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A Transformational Leadership Program: A Necessity in Today's Healthcare Environment

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Capstone Project

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Background and Significance

Leadership is an essential component in most aspects of a nurse's role. This component of practice is not always considered as important as other areas, particularly clinical skills. However, effective nurse leaders are critical in today's fast-changing and uncertain healthcare environment. Competent leaders positively influence the nursing work environment, staff retention, patient safety, and quality outcomes (Curtis, De Vries, Sheerin, 2011). Healthcare organizations must continue to develop and support leadership training, while also seeking ways of maintaining and promoting leadership development in practice. Leadership competencies, when effectively taught and integrated into nursing practice, impact nurses' leadership skills and practice.

Leaders who display an authentic and transformational leadership style allow for the recognition of needed change and are capable of guiding change by inspiring followers and creating a sense of commitment. These qualities allow the nurse leader to feel more comfortable and confident when engaging in the development of themselves and those around them. Thus, it is imperative that in today's nursing realm, healthcare leaders identify and grow the skill sets that are necessary for future nurse leaders (Huston, 2008). The identification and development of the skill set needed for a nurse leader to successfully lead a team to high-quality patient care, as well as patient and staff satisfaction is vital to the formation of a new generation of nurse leaders (Zori & Morrison, 2009).

Purpose

The purpose of this project was to enhance the leadership capabilities of the nursing leaders in a 225 bed community hospital by implementing a leadership development course. The

leadership principles described by Kouzes and Posner (2012) provided the framework for the course.

Literature Review

Significance of Leadership in Healthcare

Leadership in healthcare has been defined as "the process of engaged decision making linked with actions taken in the face of complex, uncharted, or perilous circumstances present in clinical situations for which no standardized solution exists" (Yoder-Wise, 2011, p .5). Universally, leadership is described as a process of one person influencing others towards goal attainment (Kelly, 2008). Today, nurse leaders are located in all positions throughout healthcare organizations. These roles can be administrative, managerial, educational, as well as at the bedside. As healthcare structures become flatter and less hierarchical, leadership has transitioned to become more about influencing others than about the position the individual holds (Ferguson & Brindle, 2000).

The nurse leader plays a critical role in healthcare. This individual sets the tone of any healthcare organization and can be seen as the backbone of the clinical unit. The quality of patient care, as well as staff recruitment and retention success, resides with this key role. Over time it will be the strength of the nurse leader group that determines the success or failure of the organization (Zori & Morrison, 2009).

Financial Implications of Effective Leaders

Healthcare is a complex industry, requiring a diverse group of health care professionals to lead initiatives for efficient and effective patient care delivery. Nursing leaders are central members in these leadership teams. The responsibility of the nurse leader is to lead healthcare systems in clinical, operational, patient safety, and patient satisfaction processes and outcomes.

This is an evolving role requiring specific competencies for success in this position (Rudisill & Thompson, 2012).

Effective nursing leadership is associated with greater work satisfaction among staff nurses and is a key factor in staff nurse retention (Kleinman, 2004). The estimated cost of replacing one nurse is $66,560 to $133,120, depending on the specialty and unit requirements. These costs encompass recruitment, orientation, overtime expenditures when vacancies occur, and using agency staff for filling schedule holes. In the current economy, with hospitals reporting a decrease in nursing turnover and vacancy rates, Chief Nursing Officers may not see these expenditures as threats to the organization's success (Sanford, 2011). Nonetheless, as the country's financial outlook recuperates, staff vacancy and retirement rates will amplify as some nurses retire and others pursue different career opportunities. Additionally, it is projected that the nursing shortage will rise to 260,000 vacant positions by 2025. Innovative and different nursing career opportunities in the shifting gamut of care model will intensify the lack of staff. Thus, it is apparent that healthcare organizations need to take the steps to entice and retain a capable and proficient nursing staff. Since nursing turnover is directly affected by nursing management skills, the price of ignoring effective nurse leadership development will only become more important as significant changes in healthcare occur (Sanford, 2011).

