University of St. Thomas, Minnesota
UST Research Online

Education Doctoral Dissertations in Leadership

School of Education

2013

Navigating the Hazardous Terrain and the Tranquil Waters: A Grounded Theory Study of the Leadership Development of Nurse Managers

Rebecca L. McGill
University of St. Thomas, Minnesota

Follow this and additional works at: https://ir.stthomas.edu/caps_ed_lead_docdiss

Part of the Education Commons

Recommended Citation

LEADERSHIP DEVELOPMENT OF NURSE MANAGERS

Navigating the Hazardous Terrain and the Tranquil Waters:

A Grounded Theory Study of the Leadership Development of Nurse Managers

A DISSERATION SUBMITTED TO THE FACULTY OF THE

UNIVERSITY OF ST. THOMAS

By

Rebecca L. McGill,

IN PARTIAL FULFILLMENT OF THE REQUIREMENTS

FOR THE DEGREE OF

DOCTOR OF EDUCATION

2013

UNIVERSITY OF ST. THOMAS

ST. PAUL, MINNESOTA
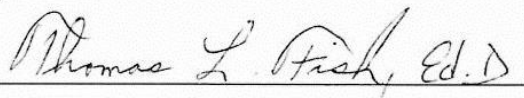
Navigating the Hazardous Terrain and the Tranquil Waters:
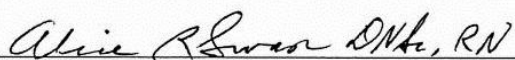
A Grounded Theory Study of the Leadership Development of Nurse Managers

We certify that we have read this dissertation and approve it as adequate in scope and quality. We have found that it is complete and satisfactory in all respects, and that any and all revisions required by the final examining committee have been made.

Dissertation Committee

_____

Thomas L. Fish, Ed.D.
_____

Alice R Swan DNP, RN
_____

December 10, 2013
Final Approval Date

ABSTRACT

The purpose of this grounded theory study was to provide nurse managers in two healthcare organizations with an opportunity to share their reflections on their leadership development and transition from staff nurs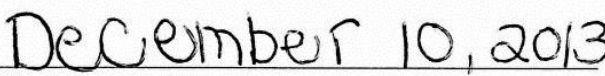e to nurse manager. This qualitative study provides analysis grounded in the data and themes from the interviews, developing theory, and recommendations, which should prove useful to the leaders in the agencies where the study was done.

Through 19 semi-structured interviews of current or previous nurse managers, the participants described what contributed to their leadership development and the challenges they encountered.   In the category of contributors, the themes included identity and purpose, "Emotional Intelligence", mental models of continuous learning, and a nurturing community. Challenges included the transition from staff to manager, learning from adversity, and the large scope and rapid pace of change.

The researcher conducted an analysis of the findings using the lenses of Symbolic Interactionism (SI) combined with Goffman's (1959) dramaturgy and theatrical performance, and the four frames of Bolman and Deal (2008). There are definite front stage and back stage aspects to the leadership development of nurse managers. These theories help represent the complexity of the individual and organizational aspects of the leadership development of nurse managers. Additionally, a theory emerged that outlined the symbiotic forces which help nurses develop as leaders. These symbiotic forces include the hazardous terrain with the unpredictable and the unknown, as well as the tranquil waters of reflection, renewal, and support. The theory also describes the ripple effect of nurse managers as leaders in the organizational context.   The study yielded

significant implications and recommendations for nursing educators, nursing practice and

the organization, nurse leaders, and future researchers.

ACKNOWLEDGEMENTS

Writing a dissertation is both an individual and collective process.   I am grateful for a wonderful, diverse community who supported me on this journey. From colleagues and co-workers who asked frequently how things were going, to readers, editors, library staff, and dear friends. Everyone is important and I could not have done this without all of you.

I want to thank my chair, Dr. John Holst for his calm support, scholarly wisdom, and for encouraging me along the way.   To my committee members, Dr. Tom Fish and Dr. Alice Swan, you have both been encouraging and supportive in my journey through this process. I express my sincere thanks to my boss and mentor, Dr. Penny Moyers, thank you for your unwavering faith in me and helping me through a rough patch in the journey. I have learned so much from you. Nicole Evans, our regular writing appointments were unbelievably helpful. What I have learned from you about writing well, I will pass on to others. Much gratitude goes to Gina Ebhardt, a dear friend and skilled executive assistant. Gina's work on layout and editing made this scholarly paper crisp and professional.

My family made sacrifices over the four and ½ years since I started to work on my doctorate. To my husband Russ, daughter Danielle, and sons, Tom, Matt and Mike, this adventure is coming to a close. The house wasn't as clean as before and there were fewer home cooked meals. I hope you have all learned about the commitment involved in achieving a long held dream. I will always be there for you as you work toward your dreams as you have been for me.

Lastly, I thank cohort 23 and all my other UST colleagues on this journey. Jill, you were my inspiration and I thank you for sharing all you learned and being there for me along the way. Callie, Jing, and Nancy, the scholarly writing we did together nearly every week helped to keep me going. The collective support has truly kept me motivated through this amazing process.

TABLE OF CONTENTS

Table of Figures and Tables

The Leadership Development of Nurse Managers

CHAPTER 1: INTRODUCTION

Nurse Managers, in a vital and necessary healthcare leadership role, are practicing in a time of significant transformation. Shifting social and political factors, including access to care, focus on quality, evolving care models, reimbursement and educational reform add to an already complex industry. Pressing issues include an increasing number of patients needing care and fewer nurses to deliver the care (Aiken, 2008; Fennimore & Wolf, 2011; Institute of Medicine, 2010; Manthey, 2008; Porter-O'Grady, 2009; Robert Wood Johnson Foundation, 2010; Tanner & Weinmann, 2011). As the largest number and most trusted health care providers, nurses are in the forefront of healthcare transformation (Domrose, 2002; Institute of Medicine, 2010; Robert Wood Johnson Foundation, 2010; Tanner & Weinmann, 2011), putting themselves in a unique position to lead and influence during these turbulent times. The Institute of Medicine (IOM, 2010) "calls for nurses to be prepared as leaders; ready to sit at the policy table and to lead change to improve our nation's health" (p. 239). This challenge raises a question of the central issues that contribute to the successful leadership development of nurse managers required to lead through this time of great change in health care.

Reflexive Statement

I am a Registered Nurse with 30 years of experience in the profession. The majority of my early career was spent as a staff nurse in the emergency department and urgent care settings. In these settings, where patients sought care for urgent and emergent conditions, usually on an unplanned basis, my compassion, empathy, and relationship skills were important as were my technical and clinical skills, quick decision–making,

and priority setting. Over my career, I have also held a variety of nursing and

organizational leadership roles. Throughout my career, these experiences have nurtured

my interest in leadership development. I am passionate about understanding how bedside

nurses make the transition to leadership, specifically to their first Nurse Manager role.

 My grandmother was a registered nurse and has always been a strong role model

for me. She worked outside of the home as a nurse in hospitals, the Red Cross, and

doctor offices and was ahead of her time as a working mother in the 1930s and 40s. She

modeled a strong tie to her nursing colleagues throughout her life and taught me that

nurses were not just about caring for the sick but could also be influential in promoting

health.

As an adolescent exploring nursing as a profession, I worked as a candy striper (a

youth or teen hospital volunteer) for several years and remember being enchanted with

the nurses and the activities of the hospital. As a volunteer, my duties were watering the

flowers, bringing around fresh ice water to all the rooms, and helping to pass and set up

patient trays at mealtime. These activities allowed me to be in patients' rooms and talk to

patients and staff. Though health care has changed much since then, I still remember the

vulnerability of the patients and being drawn to care for those who could not care for

themselves.

Upon being accepted to a college based nursing program, I took a job as a nursing

assistant at a nursing home. This job was extremely hard work both physically and

mentally. The residents needed a lot of physical care, much of which fell to those in the

nurse assistant role. In addition, the facility was short–staffed, and many of the residents

were helpless. I always felt like I had so much to do and not enough time. It tore at my

heart to see how many residents had infrequent visitors, and I was sad to realize how

alone and isolated these people were. I enjoyed talking with them and found myself very

attached to certain residents. This role helped cement my commitment to nursing as a

profession.

In 1980 and now in 2013, all Registered Nurses (RNs), regardless of their level of

preparation, take the same National Council Licensing Exam (NCLEX) or nursing

licensure exam.   Currently, nurses have the option of a two-year or four-year degree;

however, the Institute for Medicine (IOM) made a recommendation in their report on *The

Future of Nursing* (2010) that the number of nurses with baccalaureate degrees should be

80% of all practicing nurses by the year 2020. Many RNs go on to get their Master's

degree in Nursing and become Advanced Practice nurses working as Certified Nurse

Midwives, Clinical Nurse Specialists, or Nurse Practitioners. Over the years, nurses have

gone on to get a Doctorate in Nursing Science DNSc or PhD in nursing. These are

usually the nurses who work as nursing professors, deans, and in the highest nurse

leadership positions in health care organizations. More recently, the clinical doctorate

degree, Doctorate of Nursing Practice or DNP has been recognized as a valuable terminal

degree. The educational belief is that the higher the degree, the more prepared nurses are

to lead.

I have an eclectic educational background as a nurse in that, though I always

consider myself a nurse first, I did not take the traditional educational path. I received an

Associate Degree in Nursing, a Bachelors of Science degree in Health Arts, a Master of

Arts in Organizational Leadership and am most recently pursuing a Doctorate in

Education. I believe this unconventional educational path has enhanced my ability to be

a leader for nursing as well as for the interprofessional teams that are critical to the health care system of the future.

While my educational path may not be traditional, my trajectory of nursing roles and transition to leadership was more typical. As a bedside nurse, my first leadership experience was working as a charge nurse in the Emergency Department. While in this role, I was responsible to make sure not just my own patients were well-cared for, but that I looked at the whole department and all the patients in the department; I assessed each department's needs and reallocated resources, staff, equipment, and rooms to best meet the needs of the patients.

Priority setting and quick decision making were additional skills I developed in this role. My first formal leadership role was that of a Nurse Manager. I truly learned the role by jumping in and doing it. My next leadership role as a nurse and leader came after seven years as a Nurse Manager. I interviewed and was selected for a nursing director position. Over the next 10 years, I held three director roles of increasing scope and complexity, the last of which was as director of women's and children's services at two "sister" hospitals. In my current role as a fulltime administrator in a university setting, I have the opportunity to teach and influence many faculty and students from a variety of health care disciplines in the course of my work.

Throughout my career, I have had the privilege of working with many outstanding and caring nurses. Many of these same nurses were also visionary and strategic leaders. I began to wonder how nurses, and specifically nurse managers, which is generally the first formal leadership role away from the bedside, made the difficult transition, considering that a leader's skill set is much different from a nurse's skill set.

As I explored topics for my dissertation, I wanted to build on a topic which had been the subject of my Master's thesis. The paper was titled *Nursing Case Management: Developing Clinical Leaders* (1994) and it explored the experience of nurses who took on clinical leadership roles and how they were changed as nurses in this new role. In my qualitative research for my dissertation, I want to take this research a step further to better understand how Nurse Managers developed as formal leaders. It is my hope to explore and understand the leadership development of Nurse Managers.   My aim is to uncover stories and experiences that will lead to recommendations for nurse leaders and faculty to utilize in the educational and practical preparation of our nurse leaders, especially the Nurse Managers, as this role is one that is rapidly changing.

Statement of the Problem

Historical Context

In healthcare organizations, nursing leaders include nurse executives, (i.e., the Chief Nursing Officer [CNO], Vice President of Patient Care, or Director of Nursing Services), nurse managers (of a specific unit or units), and staff nurses as experts and peer leaders. The nurse manager serves as a link between nurse executives and the staff nurses, thereby facilitating the accomplishment of organizational objectives as well as the goals of the nursing profession (Anthony et al., 2005; Fennimore & Wolf, 2011; Jones, 2010). Once called the *head nurse*, the role of nurse manager was responsible to *manage* the nursing staff and the flow of the unit. Since the early 1980s, this leadership role evolved into a *Nurse Manager* who supervised additional employees beyond nurses, as the size and scope of patient care units began to grow (Mathena, 2002; Nicklin, 1993). Frequently, nurse managers assume expanded roles and responsibilities without

adequate education, resources, or support (Fennimore & Wolf, 2011; Griffith, 2012; Mathena, 2002; Parsons & Stonestreet, 2003). There has been a historic tension between nurse managers developing technical skills and competencies versus the need to develop leadership capacity to build and lead patient-centered teams.

Parsons and Stonestreet (2003) referred to the first line nurse managers as "the glue that holds the hospital together" (p. 1). Organizational leaders in health care often recruit nurse managers from the ranks of experienced, competent staff nurses. As such, these organizational leaders often make an assumption regarding the readiness of these staff nurses to assume formal leadership positions. Today's organizations have higher expectations for nurse managers to take on additional responsibilities and to lead amidst change (Griffith, 2012; Nicklin, 1993; Tanner & Weinman, 2011). For example, responsibilities once performed by the Director of Nursing now are the responsibility of the Nurse Manager. These responsibilities include budgeting, interviewing, hiring and supervision of staff, assuming 24-hour accountability for the unit(s), and participating on hospital-wide and interdepartmental committees (Nicklin, 1993). Leadership development for nurse managers has been controversial in health care organizations because there is a lack of agreement on what contributes to such development and how formal education content and on-the-job educational experience shape leaders. There is tension around what is needed for successful nurse manager development and the accompanying financial and human resources needed to deliver such content (Brady Schwartz, Spencer, & Wood, 2011; Cummings et al., 2008; Fennimore & Wolf, 2011; Fleming & Kayser, 2008; Griffith, 2012; Jones, 2010; Mathena, 2002; McAlearney,

2006; O'Connor, 2011; Paterson, Henderson, & Trivella, 2010; Roberts & Coghlan,

2011; Stanley, 2008).

In reviewing the literature I discovered several key considerations which affect

how nurse managers develop as leaders. First of all, multiple layers of hierarchy exist in

health care organizations and create power tension, which adds to the complexity for

leadership of professionals (McAlearney, 2006; Paterson et al., 2010; Roberts &

Coghlan, 2011; Valentine, 2002). A second consideration is the tension created when

nurses educated in a skill-based technical curriculum do not have the skills to navigate

the power hierarchy within healthcare (Griffith, 2012). Third is the aspect of professional

socialization where the prevailing narrative presents physicians at the top and nurses are

considered *handmaidens,* or helpers to the physician (McAlearney, 2006; Paterson et al.,

2010; Upeniaks, 2003). A fourth consideration exerting a significant effect on the nurse

leaders' identity and leadership style is that the formal educational preparation has not

equipped nurses for leading inside these power differentials among providers.

The IOM's *Report on the Future of Nursing* (2010) supports nurses having a

stronger educational background and calls for increasing the number of baccalaureate-

prepared nurses in the workforce to 80% and doubling the population of nurses with

doctoral degrees by 2020 (IOM, 2010; Jones, 2010; O'Connor, 2011; Rosseter, 2011).

Currently, only 50% of nurses have a baccalaureate degree, falling far short of the IOM's

(2010) goal. According to Tanner and Weinman (2011), the IOM's goal of educating

nurses as health care leaders is beginning to be evident in entry-level baccalaureate

nursing programs by including one leadership class and another class on health care

policy. The breadth of current required curricula is vast, leaving little room to add additional content.

In short, content on leadership falls short in preparing nurses to lead effectively (Tanner & Weinman, 2010).   Clearly, a need exists for a study that analyzes the leadership development of Nurse Managers. I desired to learn how skilled staff nurses make the transition to this important and challenging leadership role. The purpose of this study was to understand what contributes to the leadership development of Nurse Managers.

Significance of the Problem

Researchers addressed concerns that the supply of qualified nurse leaders is diminishing (Aiken, 2008; Fennimore & Wolf, 2011; Griffith, 2012; IOM, 2010; Manthey, 2008; Robert Wood Johnson Foundation, 2010; Rosseter, 2012; Westphal, 2012). Reasons cited in the nursing literature include a stressful work environment (Aiken, 2008; Kleinman, 2004; McAlearney, 2006; Robert Wood Johnson Foundation, 2010), inadequate class sizes in nursing schools (IOM 2010; Kleinman, 2004; Robert Wood Johnson Foundation, 2010; Rosseter, 2012; Valentine, 2002), and the retirement of baby boomers from the nursing profession (Jones, 2010; Manthey, 2008; Robert Wood Johnson Foundation, 2010; Rosseter, 2011; Valentine, 2002; Westphal,2012). With the passage of the Patient Protection and Affordable Care Act (PPACA) in 2011, more than 32 million Americans will soon gain access to healthcare services, including those services provided by nurses (Rosseter, 2012). Other factors adding to the strain and future capacity of the health system are the increasing number of Americans over age 65 with complex medical and health needs.

The United States Bureau of Labor Statistics (2012) identified Registered Nurses as the top occupation for job growth through 2020 because of a predicted shortage (Bureau of Labor Statistics (BLS), 2012; Buerhaus, Staiger, & Auerbach, 2009; Rosseter, 2012). The number of employed nurses is expected to increase to 3.45 million in 2020, an increase of 712,000 nurses or 26% (Rosseter, 2012; BLS, 2012). The BLS projections also predicted the need for replacing 495,000 employees in the nursing workforce. This projection supports data from the American Nurses Association (2012), which indicated that the median age of nurses as 46, and more than 50% of the nursing workforce is near retirement. Additionally, the Health Resources and Services Administration (HRSA) projected that without any aggressive intervention, the supply of nurses in America will fall 36% (more than a million nurses) below national projections of need by the year 2020 (AACN Fact Sheet, 2011). Westphal (2012) concluded that the nurse leaders pool is shrinking and identified a 30% decline in nurse leaders positions in hosptials over a 16-year period of time. Thus, it is imperative for health care organizations and professional nursing organizations to make the leadership development of nurses a high priority to meet projected demands (Anthony et al., 2005; IOM, 2010; Johansson, Andersson, Gustafsson & Sandahl, 2010; Korda & Eldridge, 2011; Parsons & Stonestreet, 2003; Paterson et al., 2010; Richardson & Storr, 2010; Westphal,2012).

Johansson et al. (2012) pointed out that nursing leadership has an effect on the quality of care, reduction in medical errors, and the overall work and patient care environment. Nurse managers are uniquely placed in the health care industry to influence the quality and safety agenda in healthcare organizations (Griffith; 2012; IOM, 2010; Mathena, 2002; Paterson et al., 2010; Richardson & Storr, 2010; Sullivan, Bretschneider,

& McClausland, 2003; Tanner & Weinman, 2011). In addition, the published outcome data will "assist in determining the economic value of nursing and the profession's contribution to the overall health and well-being of society" (Jones & Gates, 2007, p. 9).

Patient-centered interprofessional teams will replace the traditional medical model of care delivery, thus requiring nurses to have enhanced team and communication skills. A trend in the direction of these interprofessional teams appears in new legislation, new payment models, and alternative care settings in the community, such as Accountable Care Organizations and Patient Centered Medical Homes (Korda & Eldridge, 2011). These models incorporate the philosophy of team-based care and responsibility for the provision of all health needs across the care continuum for a set number of health plan enrollees.

Collective responsibility means working as a team in caring for a patient. Thus, the future models of care will require new skills and leadership from nurse managers (Paterson et al., 2010; Korda & Eldridge, 2011). Nurse managers are and will continue to be central to assuring access and quality, and to developing care delivery models which ultimately impact the financial resources for healthcare. Understanding the factors that contribute to nursing leadership is fundamental to ensuring a future supply of well-prepared nurse managers who can positively influence outcomes for health care providers and patients (Anthony et al., 2005; Cummings et al., 2008; IOM, 2010; Jones, 2010; Korda & Eldridge, 2011; Parsons & Stonestreet, 2003; Paterson et al., 2010; Richardson & Storr, 2010).

This study highlights the factors that contribute to the leadership development of nurse managers and focus on the challenges. The research questions were: What

contributes to the leadership development of nurse managers? What are the challenges faced by nurse managers? According to nurse managers, how does their transition from staff nurse to leadership happen in the organizational context?

Need for Study

Due to the lack of qualitative research on the perceptions held by nurse managers about their leadership development, I deemed a study on this topic to be appropriate and necessary. While many studies and theoretical connections primarily speak to the *what* and the *why* of leadership, there appears to be very little research conducted on the experiences of nurse managers and the process of leadership development, specifically the *how*. There is a lack of research focusing on the leadership development process for nurse managers; thus, a study on this topic was necessary to analyze the leadership development of nurse managers.   Additionally, there was a need to link the individual nurse's development as a leader within the organizational context. I conducted a study well-grounded in theoretical frameworks to fill in the gaps, specifically a grounded theory study that describes and analyzes the leadership development of nurse managers. I utilized qualitative methods that are theoretically–based to understand the leadership development of nurse managers and contribute new knowledge to both the nursing education and nursing leadership fields.

Overview of the Chapters

I have organized this dissertation into six chapters. In Chapter One, I provide an introduction to the issue and reflexive statement. In addition, I describe the statement of the problem and significance of the problem with the research questions of the study.

Chapter Two presents a review of the literature including topical literature on nurse manager leadership development. Themes include the process of socialization to the nursing profession, the inherent power and hierarchy, leadership development, and the resulting competencies needed for nurses to lead. I discuss how competencies develop through formal educational preparation, on-the-job experience, and leadership development programs. In addition, I present existing theory around the topic of nurse manager leader development. The section also presents three theoretical frameworks evident in the literature reviewed: Transformational Leadership as exemplified by Burns (1978); Dewey's (1938) concept of experience and education; and Senge's (1990) work on learning organizations. In addition, this chapter presents three alternative theoretical frameworks used to analyze the data I collected. These frameworks include: Symbolic Interactionism, Goffman's (1959) dramaturgy, and Bolman and Deal's (2008) Four Frames and Reframing.

In Chapter Three, I present the methodology of the study. This chapter includes a rationale for my research approach, sources of data, and data collection and analysis methods. This chapter also describes how I employed the three theoretical frameworks used in the study: Symbolic Interactionism, Goffman's (1959) dramaturgy, and Bolman and Deals's (2008). Lastly, I present the ethical considerations in the study.

Chapter Four includes the reporting of the findings from the 19 semi-structured interviews. The findings include the seven conceptual themes under two main core categories that emerged from the data. The two core categories include contributors to leadership development and challenges to leadership development. Under contributors, four conceptual themes of identity and purpose, "Emotional Intelligence", mental models

of continuous learning, and a nurturing community are presented. Three conceptual

themes emerged under challenges to leadership development. These three themes are:

the transition itself, learning from mistakes and adversity, and the large scope and the

rapid pace of change. For each theme, I present quotes from the 19 nurse managers

interviewed, which I believe provide evidence for the theme.

In Chapter Five, I present the analysis of the data. I analyzed the data using three

theoretical frameworks: Symbolic Interactionism, Goffman's (1959) dramaturgy, and

Bolman and Deal's (2008) Four frames and Reframing. The chapter concludes with

specific elements of an emerging theory of leadership development of nurse managers

which is grounded in the data.

The last chapter, Chapter Six, is titled Conclusions and Implications. This chapter

presents a summary of conclusions that resulted from the major findings as well as

implications from the study for nurse educators, administrators in practice settings, nurse

leaders and future researchers. Lastly, I present closing reflections from my experience.

Summary

Research indicates a future nursing shortage and many changes on the horizon for

health care. Nurse managers, as key organizational leaders, need to develop as leaders

and change agents to help with the challenges ahead. This study provides analysis

grounded in the data and themes from the interviews, developing theory, and

recommendations, which should prove useful to the leaders in the agencies where the

study was done. Additionally, there should be larger implications from these outcomes,

which should help the broader healthcare industry in the development of leaders not only

in nursing but, I hope, other health care professionals as well.   The next chapter presents

the topical and theoretical literature relevant to this study.

CHAPTER 2: TOPICAL AND THEORETICAL LITERATURE

The literature review drew mostly from electronic search engines including: EBSCO, ERIC, Pro Quest, Google/Google Scholar, Psyche APA, and Pub med/Medline, which included both quantitative and qualitative publications. First, I used the following key words to search the literature: *nursing leadership, nurse manager leadership development, nursing leadership competencies, nurse leader development programs, and nurse managers as leaders.* Finding numerous studies on competencies and specific leadership programs, I wanted to focus more on other aspects of professional socialization and education of nurse leaders, which led me to conduct advanced searches using additional keywords, such as: *professional development/socialization in nursing, nurse education and leadership, and shortage of nurse managers.* Literature findings reveal the need for developing nurses in designated formal leadership positions. The content of this literature review demonstrated the multifactoral dimensions which contribute to the leadership development of Nurse Managers. Today's nurse leaders must manage the business of healthcare with its economic and reform challenges, along with the relational aspects of the work, while being a skilled influencer and motivator. Researchers showed that educational preparation and on-the-job experiences contribute to leadership development.

In the relevant literature, I identified several themes that help illuminate the challenges and supports as nurse transition to formal leadership positions. Themes include the process of socialization to the nursing profession, the inherent power and hierarchy, leadership development, and the resulting competencies needed for nurses to lead. For purposes of this discussion, the terms *competencies* and *skills* are used

interchangeably to describe the needed know-how, proficiency, and capabilities for nurse leaders to be effective in their roles. Other themes include how competencies develop through formal educational preparation, on-the-job experience, and leadership development programs. In addition, I present existing theory around the topic of nurse manager leader development.

Topical Literature Summary

Findings from significant studies discussed a need for development of competent nurse leaders due to a potential nursing shortage, as well as outlined the specific competencies that assist leaders to be successful (Anthony et al, 2005; Benjamin, Riskus, & Skalla, 2011; Fennimore & Wolf, 2011; Griffith, 2012; IOM, 2010; Jooste, 2004; Kleinman, 2003; Mathena, 2002; Porter-O'Grady, 2009: Sullivan et al., 2003; Valentine, 2002; Westphal, 2012). A strength of the literature is its sheer volume, especially concerning the required leadership skills and competencies for nurse managers. Though the authors propose lists that vary somewhat, they all highlight the importance of relationship and emotional intelligence skills, leadership and influence, health care business skills, self-knowledge, and self-awareness. There is agreement in the studies I reviewed that advanced education is needed for the role of nurse manager and that experience in the field also plays an important role in nurse manager leadership development. Two prevailing tensions I found in the literature are first, the issue of entry level formal education, considering how leadership is taught across nursing programs, and second, determining what clinical experience and expertise is helpful to leader development. The conversation has been ongoing for more than 20 years on the requirements of standard entry level preparation for a Registered Nurse. The leadership

programs discussed have limited experiential and on-the-job components that would help

nurse managers further contextualize their learning. The programs acknowledge the need

for coaching and reflection but do not define how these ideas are incorporated into the

leadership development programs.

Socialization to the Role of Nurse

Nurses experience several challenges when transitioning out of early socialization

as a staff nurse and beginning to act in a more "leader-ly" way within the current

professional context. The literature shows that throughout the 150 year history of

nursing, the profession has focused on clinical and patient-centered tasks rather than on

leading and influencing others (Benner, 1994; Benner, Sustphan, Leonard & Day, 2009;

Brown, 1948; Cooper, 2008; Kalisch & Kalisch, 2004; Lysaught, 1981; Chitty, 2001).

The literature findings tell us that schools of nursing begin to socialize students to the

profession through course work and clinical experiences (Benner, 1994; Benner et al.,

2009; Lysaught, 1981). Upon graduation, nurses are further socialized when they gain

employment in health care organizations where novice nurses are expected (after some

time of orientation) to be capable of planning and managing the care of patients (Benner,

1984). In a sentinel study, Lysaught (1981) stated, "Through more than 100 years of

formal education, preparation, and socialization into the practice of nursing, the early

patterns of subordination and task orientation have continued to shape and influence both

education and practice" (p. 12). These prevailing attitudes are a barrier to nurse

managers and their leadership development.

Though novice nurses look to those with more experience to provide support,

leadership, role-modeling, and mentoring during their transition into practice, the

possibility of such support is not always an option. As a result, the phrases "eating our young" or "need to pay your dues" have bubbled up from the front lines of nursing (Cooper, 2008). The idea of paying your dues, according to Clavreul (2006), assumes that the student or newly graduated nurse is at the lowest rung of the pecking order and gets the least desirable tasks or shifts. This treatment of being overly critical of newer nurses, sometimes considered "hazing," may be in some cases be so internalized in the more experienced nurses that they do not even realize they are doing it (Claveul, 2006). Cooper (2008) referred to this as a the silent curriculum, or "unstated, unwritten rules and expectations we all know but were never taught, and are used to explain the effects of the workplace environment on new nurses" (p. 34).

Tensions Around Power and Hierarchy

The hierarchy of health care organizations and the longstanding roles of physicians, nurses, and other professionals are an aspect of this conflict present in the literature and have an impact on socialization and leadership development. This power and hegemony of the hierarchy in health care is cited by many authors (Cooper, 2008; Fennimore & Wolf, 2011; Mathena, 2002; McAlearney, 2006; Milbrath, 2000; Roberts & Coghlan, 2011; Tanner & Weinmann, 2011). This pervasive hierarchy was encouraged by Florence Nightingale (as cited in Cooper, 2008) as she spoke about "not wanting nurses to do any tasks unless the physician ordered it" (p. 6). Today, nursing practice is recognized as its own profession, yet the power struggles prevail within and beyond nursing. The IOM (2010) called for "nurses to be full partners, with physicians and other health care professionals, in redesigning health care in the United States" (p. 3). Another tension that exists when a nurse makes a transition to be a leader is that to provide

optimal patient outcomes, one must combine the practice of an *independent* professional

with the ability to adapt and work *collectively* as the situation may call for it (Roberts &

Coghlan, 2011).

Milbrath (2000) stated "The healthcare environment is a hegemonic system

organized around the ideology of effective, efficient, quality care" (p. 6). Milbrath

further defined a hegemonic system as existing whenever "various stakeholders with

differing ideologies, needs, and interests come together to forward a particular direction

or goal" (p. 132). Foucault (1977) said "that power is not given, exchanged, or

recovered; it is exercised… and exists only in action" (p. 89). Nursing as a profession

has a history of oppressing its youngest members, thus socializing each new generation of

nurses into a system of domination and control that perpetuates adapting to the status quo

(Cooper, 2008). This oppression that exists in health care adds to the challenge of

leadership development.

Professional Identity and Leader Development

One's professional identity is partially linked to leader development. McCauley

and Van Velsor (2004), in *The Handbook of Leadership Development,* discussed this

concept of leader development and presented a definition.

> Leader development is the expansion of a person's capacity to be effective in
>
> leadership roles and processes. Leadership roles and processes are those that
>
> facilitate setting direction, creating alignment, and maintaining commitment in
>
> groups of people who share common work (p. 2).

Roberts and Coghlan (2011) examined developing individual competency and

concluded that for effective leadership to emerge, the individual must develop first. This

is a step addressed in many leadership programs, which Roberts and Coghlan described in this way: "One discovers new ways of thinking about leadership, develops appreciation for differences, and assimilates more relational skills" (p. 242). Over time, those with less experience begin to incorporate the idea of "leader" as part of their identity and enhance their sense of self-confidence, empowerment, and motivation toward further growth**.**   Researchers do not discuss how this transition of identity occurs.

Benner et al. (2009) quoted the Carnegie Foundation report on educational preparation of the professions and emphasized the importance of "forming an identity as a member of the discipline, nursing, as a caring professional, scholar and steward" (p. 239). Socialization of nurses to their roles as staff nurses and then as leaders are key aspects of leadership development. Tanner and Weinman (2011) identified mentoring and reflection, which deepen self-understanding as helpful in building professional and leadership identity. Pierson, Liggett, and Moore, (2010) identified Benner's Novice to Expert model (1984) as a common framework for clinical ladders. Nurse identify with becoming more expert as clinicians with time, then according to Pierson et al.(2010) and Sherman and Pross (2010), they become "novices" again as they move into leadership roles. O'Connor (2011) supported the importance of identity and continued growth. "A nurse leader must learn, understand, and appreciate her or his place in the world and society. This includes nurse leaders acquiring the widest possible view of the work through discovery and integration of new ways of knowing" (p. 335)

Nursing Leadership Competencies and Skills

Leader development involves a unique and expanding set of competencies beyond those needed to be a competent registered nurse. In this review, I next examine the

relevant nursing (and some non-nursing) literature on leadership competencies, behaviors, and practices. The predominant word choice used in the literature to describe what is needed to be a nurse manager is *competencies* (AONE, 2010; Cummings et al., 2008; Donaher, Russell, Scoble, & Chen, 2007; Fennimore & Wolf, 2011; Griffith, 2012; Kleinman, 2003; Mathena, 2002; O'Connor, 2011; Sullivan et al., 2003). Competency refers to a broader base of knowledge, skill, and understanding (Moyers & Hinojosa, 2011). Several skills may be needed to address a competency. For example, financial management as a competency would include development of skills in budget preparation and management, staffing and scheduling, payroll management, and productivity monitoring and analysis.

