight.
An agreement template from the reviewing institution may be used instead of this form.*

Name of Institution or Organization Providing IRB Review (Institution/Organization A):	
ARIZONA STATE UNIVERSITY	
IRB Registration#:	IRB00000128
Federalwide Assurance (FWA) #:	0009102
IRB Study #:	0000 4254
Name of Institution Relying on the Designated IRB (Institution B):	
SALEM HEALTH, an OHSU Partner	
IRB Registration#:	IRB 00002427
Federalwide Assurance (FWA) #:	FWA 00009433

The Officials signing below agree that SALEM HEALTH IRB may rely on the designated IRB for review and continuing oversight of its human subjects research described below: (check one)

This agreement is limited to the following specific protocol(s):

SALEM HEALTH IRB #:	9920
Name of Research Project:	Clinical Manager Perceptions of New Nurse Preparation for Leadership
Name of Principal Investigator:	Nick Miehl (Pauline Komnenich)
Sponsor or Funding Agency:	n/a Award Number, if any: n/a

Other (describe): Exempt 45CFR46.101(b)(2)

The review performed by the designated IRB will meet the human subject protection requirements of Institution B's OHRP-approved FWA. The IRB at Institution/Organization A will follow written procedures for reporting its findings and actions to appropriate officials at Institution B. Relevant minutes of IRB meetings will be made available to Institution B upon request. Institution B remains responsible for ensuring compliance with the IRB's determinations and with the Terms of its OHRP-approved FWA. This document must be kept on file by both parties and provided to OHRP upon request.

Signature of Signatory Official (Institution/Organization A):	
	Date: 6-16-16
Print Full Name: Debra Murphy	Institutional Title: Institutional Official
Signature of Signatory Official (Institution B):	
	Date: 6/14/2016
Print Full Name: Joseph Schnabel, PharmD	Institutional Title: Salem Health IRB Chair

Form developed from OHRP template agreement at <http://www.hhs.gov/ohrp/assurances/forms/irbauthorispdf.pdf>