McGuire and Kennerly (2006) administered a survey to 63 nurse managers and 500 staff nurses from 21 not-for-profit hospitals in the Midwest and found that the leadership skills and talents of nurse managers made a significant impact on the achievements and outcomes of these acute care hospitals. Staff attitudes and rapport were influenced by nurses who held leadership positions. These findings indicate that the manner in which the nurse manager implements the leadership role can have a substantial influence on the milieu of the unit as well as the level of

organizational loyalty the staff demonstrate. The nurse manager who positively impacts the work setting and nurtures the staff's loyalty to the hospital encourages greater success for the unit as well as improving the hospital's viability.

Nursing turnover is not the only expenditure experienced when a healthcare organization is lacking in solid and effective clinical management and leadership. Leadership is needed to advance quality initiatives that are important to patients and the hospital's financial viability. Value-based purchasing connects information on the quality of health care, including patient outcomes and health status, with data on expenditures towards health. It focuses on managing the use of the health care system to reduce inappropriate care and identifies and rewards the best-performing providers and organizations (Meyer, Rybowski & Eichler, 1997). It is one of the greatest indicators of an organization's success. In accord with this value-based purchasing model, healthcare organizations began to accumulate incentive dollars in 2013 based on performance on both clinical and patient care quality measures (Center for Medicare and Medicaid Services, 2011). While the Centers for Medicare & Medicaid Services and other payers execute the value-based purchasing model, hospital-acquired conditions will pose an expense consequence since these conditions will no longer be reimbursable (Sanford, 2011). Thus, the talents and competence of nurse leaders are needed to ensure fiscal sustainability of an organization by reducing the clinical care inconsistency and ensuring evidence-based care (Sanford, 2011).

The World Health Organization (2000) discovered that health care quality in the United States ranks below other developed nations. Health Grades calculates that medical errors produce approximately 195,000 deaths a year in the United States (Shapiro & Loughran, 2004). Additionally, health care spending is approaching 20% of the gross domestic product (Poisal,

Truffer, Smith, Sisko, Cowan, & Keehan, 2007). The Medicare trust fund, which covers Part A hospital reimbursement, is slated to be depleted of funds by 2019 or earlier due to the recession and decreased revenue from payroll taxes (Freking, 2008; O'Sullivan, 2008). As a result of these economic factors, CMS will no longer pay for a growing list of adverse events, and insurance companies are rapidly following (Kurtzman & Buerhaus, 2008). As these financial pressures assemble, hospitals are encouraged to improve care while decreasing costs. Perfecting operational efficiency will be critical to delivering higher quality care and advancing financial performance. This environment may be viewed as difficult, but it is also a tremendous opportunity for nursing leadership to further establish their worth in patient care outcomes and champion the financial performance of an organization. Nursing contributions concerning decreased complications, declines in length of stay, and reduced costs per case should be measured, rewarded, and made evident to the public (Hines & Yu, 2009).

As hospitals and healthcare systems build campaigns for prospering in a future of fast-paced change, creating and improving clinical leaders becomes a progressively significant focus. While Chief Financial Officers plan on how to sustain positive margins, they need to work with their Chief Nursing Officer and other clinical leaders to support a clinical leader progression plan. Working collectively, healthcare leaders can strategize about how to capitalize on the financial value that nursing leaders bring to the table (Sanford, 2011).

Transformational Leadership in Nursing

There is recognition in the healthcare field of the need for strong nursing leaders. A crucial portion of the recent Institute of Medicine report, *The Future of Nursing: Leading Change*, Advancing Health (2010), focuses on the significance of nurses as leaders in healthcare. The American Nurses Association continues to encourage and support nurses to play a proactive

leadership role in the various settings in which they practice and to become involved at the state and national level (Smith, 2011). Due to the continually changing nature of this country's healthcare system, it is vital for nurse leaders to employ a transformational leadership style, which encourages adaptation to change. The transformational leadership style allows for the recognition of areas in which change is needed. These leaders guide change by inspiring followers and creating a sense of commitment. Adopting the qualities of a transformational leader allows nurse managers to be comfortable and confident when engaging in the development of healthcare policies, the ever-changing components of healthcare technology, and the mentorship of new graduate nurses (Smith, 2011).