Sullivan et al. (2003) identified leadership development needs such as introductory managerial skills involving communication, role development and transitioning, conflict resolution, scheduling, budgeting, performance evaluation, and coaching and counseling of staff. Sullivan et al. also found that aspects of the nurse manager role where development support would be helpful were: understanding the changes in healthcare delivery and industry practices; conflict management with multiple disciplines, personalities and cultures; and staffing, recruitment, and retention. From Kleinman's (2003) survey, 35 nurse managers and 93 nurse executives found many similarities regarding the needed competencies for their jobs, the most common being human resource and financial competencies. Moreover, Kleinman (2003) concluded that clinical practice competencies and management and business competencies are both essential for successful nurse managers.

Essential competencies for an effective future-oriented nurse leader, identified by Jooste (2004), are included in the framework by Kouzes and Posner (2002). The fundamental practices are "inspiring a shared vision, enabling others to act, challenging the process, modeling the way, and encouraging the heart" (Jooste, 2004, p. 221). Additionally, Jooste (2004) stated that emotional intelligence is an increasingly important leadership skill.

Jones (2010) reinforced the American Organization of Nurse Executives (AONE) leadership competencies as important. They are: "communication and relationship building, knowledge of the healthcare environment, leadership, professionalism, and business skills" (Jones, 2010, p. 3). Mathena (2002) added to the list of skills "visioning, interdisciplinary team-building, workload complexity, and work process analysis, stakeholder understanding/relationships, and interactive planning" (p. 137). Other competencies include self-confidence, ability to influence and persuade, initiative, and a results orientation. In addition, relationship-based competencies were reported to be as or more important as were technical and financial competencies in contributing to leadership effectiveness of nurse managers (Cummings et al., 2008; Griffith, 2012; Sherman & Pross, 2011).

Manthey (2002) is a strong believer that one can learn to be a leader. She advocated that leadership is a set of skills that can be learned, mastered and then incorporated into a "pragmatic notion of creativity to change the workplace cultures and the world" (p. 8). Some of the leadership skills cited by Manthey (2002) as important and similar to those of Mathena (2002) and AONE (2010) are:

- Visioning and direction setting, which includes employee enrollment

- Developing healthy self-management skills in individual staff members

- Creating a culture that is free of fear

- Maintaining positive morale (Manthey, 2002, p. 8).

Manthey's philosophy espoused the expectation of healthy relationships with self, staff,

and patients and family, and is tightly linked with the need for emotional intelligence

skills in the workplace. Though the lists of skills and competencies are somewhat

different, they all highlight relationship skills, leadership and influence, and health care

business skills. The gap in the literature is in how to help Nurse Managers develop these

skills.

"Emotional intelligence". Broome and Hughes (2004) cite a proliferation of

leadership development in the past 20+ years recognizing the importance of the leader's

emotional resonance with others. Harvard Business Review (2004) describes Goleman as

the definitive reference on the subject of Emotional Intelligence (EI). Goleman analyzed

188 competency models to identify personal outstanding capabilities and then, grouped

the competencies into three categories: purely technical skills (doing skills), cognitive

and reasoning skills (thinking skills), and emotional intelligence skills (people skills).   In

Goleman's research of these three factors, Emotional Intelligence proved to be twice as

important as cognitive or technical skills.

Goleman (2000) echoes Max DePree (2004) in his belief that leadership is more

art than science and defines EI as five skills that enable leaders to get the most from

themselves and their followers. The five skills are: 1) self–awareness, 2) self-regulation,

3) motivation, 4) empathy, and 5) social skills. The first two are self-management or *self*

mastery skills and the remaining three are relationships and participation skills. Leaders

must make the link between their feelings and what they think, do, and say and how

feelings affect their performance. Goleman calls this "living by the inner rudder" (p. 57).

Collins (2005) refers to the "window and the mirror concept" (p. 79). When

looking for who to credit for something, a humble leader looks out the window and

credits luck, other people, or the team. However, when dealing with a mistake or failure,

this leader looks in the mirror and accepts all responsibility themselves for whatever the

error is, even if they had only a small part in it. In summary, there is agreement and

overlap among authors that Emotional Intelligence or relationship skills are increasingly

important for leaders (Collins, 2005; Gardner, 1990; Griffith, 2012; Goleman, 2004;

Heifetz & Laurie, 2002; Kotter, 2001).

Expert authors agree enduring leaders model lifelong learning and that a love of

learning is a key pillar of the composite of the enduring leader. The ability to reframe,

reimagine, and ultimately reinvent ourselves and our organizations is a hallmark of

enduring leadership. Senge (1990) says, "Real learning gets to the heart of what it means

to be human. Through learning we recreate ourselves, extend our capacity to create, to be

part of the generative process of life" (p. 4).

The importance of influence as a competency. The future health care

environment will demand leaders as change agents with strong influence skills. Mathena

(2002) and Jooste (2004) remind us that the nurse leader is no longer the person who

controls the employees. The role of the leader instead is to "create a learning

environment and to foster self-management and entrepreneurial behavior" (Jooste, 2004,

p. 218). Hierarchical authority is less important in getting things done. Instead, it is

more important to be able to motivate, persuade, appreciate, understand, and negotiate in

one's role as a nurse leader (Jooste, 2004). Valentine (2002) agreed that enhancing the

leadership skills of staff nurses is important for improving patient outcomes. Porter-

O'Grady (2009) concurred, "Develop staff self-direction rather than giving direction" (p.

2). Manthey (2002) reinforced the importance of influence in her definition she suggests

leaders influence others by what they say, how they say it, and their resulting actions.

Leaders from the balcony and below, those with or without authority have to engage

people in: 1) Confronting the challenge, 2) Adjusting their values, 3) Changing

perspectives, and 4) Learning new habits (p. 47).

      The practice of self-care as a competency. O'Connor (2011) highlighted the

practice of self-care as critical to the sustainability of the nurse leader. Finding ways to

incorporate healthy and sustaining behaviors into the life of the nurse manager is

important, as is being a positive role model for these practices and the renewal for others

(Parsons & Stonestreet, 2003). When many in this profession view their career as a

calling versus merely a job, Abelson (2012) advocated professionals need to take care of

each other and foster healthy work environments. Abelson stated this gives professionals

discretionary energy to give to the demanding roles in healthcare (Abelson, 2012).

Additionally, reflective practice is identified as a form of self-care (Abelson, 2012;

Brookfield, 2000; Mezirow, 1990; 1995; O'Connor, 2011). "True reflection creates an

empty space in which we can recognize what we do not know, identify more effective

actions, and build our intuitive skills to scan the horizon" (O'Connor, 2011, p. 336).

Formal Educational Preparation and Leadership Development

      In 1995, the American Association of Colleges of Nursing (AACN) made a

recommendation which stated that Associate Degree nurses (ADN) be considered

technical nurses and those with a baccalaureate degree in Nursing (BSN) be considered professional nurses. Years later, the two levels are still not clearly differentiated in practice given that both levels of education take the same licensure exam and apply for similar positions in health care.

O' Connor (2011) wrote that the AONE called for formal educational preparation for nurse leaders. "One significant difference between the ADN and BSN education proposed by AACN is that the course work and clinical education should prepare nurses to assume a leadership role within the scope of one's practice" (p. 17). This notion of differentiated practice was further outlined in the AACN Essentials of Baccalaureate Nursing Education (2008); however, the difference in "leadership" education is not well articulated in the literature.

This 2011 recommendation ascribed that nurses in leadership roles be minimally prepared at the baccalaureate or master's level of nursing, and nurse leaders at the highest levels of executive leadership should seek educational level preparation at the doctoral level (O'Connor, 2011). The IOM (2010) has called for nurses to receive higher levels of education and training to respond to the increasing demands for public and community health, and to collaborate and coordinate teams across care settings.

The IOM (2010) articulated an expectation for improvement in the nursing education system stating that "new requisite competencies to meet complicated patient care needs include leadership, health policy, teamwork, system improvement, research, and evidence–based practice" (p. 2). Lastly, the IOM report calls for a seamless transition into higher degree programs and expects nurses to be educated alongside physicians and other professionals, both as students and throughout their careers.

There are multiple perspectives of what should be included in nursing curriculum related to leadership. Valentine (2002) claimed that in most nursing schools, some leadership theory, along with a leadership and management class is included. Content varies widely, and the real problem is there is little meaningful follow-up on leadership development once nurses reach the practice setting (Valentine, 2002).

Researchers indicated that formal curriculum must equip nurses with the knowledge and skills to operate successfully within the academic, management/leadership, and political contexts (Benner, 1994; Cooper, 2008; Fennimore & Wolf, Griffith, 2011; 2012; Jones, 2010; McAlearney, 2006; O'Connor, 2011; Sullivan et al., 2003). Cooper (2008) has two recommendations which could be an asset to leadership development "a) academic experiences should approximate the reality of the work setting and b) nursing students must be permitted to see what goes on in the *backstage* area of a nursing unit or organization" (p. ii).

On-the-Job Leadership Experience and Practice

O'Connor (2011) stated, **"**In addition to education, having experience as a nurse is a second foundational component of preparation for nurse leaders" (p. 334**)**. Nurses with clinical experience have more ease in gaining credibility and respect from those they supervise as a nurse manager. Nurse managers are often selected due to their expertise clinically (Fennimore & Wolf, 2011; Kleinman, 2003; Mathena, 2002; Paterson et al., 2010; Valentine, 2002). Thus, the statement commonly heard is that *the best nurse is promoted to be a nurse manager* (Kleinman, 2003). Cummings et al. (2008) found in their study that age and experience were positively correlated to leadership effectiveness.

There is also an assumption that the skills and knowledge that make the best nurses are transferable into leadership roles. Valentine (2002) pointed out a major tension in that not all authors agree that clinical proficiency and leadership are congruous. Kleinman (2003) stated that the practice of promoting staff nurses to manager positions based on clinical expertise has resulted in managers who were "unprepared for the scope of administrative responsibility and reality of unit-based operations" (p. 452). Yet others wrote that nurse managers are uniquely placed to make a difference in the quality and patient safety agenda, because of their true understanding of the issues that come from their clinical experience and close proximity to patients (Richardson & Storr, 2010).

Johannson et al. (2010) conducted a study on the leadership exercised by front line nurses (nurse managers). The authors categorized leadership activities into *being* and *doing*. The activities of *being* included the role of coach, mentor, or leader and include actions such as personal growth, influencing others, the ability to perform well in different contexts, increased personal development, and the ability to empower others. *Doing* was described by the authors as performing tasks and gaining skills and activities including operational processes, budget, quality project leadership, and creation of a positive work climate.

While Johannson et al. (2010) distinguished between types of leadership activities, Paterson et al. (2010) discussed the concept of effective leadership practices as "being largely dependent on an inclusive and embedded approach to learning" (p. 78). Developing nurses as leaders is achieved by targeting staff early and challenging their beliefs about their capacity to influence through leadership. They both recommended clearly delineated and progressive pathways for leadership development and believed

these pathways are essential to encourage lifelong reflection and learning that directly

impacts health care quality.

Leadership curriculum is formalized in many cases, but McAlearney (2006) stated

"Rarely are developmental experiences and opportunities built into existing jobs;

leadership development was described as something they had to make additional time

for" (p. 975). Benner et al. (2009) advocated that experiential or situated learning is

foundational in developing expertise. "Participation in experiential learning requires

openness and readiness to improve practice over time" (Benner et al., 2009, p. 41). In

short, experience, reflection, and lifelong learning all contribute to leadership

development.

Leadership Development Programs

Transition from Staff Nurse to Nurse Manager

McAlearney (2006) identified the issue of bridging the gap that exists between

administrative and clinical leadership. In her work, she reported tensions existing in the

cultural chasm between administrator and clinicians and around the issue of nurse

leadership development. Some were supportive of utilizing nationally recognized nurse

leader development programs, and others thought this type of education should be

developed and delivered internally, from the employing organization to be most effective

(Griffith, 2012; McAlearney, 2006, Matheny, 2004; Pierson, Liggett, & Moore, 2010;

Sherman & Pross, 2010).   In the absence of agreement on a standard approach to

leadership development, organizations have several options available to them besides

developing something of their own.

Paterson et al. (2010) identify two paths to leadership development. The first is for Emerging Leaders, or those nurses who are newly graduated and early in their careers. The second is called Developing Leader Programme and is available to those who are more confident in both clinical expertise and in their ability to contribute to the development of others. The Developing Leader Programme focuses on personal leadership, self-awareness, emotional intelligence, assertive communication, conflict management, leadership theories, effective teamwork, change implementation, and coaching/feedback (Paterson et al., 2010).

Cummings et al. (2008) found nine studies which evaluated the pre and post measures of leadership skills and competencies around the intervention of *leadership programs* and found this to be the most significant factor contributing to increased leadership practices in nurse managers. The leadership development programs varied greatly in time (3 days to 18 months) and venue, (remote vs. face to face, or part of a residency program (Benjamin, Riskus, & Skalla, 2011; Cummings et al, 2008; Wolf, Bradle, & Greenhouse, 2006).

Sullivan (2003) studied leadership development needs and used study findings to construct educational programs responsive to both novice and expert nurse managers. This section discusses leadership development programs that are dedicated to serving the needs for educational content involved in the transition to nurse leader. Some specific programs found in the literature are the Nurse Manager Leadership Collaborative and corresponding Nurse Manager Orientation Program, Colorado Center for Excellence in Nursing**,** The University of Pittsburgh Medical Center (UPMC), Leading Empowered Organizations (LEO), and Concentric Collaboration.

The Nurse Manager Leadership Collaborative (NMLC). In the early twenty-first century, three professional nursing organizations leveraged their natural synergy in mission and constituents to create a new joint program designed to nurture and develop nurse managers. The three professional organizations were the American Association of Critical-Care Nurses (AACN), the American Organization of Nurse Executives (AONE), and the Association of periOperative Registered Nurses (AORN). Thus, the Nurse Manager Leadership Collaborative (NMLC) was born to launch a program to serve this purpose (O'Connor, 2011; Sherman & Pross, 2010).

> The Nurse Manager Leadership Collaborative (NMLC) directs the combined knowledge, expertise and resources of three professional organizations toward effectively fulfilling this need and will give those busy managers the opportunity to work on their own development in a time in which their contributions are more important to the health care setting than ever before. (Larson, 2003, p.1)

The collaborative also developed two tools and a certification program to help document and support the leadership development of nurse mangers. The Nurse Manager Inventory Tool is a foundational component of the initiative of the NMLC to assist nurse managers in achieving their developmental goals throughout their careers. Additionally, the Essentials of Nurse Manager Orientation (ENMO), an online, 40 hour, self-paced orientation module was created, which prepares the nurse manager to sit for the AONE Credentialing Center's certification exam and become a Certified Nurse Manager and Leader (CNML).

Nurse manager orientation program. *Essentials of Nurse Manager Orientation (ENMO)* is a comprehensive Nurse Manager training course developed to promote

nursing leadership excellence. Nurse Managers, regardless of title, have added

responsibilities that directly affect the quality of patient care. ENMO is the first nursing

orientation leadership course created by experts in nurse management specifically for

nurse managers, and those aspiring to leadership, to show them how to best carry out

their complex responsibilities. The Essentials of Nurse Manager Orientation program

includes on-line modules in three main content areas. *The Science: Managing the*

Business, The Art of Leading People, and the *Leader Within* (www.AONE.org).

Areas of focus in *The Science: Managing the Business* include healthcare

financial management, human resources management, quality management, thinking

skills for Nurse Managers and decision making in a healthcare organization. Also

included are sections on strategic planning in healthcare including the creation of a

strategic plan for the manager's unit (s) and an operational plan.

The next section of competencies is in *The Art of Leading People,* which consists

of topics including how to lead your team, and key attributes of a leader such as

communication, self-awareness, emotional IQ, and management style. A few roles and

responsibilities of a leader included in the curriculum are maintaining a healthy work

environment, coaching, mentoring, collaboration, developing a professional staff,

resolving conflicts, and plan succession. Also included are the challenges of leading

people, leadership styles at work, fostering healthy work environments, practicing ethics

and organizational justice, inculcating cultural competence, and encouraging shared

governance and decision-making.

The last section of competencies and content is called *The Leader Within.* This

section includes modules and content covering personal growth and development, ethical

behavior and practice, and role negotiation with staff, other professionals, the boss, patients, and families. This section also includes career planning, professional life, reflective practice, appreciation of ambiguity, value for diversity, and the ability to hold multiple perspectives. The last modules in this section cover topics such as discovering your potential, letting go, and how to nurture the intellectual and emotional parts of the self (www.AONE.org).

Colorado Center for Excellence in Nursing. Another program for Nurse Manager Leadership Development (NMLD) is offered through the Colorado Center for Excellence in Nursing. *Colorado's* health care system developed this program which is funded by a 3-year HRSA grant. This initiative focuses on teaching frontline leaders the techniques and tools necessary for leading quality improvement projects that will be critical to the improvement of patient care outcomes. Through coursework and continued coaching, this program builds a nurse leader's capacity to lead and support quality initiatives to achieve improvement in health care quality performance. The course prepares nurses to support quality-focused initiatives using a set of defined skills not currently available to many nurse leaders. Built into the program for nurse leaders is an organized system of support by qualified coaches, primarily in senior administrative roles; this ongoing coaching is essential to stabilize and make permanent the desired changes in quality improvement.

Twelve partner organizations volunteered to participate in years one, two, and three of the Center's Frontline Nurse Leadership & Coaching Development. In its first year of operation(2008), this front line nurse leadership program trained 85 nurse-leaders in five hospital settings. The three-year project participation included 12 rural and urban

sites, covering both acute and long-term care facilities. Unfortunately, barriers to expansion are continuing funding support beyond the 3-year HRSA funding; additional funding is necessary to expand beyond the selected healthcare partners.

University of Pittsburgh Medical Center (UPMC). In 2006, under the direction of a new Chief Nurse Executive, UPMC refocused leadership development across the organization including the role of the nurse manager. At the time, the hospital used a generic leadership development program across all hospital leaders. A literature review of nursing and contemporary business literature revealed multiple leadership competencies essential to nurse managers including knowledge of complex systems and healthcare financing, interpersonal skills, conflict resolution, and motivational skills, and personal qualities, such as risk-taking, confidence, and creativity (Fennimore & Wolf, 2011; Wolf et al, 2006).

Furthermore, Fennimore and Wolf (2011) identified four transformational roles for UPMC Nurse Managers to address future business challenges. These four roles are "master strategist, change maker, relationship/network builder, and talent developer" (p. 205) all of which relate to competencies identified by other authors (Kleinman, 2003; Mathena, 2002; Paterson et al, 2010; Sullivan, 2003). These related ideas provide a vision for the future, identifying and facilitating change, emphasizing the importance of building relationships and the competency of developing and leading others.

The competencies identified and included in the UPMC Leadership Development for Nurse Managers overlapped with those included in AONE, AACN and AORN collaborative domains. Additionally, they are aligned with the work of Center for Creative Leadership, who note the most important skills as leading people and inspiring

commitment, strategic planning, managing change, and encouraging attributes such as

resourcefulness, being a quick learner, and "doing whatever it takes" (Fennimore& Wolf,

2011). The UPMC program started with a pilot of 25 nurse mangers, and over 100 nurse

leaders over the past two years have completed the course.

Evaluation of the course illuminated the most valuable content areas as financial

and budgeting, conflict management, application of emotional intelligence, and staff

motivation strategies. Additionally, the participants identified the content areas they used

the most after one month of the class' end as financial and performance accountability,

managing conflict and confrontation, and interviewing and communicating with staff.

The nurse managers also found new tools and resources to help them in their job and said

the content helped them greatly in their "day-to-day job functions" (p. 206). Some

changes in the program were implemented as a result of the program evaluation,

specifically, amount of time spent on each topic. The program is valued and considered

cost effective in this system of 20 hospitals and healthcare facilities employing over

10,000 nurses. (Fennimore& Wolf, 2011). Additionally, an outcome of the program is

that system wide turnover decreased during the time after the course.

Leading Empowered Organizations (LEO). An on-site three-day intensive

program prepares nursing leaders to use new strategies to create teams and work

environments that increase staff satisfaction and patient safety and quality. LEO was

created by Marie Manthey with Creative Health Care Management and taught by LEO-

certified faculty. During the three day LEO course, novice and experienced leaders alike

deepen their understanding of leadership. The workshop provides a conceptual

framework for leadership and practical skills and an opportunity to practice and develop

those skills. Participants also learn how to help their staff develop problem solving,

relationship and risk taking skills. The practical applications presented in LEO set it apart

from other leadership programs. Attended by more than 100,000 participants world-

wide, LEO has provided development and direction for leaders since 1982.

   Concentric Collaboration. Drawing on experience in the Midwest, Roberts and

Coghlan (2011) propose a model of leadership development based on action learning and

team work.   They found their model to both strengthen individual leadership and to

foster collective leadership. This work draws on leadership theory work including the

relationship between leaders and followers and transformational leadership (Roberts &

Coghlan, 2011). Using a group process of action learning described as a model of

experiential learning and inquiry, participants work through real issues present in

practice. This dynamic, real-life process can be effective for healthcare leaders including

nurse leaders, as it develop stronger relationships, and "increases one's capacity to

collaborate through a heightened sense of self-efficacy, meaning, and responsibility and

critical thinking (p. 234).

Similarities & Differences Among Leadership Development Programs

   The two key similarities of the six leadership development programs for nurse

managers are the emphasis and agreement on required competency development and the

inclusion of adult learning or leadership theories. Theories noted include Situational

Leadership, the Synergy Model (Kerfoot, 2001), experiential learning, and most often,

transformational leadership.

Theory within Literature

In the literature I reviewed, I found three examples of some theory being presented as it related to the leadership development of nurses. In this theoretical framework section, I present three theories evident in the literature reviewed: Transformational Leadership as exemplified by Burns (1978); Dewey's (1938) concept of experience and education; and Senge's (1990) work on learning organizations.   I also present an analysis of how these frameworks were used in the studies on the leadership development of nurse managers. Lastly, I will present the theoretical frameworks I used to guide my study.

Transformational Leadership

Transformational Leadership (Avolio, Bass & Jung, 1999, Bass, 1998; Bass & Avolio, 1993; Burns, 1978) is highlighted by several authors as being a desired and useful framework for nursing leadership (Brady Schwartz et al., 2011; Cummings et al., 2008; Jooste, 2004; Kark, Shamir, & Chen, 2003; Kleinman, 2003; Mathena, 2002; McAlearney, 2008; McDonogh, 2009; Paterson et al., 2010; Stanley, 2008; Upeniaks, 2003; Valentine, 2002; Wong & Cummings, 2009). The idea of transformational leadership first sprang from the work of James MacGregor Burns (1978) and became popular in health care in the early 1980s. As a political sociologist, Burns' work linked the roles of leadership and followership and suggested that leaders tap the motives of followers to better meet their mutual goals. Burns defined *transformational leadership* as "a process whereby a person engages with others and creates a connection that raises the level of motivation and morality in both the leader and the followers" (as cited in Northouse, 2010, p. 172).

There are four key tenets of transformational leadership which are conceptualized as a collective construct and influence the entire group as a whole, as well as the individuals within the group.   First, *inspirational motivation*, is the stirring of others to action by communicating one's vision vividly. Second, *idealized influence* means modeling high ethical standards and behaviors that place the group's good above one's personal needs. Next, *individualized consideration* is about supporting, coaching, and encouraging constituents. The last component, *intellectual stimulation,* is problem solving with constituents in collaborative and innovative ways (Kark et al., 2003). Fairholm (2001) describes Burns' work as seminal and articulates the focus of his work as an overall theory of leadership inherently based upon interpersonal relationships, motives, and values.

Theoretically, transformational leadership includes a set of assumptions Kark et al. (2003) describe, that are revealed in effective leaders and effective organizations. The results of transformational leadership are seen primarily among the followers in their empowerment, enthusiasm, and embracing of a vision as their own.   Koerner (2010) summarizes, "A transformational leader knows his or her own worldview (mental models) while appreciating and drawing of the views of others" (p. 68).

Implications and Limitations. In their study on magnet designation and leadership, Brady Schwartz et al. (2011) suggested the transformational leadership lens as being a key factor in nursing leadership to address job satisfaction, organizational culture, and other issues related to recruitment and retention. In fact, for hospitals to achieve a sought after designation, that of Magnet Hospital, a commitment and cultural shift to transformational leadership is necessary (Brady Schwartz et al., 2011; Upeniaks, 2003).

There was little exploration or discussion on the process of how one learns to lead in such a way. McAlearney (2006) conducted a qualitative study on leadership development in healthcare in which she described the context in which nursing and other healthcare leaders practice as chaotic, complex, and as one where there are multiple hierarchies, competing priorities and little focus on managerial and organizational learning. She used transformational leadership and action learning as the frameworks for her exploratory study. The results yielded six broad categories of leadership challenges which leaders and followers in healthcare must face.

McAlearney (2006), in her use of this theory with health care leaders, specifically with physicians, administrators, and nurses, found transformational leadership to be a prevalent leadership theory in health care with its focus on empowering and motivating the workforce, emphasis on relationships and adherence to values and standards. Other authors used this lens either to highlight their studies or act as a scaffolding for program development (Fennimore & Wolf, 2011; O'Connor, 2011; Stanley, 2008; Upeniaks, 2003), and some further studies explored this theory by placing emphasis on relationships, emotional intelligence, and engaging the workforce (Brady Schwartz et al., 2011; Hernez-Broome & Hughes, 2004). Furthermore, Fennimore and Wolf (2011) identified four transformational roles for UPMC Nurse Managers to address future business challenges. The four are "master strategist, change maker, relationship/network builder, and talent developer" (p. 205).

Northouse (2010) identified multiple limitations of transformational leadership. Some include that it is not specific enough and lacks conceptual clarity; another is that it is described as a personality trait versus a behavior that can be learned. Bass and Avolio

(1993) expressed concern that this approach to leadership is elitist and antidemocratic.

Lastly, there is concern for how transformational leadership is measured and that it has

the potential to be abusive, in that the goal is to change people's values by moving them

to a new vision (Northouse, 2010). In spite of these numerous criticisms and limitations,

transformational leadership is a predominant theory in nursing leadership literature.

Education and Experience

John Dewey's (1930; 1938) groundbreaking work has had a significant impact on

how nursing educators think about education today. One of Dewey's greatest

contributions to philosophy is his analysis of experience and its centrality to education

and learning. There are two main features to this notion of experience. One is shared

with the existentialists in that there is an emphasis on meaning. The second is that

experience is both cultural and social, a philosophy embraced in nursing curriculum.

Thus, when referring to experience in the context of learning, Dewey (1944) and nursing

educators directed the focus on meaning for the individual and on social interaction

within an organizational or educational culture.

Overall, Dewey (1938) believed good education should serve the broader society

and the individual student. Experience (provided by educators) must be immediately

valuable and better enable the students to contribute to society. In *Experience and

Education* (1938), he articulates the difference between traditional and progressive

education. Examples of traditional versus progressive education, which prevail in

nursing education, include: structured versus unstructured, disciplined versus having

freedom, teacher led and ordered versus student-directed, and didactic versus

experiential. In traditional education, the subject matter is determined by what the

teacher thinks the students need versus progressive education is where the students identify what they need. Another comparison is that traditional education looks ahead to the next exam or next course where progressive education would look ahead to what the learner needs.

Implications and Limitations. Dewey's work provided the lens through which Benner et al. (2009) explain the importance of context in how individuals learn. Unfortunately, as pointed out by Benner et al. (2009), traditional educational methods prevail in nursing educational preparation. In their work on transformation of nursing education, Benner et al. embrace Dewey's work and challenge the traditional approach. This traditional approach is top down, including a delivery of the knowledge from the one who knows, the teacher, to those who lack the knowledge, the students. (Dewey, 1938). According to Benner et al., (2009) this approach plays out in nursing curricula in the form of lengthy lectures in large groups, and leaves the processing of the information to the students.

Dewey (1938) and Benner et al. (2009) advocated for a more contextualized and meaningful approach that links content with context, and experience with reflecting and discussion, to aid in true learning. Dewey's (1938) perspective includes the premise that experiences inform our future experiences and allow individuals to contribute to the whole of society. Furthermore, Noddings (2007) adds in her description of Dewey's philosophy that values and knowledge are constructed through inquiry and social interaction.

In identifying limitations of this theory, the tensions between traditional and progressive education can present a dilemma of teaching using traditional methods only

or teaching using progressive methods only. The danger of traditional education is that it can be too structured, and progressive education is criticized for being too undisciplined. As Dewey's (1938) education philosophy is still present in Benner et al.'s (2009) work, it is evident Dewey's theory is still applicable to adult learners today. Therefore, the theory has growing potential for application in the modern day healthcare context for leadership development of nurse managers.

Senge's Theory of Learning Organizations

A third theoretical lens used to highlight research on nursing leadership is that of individual and organizational learning (McAlearney, 2006; Mathena, 2002). The rapid pace of change including staff and leadership retention, along with increased financial tensions demand greater adaptive capacity in nursing leaders. These factors, according to Senge and Sterman (1992), highlight the importance of "organizational learning, the process by which shared understanding and strategic change improves organizational flexibility and competitive advantage" (p. 1). In an earlier work, Senge (1990) stated: "The dogma of the traditional hierarchical organization was planning, managing, and controlling. The dogma of the learning organization of the future is vision, values, and mental models" (p. 1).

The specific components of Senge's (1990) theory included: *personal mastery, mental models, building shared vision, team learning,* and *systems thinking. Personal mastery* is how Senge described the discipline of personal growth and learning. "People with a high level of personal mastery live in a continual learning mode. They never arrive" (Senge, 1990, p. 142). A person does not possess personal mastery. It is a process and a lifelong discipline. Additionally, problems lie in a failure to recognize

prevailing *mental models* that hold an individual or organization back. The greater the change in worldview, the greater the change in strategy will be, according to Senge and Sterman (1992). *Mental models* are sometimes evident in broad generalizations. The important thing to note about *mental mode*ls is that they not only shape how people see the world but also how they act.

Senge (1990) also described the concept of *shared vision* as a powerful force that is more than an idea but a compelling feeling in people's hearts of what they want to collectively create. "A *shared vision* is a vision that many people are truly committed to, because it reflects their own personal vision" (Senge, 1990, p. 206).   To make a shared vision happen requires *team learning*. *Team learning* puts the emphasis of learning on achieving the collective potential. Senge (1994) describes *team learning* as the "most challenging discipline-intellectually, emotionally, socially, and spiritually" (p. 355). It goes beyond team building and inspires more fundamental and lasting changes throughout the organization.

Implications and Limitations. Senge's (1990) concept of learning organizations is reinforced as the theoretical framework in Mathena's (2002) study on nurse managers as leaders. This theory leverages learning and developing a broader worldview as a way to accelerate Nurse Manager effectiveness (Mathena, 2002).   Mathena's (2002) study supports Nurse Managers as leaders of change. Using this theory as a framework for the research illuminates both individual and team learning. Mathena argues that as leaders of change, nurse managers must be proficient in systems thinking. They need to be cognizant of how changes or inventions impact the larger system. In the challenging

future of health care ahead, Mathena concluded that the learning organization will be at an advantage over the competition.

A strength of Senge's (1990) theory and concepts is the emphasis on both the individual and the organizational context. On the other hand, critics of his work remark that not everyone wants to learn while at work. Many see work as a means to an end and wish to do their learning and living outside the organization. In fact according to Yayi (2012): "The whole concept of an learning organization seems to be an attempt to build an organization where the worker is 'trapped' to give all his time in the organization willingly, since there is the 'illusion' that he can reap intrinsic benefits from these efforts" (p. 1). Yahi (2012) continues by stating that the five disciplines of the learning organization can be seen as a tool to "conform or control" workers to work toward the organizational mission.

Existing Gaps in Literature

There was a lack of research focusing on the leadership development process for nurse managers; thus, a study on this topic was needed to analyze the leadership development of Nurse Managers. Another opportunity for future study was to examine the link between the individual nurse's development as a leader and the organizational context in which he or she works. I conducted a study, well grounded in theoretical frameworks to fill in the gaps. Specifically my study was a grounded theory study that describes and analyzes the leadership development of nurse managers. Using qualitative methods that are theoretically–based, I explored the leadership development of nurse managers in order to contribute new knowledge to both the nursing education and nursing leadership fields.

In my study, I utilized two analytic theories not presented in the nursing literature which provide a new lens through which to view the data. The innovative frameworks I applied were the four frames developed by Bolman and Deal (2008) in *Reframing Organizations* and Goffman's (1959) dramaturgy combined with the concepts of symbolic interactionism. A study combining these approaches allowed for investigation and discussion of the individual leader development while exploring aspects of the organizational context. My study utilizing the notion of reframing, and the concept of dramatic rehearsal adds a depth to the literature on this topic that was previously missing. In the following section, I describe the theories, which were used in combination for my study, Bolman and Deal's four frames, Goffman's dramaturgy, and symbolic interactionism.

Bolman and Deal's Reframing Organizations

In setting the context for their book, Bolman and Deal (2008) discussed perception as a "learned experience—the awareness of the external world (or some aspect of it), through one or more of our senses, and the interpretation of these by our mind" (p. 36). Additional leadership implications are that individuals behave not based on what the external environment is, but what they believe it to be. In short, our mental maps influence how we interpret the world. Bolman and Deal (2008) suggested a logical, yet comprehensive, set of frames through which to analyze and process what is going on at any time. In particular, analyzing the leadership development of nurse managers through the four frames uncovered rich data and insights thus adding new knowledge to the professional literature.

The structural frame. The oldest and most popular way of thinking about an organization is with the structural frame. This initial frame emphasizes goals, roles, and formal relationships with and among departments and people. Structure helps to divide labor, discern rules and policies, and define the formal hierarchy and authority. The structural frame is like a social architecture as a design to facilitate not only structure, but also, strategy, environment, implementation, experimentation, and adaptation.

The human resource frame. Bolman and Deal (2008) compared the organization to an extended family with individual needs, feelings, beliefs, strengths, and limitations. The human resource frame highlights capacity to learn but also the tendency to defend the prevailing attitudes and beliefs of the organization. The goal of the leaders in the human resource frame is to align the organization to meet organization-wide and individual needs through caring, belonging, fostering relationships, and investing in people to develop their human capacity. Bolman and Deal (2008) observed: "Slowly these values have appeared as the centerpiece of progressive company policies, always with remarkable results" (p. 125).

This frame strongly aligns with needs for emotional intelligence at work and a healthy work environment, which are important aspects of the nurse manager role according to the literature review. Important aspects of this frame include increasing empowerment and participation of others, supporting others, sharing information, and moving decision making to appropriate levels in an organization, all of which are key responsibilities of the nurse manager.

The political frame. In this frame, the organization is viewed as an arena, a contest, or a jungle where different interests compete for scarce resources (Bolman &

Deal, 2008). Here, power plays out as coalitions form and factions develop, grow, and

change. The political frame focuses on individual and group interests where political

leaders advocate and negotiate between different interest groups for use of resources.

Political leaders build power bases through networking and negotiating compromises.

There can be a negative impact when power is concentrated in the wrong places or

misused, and forward action in the organization may be impaired. This frame is helpful

in understanding the professional socialization of nursing and the factors of power and

hierarchy within healthcare. Bolman and Deal (2008) summarized the frame:

> The traditional view sees organizations as created and controlled by legitimate
>
> authorities, who set goals, design structure, hire and manage employees, and
>
> ensure pursuit of the right objectives. The political view frames a different world:
>
> Organizations are coalitions composed of individuals and groups with enduring
>
> differences who live in a world of scarce resources. This puts power and conflict
>
> at the center of decision-making. (p. 209)

The symbolic frame. Leaders working in the symbolic frame instill enthusiasm,

charisma, and drama to their organization. Bolman and Deal (2008) compared the leader

in this frame to a prophet, whose leadership style is inspirational. The symbolic frame

views organizations as a stage or theater to play certain roles and give impressions; these

leaders use symbols to capture attention and try to frame experience by providing

plausible interpretations of experiences to discover and communicate a vision. The

symbolic leader develops symbols and culture to shape human behavior and reflect a

shared mission and identity for the organization. This particular frame is a fit with the

theory of symbolic interactionism with its emphasis on meaning and the metaphor of theater provided by Goffman (1959).

Symbolic Interactionism and Goffman's Dramaturgy

Symbolic Interactionism (SI) is a sociological and social-psychological perspective which is grounded in studying the meanings that are learned and then assigned by individuals to the objects and actions of everyday experiences (Given, 2008). SI, as a perspective, can describe everyday situations, complex social problems, and serves as an important guide to the understanding of the self and others (Charon, 2010). As a theoretical perspective, it evolved from scholars at the University of Chicago. SI is comprised of two terms, "symbol" and "interaction," which are defined as follows: First, a symbol refers to social objects that stand for or represent something else (Given, 2008). Second, interaction highlights the significance of communication in creating meaning of symbols, from which culture arises. As Given (2008) stated "Interactionists understand culture to be the ideas, objects and practices that constitute everyday life" (p. 848).

Similarly, Goffman (1959), who also has Chicago School roots, presented his dramaturgical approach as the idea of *life as theater*. Metaphorically, Goffman (1959) suggested life is like a performance or presentation and uses actors, teams, audiences, scripts, and front stage/back stage to describe everyday life. The process, known as *dramatic realization*, is based upon activities of impression management.

Performance. Goffman's (1959) theory proposed that life involves a series of performances. Each performance includes a pattern of conduct designed to elicit an impression from others (the audience). The person performing at the time (actor) asks

the audience to believe that the character and impression portrayed is reality. Goffman (1959) stated, "The popular view is that the individual offers his performance and puts on his show for the benefit of others" (p.17). Within the performance, many roles and scripts exist and unfold. Additionally, Goffman (1959) highlighted the nature of group dynamics through his discussion of teams and explored the relationship between performance and audience.

Front stage/backstage. Another concept Goffman (1959) raised regarding performances is that of *mystification,* which suggests that certain matters are highlighted while others are concealed. This concept of mystification leads to parts of the performance being conducted *front stage* and other parts in the *backstage*. The official and socially acceptable stance and actions of the team is visible in the front stage performance. In the backstage (which is not visible to the audience), the conflict and tensions which exhibit reality or truth are more fully explored. There are many questions unanswered in the front stage. Using Goffman's (1959) theory, understanding the backstage activities will reveal the reality of everyday life.

Summary

The literature review revealed the need for developing nurses in designated formal leadership positions. The content of this literature review demonstrates the multifactoral dimensions which contribute to the leadership development of Nurse Managers. Today's nurse leaders must manage the business of healthcare with its economic and reform challenges along with the relational aspects of the work, all while being a skilled influencer and motivator. Researchers show that educational preparation and on-the-job experiences contribute to leadership development. Though the lists of

recommended skills and competencies are somewhat different, they all highlight

relationship, leadership and influence, and health care business skills. The gap in the

literature is in how Nurse Managers make the transition to the leadership role and

develop these needed skills. My study utilizing the four frames, the notion of reframing,

and the concept of dramatic rehearsal adds a depth and uniqueness to the literature that is

missing.

CHAPTER 3:METHODOLOGY

Anchored by Bolman and Deal's four frames (2008) and Goffman's (1959) dramaturgy combined with Symbolic Interactionism, this qualitative study allowed me to explore nurse managers' experiences and reflections of their own leadership development. This study provided these nurses with a venue to describe what contributed to their successful leadership development as well as identify the challenges along the way. For this study, I utilized the grounded theory approach as a set of systematic, yet flexible principles and practices to guide me, the researcher, in designing the study and then in collecting and analyzing qualitative data to construct theory from the data themselves. "Methods are merely tools" (Charmaz, 2006, p.15) that are bendable and elastic guidelines and not rigid, prescriptive rules. In short, grounded theorists are flexible and are open to what is happening in the study and to modifying the study as needed.

Research Design

Creswell's (2007) design of the qualitative study "begins by the researcher stating the problem or issue leading to the study, formulating the central purpose and providing the research questions" (p. 101). Bogdan and Biklen (2007) note that qualitative researchers "do not approach the research with specific questions to answer or hypotheses to test" (p. 2). Instead the researchers are "concerned with understanding behavior from the informant's own frame of reference" (p. 2). In addition, Creswell (2007) stated, "the researchers use interpretive and theoretical frameworks to further shape the study" (p. 15). Because this study focused this study on gaining an in-depth understanding of human behavior and development, I chose a qualitative method.

The foundation of grounded theory springs from the Chicago school traditions of pragmatism and research in the field. A grounded theory study considers "human beings as active agents in their worlds rather than as passive recipients of larger social forces" (Charmaz, 2006, p. 7). Researchers conducting grounded theory studies collect and analyze qualitative data from people's experiences in naturalistic settings. The aim of grounded theory research is to explain the studied social phenomena in new substantive, theoretical terms that may also apply to broad formal theories (Charmaz, 2006).

The purpose of grounded theory is to generate or discover a theory. A key distinction is that the theory is not one that exists in the books already but rather one that is grounded in the data collected from the participants (Creswell, 2007). "The study is organized around identifying the social, political, and experiential context of the problem or issue under study" (Creswell, 2007, p. 39). All participants in the study have experienced the process being studied, in this case the leadership development of nurse managers. According to Creswell (2007), "The premise is that the development of the theory might help explain practice, and furthermore provide a framework for future researchers" (p. 65).

Constructivism means that people participate in the construction of their reality and that it is built on previous knowledge and experience. Charmaz (2006) advocated for a constructivist grounded theory and states such an approach is gaining popularity in fields such as nursing, education, and psychology. A study in the constructivist tradition, according to Creswell (2007), "incorporates the paradigm assumptions of an emerging design, a context dependent inquiry, and an inductive data analysis (p. 341).

Why this approach?

I am investigating the leadership development of nurse managers as a sociological process. Glaser and Strauss (1967) define several interrelated roles of theory in sociology.

These roles are: 1) to foster prediction and explanation of behavior; 2) to be useful in advancing sociological theory; 3) to be useful in practical application, thus supporting the practitioner in understanding situations; 4) to collect data that will provide a perspective on behavior; and 5) to guide a style of research on certain behavior. (p. 3)

In addition, the authors take the view that the adequacy of a sociological theory cannot be separated from the process with which it was generated.

The context for the role of the Nurse Manager in healthcare is wrought with shifting social, political, and economic factors including access to care, evolving care models, and payment reform. I seek to "move beyond description and to generate or discover a theory" (Creswell,2007, p. 63) regarding nurse managers as they make the transition from staff nurse to nurse manager. Creswell (2007) maintains the constructivist approach of Charmaz, who "emphasizes the views, values, beliefs, feelings, assumptions, and ideologies of individuals" (p. 65), which I discovered and honored throughout data collection and analysis.

Additionally, grounded theory was selected for this study because of my desire to follow the data, and to develop a theory or framework for understanding the transformation from staff nurses to nurse manager and their leadership development. I also considered a phenomenological study, as it could provide insight into and understanding of the subject. Phenomenology focuses on distilling the meaning of a

particular experience or situation. While understanding the phenomena may be helpful, I determined that generating a theory could be more helpful to those guiding and shaping the nursing and health care leaders of the future.

In the health professions, there is an assumption that the best clinicians make the best formal leaders and because of this assumption, excellent frontline nurses are promoted to leadership roles, sometimes, with little or no attention to their leadership development needs. I wanted to better understand this concept and provide understanding from the voices of the nurse managers about the challenges and what contributes to their leadership development. This information should be useful to healthcare and nursing educational leaders.

Theoretical Lenses

Bolman and Deal (2008) and Goffman (1959) articulated a way to view the organizational world through a complex prism and multi-paned window and would allow me, as the researcher, to explore aspects of leadership development of nurse managers in the individual and organizational contexts. The reframing approach allowed me to ask questions and provide analysis using the scaffolding of the four frames: structural, human resources, political, and symbolic. Likewise, Symbolic Interactionism (SI) and Goffman's (1959) dramaturgy provide complementary lenses to explore the complexity of the leadership development journey for the nurse manager. The lenses of SI and Goffman enhanced understanding of the roles, scripts, and performances as the nurse managers described how they experienced freedom to discover new patterns and possibilities.

Data Collection

The defining components of grounded theory include simultaneous engagement in data collection and analysis, developing analytic codes and categories from data, and evolving theory development through the research process. This qualitative study used a grounded theory design. In this design, the theory is "grounded" in data acquired from the study's participants who have lived through a certain experience (Creswell, 2007). In addition, I collected data about the organizational context and what existed to support leadership development of nurse managers in each organization.

Two sources of data were utilized, interviews and document and/or program analysis. I collected data by reviewing written materials I received from participants and interviews with the nurse managers. After determining two health care systems for the study, I met or talked by phone with my executive contacts at the organizations to gain the agency consent and discuss the process of identifying participants. I was fortunate that both were very supportive and welcoming of my study and involvement in the organizations. These leaders identified people internally who would assist me in contacting potential study participants.

Participants. This qualitative research study examined nurse managers' transitions to nurse manager roles from their roles as staff nurses. My goal was to explore their leadership development. Nurse managers were given the opportunity to reflect on their experiences, whether recent or in the past, about what helped them to be successful and what was challenging.

For my study, I asked via email, for colleagues in two healthcare organizations in the Twin Cities area to identify current nurse managers to voluntarily participate in a

semi-structured interview to reflect upon their leadership development as a nurse

manager. The email I used to contact potential participants is attached. (See Appendix A

for email to potential participants). Another sampling strategy I used was the

snowballing technique. I identified the first few participants and asked them to identify

other potential interviewees. This technique helped to broaden the sample and provide a

rich database for the study. The snowballing technique brought another potential five

participants, two of whom I interviewed. I expected to perform a minimum of eight to

ten interviews in each organization for a total of 16-20 interviews. The final total was 19

interviews, at which point I had reached data saturation, that is, no new information was

unveiled. This total included interview data from my pilot study conducted in May and

June of 2012 (IRB Proposal # A11-205-01 – Analyzing Qualitative Data).

   The sample of participants was purposive, and included representatives from two

specific health care systems. These two organizations are both in the Twin Cities and

consist of multiple practice sites of hospitals and clinics. Both employ large numbers of

nurses and nurse managers and are typical of large healthcare systems today. One

organization has implemented a Nurse Manager Residency program while the other

develops nurse managers and all other organizational leaders through their organization's

Talent Development programs.

   When recruiting participants, I sought nurse managers from a variety of settings,

ages, educational backgrounds, and with varying number of years' experience as a nurse

to assist with triangulation of the data. I was also purposeful in attempting to enroll

some men in my study. I utilized a demographic data collection tool (Appendix B) to

gather the demographics of the participants at the time they agreed to be in the study. I

did not expect to have equal representation of men and women, as nursing is a profession that attracts more women.

     Interviews. My primary source of data consisted of semi-structured interviews with current or past nurse managers. I conducted the pilot study in May and June 2012 and completed the semi-structured interviews of the actual study in the summer of 2013. Interview questions consisted of open-ended questions to encourage participants to share their personal stories. (See Appendix C for Nurse Manager Interview Questions). I field tested my questions in a qualitative research class. In the class, my professor and other students provided feedback on my questions. After revising, I then tested my questions in my pilot study. I conducted all of the interviews at a location and time of the participants' choosing, most often their offices, and I planned the interviews to last from 60-75 minutes.

     After the initial email, if participants were willing to work with me, I then set up the time and place of the interview. All interviews were scheduled during the work day and at the office of the manager. This gave me the opportunity to experience their work setting. Most of the offices were directly on the patient care units, thus giving me a real life sense of the environment. After setting the appointment, I sent an email with the consent and the data collection form. I instructed the nurse managers that we would review the consent prior to starting the interview and that they could return the data collection form by email or when we did the interview. To protect the anonymity of participants, I kept the hard copies of the signed consents, data collection forms, and transcripts (all of which included pseudonyms) in a notebook that was locked in my office, if I was not working on the project.

Before the start of each interview I explained the purpose of the study to each

participant and reviewed the consent in detail answering any questions they had. Next, I

had the participants sign two copies of the consent form approved by the Institutional

Review Board of the University of St. Thomas (See Appendix D Study Consent Form).

One copy was for me and the second for the participants to keep for their records. I

informed the participants that all information was confidential and would only be read by

me, and the analysis by my dissertation committee. The participants could choose not to

answer any questions and they were advised they could leave the study at any time.

 If they left the study, data collected up to the time of them leaving would be used in the

study with the participants permission. Ultimately, all participants answered all the

questions and none dropped out of the study. I assigned pseudonyms for each participant,

organization or unit in the study. If the organizations were to be identified, it would be

possible to identify the nurse managers by some of the references in their interviews and I

also asked them some IRB questions to be sure they understood their participation in the

study (see Appendix E-Informed Consent).   I informed the participants of the minimal

risks and benefits of participation. I also informed the participants that should they

choose to talk about the interviews to their colleagues, their anonymity would be

compromised.

I recorded each interview with a digital recorder and transcribed them myself into

a Word Document. As I reflected on the interviews, I added memos and observer

comments. After each interview, I wrote a memo to begin to develop themes that I saw

emerging from the data. I adjusted questions and prompts for future interviews based on

the themes I began to see through the interviews. For example, some of the nurse

managers used the phrase "learning by doing" so I used this phrase as a prompt in some future interviews. I asked follow-up questions of the participants as needed to clarify the data gathered. I implemented member checks to allow the participants to validate the data throughout the study. Member checks proved very useful as a validation strategy, when I would receive the transcript back and the participants did not have any changes. I, then, trusted the thoroughness of my transcription. Once transcribed, I erased the recorded interviews from my digital recorder and shredded my interview notes.

For the purposes of validation, I used a triangulation design that included interviewing nurse managers across different ages, experience, education work setting, and time in the role of the nurse manager. In addition, I had conducted an extensive literature review on the topic of nurse managers and leadership development including the competencies and skills needed and the challenges for the nurse in this role. I referred to the literature review to validate particular themes or findings.

Document/program analysis. In addition to hearing the voices of the participants about their experience of leadership development, I investigated the leadership development support offered by the organization. Examples of organizational support included formal training, informal or formal support systems, i.e. mentoring programs and overall leadership development philosophy. Organizational leaders were available to direct me to educational materials such as curriculum, training materials, course offerings, competency assessments, or other organizational data and programs to review as I sought to better understand the organizational context and leadership development strategies. In some cases, the participants shared leadership development materials from the organizations with me. Prior to starting the study, I asked key leaders

in the organizations for letters of support and asked them to identify people who might provide information on the leadership development process within the organization. The goal of this review was to identify, describe, and understand the leadership development support that occurs within the organizational context.   I reviewed lists of leadership classes, nurse residency program information, lists of competencies, and on line modules which were available to the nurse managers. Based on my findings, the analysis of how nurses develop as leaders focused more heavily on the individual process of development and somewhat less on organized activities within the organization. The organizational context and mentor/leadership support, however, did emerge as a significant contributor to the leadership development process.

Data Analysis

Charmaz (2006) describes the path between collecting and analyzing data. "A journey begins before the travelers depart, so too our grounded theory adventure begins as we seek information about what a grounded theory entails and what to expect along the way" (p. 13). Additionally Charmaz (2006) cited the defining components of grounded theory practice as outlined by Glaser and Strauss (1967):

- Simultaneous involvement in data collection and analysis

- Constructing analytic codes that come from the data, not preconceived ideas

- Making comparisons at each stage of analysis

- Advancing theory development at each step of data collection and analysis.

- Memo writing to elaborate categories, define relationships between

    categories, and identify gaps.

- Sampling not for representativeness but aimed toward theory construction (summarized from Charmez, 2006, pp. 5-6).

I selected grounded theory for my study because of my desire to understand the meaning for nurses as they developed from staff nurses to nurse managers and how their separate organizations support this development. I think this approach provided insight into this experience.

Charmaz (2006) describes coding as "an emergent process" (p. 59). Through the process of open coding, I initially explored the data to determine concepts in common among the interviews and to identify the emerging themes. Next, I assembled the data in themes and began to explore the relationships among the data. This process resulted in additional grouping and nesting of concepts as part of a broader concept.

Analysis process. The elements of grounded theory included conceptual categories and their conceptual properties and hypotheses or general relationships among the categories. Per Glaser and Strauss (1967) and Holton (2010), each category must stand by itself as a concept and have a life beyond the evidence from which the concept arose. In my data, *identity and purpose* as a theme, has a life of its own and was also grounded in the data as the nurses described their identity as a nurse and leader and their strong purpose to support the needs of the patients. Also, according to Glaser and Strauss (1967), concepts should be analytic and sensitizing. Analytic means to be generalizable to designated properties of concrete entities. Sensitizing means they yield a meaningful picture of the data collected. Two concepts that arose from my data that were both generalizable and also represented a meaningful depiction of the data illustrated these concepts. *Learning from adversity* and *community* both are concepts that can be analytic

or generalizable, and sensitizing in that they shed light on the meaning of the data I collected.

Holton (2010) identified a similar approach to Glaser and Strauss (1967) in her assumptions about theoretical sensitivity. She defined theoretical sensitivity as the ability of the researcher to develop concepts from data and identify relationships among models of theory. The premise is that theoretical sensitivity requires two things from a researcher: the first is that they have the required analytic temperament, which would allow the researcher to maintain distance from the data, tolerate ambiguity and confusion, and to have trust in the process of conceptual emergence; and the second is analytical competence, which refers to the ability to develop insights about theory and to create conceptual ideas from various data sources. I worked steadily through the ambiguity for a period of months and trusted in my ability to create meaningful conceptual ideas from my data.

The coding process. I utilized a two-step coding process defined in classic grounded theory, according to Holton (2010). The first step is substantive coding, which includes both open and selective coding. Here, I, as the researcher, worked with the data collected and through open coding, identified the core categories and related conceptual themes. In this case, the data represented two main core categories, contributors and challenges to leadership development. Next, I used the process of theoretical sampling and selective coding until theoretical saturation was reached. Theoretical saturation is achieved through constant comparison of indicators in the data which leads to the creation of the elements of each conceptual theme. I continued the comparisons of the data until no new dimensions emerged from the data.

Conceptual categories/properties. According to Glaser and Strauss (1967), the elements of theory generated in comparative analysis are conceptual categories. I identified and re-identified the seven conceptual themes or categories within contributors and challenges. Additionally, through ongoing comparison, I arrived at a set of properties, which I refer to as elements, for each category. For example, one conceptual theme under contributors was *mental models of life-long learning*. The elements or properties of this conceptual category included *formal education, experiential learning* and *helping others to learn.* An additional example, in the challenges category was *learning from adversity*. The elements for this conceptual theme or category included *adversity and growth, making unpopular decisions,* and *dealing with disappointment.* The final conceptual themes, where data saturation was reached, are depicted in Chapter Four. For my final data analysis, I referred to these as themes and elements.

My next step was to develop a hypothesis and define the relationship among the themes and their elements, while being mindful that both themes and the elements are concepts indicated and generated by the data and are not the data. I began to hypothesize that one does not develop as a nurse leader without both the contributors and the challenges. This eventually became a strong component of the emerging grounded theory. "Conceptual categories and properties have a life apart from the evidence that gave rise to them" (Glaser & Strauss, 1967, p. 36).   For example, nurse managers did not explicitly say "nurturing community" was a contributor to their leadership development. They talked about the support of co-workers, managers, mentors, other nurses, family, and friends and the strength that came from this support. A few people stated, "I know I could call her anytime of the day or night and she would help me." In

addition, the nurse managers described rituals of eating lunch together and walking out to the parking lot after work. These examples spoke to me as *community*. Thus, *community* became a theme or category, that as Glaser & Strauss (1967) would say, has a life apart from the data.

Similarities and differences. Another aspect important to the process of developing conceptual themes is that of identified similarities and differences in the data. As I considered the differences and similarities of the data, I generated the abstract themes and their properties or elements. In one case in looking at similarities and differences, I chose to put identity and purpose together in a thematic category as it seemed as the nurse managers were talking, their purpose (patient care) seemed to be strongly connected to their identity. These examples arose from the data and, therefore, were important to a theory explaining the behavior under study, in this case the leadership development of nurse managers.

At first, in the early stages of data collection, lower level categories emerged from the data; for example *formal education* and *learning from experience*. Later, more overriding or higher level themes tended to emerge through my coding and analysis. In the example of *formal education, experiential leaning* and *helping others to learn,* I discerned a higher level themes that became, *mental models of lifelong learning*. Glaser and Strauss (1967) also stated that categories can be borrowed from existing theory, providing the categories fit.   This was the case with "Emotional Intelligence" which is a term written about by Daniel Goleman (1995, 2002) and is again, a term that is both generalizable and meaningful on its own.

Before and after each interview and upon examining documents and organizational material, I used memos to keep note of thoughts and impressions of the interviews, occurrences, and information that warranted my attention. For example after each interview, I wrote a post interview memo with my impressions, any themes of the interview, and highlights or memorable quotes from each interview participant. I developed several concept maps to visually play with and sort the data to identify patterns contributing to the leadership development of nurse managers and patterns or themes of challenges. It was one of my concept maps that made me see that I had categories listed as *relationships, building teams,* and *self-awareness*. As I saw these together in a concept map, I thought that all three categories should be altogether in a broader conceptual theme called *"Emotional Intelligence."* At this point, I connected the causal conditions together to present hypotheses for the relationships, or as Creswell (2007) called this, developing a story line. From there, I developed theory from the themes. In this particular study, I developed theory around the factors that contribute and are challenges to leadership development of nurse managers from the perspective of the nurse managers themselves.

Use of the Theoretical Frameworks

Upon defining the conceptual categories and properties, I then organized the concepts utilizing the lens from Bolman and Deal's (2008) reframing and Goffman's (1959) dramaturgy. The symbolic frame linked well to the dramaturgy concepts of performances, roles, scripts, and impressions which shape culture and identity.

Bolman and Deal's (2008) four frames and reframing. As the literature showed, the leadership development of nurse managers is compounded by multiple

factors within the health care context including shifting social, political, and economic factors. This framework offered multiples lenses through which to view the data and conceptual categories, and I realized that my data had much more depth in the human resource, political, and symbolic frames and less in the structural frame. Aspects of the phenomenon such as hierarchy, roles, and division of labor were examined through the structural frame. The human resource frame provided the lens to understand how the individual needs, strengths, and learning are enhanced or limited within the organizational environment. Relationships also fit into the human resource frame. The third frame, the political frame, identified with the power and scarcity of resource issues which nurse managers' experience. The symbolic frame offers a way of looking at the meaning of images and social interaction.

Symbolic interactionism and Goffman's dramaturgy. The theoretical frameworks of symbolic interactionism and Goffman's (1959) dramaturgy allowed me to look at the everyday life and leadership development of nurse managers and understand it better when comparing its aspects to a performance. Creswell (2007) stated that a research study should be "organized around identifying the social, political, and experiential context of the problem under study" (p. 39). When applied to the role of nurse manager leadership development, there are many roles, scripts, costumes, and rituals to be explored. This grounded theory design allowed the voice of the nurse managers to be heard regarding their experience and in turn, allowed me, the researcher, to explore and develop theory about the interrelationships of the themes that I gathered from the nurse managers themselves.

I surmised prior to my research that the front stage application may be the performance that the patient sees (i.e. front stage), while in the reality of the backstage, there may be many shifts in the act that occur. Examples of some back stage questions included: Who are the main actors in this drama? How does one learn the leadership script? The challenges of the hierarchy, identity issues, and role tensions among physicians, nurses, and other team members exist in the back-stage and add to the complexity of the nurse manager role. This mystification or concealing of tension may have a significant impact on a nurse manager's leadership development. Moreover, symbolic interactionism and dramaturgy provided the lens to better understand the meaning of the nurse manager's work, identity, and leadership development.

Validity and Ethical Mindfulness

In the following section, I will describe how I addressed validity and generalizability for my study. Next, I will present information regarding confidentiality and ethical responsibility.

Validity and generalizability. For validation purposes, the triangulation design includes interviewing nurse managers at different levels of experience, education, and age, as well as in different units and organizations. An additional source of triangulation included the document and program material review. In the pilot study one person had been in a nurse manager role of increasing scope for 26 years and another had been in the role less than one year. These validation strategies proved essential to assure data would be replicable in another study. Creswell (2007) asked a question about qualitative studies: "Is the account valid, and by whose standards" (p. 201)? This question translates to: Is the study credible, transferable, and dependable? My study needed to be all of

these so that the findings will be useful to those developing nurses as leaders and those responsible for professional and organizational development. As I uncovered the most significant events and learning moments in one's career as a leader, I anticipate my study will inspire and help future nurse managers.

Additional mechanisms I utilized for triangulation were including member checks, creating an audit trail, and observing for data saturation. Performing member checks in my study consisted of asking participants to review transcripts and report any inaccuracies and to also validate that the transcript captured the interview as a way to enhance validity. This approach, according to Creswell (2007), served to strengthen a study if the researcher took data analysis, interpretations, and conclusions back to the participants so that they could judge the accuracy and credibility of information. This process was very affirming that I had captured the data accurately in my transcripts. I used a second strategy by creating an audit trail as a way to enhance reliability. This audit trail provided a detailed description of the research process, member checks, and the evolution of codes, categories, and themes (Creswell, 2007). Additionally, I was always on the alert for data saturation, which is the point at which I would be finding nothing new in my interviews, as a way to enhance validity.

Another plan in the realm of validation strategies from Creswell is for the researcher to have prolonged engagement and ongoing observation in the field. For my study, these processes included building trust with participants, learning from the culture, and checking for misinformation. In the consent, I included the options for additional interviews with the participants and did selected follow-up with email or phone questions for clarification. For example, some nurse managers referred to specific classes they had

taken and I would follow-up after the interview to get a list of the classes. Validation was

aided greatly by the feedback and questions from my dissertation committee. Managers

from the same organizations referenced some of the same truths about that organization,

thus further validating the data. Common themes were the helpfulness of the color

analysis/ leadership style assessments and also the specific leadership classes like *how to*

lead a team and *performance management*. This proved to be an expanding theme as I

interviewed multiple participants in the two organizations.   Not only did the interview

data produce themes, but the participants validated comments others had made.

As another option to triangulate my data, I spoke with health care executives

responsible for the leadership development or learning strategies in organizations and

other nursing leadership experts as identified by the snowballing method.   The use of

multiple data sources, documents, course outlines, interviews, literature review, all

allowed me to triangulate the data and determine whether the sources corroborated each

other.

Bogdan and Biklen (2007) use the term generalizability to describe study findings

that bear attention beyond a specific setting and subjects. A goal in this study was to

ensure the usefulness and rigor of the study and the dependability and transferability of

the results. One strategy to assure this happened was selecting participants across a

variety of educational, work setting, and experience and time in the nurse manager role.

Another was to compare published literature and other studies, both qualitative and

quantitative, on nurse manager leadership development with data gathered from

participants and to compare and contrasts findings.

Role of the researcher. The embodied researcher in qualitative research is part of the research. For the pilot study, the participants were all people I knew fairly well. In my pilot study, I attempted to remove researcher bias by a thorough review of data by the professor and students in my editing group. Systematic coding of data was helpful in removing researcher bias. Lastly, utilization of the snowballing techniques to identify study participants also helped to reduce and eliminate researcher bias by including people that I did not previously know.

Creswell (2007) states that in qualitative research, the researcher is a "key instrument" in data collection (p. 38). Moreover, qualitative research is based on the premise that "researchers bring their own worldview, paradigms, or set of beliefs to the research project" (Creswell, 2007, p.15). Maxwell (2005) asserted that "separating your research from other aspects of your life cuts you from a major source of insights, hypotheses, and validity checks" (p. 38). Therefore, my experience as a nurse manager and my own leadership development affected this research.

My experiences as leader and one who has contributed to the leadership development of many nurse managers played a key role in the selection of this study. My background and experiences have caused me to ask questions and seek understanding of the individual process of leadership development and what and how external factors contributed to this development. In addition, my experiences as a nurse and leader assisted in gaining a deeper understanding of the stories that individual study participants share.