Transformational leadership is also one of the five Magnet components (Smith, 2011). The role of the transformational leader in the healthcare setting includes promoting teamwork among staff, encouraging positive self-esteem, motivating staff to function at a high level of performance, and empowering staff to become more involved in the development and implementation of policies and procedures. The transformational leader portrays trustworthiness and serves as an inspiration to others, possessing an optimistic, positive, and encouraging outlook. A transformational leadership presence is vital, especially in clinical areas where new graduate nurses are present. Transformational leadership qualities promote a healthy environment for employees and staff, which will produce improved staff satisfaction, retention, and patient satisfaction (Smith, 2001).

Current State

Unfortunately, many organizations are not investing resources in the development of their current and future nurse leaders that would help them build the skills needed to promote healthy, efficient, and cost-effective work environments (Sherman, Bishop, Eggenberger, & Karden,

2007). It is rare that nurse managers are given the opportunity to acquire the operational, financial, and management skills essential to their success and the success of their organization (Zori & Morrison, 2009). A proportionately critical concern, while not yet receiving as much attention is the impending lack of nurses ready to undertake leadership roles within clinical groups, professional organizations and healthcare overall (Woodring, 2004). The shortage of both leaders and leadership in nursing is a recurring theme in the nursing literature (Carney, 1999; Mahoney, 2001; Wolfe, Bradley & Nelson. 2005; Woodring, 2004). Developing leaders in both clinical and academic arenas is imperative to the nursing profession and mandates critical awareness (Woodring, 2004).

Future Needs

Formal education and support are needed for nurse managers to effectively function in their role in the current health care environment. A traditional proposal is that the difficulties of clinical care, nursing leadership, and management responsibilities be linked through education and training (Kleinman, 2003). Further, Mahoney (2001) recommends that leadership talents can be developed via leadership curricula, workshops, and professional education conferences.

This demand for leadership education programs suggests two important topics for contemplation. First, there is the concern of whether basic degrees in nursing cover leadership adequately to prepare nurses for leadership roles in professional practice or whether supplementary preparation is needed. Some authors advise that primary degrees overall do not train nurses for leadership necessary in today's organizations (Curtis, De Vries & Sheerin, 2011). Therefore, healthcare organizations should pursue other options to prepare for this by supporting and creating leadership programs and agendas.

However, there is still the question of what should be covered and how to do so. Cooke (2001) indicates that while the literature has regularly stated successful leadership is essential for superior nursing care, few policy documents outline or define what is indicated by the term *effective leadership*. In a study undertaken by the Cabinet Office Performance and Innovations Unit in the UK (2001) it was observed that programs intended to develop and enhance leaders, actually concentrate more on management than on leadership. These programs focus on universal principles in healthcare and frequently do not tackle the concerns and problems related to clinical environments and specific nurse manager issues (Curtis et al., 2011).

Furthermore, the methods used for developing leadership competencies originate from the business setting where they offer useful learning. However, these approaches need to be adapted for clinical healthcare (Cabinet Office Performance and Innovations Unit, 2001). Cummings (2008) corroborates this in a systematic review that found a lack of theoretical approach specific to leadership development in nursing. Paterson et al. (2010) advise that a key factor in creating and building a leadership program is making the program applicable to nursing leadership practice. Nurse leaders must be afforded with occasions to reflect, deeply think about, and employ new knowledge and experiences to practice, as this is vital for supporting theoretical learning. Shifting trends in financing healthcare, improvements in technology, and a change in the way patient care is provided are only a few of the alterations taking place in the healthcare setting. As a result, the function and duties of nurse managers are shifting, just as the educational demands are refocusing. Still, as Kleinman (2003) indicates, there is no reference in the professional literature in the United States concerning how nurse leaders can be equipped for the responsibility and significant challenges within healthcare.