Additionally, Charmaz (2006) points out that "every researcher holds preconceptions that influence, but may not determine, what we attend to and how we

make sense of it" (p. 67). Thus, my experiences as a student of leadership *and* my

previous role as a nurse manager influenced my interpretation of what each participant

reported during the interviews. Bogdan and Biklan (2007) caution that the prejudices and

attitudes of the researcher may bias the data. They suggested the researcher be mindful

of this subjectivity and must "continually confront his or her opinions and prejudices with

the data" (p. 37). Because of my past experiences, I needed to be vigilant and aware of

what I *perceived was* being said, and what *actually was* being said, in order to allow the

data to uncover an accurate and clear theory. I also used a strategy Creswell (2007) and

Charmaz (2006) identify as reflexivity, which requires "the researcher's scrutiny of their

own research experience, decisions, and interpretations …which allow the researcher to

assess to what extent the researcher's interests, positions, and assumptions have

influenced the process of inquiry" (Charmaz, 2006, p. 188). For example, reflexivity

appeared as many nurse managers described the transition as overwhelming, and a huge

learning curve. These comments were identical to what I experienced in my own

transition to leadership.   In addition, when nurse managers spoke about unpopular

decisions, I immediately remembered some of my own decisions and how others reacted

to them.

Lastly, another data analysis warning comes from Maxwell (2005) who says the

discussion of data analysis is often the weakest part of a qualitative proposal. He

suggested that researchers make decisions about how the analysis will be done, and these

decisions should inform and be informed by the rest of the design. Moreover, as I am

also a participant in my research, I addressed my biases in my observer comments and

field notes as an additional, reflexive source of data and further means of triangulation and validation.

Ethics and confidentiality. I collaborated with my chair to develop an IRB proposal to receive human subject approval. All study participants were treated in accordance to the ethical guidelines of the University of St. Thomas's Institutional Review Board (IRB). Participation in this study was completely voluntary. To mitigate the risks to the participants, I used a pseudonym for each participant and for all organizations or units they discuss. If the organizations were to be identified, it would be possible to identify the nurse managers by some of the references in their interviews. I explained the purpose, minimal risks, and benefits of the study to each participant, and I had the participants sign a confidentiality agreement approved by the Institutional Review Board of the University of St. Thomas. I asked participants the IRB questions (included in Appendix E) about the study prior to their signing the document to ensure their understanding.

Permission for my pilot study came from IRB #A11-205-01 and includes participant interviews and observation completed in May and June 2012. I transcribed the interviews myself using pseudonyms for any names or places. I erased the digital recordings once transcribed and destroyed hard copies of analysis summaries once reviewed. I kept any transcribed data and my analysis on my hard drive and password protected computer for the purposes of my research and dissertation only.

The records of this study are confidential. In any sort of report I publish now or in the future, I will not include information that will make it possible to identify participants in any way. The types of records I created include recordings, transcripts,

personal notes, and analysis in order to complete my dissertation. My dissertation chair and committee reviewed the analysis and findings.

Summary

In Chapter Three, I presented a methodology of this study. I outlined the rationale for using a qualitative approach and how grounded theory and theory from nursing and sociology informed my study. I also explained the details of study design, data collection, participant selection, and the process for data analysis. I presented and described the theoretical frameworks used: Bolman and Deal's (2008) four frames and reframing theory and Goffman's (1959) dramaturgy. In addition, I discussed the similarities of these theoretical frameworks and how I used them to guide my research. Lastly, I presented the validity, generalizability, and ethics considered in the study. In the next chapter, I provide a detailed review of my findings in this study.

CHAPTER 4: FINDINGS: THE VOICES OF NURSE MANAGERS

This qualitative study attempted to answer the following three questions: What contributes to the leadership development of nurse managers? What are the challenges faced by nurse managers? According to nurse managers, how does their transition from staff nurse to leadership happen in the organizational context? In the following chapter, I present the findings of 19 semi-structured interviews with nurse managers in two healthcare organizations; the nurse managers all practice in a hospital setting. These findings are also the result of document review of material I received from the organization First, I provide a demographic overview and an introduction to the participants. Next, I describe a day in the life of a nurse manager based on information from the nurse manager interviews and my own experience. Lastly, I present the findings from my interviews with the nurse managers.

Organization of Findings

I organized my findings from the interviews into two main core categories: Contributors and challenges to leadership development. Within the contributor category, four conceptual themes emerged from the data including: 1) identity and purpose, 2) "Emotional Intelligence," 3) mental models of lifelong learning and 4) a nurturing community. Within the second main core category, challenges of leadership development, three conceptual themes emerged. First, is the transition from staff nurse to leader; second is the notion of learning from adversity and mistakes; and last is the large scope of responsibility and rapid pace of change. I based findings for this study upon the data gathered through document analysis and semi-structured interviews of the 19 nurse manager participants.

Nurse Manager Roles /Introduction to Participants

I asked each participant to fill out a data collection form prior to the interviews. I used this information as a validation and triangulation strategy to assure I conducted interviews across a wide variety of ages, gender, experiences, and education levels and in different care settings (See Table 1). I also included the number or direct reports and/or units for which the nurse manager is responsible.

Table 1

Demographic Data Collection - Nurse Manager Leadership

Data Requested	Participants Data
Organization	Two organizations 10 from one and 9 from the other
Highest degree in nursing education: AD, BSN, MSN< etc.	BSN-12 MSN-5 DNP 2
Age	Range from 29 – 55
# Years of experience as a nurse	3 - 33 years
# Years of experience as a nurse manager	3 month-15 years
Male/ Female	16 F 3 M
Approximate number of direct reports	20 - 165 one manages a program with no direct reports Average # of direct reports 76

I also included Table 2, which provides an introduction to the participants including their educational background and experience. All of the names and units are pseudonyms for the real persons and places so as to assure confidentiality. The final column includes a symbol identified by the nurse managers. I asked them to describe

their own leadership and then a follow-up question, Do any symbols or images come to

mind? These data are discussed further in the analysis chapter.

Table 2

Introduction To Participants

Introduction to participants including experience, education and span of control.	Educational Background/	Symbol or image for their leadership
Eric is the first male I interviewed. He is young and ambitious. He says he doesn't want to be stuck and is always looking for the next step. He has been in nursing three years; his BSN is his second baccalaureate degree and he has been in the nurse manager role for 9 months. He has 75 direct reports on a unit where he was formerly a staff nurse.	BA, **BSN**	A guide
Summer has been a nurse for 10 years and seven of those she has served in leadership positions. Her highest degree completed recently is her DNP. She is in a director role with three managers reporting to her after being in manager and Asst. Nurse Manager roles in two other organizations She has 30 direct reports and 140 additional through the managers that report to her.	DNP, MSN, **BSN**	Colors- I see colors!
Mike started as a diploma nurse and was the only participant with a military background. He is a strong believer in relationships and that trust is the best support for superior performance out of people without trust. He has been a nurse for 18 years with two as a nurse manager and has 140 direct reports in the ICU. Mike will be starting an MBA program soon.	Diploma RN, **BSN** Has been accepted into MBA program	The Olympic Symbol- interconnected circles
Beth started as an associate degree nurse and while working, completed her BSN**.** She is a fairly new leader who became a nurse manager on a busy unit where she had been a staff nurse. Beth has been a nurse for eight years and a manager for 2 years. She has 72 direct reports and is considering an MSN degree.	ADN, **BSN**	Stairs, one step at a time

Mary Ann has worked in three different systems and started in leadership as a clinical educator. She recently moved to a manager role and is learning a lot. Mary Ann describes herself as a perfectionist and loves ICU where she has 40 direct reports. Mary Ann did not mention returning to school.	**BSN**	A butterfly
MJ is a leader with over 27 years of experience as a nurse. She has been in leadership for 13 years, with 9 years as a nurse manager and now four in a director role where she has three units and 120 direct reports. Most of her specialty experience has been in pediatrics and women's health.	AD, **BSN**, MSN	No symbol
Zena is a people person and also very patient centered. Her young age presented a challenge of being taken seriously as she moved into her first leadership role. She has thirteen years of experience with nine in a leader role, eight and a half years in an administrative supervisor role and now six months in a manager role with 35 direct reports. Zena has a goal of getting an MSN in the future.	**BSN**	The sun
Sandy grew up in another system and worked there for 32 years. She has had early leadership experience as an Assistant Head Nurse (AHN) and has been working 35 years in Nursing. She has worked 16 months as a nurse manager with 40 RNs reporting to her in the perioperative setting.	Diploma nurse then **BSN** completion-	Otter-
Cami holds a different role but is still called a nurse manager. She does not have direct reports, however, she manages a program, and gets her work accomplished by influencing others. Cami became a nurse after having a previous bachelor's degree and becoming a phlebotomist and a medical assistant first. She described wanting to be in the nurses role. She has 13 years of	BA, **BSN**	Is there a symbol for organized chaos?

experience as a nurse and six months in her manager role.		
Leah is a lively and reflective nurse who originally studied nursing to aid her in understanding the disease process of patients as she was intending to be a psychologist and counselor. She found she loved nursing and has worked with the pediatric population since graduation. Recently, she has set her sights on leadership and is in her first nurse manager role. She has had seven years' experience as a nurse and one year as a manager supervising 20 people.	**BSN**, MA counseling	Pressure cooker or shock absorber
Emma is thoughtful and passionate about her work. This nurse has spent her entire career of 11 years in one organization. For the last 2 years and 9 months she has been a nurse manager with 72 direct reports. She did not mention returning to school.	**BSN**	A heart
Mara has been a nurse for 25 years, and has spent the last year as a nurse manager in a system-wide role with 33 direct reports. She has worked in UR and Quality and also in a health plan. She loved her diploma program, then went on to get her BSN and is starting to look into MSN program.	Diploma, **BSN** and MSN	A flower blossoming
Jay said he jumped right into leadership after a year of experience as a nurse. This quiet young man has been a nurse and started as an AD for 6 years; 5 of them have been in leadership -- much of it long term care. He did an online BSN and worked aggressively to finish quickly. He currently is a nurse manager with 90 direct reports and is exploring MSN programs.	AD, then **BSN** starting to look at MSN programs	A teacher
Katie recently finished her DNP. Nursing is a second career for her, and her path included an associate degree, BSN completion, and a double master's degree in Nursing and organizational leadership. She has 22 years	AD, **BSN** MAN, MAOL, DNP	heart

of experience as a nurse and 10 in leadership roles. She has been an administrative supervisor and director also.		
Tanya started her health care career as a nursing assistant, then an LPN, then she got an associate degree in nursing. She then got her BSN and is now a MSN student. She has been a nurse for 10 years and has worked 3 months in her leadership position with 35 direct reports. She has also spent time as a utilization review nurse.	AD, **BSN** MSN student	Wings
Mindy has 23 years of experience as a nurse, all in ICU where she started as a new graduate. She has been a nurse manager for 8 years and has 60 direct reports. Nursing is Mindy's second degree. When she decided to become a nurse, she did AD first, then an online BSN completion. In addition, she is nearly half finished with her MSN.	AD**, BSN**, MSN student	A duck
ML has worked 24 years as a nurse, most of it in ICU and with 11 years in leadership. She has worked in 2 different states and currently manages a busy surgical unit with 90 direct reports.	**BSN**, MSN	A chameleon or an octopus
Melanie supervises 62 staff and has more than 14 years in nursing, with three in a nurse manager role. She has worked in three large systems in the Twin Cities. She is also currently serving as an interim manager for another step down unit within the health system while that nurse manager is on an LOA.	**BSN**	Transformation—a butterfly
Maggie is an RN with 33 years of experience and 13 as a nurse manager. She started her career in orthopedics but always wanted to work in OB. She got her wish and now manages a large, busy maternity unit in a suburban hospital with 105 direct reports.	**BSN**, MA	A team huddle

A Day in the Life of a Nurse Manager

I learned from my interviews that no two days in the life of a nurse manager are the same. The main activities on which nurse managers spend their time encompass three overlapping categories which I will describe. The three categories are: connecting and communicating, attending and participating in meetings, and problem-solving and crisis management. As I describe these activities, the overlap will be apparent.   Just as the work of a professional nurse requires multitasking, adaptability, and reframing priorities on an ongoing basis, this is also true of leadership.

Connecting and communicating. A key activity of a nurse manager is time spent connecting and communicating with others. Nursing management is a people-centric profession that involves interactions with many others on a daily basis. Sometimes the interactions are with the patients and families, sometimes with staff, and sometimes with physicians and other health care workers. For the most part, with one exception, the nurse managers I interviewed worked the day shift.   I learned that many nurse managers start their day very early, with the goal of connecting with the night shift staff. Maggie is always at the hospital by six, "How can they connect with me and how can I know what issues they are facing if we never see each other?" Summer also starts her day rounding through the multiple units for which she is responsible.

> I come in about 6:30 and before I go to my office, I make rounds through all the
> units so the staff can see me. I ask how was the night? I stop and chat. Most days
> it takes me about an hour before I even get to my office and take off my coat. I
> think the day shift has more dependence on me as they see me more. I try to be
> visible and they tend to call me with more questions. Before I leave for the day I

do the rounds again on the evening shift so that staff can see me and I can connect

with them. I think that connection with staff is really important.

Melanie also makes it a priority to do "daily rounding" with her staff and finds it a

favorite part of the job. Melanie has 62 direct reports on her busy "step down" unit.

I am out rounding on the staff.   Asking them what are their goals? How can I

help? What is challenging today? This just became a part of our daily work. We

huddle every day. We discuss what's going on and we move the improvement

cards forward. I am a barrier buster. I help people check up on things or help

people to move things forward. This is my work. My work is not in this office.

Meetings. Participating in meetings is another mechanism to get things done.

There are a variety of meetings nurse managers may need to attend. Some are related to

the unit and some are related to the overall organization. For example, Mindy has

hospital-wide leadership responsibilities that extend beyond her units.

I have additional responsibilities beyond my responsibilities to my units. I am

involved in critical care committee, Code Blue Committee; I chair the ethics

committee, and the rapid response team. So I have a lot of additional

responsibilities that the other directors do not have because of the ICU.

There are quality meetings, nurse manager meetings, and 1:1 meetings with staff. Time

spent with staff is a big priority for nurse managers. Melanie stated her perspective on all

the meetings, "There is no one who went to a meeting and said wow, that meeting really

fulfilled me." Eric describes how being available to staff and helping them with problem

solving is a big part of his job.

I had a staff nurse who came in to see me the other day with their schedule. This

person was really upset as the staffing office did not give him a day off that he

requested and he needed it off for class, so I sat down with him and we looked

over the schedule. I helped figure out who could possibly pick up the day and

when that person was working so they could ask them to work. It all worked out

and all I really gave of was my time and willingness to help with problem-

solving.

Problem solving/crisis management. A third area of focus that takes up a large

amount of time is solving problems, crisis management, and "putting out fires." A

common theme is that no two days are alike, and flexibility and adaptability are needed.

The best laid plans for the day can be changed because of a more pressing priority.   The

entire group of nurse managers I interviewed portrayed a refreshing optimism. These

Nurse managers were can-do and hopeful. I was a bit surprised as I know the nurse

manager role is one of the most difficult roles in health care and that the scope of many

nurse managers is very large. Emma, who has only worked at one institution since

graduation, manages two units and 72 people, has learned to be flexible while being a

nurse manager. "You might have a plan and it just doesn't work out." She talks about

setting priorities and being adaptable:

 There are days you will have the best plan in place and you will come in to work

with the idea of what tasks you want to accomplish. Then you will leave work 10

hours later not having gotten to any one of those things.   Each day brings some

new challenge to address; it could be a patient care issue on the unit, a staffing

challenge, an upset patient or family. And I have learned this too. You have to

have flexibility—to be flexible. The work will always be there. Sometimes it is

hard to leave after a long day if something is not finished. You think you will do it

tomorrow. But I never know what a day will bring so I struggle with leaving

something for the next day. You always have to try to have that balance of all the

work that needs to get done in an eight hour day.

Mara agrees that there is always so much to do and it can be hard to find balance.

"I work by my deadlines and I live by my priorities. And I know family is important and

my boss supports me in that." Melanie agrees, echoing that you never know what will

come up. "My husband thinks I spend time in meetings and my office." I told him, "I

did chest compressions in a suit last week. I spend very little time in here, (gesturing to

the neat, but tiny office which is located around the corner from the patient care station)...

I have spent less than 2 hours in this office this week."

Beth describes taking over as a new manager on her busy unit where she has 75

direct reports. A common theme is that lengths of stay in hospital have gotten shorter,

and there is pressure to turn over beds quickly to make room for the next patients.

As you can see it's a busy unit with short lengths of stay. We turn over 90% of

our patients every 24 hours. I fondly say "We run with our hair on fire and we run

at that pace 24/7". This unit is really, really busy. The unit and staff were in a

great need for leadership. I feel very proud as a nurse who still knows what to do

on the unit. I want of be a part of the unit… so when it is crazy busy, I can go to a

staff nurse and ask her "what one thing could I do for you right now that would

help you have a better hour? And I can do it; maybe it is stripping a unit, walking

a patient, giving some pain meds or starting an IV…

Especially for nurse managers, it is imperative to be available for staff when the hospital setting gets chaotic. Most of the offices where I visited were located on the patient care unit, so the manager was always available and was aware of what was happening on the unit. The managers believe it is important to be accessible to the staff; it builds team and fosters collaboration. Maggie stated: "They know I am here. I can see everything from my office so they know they just have to give me a look and I will be there to help."

The nurse managers talk of long days but also, as managers, they have flexibility to set their own schedule. This is considered a perk of the job. Overall, no two days are alike, the manager needs to be flexible and adaptable, and activities vary with connecting and communicating, and attending meetings, with crisis management and problem solving both frequent activities.

In the next section, I will lay out my core findings from the interviews. These core findings include what the nurse managers, as a whole, claim contributed to their development as leaders and also what they articulate as the significant challenges.

Contributors to Nurse Leadership Development

There are four overarching themes of contributors of leadership development. The contributing themes are1) identity and purpose, 2) "Emotional Intelligence (EI)", 3) mental models of lifelong learning and 4) a nurturing community. Within each theme are one or more elements which I will discuss. This section will describe the contributing themes using data bits from the interviewees.

Figure 1. Contributors to Leadership Development of Nurse Managers

Identity and purpose	"Emotional intelligence"	Mental models of lifelong learning	Nurturing community
Identity as a nurse	Self-awareness and management	Formal education	Organizational context and relationship
Early leadership opportunities	Fostering relationships	Experimental learning	Mentor support
Identity as a leader	Building teams	Helping others to learn	Nursing colleagues and the profession

Identity and purpose. Though the nurses I interviewed were nurses for anywhere from three years to 35 years, a common theme was that of holding a strong identity as a nurse. They described being present for patients, a competent nurse first, and taking every opportunity to become a better nurse. A consistent theme was also being patient and staff centered. They also described how early staff-leadership opportunities reframed nursing for them in unexpected ways. I heard many nurse managers say that though leadership was not the initial goal, to be the best nurse possible, many found themselves drawn to leadership or described how they were invited to try leadership because others saw leadership potential. Thus, there was a redefinition of self and identity as a leader.

Identity as a nurse. Six of the 19 nurse managers shared with me about how they decided to pursue a nursing career. Mara, who started as a diploma nurse answered a question I asked regarding what experiences have shaped her as a leader.

> I grew up thinking that I had two options: I could either be a teacher or a nurse.
> My sister was a teacher and we did not get along very well, so that left nursing for
> me. And in nursing school, in my diploma program, we had high expectations of
> us from the get-go.

> Other nurses expressed a deep connection to patients and a patient focus. "I am a
> nurse first; I felt I was making a difference."   Melanie does not hesitate, "I need to be
> connected with patients. That is where I get my joy. That is a truth". And Cami, who
> had another degree before starting the journey to become a nurse 12 years ago, describes
> what is important to her, "Nurse first—then leader. I had to redefine myself and my
> practice, I love taking care of patients. Sometimes you interact with special patients and
> you can say, yes, you are why I became a nurse!" Katie, who has been a nurse for 25
> years agreed, "I have always loved being a nurse. I am thrilled to be a nurse. I continue to
> be thrilled to be a nurse; in fact, I consider it a privilege."

Mindy, for whom nursing is also a second career after she completed a bachelor's degree in another field, described how she became a nurse. She said she has always been a caregiver type. As a child, her five siblings called Mindy the "second mom."

> Even with being a caregiver, I could not stand the sight of blood, if someone was
> getting sick, I would start to get sick and I would run when there was an accident.
> I ended up in California, with a boyfriend and the relationship went very bad. I
> started working with a therapist----- she recommended this women's group for me

that was starting up, we met weekly, about 12 women and everyone shared about

their issues. After a while she said to me 'Mindy, Have you ever thought of

becoming a nurse? You would go to work and for eight hours you could be paid

for helping to fix other people's problems. And then you wouldn't feel the need

to go home and fix everybody's problems' I was always the first one in the group

to speak up and to try to fix things for everybody else!

Mindy went on to say her choice of critical care nursing has been a perfect choice for her,

and she cannot imagine doing anything else.

It is what I love; it is my passion. I am kind of a puzzle person. In floor nursing

you do not have the luxury of time to fit all the pieces together and I really like

that aspects of ICU nursing. That and I love getting to know and bonding with

the families.

A commitment to the population served was a common theme among nurse

managers. One nurse manager reflected about how she describes the care setting to

prospective nurses when they are in the interview process. Summer stated, "Sometimes

you are taking care of the patients and other times you are taking care of the family."

The caring and empathy that is associated with nursing as a profession was evident in the

nurse managers interviewed. Emma spoke with such understanding and compassion

about what challenges exist for the patients on her units.

Most of the patients on our units have come out of the ICU. They have made it

through the crisis and are grateful to be alive. But for them, what they knew of

their life is now going to be very different. They are trying to figure out what

their life is going to be like now. And with facing that come a lot of challenges.

Now they have to face the reality of their situation and the change in their life.

We provide support for them in this process. Imagine taking care of four patients

like that, who are someone's dad, brother, maybe husband or wife? With such

great challenges, it is hard for the staff too if they are taking care of four patients

all with these big challenges to face… so the staff need a lot of support also.

Patients have such great needs that nurses need to think more broadly and know a lot

more to help the patients. The patient population and needs were what made Beth's first

job as a new grad so rewarding. Beth described:

I was very lucky to get a job at St. Steven's Hospital right out of school. They

took a chance on me in 2007. I started as a staff nurse on an oncology and

hospice unit. I loved my work on that unit. We had patients that were very sick; I

was a chemo nurse so we would have patients come back over and over for their

chemotherapy. It was a wonderful nursing experience and I had some of the most

profound human experiences not only as a nurse but as a person on that unit.

Leah has accepted another leadership role in another hospital within the current

system and will be leaving her current manager role in a few weeks for that new job. She

feels the new role will be a better fit for her skills and abilities. She stated she is also just

finishing up her master's degree in counseling psychology.

I enjoyed nursing much more than I thought I would. I got my degree in nursing

and psychology as I thought I would work with the families and patients that were

medically complicated. I studied nursing so I could understand health and the

family. But it turned out; I fell in love with nursing. I love working in health care

and working with the families.

Katie agrees, "Nursing has provided me some of the most profound experiences both personally and professionally." She expressed the impact of being a nurse has had on her overall self. "It is a symbiotic relationship. Being a nurse has made me a better parent, wife and person. Being a nurse helps define who I am."

Early leadership opportunities. In all of the 19 nurse leader interviews, the nurses described their nursing careers and their transition into leadership. Nineteen of the 19 interviewees spoke about their first nursing job after graduation and then how within a short time, six months to a year, they were working as a charge nurse or some other staff leadership role. Eric spoke of his first job and the various leadership opportunities that he encountered as a "newer nurse." He stated: "Within nine months, I was working charge. I was a charge nurse, lead preceptor, and on the SWAT team." Summer also had staff leader roles. "Soon I had the role of charge nurse and preceptor. I took on the Assistant Nurse Manager role and I did that for two years". Mindy shared her experience, "After a year, I was working charge; I found I liked leadership. After a while I was ready for a change." Additionally, Emma shared her early leadership experience.

> First, I became a nursing supervisor and I was the first one in that role. [The]
> Prior structure was only directors over the patient care units. I had been working
> in the charge nurse role for about four to five years for the majority of shifts that I
> worked. So I had some experience in leading the staff. At that point in my
> nursing profession I felt ready for some type of change… I knew I was ready to
> do something else, I did not know what that would look like. I did not want to
> leave this facility. So this new role came up and my director brought it up to me.
> When she first brought it up to me, she said that one of the things I would be

doing is rounding on patients. And that really interested me but in general I do not think anyone really knew what exactly I would be doing.

Patient rounding is a very purposeful activity that involves connecting with patients and families. Patient rounds and rounding on staff give the nurses and leaders a great deal of information. Tanya has only been in her current role for three months, the newest of all the nurse managers I interviewed. She remembered when she started to think about a leadership position.

> As I was in the Utilization Review role I sat in on Patient Rounds every day. And what I noticed about myself is that I started to listen to what the nurses were saying. The staff nurses were saying 'I haven't even seen that patient yet, but I can tell you what I know' and I would go…. (She inhales deeply as if scared or shocked) what? It is 9:30 and you haven't seen your patients yet? So I started to think what are those barriers that the nurses face and what would help make it better. So I started thinking about management and being a leader.

MJ has had multiple leadership positions over 15 years and is currently a director supervising multiple units and 140 direct reports.

> Each one of my leadership positions have almost been a seamless transition. When I spread my wings and moved to Hope Hospital, I did have to apply for the position and I can say that it was really scary. The charge nurse and straight day charge nurse positions just kind of came to be, and I wanted more of a challenge.

Identity as a leader. I found it interesting that many nurses did not think of themselves initially as leaders. Many times someone approached them and because they

were approached, the nurses started to think about leadership. Eric was one of those

leaders.

> My director approached me one day and told me there was a management
>
> position open. She thought I would be good at it and said I should take a look at it.
>
> I had never really had being a nursing leader as a goal; I guess I thought I would
>
> maybe go on to be a nurse practitioner or CNS or something along those lines.
>
> But I looked into it, applied interviewed and got the job. I am learning every day
>
> and still have a lot to learn.

Mindy describes a restructuring that resulted in the creation of a new role. "Really, it was

most helpful that I am a self-starter. They created this new manager role for me, it was a

new position and it was mine to create and make into what I wanted. So that was great."

Beth described a kind of restlessness in her staff nurse role and wanting to do more.

"Within two years as a staff nurse though, I became restless and was asking myself

"What else is there? What else could I be doing? Is there more?" She sought out her

manager,

> When I approached my manager Paula for whom I have great respect, I asked her
>
> what else is there? She was not surprised by my questions and said she had seen
>
> it in me when she hired me. She thought I would be a great leader. She had seen
>
> that in me as a brand new nurse and really worked to foster that growth in me.

MJ agrees she also gets restless. She has been a nurse for 25 year and a leader for 12.

She is still evolving as a leader.

> Seems like every four to five years I am seeking a new challenge. I get restless.
>
> Honest and real time feedback is most helpful for me to grow and continually

shape me as a leader. My leadership is work in progress. I am still growing and

working on things to become a better nurse and a better leader.

Others stated this sense of wanting more in some additional ways. Sandy shared, "After

working so hard on getting my BSN and these certifications, I felt ready for a change. I

was willing to go onto another shift to get an opportunity to do something different as an

Assistant Nurse Manager (AHN)" Others like Melanie and Summer respectively,

described this feeling as "Wanting more, What's next? and What else is there? I was

open for anything. I liked new roles and learning new skills." Eric also shared his

perspective. "I have a natural tendency to step up and lead. I do not want to get stuck. I

am always thinking—what should be my next step? I was not satisfied and I wanted to

do more."

 Mike is no novice to leadership and expressed deep satisfaction with his role.

I love my job and being a nurse manager. The perks are that I am salaried; I can

come and go as I please. And I am intellectually challenged. I feel fortunate to

manage a great group of people. I want our unit to have a reputation of a great

place to work so I can attract the most talented, skilled people to work here.

 Melanie agreed: "Right now what is most transforming is the rapid change. It is all about

making a difference for patients. It is a million little things, that transformation happens

and it is not one moment".

"Emotional Intelligence." Daniel Goleman (1995; 2000) is a key author on

Emotional Intelligence or EI. Goleman (1995) argued that EI can matter more than your

IQ. There are many articles and books written on this topic, with each revision including

a slightly different definition of the emotionally intelligent leader.   The common themes

include managing the self (i.e., self-awareness, self-management), building relationships

and fostering team work. These are congruent with key contributors to leadership

development that the nurse managers described. In fact, five of those interviewed used

the term "emotional intelligence" in our conversations.

    Self-awareness and management. The nurse managers described developing the

self, increasing self-awareness and discovery, and building up their confidence over time.

They describe the importance of knowing oneself, knowing one's own strengths and

challenges, and how this helps one to be the best leader possible. Zena elaborated, "I

think my social personality warms people up. I am approachable and it has helped me to

be successful." Summer describes herself as willing to take on new things: "I'll try

anything! I am the type that would rather ask for forgiveness than ask for permission. I

will just try it and if it doesn't work well then, try something else."   She goes on to

describe her orientation and a personality assessment that she completed. She uses this

knowledge of herself every day in her nursing leadership role.

        In my orientation we did this personality analysis, Color Analysis. It has been

        really helpful. I found out that I am about 98% Red. It is really cool. The

        test/survey takes about 20 minutes and then you get the results and it is like

        someone has been following you around and watching you for a month or two! It

        was unbelievable how right on it was! So I am red-very results oriented, get it

        done. Then I also have some yellow which is the cheerleader and inspirer. The

        other colors are blue and green. Green is the people and processing who have

        trouble completing things because they always want more input and discussion. I

love this stuff! I probably refer to this information about once a month. It has

been incredibly useful.

ML agreed with how accurate the test seemed to be. She pulled out the Insights

Discovery- which was right on her desk and readily available. She flipped through the

pages and reflected.

It's huge. I recently took a class on Emotional Intelligence and how you have

certain colors that describe your leadership. You are not going to change who you

are and your "colors." This organization has been termed very green. Green

which is very sensitive and we do not want to hurt anyone's feelings. I am

motivating inspirer.

Beth talked about another assessment which helped to increase her own self-awareness.

Another part of the leadership development process was doing the Gallup

Strength Finder assessment. I learned that I am instinctive, that I put energy into

the people, building people, coaching mentoring, and laying the foundation for

others to lead.

 Additionally, MJ reflects on her own leadership: "My own leadership is still in

development. I am perceived as a good leader, willing to take on the tough challenges,

thick skinned, knowledgeable, and willing to listen and be listened to." Melanie thought

and reflected on her development and described how she tries to both participate and

observe the situations.

Well I really try to be both participating and listening–you know, seeing what is

happening from the balcony. I try to be that observer in the situation. One thing

that I bring with me is that I am an empathetic person. I am able to read the

situation and see if that person is not listening or engaged and sometimes that has

been a challenge because I then have to determine what part of this do I own,

what is theirs and what is mine to own. So that has been developmental for me. I

have become more self-aware. I have learned that most of that is not mine to

own... I do feel I am more self-aware; because in this environment you do have to

be careful about what you say and consider how it affects your team.

With self-awareness comes the ability to manage oneself and exhibit self-control.

Mara describes a formative experience in early adolescence. "I was a candy striper in the

hospital in a small town in Iowa. I think I had registered the most hours ever! I was in

the department called the auxiliary but I worked independently from a list of things I

could do. I learned to manage myself as a teenager."   The nurses described building

self-confidence and the importance of competence as a nurse. Sandy stated confidently:

"I was also focused on being very competent in my field of practice so I studied for and

received two certifications."

Fostering relationships. More than 50 times in the data analysis of themes and

from each and every nurse interviewed, significant statements about the importance of

relationships emerged. The nurse managers stated that building trust, connecting with

people, having empathy, building relationships, and knowing staff on a personal level

were keys to having a high performing and happy staff.

Tanya, new to the role, says her first goal is to be caring and nurturing to the staff.

"My first goal is building rapport and getting to know the staff.   That is my goal for the

first six months here. That and building trust and knowing who I can count on" She gives

an example.

I also have a goal to be present on the off shifts. I have come in and made

breakfast for the nurses. I came in and we made tacos on the night shift. I also

held a potluck on the night shift and they loved, they said no one has ever come in

and had pot luck on the night shift.

Caring for the staff is important according to Eric.

I see it this way, in my role as a staff nurse, I took care of the patients, now it is

my role to use my nursing skills of listening, caring and relationship skills with

the staff. You take care of your staff. It is important for them to have job

satisfaction and to have what they need to do the job. I can do that.

Mike described what it was like as a leader in his military unit. In addition to his

18 years as a leader, Mike served two years of duty on Afghanistan. He reflected on his

military experience and leadership, "Honestly, what I learned from my military

experience is that you cannot advance a group or get the best performance from people

without establishing trust. I believe relationship-based leadership is the way to go."

MJ described herself and what has worked well in building relationships. She

believes it is important to know people on a personal level and recommends shadowing

as a way to learn about other's roles.

I am a very personable person and with each position, I try to shadow the staff I

am leading.   So with effective listening and emotional intelligence; with that you

can lead them and they will follow if they know you. Each situation is different

in a nurse manager's role, but they often don't have the "time" to seek out support

from their peers which is very, very important. Nurse Managers have minimal

education in leadership. They are often "good" staff nurses; most likely have

taken on some opportunities to prove their skills, but have never been faced with

or really understand the role they are applying for. Shadowing a nurse manager

and really understanding all of the employee personal issues that they face are eye

opening.

Good nurse managers have the respect and are intentional in building relationships. The

nurse managers I interviewed are committed to engaging staff and in understanding

others perspectives. With good relationships and respect as a foundation, the managers

can set expectations for their staff; however, this takes time.

  Building teams. The nurse managers indicated that building rapport and building

trust with the individual staff nurses is vital to success in the role. Equally important is

developing a team, as is the process of building connections and fostering ownership of

staff. Mindy talked about her staff as a team. She used the analogy of a sports team to

discuss how she works with the staff.

  Also in my leadership we are always equals. We are all part of this team; we just

  have different roles. I do not feel any better or any different than the charge nurse

  or the bedside nurse. It is not to say they have free reign, I hold everyone

  accountable and to do that you must have clear expectations. What comes to

  mind is like a huddle, maybe a team huddle maybe like in football with the

  quarterback and the coach. That is how I think about our ICU team and how are

  we going to get through this shift and this week or this month. And we are

  deciding on what we will do for the next shift or what new play will we do

  together.

Mike echoes her thoughts with his comments on change and the importance of enrolling people.

> Change is so difficult and so constant that I have worked very hard to build our team. This is our team and our unit, not my team or my unit… Thus it is always our unit, our staff, own work, and our plan. It is about gaining ownership from the staff of their own work. They have a stake in it. The challenges are trying to find ways to get the staff engaged.

Mindy builds and reinforces the concept of team when she hires new staff. She told me it can be scary to come to work in an ICU and she "wants the staff to know we have their back." Mindy communicated a specific message to every one she hired.

> Another thing I tell people who come here, I am not sure if they believe me, but the team work in our ICU is incredible. The best thing about our ICU is that you will never be alone. You may be assigned to two patients and they are your patients but they are all our patients and the staff really fells that. Everyone is here to help. And when I talk to people at 30 days and at 90 days, how long they have been here, one of the questions I ask them is how much of what we told you in orientation is true. They say you were right. I never felt alone. The team is great!

Building the team can mean some crucial conversations and giving feedback according to Mara. She talked about building camaraderie and relationships with and among the team, which builds longevity. She said the 'Healthy Environment Initiative' has helped her develop her own skills. "This idea of holding the mirror up; explaining how what someone is doing impacts you, that stuff is what builds the team. Being able to

say, I did not expect you to… what you did impacted me in this specific way." She

acknowledges that it can be hard to learn to stop in the moment and give the feedback.

Mara adds that the more people practice the more confidence they gain.

Emma stated that you must find balance between caring and holding staff accountable.

> Balancing between being connected to the staff and also being able to motivate
>
> them is important. Finding the line of communicating with staff, motivating
>
> them, and being self-assured. I know the goals of the organization and our team.
>
> It is my role to make the rules and the structure for the staff to be successful. I am
>
> analytical–I generally do not make a lot of quick decisions. I know a lot of great
>
> things can happen with a motivated and satisfied team.

> Mike told me about how there are organizational initiatives, as a manager you are

expected to participate, and sometimes a target will be set by senior leadership. He sees

this as an opportunity to engage the staff.

> Instead of telling them we are going to do this, managers can say, this is our
>
> challenge and how are we as a team going to solve it? This enlists and engages
>
> staff, give them some time to work on the problem and the outcome is much
>
> better than if you had told them what to do.

> When I asked Mike if any symbols or images come to mind about his leadership,

He did not hesitate and said the Olympic symbol; He described this image, "…all the

rings are the same size, overlapping connected, and different colors. I am one of the

rings. That is the image I have of my leadership. It is not top down but team focused,

collaborative, and connected."

Mental models of lifelong learning. Some of the rewards from being a nurse manager come from their mental model about learning. In fact, each of the 19 interview participants discussed some aspects of learning and all are lifelong learners. They expressed value from their formal education and embraced experiential learning. In addition, they see their role as helping others to learn and developing others as leaders.

Formal education. Seventeen of the 19 nurses affirmed that their formal education was foundational and essential to their leadership development. There was less agreement that any specific types of classes contributed to their leadership development. What the nurse managers highlighted as valuable was more about working in groups, the reflection, the professional dialogue, and appreciation of the bigger picture. Tanya has been a nurse for 10 years and has only been a manager for three months. She stated she is very new to leadership.   On the day I interviewed her, she seemed so animated and excited and full of ideas. Her office is small, sunny, and adjacent to the unit with inspirational quotes on papers all over the walls.

> At first I did not get it, why the BSN was so important and the big push
>
> organizationally to increase the number of nurses with a BSN. As a new grad, I
>
> just wanted to get out of school and I was going to start working and do my job
>
> every day and go home. But I really recognize it as a better approach. I started to
>
> notice this when I was in the UR role. There is a bigger picture, there is more to it.
>
> You do not just do your job every day and go home. There is a bigger picture of
>
> healthcare and nurses have a role to play. Now I really get why a BSN is so
>
> important. I think my two-year program prepared me very well with the solid
>
> skills I needed to take care of patients.   But then you get into your classes like

Transcultural Nursing, Evidence–Based Practice, and the Capstone program.

These courses were really awesome. I am at Winsted University in the leadership

and management MSN. I am in my second quarter and I could get it done very

quickly, however, I am in it for the learning. Not to just do the minimum and get

finished as fast as I can.

MJ returned to school for a bachelor's degree early in her nursing career. "I knew I

needed bachelors for the role so I went back to school. My education and hard work in

school taught me the self-discipline I need for this job."   Mara, originally a diploma

graduate, related to me how much she appreciated her more recent education.

 I think the biggest gain I had from my program was in the whole use of evidence

and evidenced–based research. It opened up my eyes, having to find articles and

do the citations. I really began to understand the process of how nursing moves

ahead as a profession. I have known how to get along with people and I have

taken a lot of classes on emotional intelligence but my BSN helped me understand

the professionalism of nursing-it was an eye opener in how the profession moves

forward.

In thinking about what they would advise others to do, there is consensus to make

education a goal. Mara started as a diploma nurse and got her BSN in 2010.

At first, I did not think I needed all those pre-requisite college courses; the ones

that were non nursing and that I might not use every day. It was so good for me

to take them. I found I loved them. I am an analytical person so I am thoughtful,

however, I think the classes I took really help me to pause and reflect and to be

more contemplative, to take my time thinking. I think the entire experience was

very rich. It took me three years to do my RN-BS. I am now doing my MSN and

the program is all online and it totally opens your mind. It is great to hear other

perspectives.

Mike, an experienced nurse who recently finished his BSN and will be starting a

master's degree program in the fall stated:

I was in an interim role and then I was given the role formally once I finished my

BSN. My communication and professional exchanges have been enhanced from

learning and working in groups in my degrees program. I also learned so much

about evidence-based practice and how to use it on a daily basis.

Summer reflected back to when she was getting her MSN knowing that she would

eventually want to move into a broader role, maybe in leadership.

I had already gone back to school because I did not think I wanted to stay at the

bedside for my entire career. I learned a lot about evidence-based practice and

theories. I continue to use those skills all the time. I will bring a couple articles to

the staff and say, 'What do you think? Is this something we could do?' I always

say someone has probably done this before so let's look at the literature.

She continues to talk about the value of specific learning in her program of study.

One of my favorites in my masters is I had a finance class – wish they would do

that in the BSN program. Also it was so helpful to understand the high level

Medicare and government concepts. I always wondered how Nurse Managers

figure that out. The reimbursement, all that… Sandy described her student

experience as eye opening!

It just really opened my eyes in unbelievable ways. I learned about healthcare as

a business and to think of business models. We had one instructor who gave us

exercise where we had to take care of a hospital and figure out how to run it and

solve the problems. She really challenged us. The answer to problems had to be

more than just adding staff. That's always what people seem to think is the

answer.

Experiential learning. Learning from experience or as some described this

process as "learning by doing" involves taking risks and stepping out of the comfort

zone. Summer advises new nurse managers to be bold.

Put yourself out there and accept the challenges-You don't know what you don't

know. Jump in. Some people call it baptism by fire. Try new things! I wanted

more of a challenge and I needed to spread my wings and try something new.

Scary! I took a job as a travel nurse and got that out of my system. I did not want

to be the person that stayed in the same organization for my whole career.

Like Summer, Eric also agrees with this philosophy.

Push yourself to try new things and to get out of your comfort zone. Do not say

no to any opportunity. You never know where it can lead and if it doesn't work

out you can always choose to do something different. Go for it!

Emma described her experience with learning.

Yes, I still learn every day. I reported to a different director at first and over time

now there was a restructuring. Currently, there are two directors and five nurse

managers. I now work with a different director and it has been great to get to

know her and her leadership style is a little different. She is so great and always

available to me. If I needed to talk to her at 2 AM in the morning, I know she

would be there for me. I know she has my back and that is so important and

helpful. She has helped me in learning to do corrective action plans and together

we give a consistent message to the staff.

Melanie is ready and eager to get out of her comfort zone. **"I am always first I

will jump in. I will ask a few questions and then say ok yep let's go!"** Generally, the

nurse managers embrace learning and watching others. They are willing to try new

things and find out what works. MJ affirmed, "Every situation is helpful; both when I do

things well, or fall flat on my face." You have to reflect on what works. Tanya said, "I

had to try a different approach. What I was doing wasn't working." And Eric described

his own growth. "While I used to be the quietest person in the room, I have learned to be

more comfortable taking on new things and trying new opportunities."

Helping others learn. There has also been a shift in both organizations where I

situated my study from leaders being the problem solvers to the practice of developing

others to be problem solvers. Melanie embraced this concept but still struggles to not fix

everything herself.

So our role as managers is trying to teach someone else to do it. Cause, I have the

answer in here. (she points to her chest) But helping the other person to find the

answer. And there are projects that the staff is focusing on. I might know this

may not work but I have to let them try and figure it out themselves because the

solutions are more self-sustaining when they have come from the staff. And it is

about trying to find fulfillment in a different way. It will take years to develop so

that I am always being the coach. The coach is the person who is playing along

and not standing over. You are doing the work together. As the manager, I now

have a different role on the team.

There is a theme of developing others, not by fixing it but by coaching. Melanie

reflected, "There are a lot of natural leaders that emerge. The direct results of this job are

different." She expanded on this idea.

> You get your satisfaction from different things … like developing others. You
>
> must realize that there is always a curve of low, middle or sound, and high
>
> performers or the rock stars. The 80% who are sound, you just need to reinforce
>
> and then trying to discover why the low performers are low and helping to find
>
> and reach their potential.

Summer described the process of developing a staff nurse on her unit. She utilized

shared governance councils which really engaged and involved the staff. She described

an example of getting staff involved and how they developed as leaders through this

process.

> I had this great staff nurse that worked in one of my units. He was always taking
>
> on new responsibilities, we got him to be charge, then a preceptor, and then he
>
> went to be on the house wide SWAT team. He thought he might want to be a
>
> CNS in the future. I heard about a manager opening on another unit and I thought
>
> of him. I said –You really should look into this. I think it would be a good fit.
>
> He's like really… I don't know… No really, I said, just take a look at it. I think
>
> you would be great! He did look into it, applied and got the job! When the notice
>
> came out, I took the notice and put it up on my fridge---That where I get my

satisfaction! Because I helped him achieve this, I suggested him for the role and helped him get there.

Mindy begins the process of developing staff when she interviews them to come to work in her unit. She stated that it is important to set the expectations for staff from the beginning as new employees.

If you come to work here, I promise you that you will be successful. We will make you successful, no matter how nervous or scared or how many things you have never done. When you come to work, you are going to do your job and when you leave at the end of the day, I want you to be able to feel that you made the difference. If you do not feel that at the end of a shift, then you have not done your job. It may not be that every patient is awake and able to interact but if you are able to do 10 minutes of teaching with a family member or if you are able to get a family who is so tired to go home for a couple of hours to get some rest, that is making a difference. You will not save every patient but you can make a difference for a patient, family or co-worker every day you come to work.

Similarly, Beth has a strategy for developing staff and getting her "shining stars" to the next level.

I see it as setting the bar and then getting there and setting the bar and then working to get there. I see this applies to developing myself and to building people. You can't really let up or you'll go back. You have to work and strive to keep going forward. Keep climbing.

Mindy spoke of one of her staff who was in the preceptor role previously. Mindy developed her to go on to another leader role in the hospital.

.   It is a good feeling that I have developed someone who now has moved into a

clinical director role. I like developing my former preceptors. That is my

satisfaction, in identifying the strengths of the staff; I do not feel they should stay

where they are, even if it might mean I have to fill a position! I want to help them

set goals and help them to grow.

Beth also relates a story that happened in a review she did with one of her staff in

February. They were in Beth's office and had been talking about her work.   It was a

great review as she is one of the shining stars on the unit.   Beth had hired her, and since

then, the nurse has been oriented to be a charge nurse.   Beth described this nurse as calm,

collected, and capable and "to be frank she is right now one of our strongest charge

nurses. So I said to her, seriously, so what's next?"

Beth spoke with excitement as she told this story. In response to Beth's

questions, this staff nurse stated. "You know I have been starting to think about talking

to you …What was it like when you made the transition to leadership? How did you

know it was time, you were ready? What did you do?" Beth went on to say that the rest

is history as they are now in the process of orienting Lisa to be the clinical manager for

the unit. The clinical manager role will be to be a resource to the staff, to be involved in

patient rounds, to do discharge phone calls, and to help make adjustments in the staffing

as needed.   Beth concluded the story.

What I learned and love about this story is how you work with people and how

one question can open up a whole new conversation. You ask the questions, what

are your interested in, what do you think, where do you see yourself so what next?

It is awesome and a wonderful part of the job.

MJ agrees that this part of the job is enormously satisfying.   She described,

> The rewards for the staff nurses are recognition from other employees, managers,
>
> staff and patients. Your rewards as a manager come from bringing staff to a
>
> higher level, when you see and AH-HA from a new employee, when a change that
>
> you did not fully support is implemented and it went well, and you were able to
>
> lead the staff where they needed to go. In healthcare leadership is very difficult
>
> but it can be rewarding as you develop and lead others.

In summary, there are three aspects of this mental model of continuous learning. The first is a deep commitment to lifelong learning and to formal education as a mean of furthering one's leadership expertise..   Second, the nurse managers discuss how they learn from experience and how this is a valuable way of learning.   Experiential learning has been transformative for the nurses in their leadership development. The third aspect that makes up the mental model of learning means identifying the potential in others and teaching and coaching others to be the best they can be.

Nurturing community. The nurse managers communicated that a supportive community is necessary to the leadership development processes and nurse manager role. This sense of community presents itself through a variety of ways. The first is through the organizational context and the leadership philosophy of the organization; the second is evident in role models and mentor support; and the third is through the connection to the broader nursing profession and colleagues. All of these comprise a nurturing community that helps the nurse leader remain fresh and optimistic and thus, able to meet the ongoing challenges of their role.

Organization context and resources. The nurse managers represented two

organizations which had a visible and supportive approach to leadership development.

One organization has a Talent Management department, and classes and leadership

development opportunities are ongoing. Talent management refers to the anticipation of

human capital needs of the organizations and developing a plan to meet those needs. The

second organization has a department of organizational learning. The support for

leadership development is evident in a leadership curriculum including specific classes

such as *Insights Discovery, How to Be a Team leader,* and *Performance Management.*

Some examples of these educational opportunities are in skill development, increasing

self-awareness, and understanding the bigger picture.

Several nurse managers spoke about the organization giving them the time to

attend the classes and that attending is a priority. Mara talked about the support of senior

leadership for making a development plan and carrying out the plan. Mara met with the

Chief Nursing Officer (CNO) to discuss Mara's development plan. "She had me do an

assessment and then develop a plan to get the learning and support I needed. She was

amazing and was very committed to my development." Mara remembered that

developing the plan and working with this leader gave her a lot of confidence.

> It was acknowledged that I had needs to develop and there was support for that. I
>
> learned it is OK if I make a mistake. And I learned it is my responsibility to ask
>
> questions and to be deliberate in identifying my learning needs.

One of the organizations in which the study was situated recently implemented a

Nurse Manager Residency. Several of the study participants were members of the first

cohort. Six of the nine nurse from one organization all spoke about the value of this

opportunity and appreciated the structure this forum provided. The residency consists of

a structured mentor program, regular monthly meetings, and access to the AONE ENMO

modules for leadership development. The residency includes a written timeline for

completion of the modules. This forum supports findings in the literature that

organizational support is needed for nurses to develop as leaders.

Emma described another organizational initiative and how everyone is involved in

quality improvement. There is great organizational support for managers and for staff to

take their own ideas to implementation to improve the care and experience for patients

and families. Implemented in October of last year, *Value-based Improvement* engaged

the staff and leaders in small changes to improve the patient experience and outcomes.

> We have monthly learning sessions that involve coaching, working with the
>
> employees, those have been helpful on working with employees, coaching
>
> employees and how to lead the conversation with the employee and yet not tell
>
> them what to do. So this took a long time to get going but has been very helpful.

Nurse managers gain confidence when they find out who their resources are and

ask the right questions. Jackie and Zena talked about being a change agent and the

importance of knowing who to go to for help. They both learned by watching others in

certain situations. Three of the nurse managers highlighted that being in the

Administrative Supervisor role taught them about who their resources were, day or night,

for any situation "You can't know everything on day one or month six or month ten so

learn to ask questions and find people you trust to help you."

According to Mike, Human Resource and Finance information are important resources.

He learned this by finding out his resources and seeking them out.

In the early years, if I had an HR issue, I made an appointment with someone in

HR and we talked through the issue and my options. Same with finance, I did not

really understand productivity and the reports so I found out my finance resource

person and we sat down and went over everything. Sometimes it takes more than

one meeting to learn what you need. For example, the benchmarking when I

came to this role, our ICU was in the very bottom of the percentile for

productivity benchmarking. So I met with finance multiple times to understand

this. We tried to improve but our results in the benchmarking data did not change,

it had been like that for years. We looked terrible. But I actually thought we were

pretty lean so I kept trying to figure it out.   Finally, after we reviewed the

compare groups and definitions we discovered that we were in the wrong compare

group. All these years, no one had ever figured it out. So just that change getting

in to the correct compare group we went from the bottom of the heap to the 50th

percentile!   And the way it happened was through relationships, knowing my

resources, building the trust and good relationships and knowing who I could

count on to help me.

Mentor support. The nurse managers described working with mentors as helpful

in opening their eyes and in opening doors. The relationships with mentors are invaluable

to the day to day support needed in these challenging roles. Mentors and role models

opened their eyes. They described a feeling of being part of a caring and nurturing

community. Eric talks about his mentor, a former boss:

My former manager still checks on me to see how I am doing. All the leaders here

have taken the courses so you can talk to anyone about them. Having a leader

who was a great resource to me really helped. I could ask questions and seek out

clarity as needed. Having a great boss who was a huge role model was

invaluable.

Jay has been a nurse for six years and five of them have been in leadership. Jay

worked in long term care for the first four years of his career. He highlighted the

importance of connecting with people. His mentors have created opportunities for him.

Next, my CNO asked me to be a Director of Nursing and I did that for a couple of

years. People saw what I was capable of doing and provided opportunities for

me. I have had many positive role models. And I have had great support from

other managers and leaders. There is another manager here and we just clicked so

that is someone I can just bounce things off of besides my boss and it is very safe

and supportive.

Many told of the support from their boss. Summer described how a former

manager developed her as part of succession planning, and Summer did not realize it at

the time.

I had this really liberal Nurse Manager who would ask me probing questions

whenever we would meet. What do you want to do? What do you want to do

next? How many direct reports would you like to have? Do you want to get

involved with quality? She opened up many opportunities for me. Two years

later when she retired and I was going to move into her job? I said "What else do I

need to know? She said you are done! I have been teaching you this stuff all

along the way!"

Beth has names to describe her role models and mentors. One is the "Master Diplomat" and another she goes to with challenging situations to help her figure things out.

> I call her my muddy questions go to girl. When I have a situation where there might be about seven options or ways to go, I will find her and I will ask her questions. She always answers my questions by posing more questions and I always think of things I hadn't thought of before. She takes me down new roads of thinking and learning.

Sandy talked about two colleagues and could not imagine functioning without them. There is power in knowing others have walked this way before and will share their experience.

> There is this manager that I met on another unit and we kind of clicked. If I start to feel overwhelmed or bring up an issue she tells me, **Come talk to me**. And there is an educator in the department who has been a life saver. She helps me and if I can't figure something out she says **let's do it together**.

 And Emma shared that it was helpful just to be working side by side with the director who hired her and really seeing what she was doing and observing. "I got to observe her for a while maybe a week or so. Yet, I was also just thrown in to it. There were some things that she just asked me to do but we still worked side by side."   Maggie reflected, "Know who you can go to for questions and support. I was assigned to a mentor which I did not use as much as I should of. I learned that after the fact. Ask them- they are there to help."

Mentors and role models can be other nurses or others beyond nursing. Many times, they are someone from beyond the work setting. In Sandy's case, her husband serves as an ongoing mentor for her.

> Another person who has always been very helpful in my leadership development is my husband.   He has experience as a manager, leader, and a business background and is very supportive to me.   He helps me see that I can do anything!

Nursing colleagues and the profession. The nurse managers communicate a sense of being part of a respected and valued profession. They value their nursing colleagues and the support they give to each other. The support and encouragement of many nurse leaders such as nurse manager peers, their direct boss, the Patient Care Executive, and also previous managers.   Beth described being involved in a system–wide mentor program at her organization. She was matched in a system of 6-8,000 employees to the Chief Nursing Executive. They had spent a year together in a mentor/mentee relationship.   Beth described the experience:

> I also signed up for the St. Steven's system mentor project. It is a one year commitment with a rigorous matching process. As a staff nurse who aspired to leadership, I was so lucky to be matched with Maria our CNO. It was great experience, sometimes we would have a very structured meetings and talk about specific situations. Other times, it would feel very social, like just going out to lunch, but I always learned something. I have tremendous respect and admiration from her and feel so lucky that I had a year with Maria, learning how to manage and how to lead and the difference between the two. I felt much empowered and

she helped me with defining my identity.   Maria is the one who gave me

permission to define myself… I am a nurse first, if you ask me what I do, I will

say that first because that is how I see myself.   Nursing is the foundation for who

I am as a leader. I give Maria enormous credit for helping me see that as central

to who I am for opening doors and opening my eyes.

New managers need to be patient and give themselves time to settle into their new role.

Jay stated, "Relax and get the feel for it. You have to give yourself time to understand the

role before you can really make an impact." New leaders should embrace your peers and

other leaders who will support you along the way. Emma values her peers:

I really like the managers and the leaders that I work with. We are all very

consistent in how we deal with the staff. I feel I could go to any one of the leaders

to help me if I had problems. I am very grateful for the staff that I work with.

And the work that we do is so important. The patients are so complex and yet they

come back later and they are so grateful for the care that they received.

There are many ways to foster this nurturing community. Mindy talks about a

ritual at her hospital that she and others encourage new nurse managers to make a

priority.

Well, it is kind if a small thing but For example, U8 just hired a new manager and

we (the other managers and directors) told her she should come to lunch with us

every day—as kind of a support group. We told her that that had to be a priority

to come to lunch with us every day. So we can support her and see how she is

doing and what she needs. It is kind of an unwritten that all of us go to lunch

together. We do not have a morning meeting or a lot of other manager meetings

so if I did not go to lunch with my peers daily, I would go all day without ever seeing them.

Challenges to Leadership Development

One of the questions I asked in the interviews about leadership development was regarding the challenges faced by nurse leaders. As I coded and recoded the data, there were three conceptual themes that emerged as challenges. The three themes included the transition from staff nurse to manager, dealing with adversity, and the large scope of the role and the rapid pace of change. (See Figure 1.) The voices of the nurse managers are presented in this section.

Figure 2. *Challenges to Leadership Development of Nurse anagers*.

Transition into leadership	Learning from adversity	Large scope and relentless pace of change
Steep learning curve	Adversity and growth	Large scope of responsibility
Staff nurse to manager on the same unit	Making unpopular decisions	Understanding the business
New role and new unit	Dealing with disappointments	Rapid pace of change
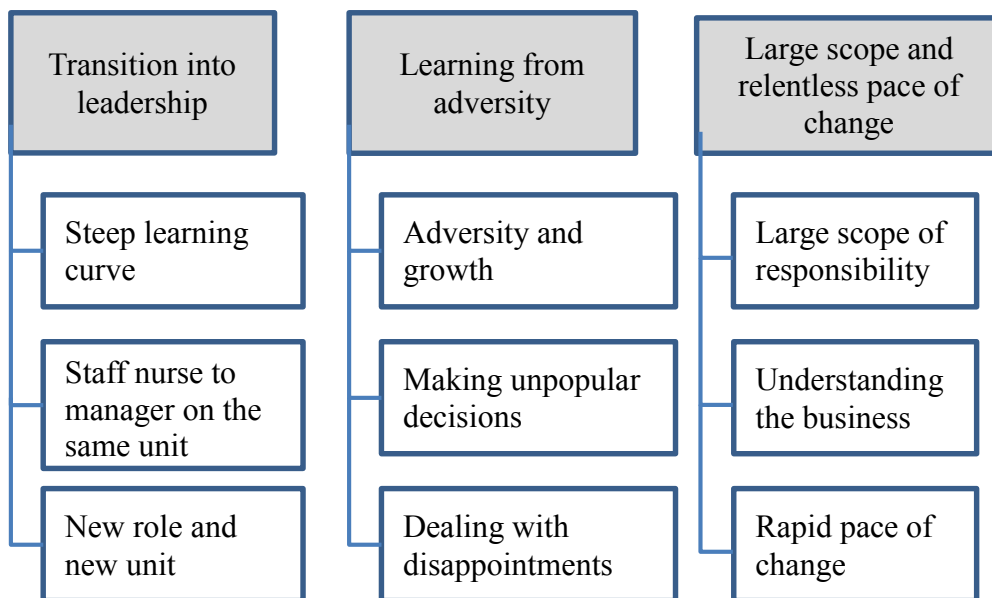
Transition into leadership. One of the most significant challenges stated in the interviews was that of the transition itself. Bridges (1991) discerns a transition from a change which he says is something that happens *to people*. A transition, on the other

hand is an internal process, what happens *in people's minds* as they experience and go through change. Another key distinction is that change can happen quickly and transitions can happen over a longer period of time, depending on the individual.

Steep learning curve. Zena described the transition as a huge learning curve and Leah said, "It was a complete blur!" When Sandy made the transition into her current role, she was "both excited and terrified!" Beth too found it a mix of scary and exciting newness! "I found the transition to be an exhilarating experience even though it was baptism by fire! It might not work for everyone but I loved being thrown in and it worked for me." The downside of the transition for Beth was a feeling of loss.

> I missed my work and my patients so much! As I said I was a chemo nurse, some of my patients were very sick and I had taken care of them for a very long time. I actually went through my own grieving process when I left the bedside. It was very hard. I missed my patients! I went through an internal process of redefining myself and my practice. I love nursing and I took great pride in my work. I had a hard time shifting my thinking that I wasn't doing meaningful work unless I was taking care of my own four patients on a shift and doing the very best I could for them. But after a while I was able to think differently about it, and to redefine my role as a nurse. Did I really leave the bedside when I now had much more influence over the care all patients on our unit were getting round the clock. Instead of doing a good job and having an impact on my four patients on a shift in my role as a bedside nurse, now I can have an impact on the care of 32 patients 24/7 in my role as the clinical director

Staff nurse to manager on the same unit. Becoming a manager in a unit where you were a staff nurse was a challenge for seven of the 19 nurse managers.   Mindy described her experience with the leap from charge nurse to nurse manager in her ICU .

When I was in the charge nurse role, I did eat lunch with the staff because I identified with them. So as the director/manager, I have had to remove myself a little bit. It hasn't been that hard because as I said I am pretty clear with expectations. But I am in a different role now. And they need me to be in that role, for them. I do very visibly fight for them and they can see that I fight for them. I do not take the credit. I feel like it is the team that did this. And I am good at sharing the credit and celebrating the wins. We did it together. There have been other past leaders that have maybe taken that success and held it to themselves. And I think it is not my success but our success.

Mike also made the transition from being a staff nurse to the leader on the same unit. He had many friends at work and he found being in a different role to be a challenge at first.

I became a top notch clinician. So then I would say the biggest challenge has been going from a peer to a superior with the staff. It was difficult. My friends understand that we are still friends but that it is different. I have a responsibility to the organization and I cannot show any favoritism to any of my friends at work, regarding vacation, work assignments etc. It altered some people's perceptions of me and some relationships but I have been able to maintain my friendships.

Emma shared her experience as well. She shared that there are challenges building trust with the staff, and also with the concept of not doing shift work. "There is a shift in

thinking from shift work and doing tasks looking at the bigger picture." She described her experience.

> The unit I worked on before as a staff nurse is now one of the units that I now manage. A little bit of a unique transition. And one of the challenges is that I now supervise people who were my colleagues. I have two units here, on one of them, I know more people than the other.

New role and new unit. Five others like Cami and Sandy felt it was an advantage to be on a unit where they had not worked as s staff nurse. Cami described that being a leader in a different organization where she did not really know anyone was very helpful.

> I had the opportunity to set the stage and expectations for who I was and what I wanted to accomplish. I am in a different role now as the manager and I come at it from a different perspective. It is challenging to make the shift from the staff nurse mentality. I am a lot less tolerant of the whining and complaining of the staff nurses.

Zena explained that her orientation to being a nurse manager was not helpful; she had only a few years of experience in one specific area when she was asked to work as an administrative supervisor. She related that becoming a leader when she was very young complicated the transition.

> Unfortunately, there was no mentor program and I think my age was a challenge at first. Being so young and in a role of house supervisor when I hadn't worked in many of the patient care areas. I had a lot to learn in the beginning, but luckily, I learn quickly. I am very independent and I found people who would be helpful to me and built relationships with them. I also had a huge learning curve and I had to

learn very fast what kind of patients went to ICU. First, transition was hard and to

tell you the truth I think my age held me back. I was 26 years old and here I was

going into the ICU about a patient admission. I had never worked ICU and you

have nurses that have been working there for 40 years who are not about to listen

to a young whipper snapper like me. As a supervisor no one really likes to see

you coming because they know you want something, either to pull staff or for the

staff to take another admission. Well, we always described it as what turning on a

light is to cock roaches-and when the supervisor would come every one would

just go and hide!

In summary, one of the biggest challenges in leadership development of nurse

managers is the transition itself. Nurse managers talked a great deal about the reframing

and evolving of relationships that occurred during this process of transition. They

describe it as exciting and yet scary, a mix of good stress and difficult stress. It involves

a shift in the work and a different perspective, new ways of interacting with staff and

former peers, and ultimately a reframing of one's self and identity.

Learning from adversity. One of the questions I asked in the interviews was

about what experiences came to mind that were helpful in shaping the interviewees as

leaders. All responses to this were all about a challenges or experience with facing some

type of adversity. Nineteen of 19 nurse managers described learning from mistakes and

difficulties. Summer recalled, **"**Mostly what have shaped me are the difficult

experiences. Like having to work through a corrective action plan with someone. Or

terminating someone. Each experience you learn from does shape you."   As she thought

about these times, she remembered, "When I was in my lean training they had this phrase

that has been helpful to me since then; Fail, Forward, Fast!" When pushed to explain

what this means to her, she responded, "Learn from your mistakes. If something doesn't

work, Move on quickly. Try something else. Don't dwell on it."

    Adversity and growth. Eleven nurses responded that nurse managers must have

the courage to stay the course during the dark times. Cami was adamant.