Another essential question is whether nursing leadership should be deemed a characteristic of personality or a skill-set that can be learned by way of experience or education. Cummings (2008) found that both are necessary. Successful leaders are likely to exhibit a temperament that includes openness, extroversion, and motivation. Experience is an important factor as evidenced by the finding that older and more practiced nurses were more successful leaders.

Researchers are finding that leadership development programs can be successful and valuable to the organization. Glasman, Cibulka, and Ashby (2002) found that leadership development curriculums have a positive influence on new leaders and that leadership coaching has an encouraging influence on institutions. Experience has an important impact on leadership development, but a formal education creates a substantial influence as well (Hughes, Ginnett, & Curphy, 2006). Cummings (2008), in a review of studies, deducted that leadership can be cultivated through specialized educational modalities and by exhibiting and rehearsing leadership proficiencies.

Sherman (2013) states that the best leaders are the best learners and that personal growth should be intentional. Healthcare today is filled with unpredictability, uncertainty, and complexity and to navigate through these situations a nurse leader must keep asking questions, reviewing goals and building a knowledge base. Thus, personal growth does not just happen; a person must develop strategies for ongoing development. Intentional growth is personal development that comes from choosing to test one's self and develop the mind and ability in a very precise way. Intentional growth for a nurse leader should have an objective, a stretch experience, and a timeline (Sherman, 2013).

Leadership

A search of the databases MEDLINE and CINAHL was conducted for the years 1995-2012 using the terms "leadership qualities" and "nurse leaders." Research and peer reviewed articles only were used for the selection criteria. Additionally, articles were selected that included (a) primary studies of current nurse leaders, (b) studies including nurse leaders in a variety of clinical areas, and (c) studies conducted both in the United States and abroad. Studies meeting the selection criteria were also assessed for adequate description of methodology, sample selection and size, reliability of results and conclusions.

A total of seven articles that met the described search criteria were found. All seven of the studies were a mix of qualitative and quantitative studies. The studies took place across the spectrum of healthcare settings from inpatient, home-health, palliative care, nurse education and academia. The selected studies were from the United States, Australia and Denmark.

The articles were placed into a data review matrix (Appendix A) that included the author(s), reference, purpose/aims, study design, instruments, sample size, results, conclusions, recommendations, and limitations. Descriptive synthesis of the findings revealed four themes that were characteristics of an effective nurse manager in the health care setting: Inspiration, Communication, Mentoring, and Reflection. In the final step of the synthesis process these findings were integrated into the conceptual framework developed by Avolio and Bass (1990) known as the Full Range Leadership Theory.

Inspirational leadership. Inspirational leadership, often called Transformational Leadership, was present in four of the seven articles and was a central finding in the search (Heuston & Wolfe, 2011; Malloy & Penprase, 2010; Nielson, Randall, & Brenner 2008; Spinelli, 2006). Nielson et al. (2008) found leaders who stimulate employees to participate in decision-

making create an environment in which employees have a greater sense of well-being. This study also suggests that training managers to inspire staff, or employ transformational leadership, may bring about higher levels of staff involvement of unit process design changes. These employees may also perceive their jobs as meaningful and have a high level of influence over their peers. Heuston and Wolf (2011) found that inspiring a vision that is shared by the unit staff helps to engage the staff in aligning the unit's vision to that of the hospital. It was also noted that explaining the *why* behind the *what* inspires staff to embrace change to improve the delivery of care to patients.

Spinelli (2006) described that employing an inspirational leadership strategy correlates positively with three factors: subordinates wanting to apply extra effort during a shift, satisfaction with the leader, and crediting the leader as being more effective in the organization. Malloy and Penprase (2010) suggest that inspirational leadership creates a healthier psychosocial work environment for employees. Employees had a higher job commitment, satisfaction and stronger collegial relationships.