> It is so important to have a mentor who is not your boss to use as a sounding
>
> board. Then nurse managers do not feel like they are the Captain of the Titanic.
>
> There are others who are in the same boat with you in the hard times!

    Mike indicated that nurse managers have to be careful as there can be landmines

out there. "I learned the hard way on some things, for example terminating an employee.

I learned the hard way by not having adequate documentation that was required by the

union." Eric says it can be difficult dealing with the pressure of former peers. "They will

sometimes say to me "you were on the floor, you know what it is like" But I am in a

new role now and I have to come at things from a different perspective." I asked him how

he responded to that type of pressure and challenge.

> I tell them I am still here on the unit. I am here with you. And yes I understand
>
> where you are coming from but it is my role now to work for the common good. I
>
> work hard to listen to staff and find the common ground we share.

    Melanie described a time in her early career of great adversity and growth when

she was working as a charge nurse and beginning to think about leadership roles. "I

found I loved critical care and in the role of charge nurse I learned how to work with

people and I probably made most of my mistakes in this role." She went into more detail.

At my two year evaluation, my nurse manager, who was a fabulous leader and

mentor, started giving me more projects to work on. My last year at this job, I got

off of nights and worked as the unit educator. There was a lot more politics on

days. A lot of the nurses were mean to me and I didn't feel like they liked me. I

was 21 years old and I think they thought, "who is she to tell us what to do"? I

was working in a level 1 trauma center and I would have a patient with an open

chest wound and another post-op from an open heart. It was a lot of responsibility.

I was very perfectionistic and extremely focused in all the detail. I wanted to give

the very best care to my patients. I cried a lot. I had trouble sleeping and I

became very guarded with my work team. I just couldn't connect with my peers.

They were mean to me, sometimes very passive-aggressive, and I felt very

isolated as time went on. As I look back, I did not know at that time how to relate

to others and how important it is to connect with people.

Zena talked about some of her personal experiences with adversity and how they

have shaped her as a leader. She indicated that she has had exposure in her life to a lot of

diversity, social issues, and personal issues.

I think that exposure makes me non-judgmental. I have empathy and can build

rapport and understanding with people because of my experiences. This is not a

sob story, but just some of my experiences. For example, my parents got

divorced, I was young… My mom had to go on welfare and we were on food

stamps. So I know what that experience is like. I have experienced hate, my

sister was raped, and I have experienced disability. So I had these experiences in

my 20s and though I am 35 now people used to say I was an "Old soul" because

of what I have experienced. Because I have struggled so much personally,

anyone who is struggling with some issues, I feel I can relate and empathize with

them.

Making unpopular decisions. Dealing with adversity, resistance, negativity, and

making unpopular decisions are all part of leadership development   Jay said, "You have

to take on the tough challenges. Do not beat up on yourself when things go wrong. Learn

from your mistakes." Several nurse managers also identified that, often times, being the

manager is the loneliest job and nurse managers can feel very isolated. MJ related her

thoughts on this middle manager concept.

> You are the middle person, trying to support the staff as well as your director but
>
> with really no level of authority. You will not please some people, in fact many
>
> people. The nurse manager job is one of the hardest jobs in the organization. For
>
> the first year while learning the role as well as the employee you need to put in a
>
> lot of time to succeed. At times you will feel like throwing in the towel but in the
>
> end it is worth it.
>
> Zena shares some wisdom she learned from her father. "What is always popular is
>
> not always right, what is always right is not always popular." She continued,
>
> "This was true for me in a tough supervisor role. You had to be able to break it
>
> down and in the end, we did what was best for the patients."

When asked about the challenge of making unpopular decisions, this was again a

common theme. An example comes to mind for Eric:

> Yes, when they think they need extra staff, I really have to evaluate it and make
>
> the decision on whether the situation and mix of patients really warrants another

nurse. And if I do not think it does, they can get upset. They'll say but we always

have gotten another nurse. And I will say, "We really need the evidence that it is

needed. I want to be able to give you extra staff when needed but I do not see the

need now. This was a change from before in a little tighter staffing control on my

part as I am watching the resource use and I know my budget. So that was hard.

A few managers related the challenges of building credibility with staff as they came in

to be the new manager. In some cases like for Maggie and ML, who were new managers

to their units. The staff had been used to a very different style. ML recalled:

At first, my first year, the staff hated me. They wanted me fired. We kind of joke

about it now. The previous nurse manager had been here for 20 years and she and

I had very different styles. The former manager was a dictator-told them what to

do, and yet she pretty much let a group of informal leaders control the unit.

Especially, there was one permanent day charge nurse who influenced all the

others. This charge nurse did not like me. My style was to come out and ask

questions, what was going on with the patients, what issues were they dealing

with. I wanted to know and help and also learn. This charge nurse hated this. I

wasn't going to tolerate this and I finally told her she would not be working

charge if she was going to work with me. After that she transferred to elsewhere

in the hospital and the staff were very upset at first. We actually had a meeting

with our VP and the staff to voice their concerns to hear them and to work on

what the issues were. It was a good time to talk and air the issues. Things have

gotten better with the staff ever since. In fact, our last employee engagement

surveys have been some of the highest ever for the unit! And the nurses tell me all

the time. We never want you to leave.

    Dealing with disappointment. Sometimes there are disappointments that help

nurse managers grow as leaders as they work through these darker times and feelings that

things are not fair. Sandy described applying for an internal position in her hospital and

feeling she was highly qualified. Another peer had also applied.

.   In fact, neither of us as internal candidates got the job. They gave it to a male

nurse from the outside with a Master's degree and I took this very hard. I

couldn't believe it. Here I had been the Magnet Champion, waiting room liaison,

house wide preceptor award, I trained nurse externs, etc. I was really down.

Then, it was my 25 year old son who said to me. 'Mom this is time for you to

really shine and don't get all down about this. This is a positive. See where this

takes you.' I was amazed that he would be a mentor. Anyway, his comments

helped get me out of my funk!

       Leah, a new manager, found the role she was in was just not a good fit for her. It

was not really what she thought she would be doing. She and her manager did not seem

to be the most compatible match. She had gone back and forth about leaving but did not

want to be unprofessional in leaving a job before she had at least given it a year. She

describes how she made the decision.

       But for me I finally pulled the trigger to think about doing something different

when something happened with my own manager that made me start looking. We

didn't always see eye to eye and maybe we were just not on the same page. But I

can remember the exact day when she told me I was getting in the way of her

doing her job. She was clearly having a bad day. But I am the type of person that
when you tell me that I will say what is going on? I didn't really know what to do
with that. I did not know what to do different. It is amazing. I am a person who is
so much harder on myself than others would be. During that season with her, I
was just trying to figure it out and reflecting on it myself. So I became very
introverted and withdrawn.

Learning from mistakes and dealing with adversity, though a huge challenge for many of
the nurse managers, led to enormous personal and professional growth from these
situations.   An additional challenge in the leadership development of nurse managers is
that of the large and broad scope of the role and dealing with the rapid pace of change.

Challenge of a large scope and relentless pace of change. A third challenge
identified by more than half of the nurse managers interviewed is the continual need to
adapt and be a facilitator of change. Many nurse managers highlighted their large scope
and 24 hour accountability coupled with the rapid pace of chance as being a great
challenge. The managers who had been in the role more than five years, like Jay,
Summer, Emma, and Katie, advised new managers to take time to know the role. Jay
advised future managers. "Sit back and take it in. Don't be a bull in a china closet and try
to change everything all at once. Listen to those around you and then slowly try to
suggest a change."

Large scope of responsibility. The scope of responsibility varied greatly with one
manager responsible for a hospital wide program and four leaders with well over 100
direct reports. The highest number of direct reports was 165, and the average number of
staff a nurse manager supervised was 76. In addition, six of the nurse managers

interviewed had responsibility for more than one unit. One nurse manager, Katie, with

25 years of experience as a nurse and 10 as a nurse manager said this: "Frankly, the

complexity and scope of the nurse manager is outrageous!" She supervises 140 people

and she stated that with all the HR (Human Resource) requirements and performance

management, physician issues, and meeting obligations there is little time for innovation.

She is responsible for 35 beds on a unit with a length of stay (LOS) of between one and

five days and has 120 RNs and approximately 20 monitor techs who report to her. Katie

highlights that being responsible for the clinical outcomes on the unit is a heavy

responsibility.

> Our core business is at the bedside.   And that is my priority. In addition to my
>
> day to day responsibilities, I am serving as an interim manager for another
>
> department. Because this is health care and things are always in flux. So right
>
> now there is a reorganization going on and so what do you do in the meantime?
>
> There is so much that I am responsible for and the physician piece within an
>
> academic health center is complex. All the attending, and fellow and residents,
>
> etc. and then there is Lab, Transport, Pharmacy and all of the other departments
>
> who support the care of the patients. My sense from doing this job for a very long
>
> time is that even though many issues are the responsibility of another department,
>
> be it Transport or Lab, it falls to nursing and nursing will fix it or at least be very
>
> involved. Nursing steps in and mitigates all the issues that affect patient care.
>
> And that's big!

Understanding the business.   In addition, the managers see the importance of understanding the business. Mike knows that health care is a business but it is still a challenge.

> Nurses and even some Nurse Managers I work with do not understand the
> business of healthcare and that is what it is, a business. I am managing an ICU but
> also a business. I am responsible for a half to 1 million dollars of personnel and
> other assets.

Beth noted, "I get it now; there is more to being a nurse than just doing our work with individual patients." She also described being a nurse manager as becoming a "master communicator and diplomat."

Many of the changes involve adjusting staffing, and trying to get the staff engaged. Mike added that it is important to engage the staff in constructing the change. Staff want to know why they should change. He talked in detail about an example where he received an organizational staffing target and he took the challenge to his staff. "I gave the staff time to work on the problem and this process yielded a much better solution than if I had sat in my office coming up with ideas by myself."

> Last year we had to do some budget and FTE reductions across the
> organization—it was called "Care Model Innovation," short for cutting staff. I
> knew we had to do it, it was not up for discussion but I wanted to make it the least
> negative experience as possible for the staff and to turn it into an opportunity. So I
> researched the community standards around staffing. I called all the ICU Nurse
> Managers in the cities and around us and asked them their practices, also about
> resource nurses, which is an additional nurse that is not in the staffing. When I

had the information, I put together a group of 12 nurses, targeting some resistors, some new nurses, some from each shifts, some who had been here the longest, newer staff, and including some that float to our unit.

Mike told the staff that he valued their experience and asked them to work as a team to figure out what they as a unit could do. "We are going to fix this problem together. If we do not do this, someone else will tell us what changes to make and we may not like it." He outlined what he called a great process, though difficult, and how the team came up with their recommendations.

Throughout the process, I sent out the pictures and names of the staff participating to all the staff members so would see who was on the team. I think the team felt good about our work together and being involved. When It came time to report out with our action items to the large senior leadership team, I brought the whole team with me, We all took a couple slides so the report was a team effort not me speaking on behalf of the group. It was a demonstration of solidarity, much like we strived for in the military.

Mike noted that this collaborative team approach from their unit was in sharp contrast to a couple other teams, one more than the other. The one was clearly leader driven and the other was very adversarial-administration vs. staff. It was a volatile report out process with no staff buy in, according to Mike. The staff clearly did not support the process or outcome and was attacking the manager. Mike summarized:

The success of my process, I attribute was relationship centered leadership. I am their manager not their peer but that does not mean we cannot work well together. I worked alongside the staff on this process.

Rapid pace of change.   The change is so rapid and constant, and thus, being an effective change agent is essential. It is important to share with staff about why they need to change. Some of the changes happen when you find out who your resources are and ask the right questions. So it has been helpful to be a change agent and to understand the resources that are available to the nurse manager. When asked for a symbol or image that came to mind to describe her leadership, ML selected those images that indicate changing, adapting, and multitasking.

> Either a chameleon or an octopus. Changing with the need, wearing different
>
> hats. One of the charge nurse observed me and said I had my "confrontation
>
> shoes on. I guess I walk a little different when I am in that mode." And there are
>
> times that you are going to dig in and help. Or an octopus which means, being
>
> pulled in many directions. I had a student shadowing me for a leadership
>
> practicum and the student asked me: "Do you ever just go and do what you
>
> thought were going to do … is it always just interruptions, changes and
>
> multitasking? I said yes, every day is like this. I love it though. You are
>
> constantly being pulled in different directions. To me I do not mind, I like it but
>
> you better like it because that is what the role is like.

Summary

In this chapter, I outlined the findings of 19 semi-structured interviews of current or previous nurse managers. I described each of the participants, summarized the characteristics of the group, and described a typical day of a nurse manager. I organized the findings into two larger categories including the contributors and challenges of leadership development of nurse managers. In the category of contributors, the themes

included identity and purpose, "Emotional Intelligence", mental models of continuous

learning, and a nurturing community. Challenges included the transition from staff to

manager, learning from adversity, and the large scope and rapid pace of change. The

findings presented included the words of the 19 nurse managers. The next chapter will

provide an analysis of the findings using the lenses of Symbolic Interactionsim (SI)

combined with Goffman's (1959) dramaturgy and the four frames of Bolman and Deal

(2002). In addition, I present an emerging theory about the leadership development of

nurse managers.

CHAPTER 5-ANALYSIS: PATTERNS OF LEADERSHIP DEVELOPMENT

The purpose of this study was to understand and develop a theory grounded in the data about the leadership development of nurse managers. As I analyzed and scrutinized the core categories, themes and their elements that contribute to the leadership development of nurse managers, I began reflecting on these aspects from symbolic interactionist and dramaturgical lenses while seeking to understand the meaning in the social interactions. From this perspective, I saw the parts of the performance. This deliberate analysis will identify the leadership development of the nurse managers, utilizing the lenses of three theoretical frameworks: symbolic interactionism, Goffman's (1959) dramaturgy, and Bolman and Deal's (2008) four frames and reframing. Additionally, I will describe how these social theories informed my thinking as I ultimately proposed an emerging theory that explains how nurse managers develop as leaders. The relevance of these existing theories was a critical component for my process of data analysis and theory development.

Data Analysis and Theory Integration

Using constructivist and comparative analysis approaches, I viewed the findings from the study through existing social theories. I selected three social theories, first to frame this study and second, to assist me with developing a grounded theory of leadership development of nurse managers. As social theories, these theories depict social interaction, and the meaning of relationships and actions. Moreover, the designated theories demonstrate through symbols and metaphors the complexity of the process of leadership development of nurse managers. Additionally these theories, while each distinct on its own, when considered together, complement one another.

The theories have natural relationships and linkages. For example symbolic interactionism (SI) demonstrates meaning in social actions much in the same way that dramaturgy highlights actions as parts of the performance. Thus, SI links to Goffman's dramaturgy and the symbolic meaning of front stage and back stage performances. Goffman (1959) and Bolman and Deal (2008) shine a light on the symbolic meaning within the context of the study. Furthermore, SI connects to the four frames of Bolman and Deal (2008) through the multiple lenses and by interpretation of meaning within the structural, human resource, political, and symbolic aspects of nurse manager leadership development. Overall, reflecting on front stage and back stage dimensions and the four frames, helped me to think about my data in many new and creative ways.

Theory Development

Over time as I analyzed and compared the data, I began to see the contributors and challenges as two harmonious forces. The process of comparative analysis and reframing led to the development of the theoretical concepts of the symbiotic forces of hazardous terrain and tranquil waters. In short, in my analysis the challenges represented the hazardous and unpredictable terrain and the contributors, represented the tranquil waters. This process of theory development occurred over many weeks and months of data analysis. I developed the emerging theory through an iterative process which involved application of theory, reframing of ideas, and creating new theory.

The Lens of Symbolic Interactionism

Symbolic interactionism (SI) explores how individuals understand their reality and thus how their actions communicate what they believe about their reality. Meaning can be expressed by the use of certain words, objects, or images. The symbols identified

and their meanings become the basis for actions and interactions. Symbolic meaning is

very personal and individual. In social interactions, meaning is shared by groups and

passed on to new members of the groups through the process of socialization. Nurse

managers then have shared experiences and shared meaning as they develop in the role.

    The nurse managers in this study experienced shared meanings that are common

for the group. One example would be the early leadership opportunities. In many cases,

the nurses were invited to take on leadership roles. In other cases, the nurses themselves

felt a desire to take on more responsibilities and challenges. Yet each early leadership

opportunity also carried a very individual and personal meaning for the specific leader.

The most meaningful interactions in the stories from the nurse managers are those

that involved patients and families. An impression has stayed with Emma for over 11

years and has shaped her development as a nurse leader.

> In nursing school, I had a job in home care and took care of a patient who was
>
> ventilator dependent. I really got to know him and his family. I found I liked
>
> establishing and building relationships with patients and families that were longer
>
> term. And when I was trying to find a job after graduation, I looked for a place
>
> that would give me that type of experience.

This experience of taking care of someone who was on a ventilator in his home made a

huge impact on Emma and how she viewed her work as a nurse and nurse leader. Emma

described this experience in more detail.

> I was still in nursing school so I was still learning myself. But what impacted me
>
> the most was seeing what the patient, his family, and young kids were going
>
> through. It reminded me always of the stressful experience of what he was going

through on a daily basis. And he was cared for in his home. So if a nurse did not

show up for her shift that was a big deal. He was supposed to have round the

clock nursing care, but it really opened my eyes to the whole experience of home

care since if someone didn't show up, the stress fell to the family. With any

patient and family now, I just try to think of what they are going through. And I

focus on just figuring out what I can do to help. So that experience has really

shaped me.

Another example of the meaning of her social interactions as a nurse was told by ML.

She discussed a theme of the commitment to patient advocacy which came through in my

interviews. Here are the thoughts of ML.

I have always been very strong about patient advocacy. I think my time at the

bedside has shaped me as a leader. It comes from my bedside nursing and

working in ICU. It is all about the patient and making things better for them.

That's why I went into nursing. Advocating as in when I knew something was

wrong… and seeing what happens from this advocacy, which the outcome can be

changed and a life can be saved because of you. That is very helpful in

reinforcing the behavior.

In summary, through the lens of symbolic interactionism, I viewed the meaning of

social interaction in this study more clearly. These examples of Emma and ML

highlighted the deep meaning of patient stories and how this meaning is a driver of the

actions of these nurses as leaders. The patient, and what is best for the patient, drives all

decisions. I observed further symbolic understanding using the lens of theatric

performance.

Analysis Through the Lens of Theatric Performance

        The nurse manager and dramaturgy. Goffman (1959), in using the metaphor of theatrical performance, puts forth that each person in social interactions presents themselves to others using certain techniques to sustain their performance and control others' impressions. This occurs everywhere in social life. When the nurse managers appear before others there are many motives to control the impression of others. For example, Emma's motive to control the staff impressions of her are two fold; she wants them to see her as both caring and firm.

> I think I am very sensitive to the staff. Yet there are times when I need to put my foot down and be firm. I think they would say Emma is a caring person; however, you must have that firmness and set expectations for the staff as professional nurses. Staff knows that I care about them, hopefully that comes through, but that they also have requirements-and if they don't meet the requirements, then I am going to have a conversation with them. It is tough. It can be challenging and some people feel like I am being mean.

        A performance may be defined as "all the activities of a given participant on a given occasion which serves to influence any of the other participants" (Goffman, 1959, p. 15). Goffman stated that the individual offers his performance for the benefit of others. In the case of the nurse managers, the performance is always for the benefit of the patient, the staff, and the larger organization. According to Melanie, her purpose in the nurse manager role is for her team to have what they need to take care of their patients.

> Even in this new framework, I find that the littlest things really make a difference for the patient. So for example there is a sign right across from this door. The

sign includes the date and time, and indicates that the patient is resting and asks

that persons not enter the room during that time. We used to have all these signs

that say *patient is resting* but it never meant anything. Lab, nursing staff, and

visitors would just walk right in. But a staff nurse had the idea of putting the date

and a specific time, say like 12-2 PM or whatever, and then the patient can count

on getting their rest and nurses can count on giving their attention to other patients

during that time.

Melanie's performance in supporting the staff nurse to try a new solution was all

for the benefit of the patient. As I analyzed the findings from the nurse manager

interviews, I used the performance to think about what activities occurred in the front

stage and which occurred in the back stage (See Table 3).

Front stage. By presenting themselves through a front we see how the performer

is "socialized" to fit the expectations of society. In some cases this social front can

become institutionalized in how it is presented.   The front stage performance features

many people who all play a role in the care of the patients. This could include

physicians, therapists, pharmacists, nursing assistants, housekeepers, health unit

coordinators, social workers, and of course, the nursing staff.   Each role in the

performance has its own script. The job of the nurse manager is to direct the

performance; to include all of the roles, or performers; and to adapt the script and roles to

meet the needs of the lead actors, the patients and families. Another example in

impression management is that expectations exist that the nurse manager will be fair and

consistent. Zena shared her philosophy about this expectation and the importance of this

aspect of the performance.

Remember there are always two sides to the story. Be fair and consistent. For

example, when one of my Rock Star employees comes and says she needs

tomorrow off, do I help her out? I will grant the request only if I would do the

same thing for any other employee. You have to be really careful not to have

favoritism.

Table 3. *Front Stage and Back Stage Performance*

Front Stage Performance	Back Stage Performance
• Metaphor of theater • The activities that happen with the patients and in front of the staff, patients and families • Various performances, roles, scripts, and costumes.	• Activities behind the scenes • Reflection, renewal and resilience • Support from mentors, role models, and colleagues

Zena had more to say on coaching the performance of others in the front stage.

Everyone's performance matters and has an impact on the overall impression

created. Another challenge is to not try to fix everything but to help others work

through the situations and then grow in their own leadership and their roles.

Developing others; realizing that there is always a curve of low, middle or sound

performers, and high performers or the rock stars. The 80% who are sound, you

need to reinforce and then you try to discover why the low performers are low and

help them to find and reach their potential.

Throughout the front stage performance there can be many different scripts. For

example, there is a script for the quality and patient safety goals of the organization and

unit. There is another script for emergencies, such as a crashing patient or when a patient

falls. There are also specific scripts for coaching staff, especially low performers. The

scripts are written by the individual professions and formulated to include legal, ethical,

and scope of practice features. Some of the scripts are developed by the leaders and

others by regulatory and quality agencies. These scripts require different things from the

actors in each type of performance. Nurse managers must harness both compassion and

firmness in articulating the expectations of the staff. They also use skills of influence to

engage the staff in changes and new strategies which are frequent and sometimes

complex.

      The patient represents the central, lead character in the performance of health care

and nursing practice. All front stage activities evolve around the patient and family. This

is the clear priority which is grounded in the data. Rarely, if an actor's performance

interferes with safe, high quality patient care or violates ethical parameters, that person or

actor can be swiftly moved out and another performer will enter to continue the

performance. Patient care is one of the longest running performances in history and

continues without interruption or intermission, 24 hours a day, seven days a week, 365

days a year. Thus, front stage agility is essential from the actors and roles. Leah

struggled with the new front stage and the work of the nurse manager. It was very

different from the front stage as a staff nurse.

      For me the biggest learning was dealing with what I didn't know. As a staff

      nurse, I could handle anything. I was very confident in my skills. I was a very

      knowledgeable and skilled nurse. You could give me any crashing kid that came

      in and I would know how to take care of them. But I did not have the Nurse

Manager skills yet. That was a huge problem. I was always questioning myself.

I am an outspoken person but I questioned myself so much. I had trouble

listening to what I thought was the right thing to do; I had no structure for

decision-making. It was just too new. Therefore, it was easy for someone to make

me feel small as I lacked confidence and knowledge.

Another front stage impression management performance came from Leah when

interviewing for a leadership position. She was sensing that her age was a barrier to

those interviewing her and felt it was important to speak about the potential

misconceptions this may create for those on the interview panel. So she addressed this

perception head on with the interview team.

I am sensing that my age and experience is an issue for you. I know you cannot

ask me about my age but I want to tell you where I am coming from. If you need

someone to come in and look over the business plan and the finances and tell you

something you need to do different then that is not me right now. I do not have

experience with that. However, if you want someone that can come in and repair

relationships with the staff and has strong clinical skills, then I'm it. That is what

I can do right now.

In summary, impression management involves a strong front stage presence and

ability to act quickly. Impression management in the leadership development of nurse

managers is driven by the purpose of patient-centered and high quality care and also a

strong commitment to the staff on the unit. In continuing with the metaphor of the

theater, the questions and confusion that are inevitable in the front stage are then

processed and worked on in the backstage environment.

Back stage. The backstage is where the reflection occurs to allow learning, where mentors enter the performance to support and counsel the nurse managers, and where a nurturing community affirms the nurse managers giving them the fortitude and perseverance to carry on in the front stage. Nurse managers prioritize activities in the back stage for these exact reasons. In the safety of the backstage, they gain the resiliency and perspective to act swiftly and deliberately in the front stage in the ever changing environment. Some of the specific activities of the backstage include reflection, and the supportive role of mentors.

Reflection as a back stage strategy. Reflection was cited by more than half of the nurses as an important aspect of their practice and leadership development. Leah talked extensively about reflection in our interview.

> For me reflection is important. I do not feel I do it enough-daily reflection is
> needed. I am working on the Insights Discovery assessment, a leadership style
> and strengths assessment. It tells me I should be reflecting daily. I learned that I
> value efficiencies and putting your time in on something that matters. I may be
> running fast but in the wrong direction. When I don't reflect, I find I take things
> very personally. I get to the point where I am overwhelmed and emotional.

Leah was able to look back, process what happened, and learn from her actions. She was teaching as an adjunct at a university at the same time she had taken on a new role as a nurse manager.

> As I reflect on it, it probably wasn't good to be new to teaching and to
> management. It was all a complete blur. All I was really doing was just putting
> out fires around here. I was just on this straight learning path with my two jobs

and I did not have a minute to reflect. I just couldn't. The position had been open

for a while and when I started and people found out the role I was in they would

meet me and say oh, 'Good luck,' like they felt sorry for me. So that was fall, and

then January was still quite busy. February–April, it started to slow down and I

was able to slow down myself and to think and reflect.

Reflection helps increase self-awareness and promotes self-understanding. Leah

continued to reflect on what she learned about herself in making a decision to leave her

current job. She had been torn between thinking the current job was not a good fit for her

and yet wanting to stay the course long enough to give herself a chance to succeed in the

role. She stated that she had not been there very long and believed it would not be

professional to leave so soon. Leah described something that happened to move her to

action.

I finally pulled the trigger to think about doing something different when

something happened with my own manager that made me start looking. We

didn't always see eye to eye.   However, I can remember the exact day when she

told me I was getting in the way of her doing her job. She was clearly having a

bad day. I am the type of person that when you tell me that I will say what is

going on?   I didn't really know what to do with that or what to do differently. I

am a person who is so much harder on me than others would be. During that

season with her, I was just trying to figure it out and reflecting on it myself. So I

became very introverted and withdrawn. As I was reflecting, I thought I should

look around a bit and I decided to apply for a position; the Float Pool manager job

and the process is so slow. I went through the interview process and I just got the

offer about a week ago. I really wanted to manage nurses and I found that I

missed pediatrics!

Another example is from Zena, who highlighted that, with reflection, she was able

to see the value of something she learned in her nursing program. Zena reflected on the

difference made by what she learned about therapeutic communication in nursing school

and its effect on patients and families. It was an "ah-ha" moment that, upon reflection,

had great meaning and impacted her leadership.

Here's story about my formal education. I had a course called therapeutic

communication-and I hated it! But let me tell you, my first year as a nurse, I was

in oncology, and I found out that it was my passion. I was with this patient who

 was so withdrawn and a therapeutic communication came out of my mouth.

"What I hear you saying is… Did I just say that? I couldn't even believe I was

uttering these phrases! I put my hand right over my mouth! *(Note to self: We are*

both laughing now at this incredible story as Zena demonstrates this, covering up

her mouth. She is so engaging and truthful. It is fun to listen to her stories) I just

couldn't believe I heard myself say that. But you know, the patient responded and

opened up. It was unbelievable to me that my instructor could have been right and

that the technique worked!

During the interview, I remarked to Leah that she seemed to know herself well.

She smiled and responded,

It is a good time for you to be asking me these questions as I have been reflecting.

First of all, you can't be developing others or have a true mentoring relationship

with staff without knowing yourself first. You have to be able to lift other people

up. But you can get too emotional especially with ours being a mostly female job.

That emotional piece comes in when dealing with people but it can be a detriment

when dealing with process. In counseling, I learned that you really have to know

yourself.

Reflection can occur as individuals with others, such as with the mentors and role models

whom are valued greatly by the nurse managers.

Mentors are a part of the back stage. The support of mentors can help to identify

opportunities, to point out strengths, resources, and to open doors for future growth. As

Zena remembered:

My Director of Nursing came to me and said I want you to fill the shoes as a

house supervisor. I was like what? I have only been a nurse for four years, I have

never worked ICU. What? But I guess she had confidence in my abilities.

Emma identified what was most helpful to her was the one to one mentoring she received

from another manager during her orientation. She described the single most helpful

aspect of her orientation as being able to shadow another nurse manager from the same

shift.

She stayed over to help me and I just followed her around. It was typical shift.

She would say you need to know about this courier service, you will need it. You

need these phone numbers, this always happens. It was just great to have

someone who knew the job, to identify some of what I needed to be successful.

The front stage and back stage served as helpful lenses to understand the process

of leadership development of nurse managers. In comparing the social interaction in this

role with the impression management in theatrical performance, one is able to see how

the findings of this study play out in either the front stage or backstage. The next section

applies the four frames of Bolman and Deal (2008) to the transition from staff nurse to

nurse manager.

The Four Frames and Reframing

Nursing has been studied as a sociological process. As such, the application of

theory can assist in the researcher's ability to predict and explain behavior. Furthermore,

the application of theory can provide a framework to support the practitioner in

understanding situations in everyday life.

The four frames of Bolman and Deal (2008) act as a multi-prismed eye glass

through which leaders can view situations. Bolman and Deal (2008) claimed that

managers often misread situations because they have not learned how to use multiple

lenses to understand what is happening and thus, decide on what action to take. These

four frames, structural, human resource, political, and symbolic add another layer of

understanding when applied to the findings of this study on nurse manager leadership

development (See Figure 3 for examples of the findings that are highlighted by the

various frames).

The nurse manager and the structural frame. According to Bolman and Deal

(2008), "At any given moment, an organizational structure represents its best effort to

align internal workings with outside concerns" (p. 97). In the structural frame, nurse

managers encounter rules, organizational structure, roles, work division, and formal

training.

Due to the potential for error in health care, there are many guidelines, policies,

procedures, and rules that guide care to be effective, efficient, safe, and timely. The

nurse manager is responsible for the quality of care on the unit or units and thus, for the

policies that drive this care. Another structural frame component is the overall

organizational structure which includes nursing as a department and reporting

relationships among the hospital departments. On some units all the staff including non-

nursing roles report to the nurse manager. On others, the RNs report to the nurse

manager and other staff report to another leader. In this frame, the experience of serving

in previous staff leadership roles and work division is highlighted. Leah shared, "I

needed the structure and information. I needed to know who does what, what is mine and

what decisions the Human Resources Department is responsible to make."

Figure 3: *Overview of the Leadership Development: Four Frames (Bolman & Deal,*

2008)

Structural Frame	• Rules, policies & procedures • Nursing as a department • Staff leadership roles • Formal education as foundational
Human Resource Frame	• Caring for and building relationships • Purpose -Work as calling • Creating community and team • Mentors and role models
Political Frame	• Hazardous unpredictable environment • Health care as a business • Tensions in roles/priorities • Nursing vs. other departments/professions
Symbolic Frame	• Rituals • Symbols-Images ,metaphors • Nursing is sacred work

The last finding that manifests itself in this frame is that formal education is foundational to becoming a competent nurse. Tanya, one of the newest managers stated:

> There is power and confidence in education so continue on with your formal education. I have been taking some class offered by the organization, every month or two. I thought it was good to consider over the next two months or so, what are my goals and how am I going to get there? I appreciate having that structure to guide my learning.

Summer does not hesitate to recommend going back to school. She advised, "Go back to school. My education has helped me so much. It helps you set the foundation for the learning in the workplace."

The nurse manager and the human resource frame. The human resource frame, sometimes referred to as the *family* frame, centers on what people and organizations do to and for each other (Bolman & Deal, 2008). Additionally, due to the great amount of time people spend at work, many consider their workplace colleagues as their extended family. One aspect of this frame is how the organization cares for people and the relationships. Zena described herself. "I feel I am blessed with a charismatic and social personality which makes me able to meet people, build rapport and teams among the staff." Emma remarked:

> I have had a lot of opportunities to do coaching and corrective active plans. Staff have opportunities to grow through a corrective action plan, though they may not see it that way, and I will help them get there because I care.