Communication. Crosby and Shields (2010) found communication to be the most important theme in a study of successful nurse leaders. Effective communication or people skills were illustrated as a facilitating factor that cultivates staff development. Nurse leaders who were viewed as supportive and communicative were identified as championing employee growth and creating a positive environment. Not only was effective communication identified as important with leaders and their employees, it was also noted that efficient communication needs to occur both within the inter-professional interactions and those within nursing from the top level administrator to the staff nurse (Crosby & Shields, 2010).

Heuston and Wolf (2011) found that connecting to the staff through communication is an important trait of a successful nurse leader. Personal and frequent communication sessions are vital in creating a satisfied workforce and a healthy work environment. Meaningful conversations and face-to-face meetings with each staff member involve learning about each nurse and finding specific interests. This communication interaction is important when rewarding or acknowledging the individual employee, allowing the recognition to be personal and significant. This premise is also a component of Kouzes and Posner's Five Practices of Exemplary Leadership. Kouzes and Posner (2012) coined this concept as Encouraging the Heart, which is achieved through individual and constant communication.

Mentoring. Mentoring creates a relationship with the employee that allows the leader to challenge and discuss unit concerns. Cultivating a mentoring relationship with staff provides the mentees with a freedom to talk about complex unit issues and recognize areas of apprehension. The mentoring relationship not only facilitates professional development of the employee but also creates a sense of worth and admiration between mentor and mentee (McCloughen, O'Brien & Jackson, 2009).

Heuston and Wolf (2011) similarly found that coaching and mentoring are important elements in effective leadership. Mentoring can be perceived as a way of allowing others to perform their duties at a high level. Kouzes and Posner (2007) describe mentoring as Enabling Others to Act. A competent nurse leader not only gives staff the tools to do their job, but also coaches and mentors them along the way.

Crosby and Shields (2010) describe mentoring as a strong theme identified by their respondents. Mentor relationships were noted to be an important resource that enabled both the staff and leader to achieve unit goals and foster a positive work environment. Nurturing the

mentor-mentee relationship elevates the professional environment of the unit as well as the environment of the hospital.

Reflection. Reflection is a theme identified as an important trait of an effective nurse leader. Cathcart et al. (2010) found that without self-reflection, the leader's accomplishments and/or challenges can be recognized as isolated situations that can be forgotten until the next one transpires. These researchers recommend that journaling or writing down scenarios provide the leader a chance to relive the incident and begin to understand the meaning of the event. The experiential learning rooted in the narratives strengthens the fact that nursing management is a lasting process based on constant contact with varied experiences (Cathcart, Greenspsan & Quin., 2010).

Nielson et al. (2008) recognizes self-awareness as an important attribute for nurse leaders, requiring them to be mindful of the degree to which they influence staff. They also report that a feedback loop is beneficial to have in place for both the staff and manager. This feedback loop differs from journaling, but can be advantageous to continue learning from events that occur for both the nurse leader and employee.

Theoretical Framework

The Full Range Leadership Theory (Avolio & Bass, 1990) consists of four attributes of leadership, which encompass all the major themes identified in this literature review. This leadership theory, derived from the Transformational Leadership Theory, is comprised of four elements: Individual Consideration, Intellectual Stimulation, Inspirational Motivation and Idealized Influence. The Full Range Leadership Theory was first introduced by James MacGregor Burns in 1978. He initially introduced the concept of transforming leadership in his descriptive research on political leaders, but this term is now used in organizational psychology

as well. According to Burns, transforming leadership is a process in which leaders and followers help each other to advance to a higher level of morale and motivation. Burns described the difficulty in differentiation between management and leadership and claimed that the differences are in characteristics and behaviors. Avolio and Bass further expanded this theory in 1990 that additionally describes the four core elements.

Individual consideration is the ability to identify and respect the unique dignity and interests of followers. Intellectual stimulation is exemplified by the ability to engage followers in dynamic, transcendent endeavors. Inspirational motivation is the ability to live out a true commitment to the empowerment and self-actualization of each follower. Idealized influence is the authentic charisma that engenders trust among followers. Summarized, the individual who employs the Full Range Leadership Theory is a transformational leader who is authentic, self-aware and generates engagement to the same higher levels of performance, satisfaction, and commitment of followers to the group and the organization (Smith, 2001). These concepts were integrated into the leadership program implemented in this project so that the leaders could initiate positive change.