Sandy also focuses on the people aspects of her role. She is glad she went to a manager role on a different unit where she did not have to manage her former colleagues who were her friends.

> I think the hardest part for me is calling out staff when there are performance issues. Yet I have to address these issues because my first responsibility and priority is to the patients. I look at their situation and ultimately decide, what will be the best for the patients?

Eric acknowledged the importance of caring for the staff. He remarked that he is in a different role now as the manager and comes at the work from a different perspective.

> I see myself as a guide. I am there for my staff to guide them and help them go wherever they want to go. My role is to care for the staff, to make sure they are happy so they can give the best care to our patients. I work on my listening, caring, and relationship skills with the staff. It is important for them to have job satisfaction and to have what they need to do their job.

Mark shares a powerful example of trust and support from his military background as viewed through the human resources frame.

> And when I was in the military, I was like the CEO in a civilian hospital and, I had a great relationship with the soldiers. I know that the soldiers working for me would run into a burning building for me if I asked them to. They were that committed. I have thought a lot about this, the relationship that we have with our staff is the most important thing.

A second aspect of the Human Resource frame is that of creating community and building teams. Melanie is grateful for the nurturing community that is her work team.

She shared, "My community is my team that I work with every day. We stay connected. I support them and they support me. If they were not doing such amazing patient care, we would not have such a great unit."

A third connection of the findings with the human resource frame is that of the commitment to purpose and the perception of work as a calling to a higher purpose. Katie is passionate about the connection between herself as a person and who she is as a nurse. "As I have worked as a nurse, I have grown as a person. Being a nurse is integral to who I am." In addition, Katie holds high standards in hiring her staff looking only for "the best of the best because of our responsibility to our patients."

A final aspect of this frame is the importance of mentors and role models to the nurse managers. Mark valued his mentor who is someone other than his boss.

> There is another manager here and we just clicked so that is someone to bounce things off of besides my boss. It is very safe and supportive. I have a good relationship with my boss but sometimes I just need a peer to talk to. Building trust and relationships with your staff is so important and with other hospital staff.
>
> My director trusts me and gives me the autonomy and support to do my job.

Emma, too, relies on her circle of mentors and said this includes other managers who are her peers but also other leaders in the organization.

> You have to find a trusted colleague to bounce ideas off of and talk things through. Regarding this, I have also really appreciated our HEI, the Healthy Environment Initiative. It helps us to establish trust with each other. I really like the managers and the leaders that I work with. We are all very consistent in how we deal with the staff. I feel I could call on any one of the leaders to help me if I

had problems…I do not think you can expect to know what to do in the beginning. You have to have a good mentor. This person will be there for you and help you get through the challenging times.

Cami reflected on something she learned from a former role model and associate degree instructor. She says she tries to always be nurturing and supportive with new people and all those she works with, especially the patients. She described something she learned early on "No one really comes to the hospital on purpose; it is usually something unexpected that has disrupted their life that has brought them here. This idea keeps me focused on the importance of connecting with people."

The nurse manager and the political frame. Bolman and Deal (2008) present the political frame as mostly negative and sometimes refer to it as a jungle. The term *politics* is usually not perceived in a positive light, as are the aspects of leadership development discussed in the political frame. The idea of power is included, and while power is needed to make change, its misuse may cause conflict and suffering. The findings of this study demonstrate aspects of leadership development such as a 1) hazardous unpredictable environment, 2) health care as a business, 3) tensions with other departments/professions and, 4) time constraints.

Hazardous unpredictable environment. The hazards and unpredictable aspects of leadership development are highlighted by Mike and Summer respectively. "In a leadership position you have to be very cautious, there can be *Landmines*. These can be undermining and you have to have someone you can trust." Summers adds, "Oh and follow-through. You can lose credibility so fast if you do not follow-through."

Health care as a business. Sandy is very aware that heath care is business with regulatory and governmental requirements and significant financial pressure. She commented, "I think of our role as minding the gap. And the gap is between the reality of patient care and patient needs vs. the CMS (Center for Medicare Services) world, regulatory expectations, and perfection." Additionally, Sandy commented on her feelings as she made the transition to the role of nurse manager. "It was both terrifying and exciting! I can still conjure up the emotions in my heart that I felt during the transition." Emma also had experienced the challenges of health care as a business. She described her experience.

> I have had to deal with a lot in this job. I have been sued for human rights issues, dealt with many grievances, 75% of those who report to me have not been managed and so they have a lot of accountability issues. It is learning what is yours, what is mine, not taking things personally, reflecting on the situation and what is going on. Not escalating and being to de-escalate situations.

Interdepartmental tensions. There are tensions that exist among departments. While nursing is a powerful force in any organization, the nurse managers do not have control over other departments. Yet, many solutions to issues patients experience involve multiple departments. It is easier to affect change in your own department versus across departments. Melanie explained the improvement work on her unit. Staff nurses are empowered to implement ideas they have to improve patient care. One of the guidelines is that the solution has to be "within our sandbox."   Melanie continued,

> If it is not within our sandbox or grasp of the situation, we do not try to fix it alone. We try not to throw sand at other departments or try to fix things outside

of our control and influence. So we will try to improve things only if it does not

involve anyone outside of our unit.

More tension appeared due to age or emotional response as Leah described. She has

experienced issues with being young and not having people take her seriously as a leader.

Even when I came here I think my age was somewhat of an issue, I was young

there was some testing, not real hazing. I expected a little hazing but the staff

here were actually more open to a younger manager and some of the younger staff

were friendlier to me. It took a while to trust my own intuition in this job.

Leah is insightful as she reflects on how the feminine aspects of a predominantly female

work force appear in daily interactions. She describes this as a challenge.

I have been reflecting on females in leadership. There is a lot of emotion. I

learned some of this in my psych studies. And sometimes there is insecurity that

is really obvious. I was lucky to have a colleague and mentor who helped me in

understanding myself and how I came across to others. She said when she first

met me I seemed to be successful, motivated, and comfortable with myself. She

stated 'I thought 'who is that girl?'' I hated you!' …Women can be very jealous

and cruel to each other-there is a lot of insecurity. There is always politics-like it

makes me stronger if I keep everybody small. But the best leaders are the ones

that build everybody up! That will invest in people and watch them grow. Yes, the

best part is really developing others.

Time constraints. The last tension is that of not enough time. Leah commented,

"The worst thing is not having enough time to see all the staff, to connect with people,

follow-up, be visible, connect with HR, oh yes, and put out all the fires!" Every day is

different and what a nurse manager may think are going to be the priorities of the day,

may not end up that way. The nurse manager's attention must be on setting priorities

given that there is always much to do. It is important to be able to set some things aside

in order to accomplish the top needs of the day, be it a staffing issue, patient care crisis or

other high priority unit or organizational need.

The nurse manager and the symbolic frame. This frame shows the sacred and

holy parts of leadership development and included rituals**,** symbols, and the recognition

of nursing as sacred work. Some of the rituals are simple, such as nurse managers

meeting to eat lunch together, or two nurse leaders on adjacent units who walk out of

work to the parking lot together every day at the end of the day.

Maggie has been a nurse leader at two different places. She has a ceramic candy

dish with a ceramic spoon in which she keeps M&Ms for the staff.   She shared with me

the story of the symbolic significance of this candy dish. The dish was a gift from two

staff nurses who brought it as a souvenir for her from a conference that she sent them to

as staff. This is the second office and role in which she has kept the same candy dish

which, in a way, represents the community of the unit. She says,

> I always have M&Ms in here and they are not for me. I eat very few of them. But
>
> people come into my office sometimes they just ask if they can have some
>
> M&Ms. Sometimes they sit down and talk. The staff knows the candy dish is
>
> here for them and they can come in any time. Yes, a candy dish can draw people
>
> like a magnet!

Another characteristic in this frame is that of images and metaphors. In the

interviews, I asked every nurse manager to describe their leadership and if any images or

symbols came to mind. All but one of the nurse managers named a symbol or image for

their leadership. Leah discussed her image as a pressure cooker or shock absorber.

> As a facilitator and advocate I can act as the pressure cooker of patient outcomes,
> what staff is dealing with, protecting patients, and being a staff advocate balanced
> with the challenging business/organizational environment. I serve as a shock
> absorber between the two worlds.

Other symbols that the nurse managers identified for their leadership were a teacher, a

guide, a heart, and the sun. These all bring powerful ideas, thoughts, and visual images as

the words are read aloud. One nurse manager describes her leadership as a duck gliding

on the water, calm, serene, and in control. I listen and then she says to me, so that is what

you see on the surface with me. She asks me, "What is the duck doing under the water?

The part you cannot see." I say without stopping to think. "The duck is paddling as fast

as it can." Maggie smiled and nodded.

The last point in the symbolic frame is that nursing is sacred work. Nurses enter

into the lives of patients and families at times of overwhelming joy or deep sadness and

tragedy. According to the nurse managers, this experience affects them in a profound

way. Nurses describe their deep connection or covenant with patients and the joy they

receive from their work.   This helping profession allows the caregivers and nurse

managers to grow and develop in very personal and meaningful ways. The nurse

managers describe their work as a calling versus a job. One nurse manager describes

"carrying the meaning of my work with me always." Other nurse managers describe

their patient experiences as profound and transformative. The nurse managers find it

very satisfying and meaningful to make things better for the patients and their families.

As Katie identified, she is a better parent, wife, friend, and person because of her career in nursing.

Another leader, Emma, described being a nurse manager as a transformative experience. "What makes me take a deep breath? Some of the transformative experiences are caring for certain patients. The patient challenges are the Nurse Manager's challenges. As a manager, you get your satisfaction from different things… like developing others." MJ sums it up with words of advice to those who may become a nurse manager in the future. She described the rewards of her work from her point of view.

> The rewards for a staff nurse come in the form of recognition from other employees, managers and patients. As a nurse manager your rewards are incremental, when you can bring staff up to a higher level, when you see the ah-ha from a newer employee, when a change that you did not support fully is implemented and it went well- you were able to lead the staff were they needed to go. Leadership is a difficult job in healthcare but it can be very rewarding as you develop and lead others.

Reframing and Reinvention: Analysis

Bolman and Deal (2008) discuss the importance of mental models or maps used as tools to capture ideas we want to convey. A frame is just that, "a set of assumptions and ideas-you carry in your head to understand a particular territory. A helpful frame helps a person to know what they are up against and what they can do about it" (p. 11). Just as the four frames helped in creating a better understanding of the data from the interviews, the action of reframing can be helpful to leaders in dealing with new and

different situations. Bolman and Deal (2008) describe this as matching situational clues with a well learned mental framework. In summary, learning to work with multiple lenses and frames provides a defense against the rapidly changing environment and multitude of complex issues nurse managers must face.

Re-invention of self. While the ability to reframe situations is essential for leaders, it is also essential to reinvent oneself through growth and renewal as a part of leadership development. Bolman and Deal's notion of reframing and reinvention connect to the work of Paulo Friere (1993), in his popular work, the individual learns to foster and advance his/her own growth through situations from daily life providing useful learning experience. Freire's work ties closely to the emerging data and themes from this study and makes the salient point that we need to constantly re-examine ourselves, if we are to authentically commit to the people, in this case the patients, families, and staff.

Emerging Grounded Theory

In the process of this analysis, a grounded theory of the leadership development of nurse managers began to emerge. First of all, this study affirms that leadership development is an ongoing process and not a final destination.   I discovered that the "light bulb" moments of leadership development occur in newer nurse managers and those nurse managers who have been in the role for 15 or more years. Dewey (1938) explains that an experience is a transaction between an individual and its environment. Any normal experience creates a situation by the interplay of objective and internal conditions in their interaction (Dewey, 1938). As such, the leadership development of nurse managers is a transaction between the individual nurse manager and the environment.

The emerging theory of leadership development of nurse managers has four key elements or facets that are interrelated to form a theory of leadership development of nurse managers. The five facets of the theory include: 1) the hazardous terrain, 2) the tranquil waters; 3) these dimensions as symbiotic forces; 4) the reframing and ongoing growth that occurs over time through the experience of the forces; and 5) the ripple effect of the leadership development of nurse managers.

The hazardous terrain and the tranquil waters. First, I defined the key elements from the data and how they fit into this model.   The contributors and challenges or front stage and backstage, can be reframed as experiences that are either hazardous or nurturing aspects of role development and are depicted in Figure 4.

Figure 4: *The Hazardous Terrain and the Tranquil Waters*
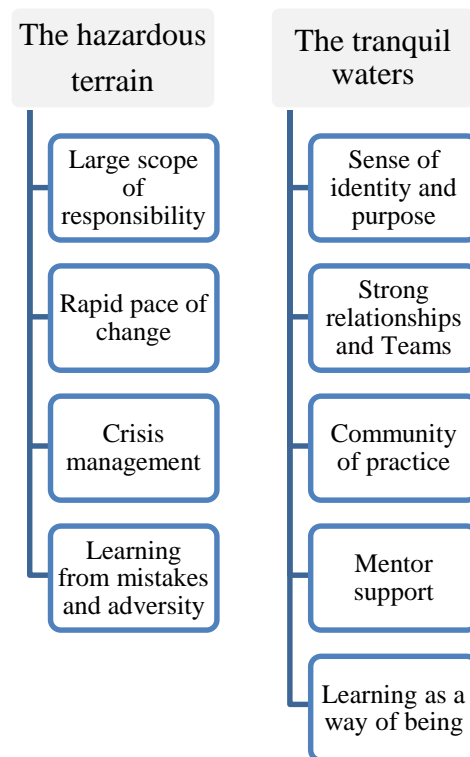
The hazardous and unpredictable experiences which were described by the nurse managers promote adaptive capacity and occur in the front stage. Through the

experience of challenges, adversity, crisis, and the unexpected, the nurse managers described how they gain an increase in comfort, tolerance of ambiguity, and with not knowing all the answers. In addition, with each new situation, they are learning and gaining confidence in their ability to be dynamically adaptive.   As indicated in the findings, wisdom comes from experiencing hazards and adversity. Thus, the hazardous terrain is a key element of the grounded theory.
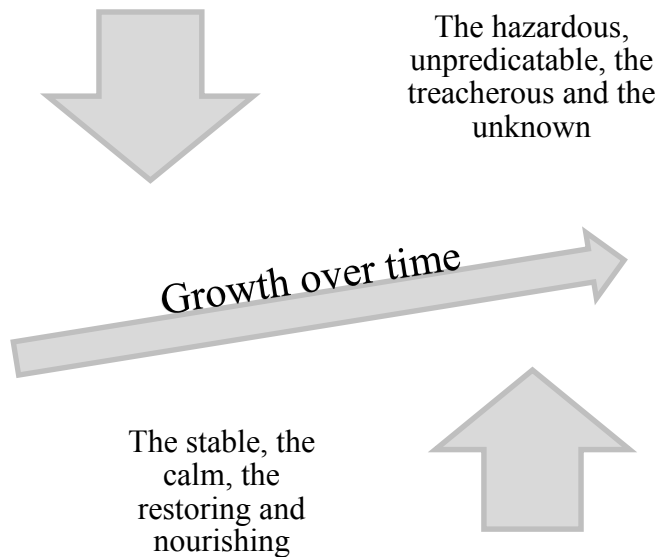
Likewise, the calm and restorative aspects of leadership development allow for reflection and provocative introspection. These aspects represent a second key element of the emerging theory. In the "tranquil waters," nurse managers discussed how they increase their self-awareness through self-assessments, reflection, and working with mentors and other colleagues. The nurse managers get support from mentors and colleagues and work through multiple issues. This experience helps the nurse managers gain confidence for the next time they deal with a similar situation. The nurse managers stated they are supported by others, which helps to build resilience and leadership capacity.

Symbiotic forces The third element of the theory, is the notion that these two forces, the hazardous and the tranquil or predictable, are symbiotic. Through the voices of the nurse managers and the data from this study, I have come to understand there are two symbiotic forces that work together as nurses develop as leaders. The analysis of the interrelations of the two forces assumes, from the voices of the nurse managers, that both work together. The two forces are both necessary and work in harmony. If *symbiotic* means to be interdependent or to exist together, then this word describes the relationships illustrated in this emerging theory. These two forces of leadership are complimentary

and synergistic. This element of the theory, which emerged from the data analysis

process, is shown in Figure 5.

Figure 5: *Symbiotic Forces*

The hazardous, unpredicatable, the treacherous and the unknown

Growth over time

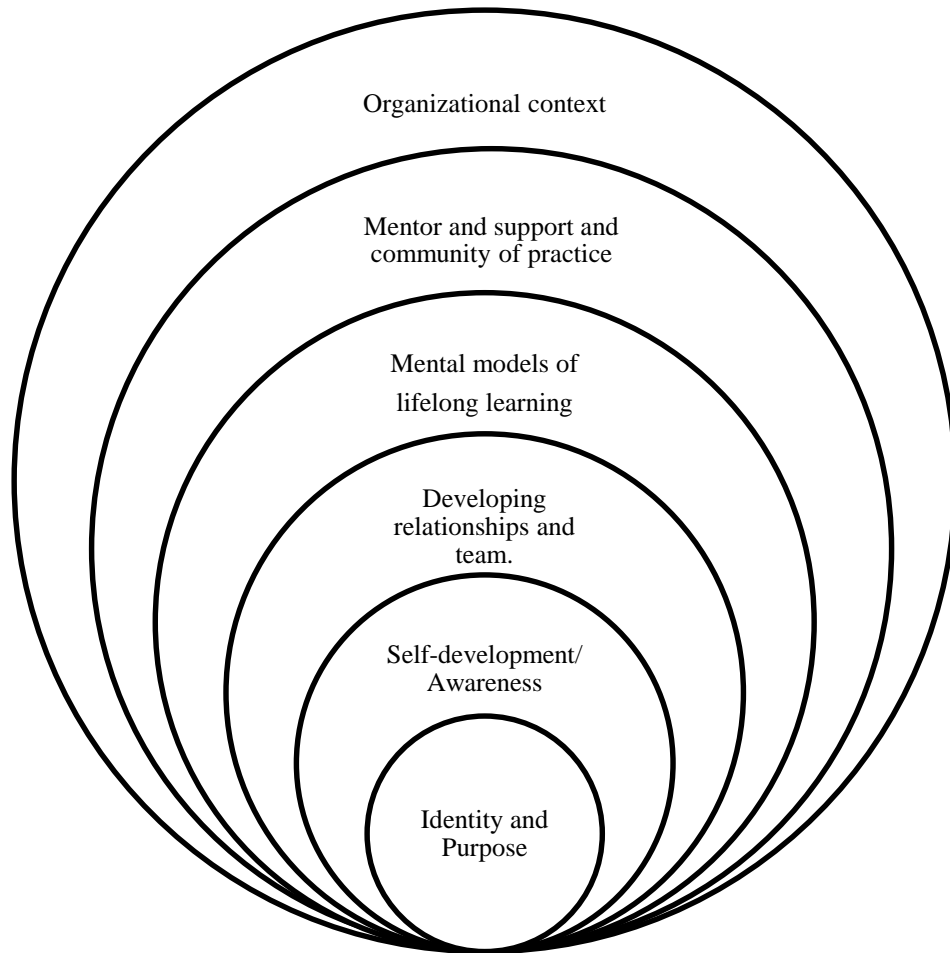The stable, the calm, the restoring and nourishing

     Reframing and ongoing growth. Fourth, also depicted in Figure 5 is the

extended line between the forces. This line represents growth over time or reframing by

the nurse managers and emerged as a key theme from the data. This theory indicates that

combination of these two forces leads to ongoing growth and to a continual reframing

and reinventing of the nurse manager role. The nurse managers continue to redefine their

identity and improvise in the context of the patient care unit and the organization. As

Dewey (1929) said, "The doings and suffering that form experience, in the degree in

which experience is charged with meanings, there is a union of the precarious, the novel,

irregular with the settled, assured and uniform (p. 291). The symbiotic forces depicted in

Figure 5 move the leader forward as a person with new consciousness, harmony, and

purpose. The leader is able to reinvent, and reframe situations and to improvise in the rapidly changing environment.   The leaders demonstrate openness to the revelation of possibilities.

   The ripple effect of nurse managers as leaders. A fifth and final element of the emerging theory is the ripple effect of nurse manager leadership development (See Figure 6). The leadership development process for nurse managers begins as a very individual journey of identity and purpose followed by increased self-awareness. From here the ripple effect extends outward to fostering relationships and teams. The next level of the ripple effect expands to influence through mental models of lifelong learning, followed by a ripple to the profession and the nurse managers' community of practice. Lastly, the nurse managers' leadership development impacts the organizational context. This ripple effect aspect indicates the broad and far reaching influence extended by nurse managers and thus emphasizes the support needed for development of the role. The role is a significant contributor in the overall organizational context according to this study.

Figure 6: *The Ripple Effect of Nurse Managers as Leaders*

Organizational context

Mentor and support and
community of practice

Mental models of
lifelong learning

Developing
relationships and
team.

Self-development/
Awareness

Identity and
Purpose

Leadership provides the context in which leaders practice how to "promote their

own growth, that of others and of the whole of society" (Noddings, 2007, p. 39). The

leadership development of these managers exhibits a ripple effect outward from their

central identity and purpose to other individuals and eventually to the broader

organizational context. This diagram represents the building of new knowledge based

upon existing knowledge. This emerging theory is well grounded in the data and evident

in the findings and analysis. "Knowledge emerges only through invention and re-

invention, through the restless, impatient, continuing, hopeful inquiry human beings

pursue in the world, with the world, and with each other" (Friere, 1993, p.53).

The emerging theory is new and unique in that it specifically identifies two

symbiotic forces, the hazardous terrain and the tranquil waters. These elements originated

directly from the data from the interviews with 19 nurse manager participants in the

study. In my analysis of the data, it became clear that these two symbiotic forces are

both required in the leadership development of nurse managers. They occur together and

over time lead to a reframing, reinvention and thus ongoing growth in the nurse managers

as leaders. Additionally, as the nurse managers develop as leaders through this process,

there is a ripple effect of the leaders that begins with self- identity and purpose and

extends out to a greater impact on others and the broader organization. This theory can

be applied and tested with other nurse managers groups and other organizational

contexts.

Summary

In this chapter, I provided an analysis of the findings through three theoretical

lenses. The three lenses included symbolic interactionism, Goffman's (1959) dramaturgy

and theatrical performance, and the four frames and reframing concepts of Bolman and

Deal (2008). These theories help represent the complexity of the individual and

organizational aspects of the leadership development of nurse managers and informed the

development of an emerging theory of nurse manager leadership development. Lastly, I

have presented an emerging theory that outlined the symbiotic forces which help nurses

to develop as leaders. These symbiotic forces include the hazardous terrain with the

unpredictable and the unknown; as well as the tranquil waters of reflection, renewal, and

support. I also proposed a theory to describe the ripple effect of nurse managers as leaders in the organizational context. In the final chapter, I will discuss the study conclusions and implications for education, practice, nurse leaders, and future researchers.

CHAPTER VI: CONCLUSIONS AND STUDY IMPLICATIONS

Overall, this qualitative study explored how nurse managers develop as leaders and attempted to answer the following three questions: 1) What contributes to the leadership development of nurse managers? 2) What are the challenges faced by nurse managers? 3) How does the transition from staff nurse to leadership happen in the organizational context? Through the interview process the nurse managers described what contributed to their leadership development and the challenges they encountered. A second purpose was to develop a theory about nurse manager leadership development.

Nurse managers today practice in tumultuous, hazardous, and unpredictable times; yet, the nurse managers' leadership is grounded in quality patient care and their role in supporting the staff who care for the patients. Although much is unknown about health care in the future, the nurse manager's purpose is crystal clear: to provide the best patient care possible. Nurses in practice and education settings will find this information useful at this time of transformation of healthcare and impending shortages of both nurses and nurse leaders.

In the following chapter, I summarize the conclusions of 19 semi-structured interviews with nurse managers. I also present relevant implications for nursing educators, administrators in practice settings, nurse leaders, and future researchers.

Conclusions

Study findings were organized into two broad categories: contributors and challenges to leadership development. Within the contributor category, four themes emerged during data analysis: identity and purpose, "Emotional Intelligence," mental models of lifelong learning, and a nurturing community. Three themes emerged within

the challenges to the leadership development category: first was the transition itself,

from staff nurse to leader; second was the notion of learning from adversity and mistakes;

and third was the large scope of responsibility and rapid pace of change.

From these findings, study conclusions appeared in four main categories 1)

individual nurse manager development in the organizational context; 2) the value of

education and learning; 3) identity formation and socialization; and 4) front stage and

back stage ideals.

Individual Nurse Manager Development in the Organizational Context

The study results portrayed both how the individual develops *and* the importance

of the organizational context. Indeed, nurse managers develop as individuals as they

increase their own self-understanding and self-awareness. The study results also

confirmed valuable organizational supports such as leadership classes, mentoring

programs, time to allocate to professional development and learning, and residency

programs. These organizational supports and systems are significant contributors to

leadership development according to the nurse managers. The practice environment can

be unpredictable, yet the purpose and mission of caring for patients remained a constant

and fixed compass for the nurse managers.

For nurse managers today and according to this study, scopes of responsibility are

much larger than other industry sectors. In the study hospitals, nurse managers directly

supervise an average of 70-100 direct reports in environments that are complex and

rapidly changing. The study results highlighted two representative organizations serving

as the study context. The two organizations were places where leadership development

and growth was supported and where leaders thrive.

The Value of Formal Education and Experiential Learning

The study results affirmed that formal education plays a role in identity and leadership development. The nurse managers recognized the value of the BSN degree as foundational and essential to leadership. The nurse managers support the organizational goals of requiring all leaders and eventually all R.N. s, to have a Baccalaureate degree. Furthermore, the nurse managers acknowledged that lifelong learning is the mark of a professional. Performance management and financial knowledge and acumen were identified as skills and competencies essential to leadership. Additionally, "emotional intelligence" skills included self-awareness, building relationships, and fostering teamwork. The nurse managers identified "emotional intelligence" skills as central in their daily work.

Continuing learning emerged as a theme and emphasized formal education and training, experiential learning, and fostering learning in others. Finally, the study results showed that, given the fast and changing pace, it is essential to reflect and to process situations with mentors and other leaders. This reflective exercise contributes to the integration of new learning into leadership practice.

Identity Formation and Early Socialization

The researcher uncovered specific themes that point to strong professional identity and the prominence of the process of socialization into professional roles. For example, the socialization aspects of leadership development encompassed identity formation, early leadership opportunities, the role of mentors, and organization support for leaders. The study results begin to break down some of the long held beliefs and socialization patterns of the past. Collaborative, patient-centered teams are taking the

place of the weary hierarchy. This study affirmed that nursing staff at the bedside are

developing as problem-solvers and resource stewards, while remaining the strongest of

patient advocates, thus, countering a mentality of scarcity of resources and restrictive

staffing patterns. Nurse managers empower the staff nurses to act on behalf of the

patients and the organization. Some of the old models of "nurses eating our young" are

becoming extinct. The culture replacing these attitudes is engulfed in a "stand by me/I

have got your back" camaraderie. Nurse managers experienced satisfaction in

developing others and leveraging team and individual strengths.

Front Stage and Back Stage Ideals

The study results correspondingly confirmed that there are distinct front stage and

back stage facets to leadership development. Formal education and day to day patient

care and unit challenges were front stage activities. Explicitly, self-reflection, role

models and mentors, and a nurturing practice community were backstage dimensions

identified through this research.

A looming challenge to be addressed is the uncertainty of the Affordable Care Act

and other health care reform initiatives. Even so, the nurse managers in the study health

care systems hold fast to the values of patient advocacy and patient-centered care. In

spite of the shifting environment, patient care priorities and operational challenges

continue on the front stage. There is a stable and nurturing backstage that provides an

opportunity for nurse managers to receive support and encouragement.

These findings point towards a theory that there is a normalization and reframing

process underway as nurse managers develop as leaders. This normalization process

comes from the symbiotic interrelationship of the *hazardous, treacherous terrain* and

unpredictable front stage activities and the safe and stable *tranquil waters* of the backstage. These dramatically differing forces provide the tension and synergy that produce strong, confident, courageous, and creative nursing leaders. Dewey (1929) points out in *Nature and Education* that nature is very hazardous and unpredictable but also stable and expected. "The doings and suffering that form experience are, in the degree in which experience is intelligent or charged with meaning, a union of the precarious, novel, and irregular with the settled, assured, and uniform" (Dewey, 1929, p. 291). The presentation of an emerging grounded theory, which was outlined in Chapter Five, further informs the discipline of nursing about central aspects of leadership development in nurse managers.

Study Limitations

There are significant limitations to this study. The first is that it is a study of nurse managers from two health care organizations with a philosophy of being intentional about developing leaders. While the study organizations were selected because the researcher believed them to be representative of health care organization, both upon further exploration, were very supportive of leadership development. This culture that supports leadership development may not be the same in other healthcare settings. Second, all the nurse managers interviewed worked in a hospital setting. The acute care settings may be a very different context for nurse managers than that of clinic or long term care facility.

These limitations must be taken into consideration when constructing leadership development strategies for broader practice settings. Leadership development strategies

may need altering in different hospital settings and also in settings where leadership

development is not well-structured and intentional.

Implications for Education, Practice, Nurse Leaders, and Future Researchers

The implications from this study are relevant to several different stakeholder

groups: nurse educators, nursing administrators in all practice settings and organizations,

current nurse leaders at all levels of an organization, and of course, future researchers.

This study offers implications to those responsible for educating the nurses and nurse

leader of the future.   Moreover, organizations must consider the impact of allocating

resources and prioritizing the leadership development of nurse managers for the future.

Nurse leaders at all levels must provide care, nurturing, and mentoring to nurse managers

by early identification of these managers and through ongoing support. Finally, this

study opens up new and additional questions which could be examined by future

researchers.

Implications for Nursing Educators

Implications for nurse educators include improving content of nursing programs

and the socialization of nurses, with more emphasis on leadership development. Benner,

Sutphen, Leonard, and Day (2010) proposed a call for radical transformation and a series

of recommended changes in nursing education. One of the significant recommendations

from Benner et al, supported by this study, was a more contextual approach to education

and ongoing reflection throughout the educational program to facilitate learning. In

addition, this study has significant implications for nursing education in the areas of

confirming entry level practice degree requirements, the socialization process of nurses as

leaders, program of study content, and continuing education.

BSN as entry level. First of all, the study confirms that the BSN should be the entry level degree and minimum educational preparation for nurses and nurse managers. The nurse managers in the study saw the value, and the organizations in the study have the BSN as an expectation. The IOM Future of Nursing Report (2010) reinforces this degree level through their recommendations. Furthermore, to align with other health professions, many of which are moving to entry level practice at the doctorate or masters level, nursing must embrace and operationalize the minimum educational requirement to practice as a registered nurse. The nurses in the study all eventually arrived at a BSN; however, with one entry–level standard and path, baseline knowledge and competencies would be further standardized and practice enhanced. In short, an all BSN-prepared workforce of nurses would be better prepared to lead and influence the changes in health care.

An additional implication for moving to the BSN as minimum preparation is that the current faculty is stretched to provide education at multiple levels. Additionally, there are clinical site shortages, as many organizations overextend to provide clinical education for students working on their associate degree, baccalaureate, or RN to BS degree. Shifting to the BSN as the entry level for RN practice would allow for more nurses to be prepared at a consistent level and thus, educators can reallocate faculty resources.

Curriculum reform. Second, this study has implications for overall nursing degree program content and for early socialization into the profession. This study confirmed the recommendations of the IOM report (2010) and Cooper (2008) regarding the need for more leadership and management content in nursing entry-level education. The IOM

report (2010) stated, "To ensure the delivery of safe, patient-centered care across settings,

the nursing education system must be improved" (p. 3). Cooper (2008), in her

unpublished dissertation, studied nursing education and the career paths of graduates in a

case study of baccalaureate prepared nurses. She concluded:

> In an attempt to promote nursing as a profession, there is perhaps an
>
> overrepresentation of leadership and management content, and an
>
> underrepresentation, or limited realistic socialization for students to enact the
>
> actual role of a professional nurse as encountered in the work setting"
>
> (Cooper, 2008 p. 145).

To address these concerns from Cooper and this study, some aspects of

baccalaureate content must change. Cooper (2008) recommended critically examining

the essential content and experiences to prepare the "generalist nurse" and acknowledged

that it is extremely challenging to determine how to make room for new, innovative, and

relevant information. In echoing Cooper's suggestions, this study revealed that

baccalaureate nursing programs need to foster increased self-awareness through self-

assessments, personality typing, or strength identification.   The study indicated that

adding more opportunities for students to work in teams to foster communication and

team-based skills will revitalize existing nursing content. Cohort models, even those that

are online, build rapport and foster the support which will be essential to successful team

practice and leadership development.

The IOM Future of Nursing Report (2010) recommends support and increased

leadership content in baccalaureate preparation programs. "Nursing education programs

should integrate leadership theory and business practices across the curriculum, including

clinical practice" (IOM report, 2010, p.5).

Continuing formal and informal education for leadership. Lastly, in addition

to the inclusion of course content on leadership, this study asserted there is a need for

more advanced preparation and continuing education offerings in leadership

development. Higher education should evaluate existing industry leadership

development content such as the Nurse Manager Leadership Collaborative (NMLC)

modules and philosophy for relevant integration into baccalaureate or continuing

education curricula.

Westphal (2012) remarked that nurse leaders are pursuing graduate education to

develop skills and competencies for leadership roles. These nurses have a choice

between business-focused graduate degrees or nursing–focused graduate education.

Their choice depends on how well nursing graduate education programs prepare nurses

for leadership and management roles. Westphal (2012) suggests that nurse educators

develop new courses to meet these leadership competency needs.

Implications for Practice Settings

Within the practice environment, there are two significant implications to address.

The first is from The Future of Nursing IOM Report (2010), a document that nursing

leaders across the nation have embraced. The second is somewhat related and involves

organizations promoting a culture that supports leadership development.

IOM recommendations. The recommendations from the IOM Report (2010)

include more nurses having BSN degrees, more nurses achieving the doctorate degree, all

nurses prepared to be leaders, and all nurses working on a level playing field with

physicians and other professionals in creating the future health care system.   This

recommendation is confirmed in the findings in two organizations within this study. To

meet these recommendations, the IOM (2010) encourages major changes in developing

nurse to lead.

> In order to ensure that nurses are ready to assume leadership roles, nursing
>
> education programs need to embed leadership-related competencies throughout.
>
> In addition, leadership development and mentoring programs need to be made
>
> available for nurses at all levels, and a culture that promotes and values leadership
>
> needs to be fostered (p. 3).

Developing future nurse managers is a long term quest. It is a challenge to predict what

knowledge, skills, and abilities will be needed to lead in the future. Sherman and Pross

(2010), recommend the Nurse Manager Leadership Collaborative (NMLC) Domain

framework as a useful tool to develop nurse managers. The collaborative offers an

inventory that is available at no cost and allows nurses to rate themselves using the

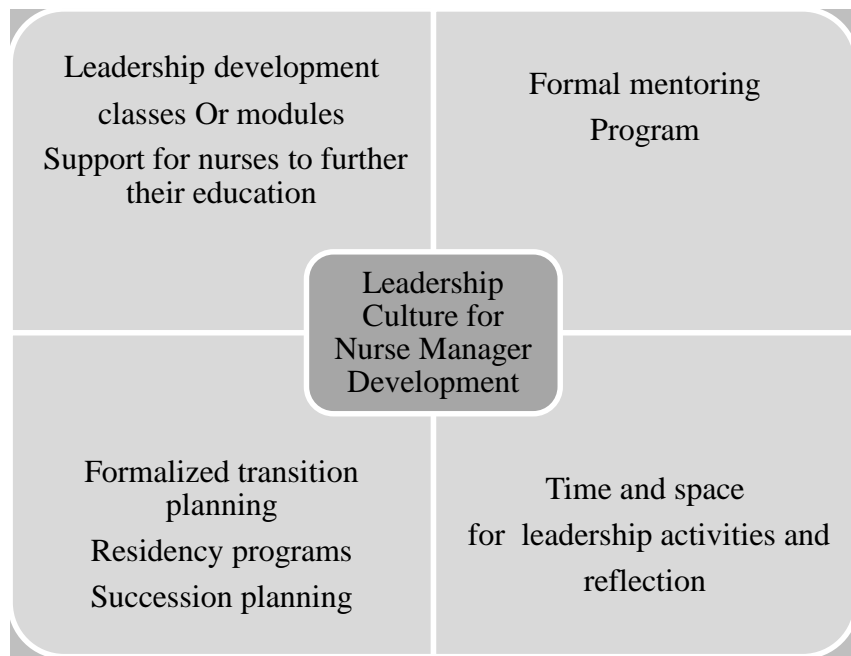*novice to expert* scale (Benner, 1984).

Organizational support. Beyond the IOM recommendations, the study results

indicated that organizational context matters and is vital to the support of nurse manager

leadership development. Thus, organizations can expand their leadership capacity by

creating and fostering a leadership development culture.   From the findings if this study,

the researcher concluded that a leadership development culture would include:

   1) leadership development classes and strategies to assist nurses to further their

      education,

   2) structured mentoring programs for aspiring and developing nurse managers,

3) structured support for the transition to leadership, such as residency programs and

succession planning,

4) support to allow time and space for these leadership development activities,

including time for reflection.

In short, the goal of developing future nurse leaders is a long term goal that requires

understanding, planning, and strategic action.   Figure 7 provides a visual depiction of

this leadership development culture which was grounded in the data from this study.

Figure 7. *Leadership Development Culture*

Leadership development classes Or modules Support for nurses to further their education	Formal mentoring Program
	Leadership Culture for Nurse Manager Development	
Formalized transition planning Residency programs Succession planning	Time and space for leadership activities and reflection

Implications for Nurse Leaders

The results of this study have implications for nurse leaders at all levels of the

organization from informal leaders such as the charge nurse to the Patient Care

Executive. These implications include: differentiating nursing and leadership practice,

supporting novice nurse leaders and managers, succession planning, and transforming

nursing leadership.

Differentiating nursing and leadership practice. From this study, there is confirmation that nursing practice is not synonymous with leadership practice. Nursing practice is centered on the individual patient and a nursing process that assesses, plans, implements interventions, and evaluates the care based on the individual needs of the patient. This process is central to the profession and to the personal health and healing that nursing brings to each patient and family. As this study identified, leadership practice requires nurses to think more broadly about use of resources, leverage staff, and be a change agent to meet individual and organizational needs. Leadership decisions often present dilemmas that involve seeking the greater good. In short, nurse managers often must make unpopular decisions. When this happens, nurse managers need more experienced leaders to support them and help them learn to reframe situations using a variety of lenses.

Supporting novice nurse leaders and managers. Current nursing leaders must welcome novice nurse leaders as mentees and support them in decision making, in evaluating dilemmas, and in reframing situations from a variety of perspectives.   This study affirmed that equally important for current nursing leaders is providing a safe and nourishing environment for developing nurse managers to grow. Current nurse leaders in both education and practice have a responsibility to our future patients to develop the prospective nurse managers who will provide leadership for the changing patient care arena. According to Crosby and Shields, (2010), "practice and education leadership can make a difference collectively" (p. 363). This statement was confirmed throughout the study findings.

Succession planning. Nursing leaders must be intentional with succession planning at all levels. Each step is to be deliberate in identifying and inviting staff nurses into the early staff leadership positions of charge nurse and preceptor. As this study revealed, staff nurses are the nurses that eventually become our nurse managers. Therefore, incorporating early professional development opportunities coupled with mentoring at all levels in the manager/leader hierarchy will help develop nurse managers reach their potential as leaders.

Transforming nursing leadership. Griffith (2012) identifies that a transformation of nursing leadership is needed. The transformation of health care requires a new kind of nurse leader, "one who is willing to listen, to involve subordinates in the decision-making process and to mentor new nurses so they can contribute to the reformation of the nation's health-care system" (p. 904). This assumption was corroborated in this study. Finally, nurse leaders should utilize the emerging theory to test its relevance. When working with developing nurse managers, call out the hazardous and unpredictable parts of the role. Moreover, harness the backstage dimensions of leadership development by role modeling self-awareness, reflection, learning, and reframing of situations.

Implications for Future Researchers

Further studies are needed on the leadership development of nurse managers. Seeking answers to one research question always results in more questions. The results of this study sparked additional areas of research that will add to the knowledge on the topic of leadership development of nurse managers. One example is the ripple effect of nurse leaders that is part of the emerging theory. This ripple effect manifests itself from a

purpose-centered identity of nurse managers to the staff and patient relationships, teams, mentors and role models, the professional community, and eventually the broader organizational context. Does the ripple extend beyond the organizational context? Future researchers should study the impact of nurse leaders on the broader context of health care. Does the nurse manager leadership development reach to the broader context of the health care system and health care reform?

Another question is whether the findings of this study have application in other health profession contexts. For example, what is the leadership development process like for occupational or physical therapists, pharmacists, radiographers, or sonography professionals? Is the path the same as for nurses where the expert clinicians are identified for leadership positions? Is the leadership road similar for these professions or are the findings of this study unique to nursing?

Additionally, I suggest some future research questions to be explored. Would a study conducted over randomly selected organizations be different than this study which was situated in two specific organizations? What outcomes in leadership development can be achieved by intentional succession planning? What are the differences in an organization with a nurse manager residency program as compared to an organization with no structured support for leadership development? Lastly, what specific leadership development needs are met and unmet by the current baccalaureate nursing educational preparation?

Summary

In summary, the 19 nurse managers in this study provided valuable information on the leadership development process of this vital role in the healthcare team. The study

results revealed both how individual nurse managers develop and the importance of the

organizational context. The study results also confirmed that there are distinct front stage

and back stage aspects to leadership development. Significant implications and

recommendations were identified for nursing education, nursing practice and the

organization, nurse leaders themselves, and future researchers.

Closing Reflections

The findings of this study affirmed some of my own perceptions and beliefs about

leadership as an ongoing life process. Though this study, I was able to reach a deeper

understanding of how those in the nurse manager role develop as leaders and the

importance of the organizational context.   I found the exploration of the front stage and

back stage dimensions of leadership both stimulating and challenging.

It has been a joy and privilege to meet these nurse managers and listen to their

stories. For this opportunity, I am, as a researcher, most grateful. Based on this study, I

am confident that patients and those nurses providing their care in the future will be in

excellent hands. This study confirms the value of qualitative research in identifying an

important perspective for future planning and development of nurse managers.

References

Abelson, J. (2012, April). *Head+ Heart Together.* Presented at the Workplace Behavior
        Summit, Minneapolis, MN.

Aiken, L. (2008). Economics of nursing. *Policy, Politics & Nursing Practice*, *9*(2), 73-79.
        Sage publications. DOI 10.1177/1527154408318253.

American Organization of Nurse Executives. (2010). Press release position statement on
        the educational preparation of nurse leaders. Retrieved from
        http://www.aone.org/aone/about/2010PressReleases/12101b.html.

American Organization of Nurse Executives-AONE. (2005). AONE nurse executive
        competencies. *Nurse Leader, 3*(1), 15-21.

Anthony, M., Standing, T., Glick, J., Duffy, M., Paschall, F., Sauer, M., Sweeney, D.,
        Modic, M., & Dumpe, M. (2005). Leadership and nurse retention: The pivotal
        role of nurse managers, *Journal of Nursing Administration, 35*(3). Retrieved
        from www.ncbi.nlm.nih.gov

Anyon, J. (2009). *Theory and educational research*. New York, NY: Routledge.

Avolio, B.J., Bass, B.M., & Jung, D.I. (1999). Reexamining the components of
        transformational and transactional leadership using the multifactor leadership
        questionaire. *Journal of Occupational and Organizational Psychology, 72*, 441-
        462.

Bass, B.M. (1998). The ethics of transformational leadership. In Ciulia, J. (Ed.), *Ethics,
        the heart of leadership.* Westport, CT: Praeger.

Bass, B.M., & Avolio, B. J. (1993). Transformational leadership: A response to critics. In
        M.M. Chemers & R. Ayman (Eds.), *Leadership Theory and Research:
        Perspectives and Directions*. New York: Free Press.

Benner, P. (1984). *From novice to expert: Excellence and power in clinical nursing
        practice.* Menlo Park, CA: Addison-Wesley Publishing.

Benner, P., Sutphen, M., Leonard, V., & Day, L. (2009). *Educating nurses: A call for
        radical transformation.* Stanford, CA: Jossey-Bass.

Benjamin K., Riskus R. & Skalla A. (2011) The emerging leader: Lleadership
        development based on the Magnet model. *Journal of Nursing Administration 41
        (4), 156–158.*

Bogdan, R. & Biklen, S. (2007*). Qualitative research for education: An introduction to
        theories and methods.* Boston, MA; Pearson Education, Inc.

Bolman, L., & Deal, T. (2008). *Reframing organizations: Artistry, choice and leadership*, 4th Edition. San Francisco, CA: Jossey Bass.

Brady-Schwartz, D. B., Spencer, T., Wilson, B., & Wood, K. (2011). Transformational leadership: Implications for nursing leaders in facilities seeking magnet designation. *AORN Journal. 93*(6), 737-48. doi: 10.1016/j.aorn.2010.09.032

Brookfield, S.D. (1995). *Becoming a Critically Reflective Teacher*. San Francisco, CA: Jossey-Bass.

Brookfield, S.D. (2000). The concept of critically reflective practice. In, A. Wilson & E. Hayes (Eds.), *Handbook of adult and continuing education.* San Francisco, CA: Jossey-Bass.

Brown, E.L. (1948). *Nursing for the Future: A Report prepared for the National Nursing Council.* New York, NY: Russell Sage Foundation.

Buerhaus P.I., Staiger D.O. & Auerbach D.I. (2009) *The Future of the Nursing Workforce in the United States: Data Trends and Implications.* Jones and Bartlett, Sudbury, MA

Bureau of Labor Statistics. (2012). *United States Department of Labor.* Retrieved from http://www.bls.gov/bls/newsrels.htm#OEP

Burns, J. (1978). *Leadership*. New York, NY: Harper & Row, Publishers, Inc.

Charmaz, K. (2006). *Constructing grounded theory: A practical guide through qualitative analysis.* Los Angeles, CA: Sage Publications.

Charon, J.M. (2001) *Symbolic Interactionaism: An Introduction, an interpretation, and integration.* (7th ed.). Upper Saddle River, NJ: Prentice-Hall.

Chitty, K.K. (2001) *Professional Nursing: Concepts & Challenges* (3rd ed.). Philadelphia.PA: W. B. Saunders Company.

Clavreul, G. M. (2005). Paying your dues: Is the cost too high? *Working Nurse.* Retrieved from www.workingnurse.com

Cooper, K. (2008). *Forged in the Fire: Comparison of Career paths of Baccalaureate Nurses Professional Education.* Unpublished dissertation, University of St. Thomas; St. Paul, MN.

Creswell, J. (2007), *Qualitative Inquiry & Research Design: Choosing Among Five Approaches,* Thousand Oaks, California: Sage Publications, Inc.

Crosby F.E. & Shields C.J. (2010) Preparing the next generation of nurse leaders: an educational needs assessment. *Journal of Continuing Education in Nursing 41,* 363–368.

Cummings, G., Lee, H., MacGregor, T., Davey, M., Wong, C., Paul, L., & Stafford, E. (2008). Factors contributing to nursing leadership: a systematic review. *Journal of Health Services Research & Policy. 13*(4), 240-248. doi:10.1258/,hsrp.2008.007154.

Dewey, J. (1929). *Experience and Nature.* La Salle, IL; Open Court Publishing Company.

Dewey, J. (1930). Three Independent Factors in Morals. *Educational Theory, 16*, 198-209

Dewey, J. (1938). *Experience and Education.* New York, NY: Touchstone.

Dewey, J. (1944). *Democracy and Education*. New York, NY: The Free Press.

Domrose, C. (2002). Mending our image. *Nurse Week News*. Retrieved from http://www.nurseweek.com/news/features/02-06/image_print.html.

Donaher, K., Russell, G., Scoble, K., & Chen, J. (2007). The human capital competencies inventory for developing nurse managers. *The Journal of Continuing Education in Nursing, 38,*(6), 277-283.

Fairholm, M. (2001). The themes and theory of leadership: James MacGregor Burns and the philosophy of leadership. Working Paper. CR01-01. The George Washington University: Center for Excellence in Municipal Management.

Fennimore, L., & Wolf, G. (2011). Nurse manager leadership development: Leveraging the evidence and system-support. *The Journal of Nursing Administration, 41*(5), 204-10*.* doi:10.1097NNA.0b013e3182171aff.

Fleming, M.L., & Kayser-Jones, J. (2008). Assuming the mantle of leadership: Issues and challenges for directors of nursing. *Journal of Gerontological Nursing, 34*(11). Retrieved from JOGNonline.com.

Foucault, M. (1977) *Power/Knowledge: Selected interviews & other writings 1972-1977.* New York, NY; Pantheon Books.

Given, L., (2008). Symbolic Interactionism. *The sage encyclopedia of qualitative research methods, 2,* 848-853*.* Thousand Oaks, CA: Sage publications.

Glaser, B., & Strauss, A. (1967) *The Discovery of Grounded Theory: Strategies for Qualitative Research,* Piscataway, New Jersey; Transaction publishers.

Goffman, E. (1959). *The presentation of self in everyday life*. New York, NY; Anchor Books, Doubleday.

Goleman, D. (1995). *Emotional Intelligence: Why it can matter more than IQ*. New York, NY: Bantam Dell.

Goleman, D. (1998). *Working with emotional intelligence*. New York, NY: Bantam Books.

Goleman, D. (2000). What makes a leader?*Harvard Business Review.* Reprint R0401H, 2-13.

Greene, M. (1988). *The dialectic of Freedom,* New York, N.Y: Teachers College Press.

Griffith, M. B. (2012) Effective succession planning in nursing: a review of the literature. *Journal of Nursing Management,20,900-911.* Doi:1111/j. 1365-2834.2012.01418.x

Hernez-Broome G., & Hughes, R. (2004). Leadership development: Past, present and future. *Human Resource Planning, 27.*

Holton, J. (2010). The coding process and its challenges. *Grounded Theory Review, 1(09). (pp.1-15)*

Institute of Medicine (IOM), (2010). *The report on the future of nursing: Leading change, advancing health.* Washington, DC: National Academy of Sciences.

Johansson, G., Andersson, L., Gustafsson, B., & Sandahl, C. (2010). Between being and doing- the nature of leadership of first line nurse mangers and registered nurses. *Journal of Clinical Nursing, 19,* 2619-2628. doi:10.1111/j.1365-2702.2010.03211.x

Jones, R. (2010). Preparing tomorrow's leaders: A review of the issues. *Journal of Nursing Administration. 40*(4), 154-157. doi:10/1097.NNA.0b013e3181d40e14

Jones, C., & Gates, M. (2007). The costs and benefits of nurse turnover: A business case for nurse retention. *OJIN: The online Journal of Issues in Nursing. 12*(3). doi:10.3912/OJIN.Vol.12,No03,Man4.

Jooste, K. (2004). Leadership: a new perspective. *Journal of Nursing Management, 12*(3), 217-223.

Kalisch, P.A., Kalisch, B.J. (2004). *American Nursing: A History, Fourth Edition.* Philadelphia, PA: Lippincott Williams & Wilkins

Kark, R., Shamir, B., & Chen , G. (2003). The two faces of transformational leadership: Empowerment and dependency. *Journal of Applied Psychology*, *88,* 246-255.

Kleinman, C. (2003) Leadership roles, competencies, and education: How prepared are our nurse managers? *The Journal of Nursing Administration, 33*(9), 451-455.

Korda, H., Eldridge, G. (2001). ACOs, PCMHs, and health care reform: Nursing's next frontier. *Policy, Politics and Nursing Practice*. 12(2) 100-103. doi:10,1177/1527154411416370.

Kouzes, J., & Posner B. (2002). *The Leadership Challenge: 3ʳᵈ edition.* San Francisco, CA: Jossey-Bass.

Lysaught, J. (1981). *Action in affirmation: Toward am unambiguous profession of nursing.* United States: McGraw-Hill, Inc.

Manthey, M. (2008). Interview: Peter Buerhaus talks about the nursing shortage. *Creative Nursing, 14*(1)*.* Springer Publishing. doi: 10.1891/10784635.14.1.36.

Manthey, M. (2002). Leadership: a creative perspective. *Creative Nursing, 8*(4), 8-9. Minneapolis, MN; Creative Nursing Management, Inc.

Marshall, C., & Rossman G. (1989). *Designing Qualitative Research*. Newbury Park, CA: Sage publications.

Mathena, K. (2002). Nursing manager leadership skills. *The Journal of Nursing Administration, 32,*(3), 136-42*.*

Maxwell, J.A. (2005). *Qualitative research design: An interactive approach* (2ⁿᵈ ed.). Thousand Oaks, CA: SAGE Publications.

McAlearney, A. (2006). Leadership development in healthcare: A qualitative study. *Journal of Organizational Behavior, Special Issue: Healthcare: The Problems are Organizational not Clinical, 27(7),* 967-982*.* doi:10.1002/job.417.

McCallin A.M. & Frankson C. (2010) The role of the charge nurse manager: A descriptive exploratory study. *Journal of Nursing Management 18, 319–325.*

McCauley, C. & Van Velsor, E. (2004). The center for creative leadership-Handbook of leadership development. San Francisco, CA: Jossey Bass.

McDonagh, K. J. (2009). Leadership in innovation: Life beyond the hospital. *Nursing Administration Quarterly, 33*(4), 325-328.

Mezirow, J. (1990). *Fostering critical reflection in adulthood.* San Francisco, CA: Jossey-Bass   Inc.

Milbrath, C. (2000). *Constructions of caring: a case study of nurses in a children's hospital.* Unpublished dissertation. University of St. Thomas, St. Paul, MN.

Moyers, P. & Hinojosa, J. (2011). Continuing competency. The Occupational Therapy Manager, Fifth Edition. Jacobs, K., & McCormack, G. Eds. 485-502. AOTA Press, The American Occupational Therapy Association, Inc: Bethesda, MD.

Nicklin, W. (1993). Understanding the transition from head nurse to nurse manager. *Canadian Medical Association Journal 148,* (4): 501-504. Retrieved from http://www.ncbi.nlm.nih.gov/pmc/articles/PMC1490497/?page=1

Noddings, N. (2007). *Philosophy of education.* Boulder, CO: Westview Press.

Northouse, P. (2010). *Leadership: Theory and practice - Fifth Edition.* Thousand Oaks, CA: Sage Publications.

O'Connor, M. (2011). Beyond the classroom: Nurse leader preparation and practices. *Nursing Administration Quarterly, 35*(4), 333-337. doi:10.1097.NAQ0b013e31822ed1c8

Parsons, M., & Stonestreet, J. (2003). Factors that contribute to nurse manager retention. *Nursing Economics, 2*(3), Jannett Publications, Inc.

Paterson, K., Henderson, A., & Trivella, A. (2010). Educating for leadership: a programme designed to build a responsive health care culture. *Journal of Nursing Management, 18*, 78-83. doi: 10,1111/j.1365-2834.2009.01065.x

Pierson M.A., Liggett C. & Moore K.S. (2010) Twenty years of experience with a clinical ladder: A tool for professional growth, evidence-based practice, recruitment, and retention. *Journal of Continuing Education in Nursing 41 (1), 33–40.*

Porter-O'Grady, T. (1999). Quantum leadership: New roles for a new age. *Journal of Nursing Administration, 29*(10), 37-42.

Radd, S. (2007) Connecting Private Roads to Public Highways: Toward a theory of School Leadership for Social Justice. Unpublished dissertation. University of St. Thomas; St. Paul, MN.

Richardson, A., & Storr J. (2010), Patient safety: a literature review on the impact of nursing empowerment, leadership and collaboration. *International Nursing Review 57*, 12-21.

Robert Wood Johnson Foundation. (2012) Nursing leadership from bedside to boardroom: Opinion leaders' perceptions. Robert Wood Johnson Foundation. Retrieved from http://www.rwjf.org/

Roberts, C. & Coghlan, R. (2011). Concentric collaboration; A model of leadership development for healthcare organization. *Action Learning: Research and practice, 8*(3), 231-252. doi:org/10.1080/14767333.2011.617136

Rosseter, R. (2011). Nursing Shortage Fact Sheet, American Association of Colleges of Nursing. Retreived from www.aacn.nche.edu.

Senge. P. (1990). *The fifth discipline: The art and practice of the learning organization*. New York, NY: Doubleday.

Senge, P. M., & Sterman, J. D. (1992). Systems thinking and organizational learning: Acting locally and thinking globally in the organization of the future. *European Journal of Operational Research*, *59*(1), 137-150.

Sherman R. & Pross E. (2010) Growing future nurse leaders to build and sustain healthy work environments at the unit level. Online Journal of Issues in Nursing 15 (1), 4.

Stanley, D. (2008). Congruent leadership: Values in action. *Journal of Nursing Management*, *16,* doi: 10.1111/j.1365-2834.2008.00895.x

Sullivan, J., Bretschneider, J., & McCausland, M. (2003). Designing a leadership program for nurse managers: An evidence driven approach. *The Journal of Nursing Administration, 33* (10), 544-9.

Svoboda, V. (2012). Constructing Class: Exploring the Lived Experience of White Female Student Affairs Professionals from Working Class Families

Tanner, C. & Weinman, J. (2011). It's all about leadership. *Journal of Nursing Education, 50 (5)* doi:10.3928/01484834-20110419-01.

Upeniaks, V. (2003). What constitutes effective leadership? Perceptions of magnet and nonmagnet nurse leaders. *The Journal of Nursing Administration, 33* (9), 456-467.

Valentine, S. (2002). Nursing leadership and the new nurse. Retrieved from http:/juns.nursing.arizona.edu/articles/Fall%202002./valentine.htm.

Westphal, J. 2012. Characteristics of nurse leaders in hosptials in the USA from 1992-2008. *Journal of Nursing Management, (20) p. 928-937.* DOI:10.1111/j.1365-2834. 2012.01403x.

Wolf G.A., Bradle J. & Greenhouse P. (2006) Investment in the future: a 3-level approach for developing the healthcare leaders of tomorrow. Journal of Nursing Administration 36 (6), 331–336.

Wong, C., & Cummings, G. (2009). Authentic leadership: A new theory for nursing or back to basics? *Journal of Health Organization and Management, 23*(5). doi:10.1108/14777260910984014

Yahi, C. M., (2000). Critique *of Peter M. Senge's "The fifth discipline: The Art and Practice of the Learning Organization."* Retrieved from http://glori.kenan-flager.unc.edu/airspace/ NUS archive/ Organization/Org00-3/sengeCr.html.

Appendix A

The Leadership Development of Nurse Managers: Potential Participant Email

To potential study participants:

    As I begin to research and complete my dissertation, I am seeking individuals who are willing to participate in interviews around the topic of your experiences as you developed from a staff nurse to a Nurse Manager. I am interested in what contributed to your development as well as the challenges. This is a great opportunity to let your voice be heard regarding your perspectives on your leadership development journey as a nurse. You are receiving this email because you have been identified as someone who is currently or has in the past, been in a Nurse Manager role. I appreciate you considering the possibility of taking part in this activity.

    Please contact me if you are willing to participate or have questions. I look forward to hearing from you.

Thank you,

Rebecca McGill

Appendix B

Demographic Data Collection-Nurse Manager Leadership Development Study

Data Requested	Participant's Data
Organization	
Education (degree) A.D, BSN, MSN< etc	
Age	
# Years of experience as a nurse	
# Years of experience as a nurse manager	
Male/ Female	
Approximate Number of direct reports	

*Please fill out this form and return to me to help me track the make-up of the participants study

Appendix C

The Leadership Development of Nurse Managers-Interview Questions

1. Tell me about your experience as a nurse and your transition into leadership?

2. What was most helpful to you in this transition?

3.   What were some particular challenges?

4. How did your formal education preparation prepare you as a leader?

5. What types of structured leadership development opportunities were most helpful?

    Prompt if needed: Such as orientation, continuing education, leadership classes?)

6. What experiences along the way have been helpful in shaping you as a leader?

7. How would you describe your own leadership?

8. Do any symbols or images come to mind?

9. What advice do you have for new and developing leaders?

10. Is there anything you would like to add as you reflect on your leadership development

    that I have not asked about?

Appendix D

CONSENT FORM
UNIVERSITY OF ST. THOMAS

The Leadership Development of Nurse Managers

IRB #398903-1

I am conducting a dissertation study about *the experience/process of leadership development of nurse managers. I invite you to participate in this research. You were selected as a possible participant because of your current or previous nurse manager role.*
I invite you to participate in this research. Please read this form and ask any questions you may have before agreeing to be in the study.

This study is being conducted by: *Rebecca McGill, a doctoral student at the University of St. Thomas, School of Education, Department of Leadership, Policy and Administration.*

Background Information:

The purpose of this study is: *to understand how Nurse Managers develop as leaders. Some aspects of leadership development to be explored are formal educational preparation, orientation to the nurse manager role, on the job training, experience, professional identity, etc. I am interested in what contributed to leadership development as well as the challenges.*

Procedures:

If you agree to be in this study, I will ask you to participate in a 60 to 75 minute interview as well as phone or email follow-up with additional questions, if necessary.

Risks and Benefits of Being in the Study:

The study has minimal risks that may include discovery of your participation by your co-workers or employer. To mitigate risks, I will use pseudonyms for participant, organization, and unit names in the interview transcriptions. Your participation in this study will remain anonymous.
 The direct benefits you will receive for participating in this study include the opportunity to reflect and share your experience with other leaders.

Confidentiality:

The records of this study will be kept confidential. In any sort of report I publish, I will not include information that will make it possible to identify you in any way.   The types

of records I will create include recordings, transcripts, personal notes, and analysis. My dissertation committee will review the transcripts, notes, and analysis. I will destroy hard copies of analysis summaries once reviewed with my committee, and I will erase digital recordings once they have been transcribed. I will store transcriptions and copies of my analysis and notes on locked files on my personal hard drive for the purposes of my research and dissertation.

Voluntary Nature of the Study:

Your participation in this study is entirely voluntary. Your decision whether or not to participate will not affect your current or future relations with the University of St. Thomas. If you decide to participate, you are free to withdraw at any time. Should you decide to withdraw data collected about you *will be used.* You are also free to skip any questions I may ask if you do not wish to answer.

Contacts and Questions

My name is *Rebecca McGill.* You may ask any questions you have now. If you have questions later, you may contact me at (612) 270-901385-4884. You may contact my dissertation chair, Dr. John Holst, at (651) 962-4433. You may also contact the University of St. Thomas Institutional Review Board at 651-962-5341 with any questions or concerns.

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

Statement of Consent:

I have read the above information. My questions have been answered to my satisfaction. I consent to participate in the study. I am at least 18 years of age.

_____ _____

Signature of Study Participant **Date**

_____

Print Name of Study Participant

_____ _____

Signature of Researcher **Date**

_____ _____

Signature of Chair **Date**

Appendix E

INFORMED CONSENT PROCESS

Project Name	The Leadership development of Nurse Managers		
Researcher Name	Rebecca L. McGill	**IRB Tracking Number**	398903-1

Informed Consent
- Simply giving a consent form to a subject does <u>not</u> constitute informed consent. Consent itself is a process of communication.
- Be sure all required consent forms are attached to your project.
- In addition to consent forms, assent forms are required if your subjects are children ages 10 and older.
- All forms are located in the document library.

Describe Study
In a script, state what you will say to the prospective participant describing your study.

I am conducting a qualitative study looking at the Nurse Manager perceptions of the process of their leadership development. I invite you to participate in this research. You were selected as a possible participant because of your current or previous nurse manager role. .

Participant Questions
What questions will be asked to assess the participant's understanding of his/her participation in your research? Identify 3-5 open-ended questions (not "yes/no" questions) that address procedures, risks (if any), confidentiality and voluntariness.

1. What is your understanding of this research project, and your participation?
2. What concerns do you have regarding your selection for participation in this research project?
3. What questions or concerns do you have regarding confidentiality, risks, and/or benefits that I can answer prior to starting the interview?
4. Who will you contact if questions or concerns arise around this research project after our interview is complete?

Obtaining Consent
At what point in the research process will consent be obtained? Be specific.

At the time of the interview, prior to the interview.

Will the investigator(s) personally secure informed consent for all subjects?	Yes	☒	No	☐
If **NO**, identify below the individuals who will obtain consent (include job title/credentials):				