The findings of the literature review are integrated throughout Full Range Leadership Theory. The themes of Inspiration, Communication, Mentoring and Reflection that were revealed in the literature review parallel the four key components of the Full Range Leadership Theory and are encompassed in the definition of a transformational leader. These themes are also present within the Five Practices of Exemplary Leadership model as developed by Kouzes and Posner (2012), which has demonstrated effectiveness as a clear, evidence-based skill set to achieving excellence for individuals, teams, organizations, and communities. This model

explains and provides examples of how these identified themes are necessary in nursing leadership.

The Five Practices of Exemplary Leadership (Kouzes & Posner, 2012) turn the abstract concept of leadership into understandable practices and behaviors that can be taught and learned by anyone eager to accept the challenge to be a leader. As measured and validated by the Leadership Practices Inventory (LPI) (Appendix F) , which is one of the most widely used leadership assessment instruments in the world. Current studies reliably confirm that The Five Practices are connected to both the effectiveness of leaders and the level of commitment, engagement, and satisfaction of those that follow. The following paragraphs describe the Five Leadership Principles in Kouzes and Posner's (2012) leadership model.

Model The Way

This principle advises that leaders' actions speak louder than words. Leaders must become involved and demonstrate their commitment to their followers. They create standards of excellence and then set an example for others to follow. For a leader to model the way, they must be authentic, know themselves and understand the values upon which they base their actions.

Inspire A Shared Vision

With this principle, leaders must have a vision of change and must be able to eloquently share that vision with others. They passionately believe that they can make a difference by envisioning the future and creating an ideal and distinctive image of what the organization can become. Leaders generate excitement about this vision and make it real for their followers.

Challenge The Process

Successful leaders use change and innovation while searching for opportunities to change the status quo. Leaders know that risk-taking encompasses mistakes and failures, and they accept

the unavoidable disappointments as learning opportunities. Challenging the Process is about discovering and applying new and improved ways of doing things in order to continually improve and develop.

Enable Others To Act

This practice acknowledges that successful leadership and accomplishments are not the result of a single person. Leaders nurture teamwork and encourage others to exceed their own expectations. They foster collaboration and build spirited work-groups while energetically involving others.

Encourage The Heart

Successful leaders know that their followers require recognition and celebration. This fosters a strong sense of community by keeping hope and determination alive. Leaders recognize contributions that individuals make by celebrating accomplishments and recognizing the contribution each person makes (Kouzes & Posner, 2012).

Connecting the Themes

The themes pulled from the literature review of mentoring, reflection, inspirational leadership, and communication were incorporated into the leadership development program through purposeful activities during the discussion of each of the Five Practices themes. The mentoring concept was tied to Enabling Others to Act and the activity associated with this concept was the discussion of finding a mentor as well as becoming a mentor themselves. The theme of reflection was connected to Challenge the Process and participants were encouraged to journal their leadership experiences as well as discuss and debrief after difficult decisions and situations encountered with colleagues. The concept inspirational leadership was tied to both Model The Way and Inspire a Shared Vision. The participants were to take a deep look at their

own leadership values and create their own leadership brand in which to lead. The final concept, communication, is closely linked to Encourage The Heart and participants were given thank you cards to write to staff and colleagues.

Methods and Procedures

Design

This project used a pre/post intervention design.

Setting

The setting was Columbus Regional Hospital, a 250 bed facility within a regional health system serving ten counties in southeastern Indiana. The hospital provides emergency and surgical services as well as comprehensive care in numerous specialty areas. Staff include 1700 employees, 225 physicians on staff, and 250 volunteers. A network of primary and specialty care physicians works closely with the hospital and outpatient locations. Columbus Regional Health is nationally recognized for quality patient care, winning the American Hospital Association's Quest for Quality Prize, the highest quality honor awarded by the hospital industry. Other recognitions include Thomson Reuters 100 Top Hospitals recognition and Modern Healthcare's 100 Best Places to Work in Healthcare. Columbus Regional Hospital was Indiana's first Magnet designated hospital for outstanding nursing care.

Participants

The participants in this program were gathered from approximately 50 healthcare leaders employed at Columbus Regional Hospital.

Instrument

The instrument used to measure leadership skills was the Leadership Practices Inventory (LPI) developed by Kouzes and Posner (1988). The LPI is a 30 item five scale tool using a 10

point Likert scale that assesses the extent to which the leader incorporates each of the Five Practices of Exemplary Leadership into their own leadership practice. The lowest possible score on each question is one and the highest is ten. Each practice is measured by six items. A higher value represents more frequent use of a particular behavior. Respondents typically complete the assessment in 10-15 minutes. Appendix C describes the LPI instrument in the Evaluation Plan.

The Five Practices of Exemplary Leadership, which form the conceptual framework of the LPI, were derived from in-depth interviews and written case studies from optimum leadership experiences. The actions that made up the five practices were translated into behavioral statements. Following several iterative psychometric processes, the assessments were created and administered to managers and non-managers across a variety of organizations, disciplines, and demographic backgrounds. The LPI is now one of the most widely used and reliable 360 degree leadership assessment instruments in the world. Over two million leaders and their observers have completed the tool since it was available online in 2002.

Studies performed by Kouzes and Posner, along with those of other researchers, and comparisons with other leadership instruments have all shown the LPI to be reliable in assessing individuals' leadership capabilities, and demonstrating that the five practices of exemplary leaders do make a difference at the personal, interpersonal, small group, and organizational level (Kouzes & Posner, 1988). The LPI has assisted in assessing individuals' leadership behaviors and in providing feedback useful for developing and enhancing leadership capabilities.

The Leadership Practices Inventory has demonstrated sound psychometric properties. Following a change in response scale from five-point to ten-point in 2007, factor analysis was performed to examine construct validity (Kouzes & Posner, 2007). While some statements loaded on more than one factor, their highest loading was generally with the other statements

conceptualized as comprising that factor. These results provide continued empirical support for the various leadership behaviors to be conceptualized within five practices which include challenging, inspiring, enabling, modeling, and encouraging. Findings are relatively consistent across gender, ethnicity and cultural backgrounds, as well as across various organizational characteristics.

Internal reliability, as measured by Cronbach's alpha, continues to be strong in the revised version, with all scales above the .75 level (see Table 2). This is true for the Self version as well as for all Observers and for each Observer category (Kouzes & Posner, 2007).

Table 2. Internal Reliability of LPI

Leadership Practice	Self	Observers (All)	Manager	Direct Report	Co-Worker or Peer	Others
Challenge	.80	.89	.89	.90	.88	.88
Inspire	.87	.92	.92	.92	.91	.91
Enable	.75	.88	.86	.89	.87	.88
Model	.77	.88	.86	.90	.87	.87
Encourage	.87	.92	.92	.93	.92	.93

Intervention

The intervention for this project was a leadership development course that incorporated the leadership principles of Kouzes and Posner (2013). The program consisted of three sessions, approximately one month apart, with each session 3-4 hours in length (Figure D). Each leadership class included a didactic portion and learning activities. The three course instructors were nurses in leadership positions; two were Directors and one functioned as a Chief Nursing

Officer. Two of the instructors possessed a Doctorate of Nursing Practice degree and the third a Master's of Science in Nursing

First Session

The first class began with a review of each participant's personal LPI 360 results. Action plans based on the participant's lowest scoring principles were developed by each leader using the Kouzes and Posner workbook. The first leadership principle, Model the Way, was presented and reinforcement activities were completed using YouTube videos and discussion of leadership articles written by Kouzes and Posner. Participants were given homework to complete before the next class. This homework included sharing the Action Plan with their own leader and with colleagues as well as sharing the leadership article with their own staff members.

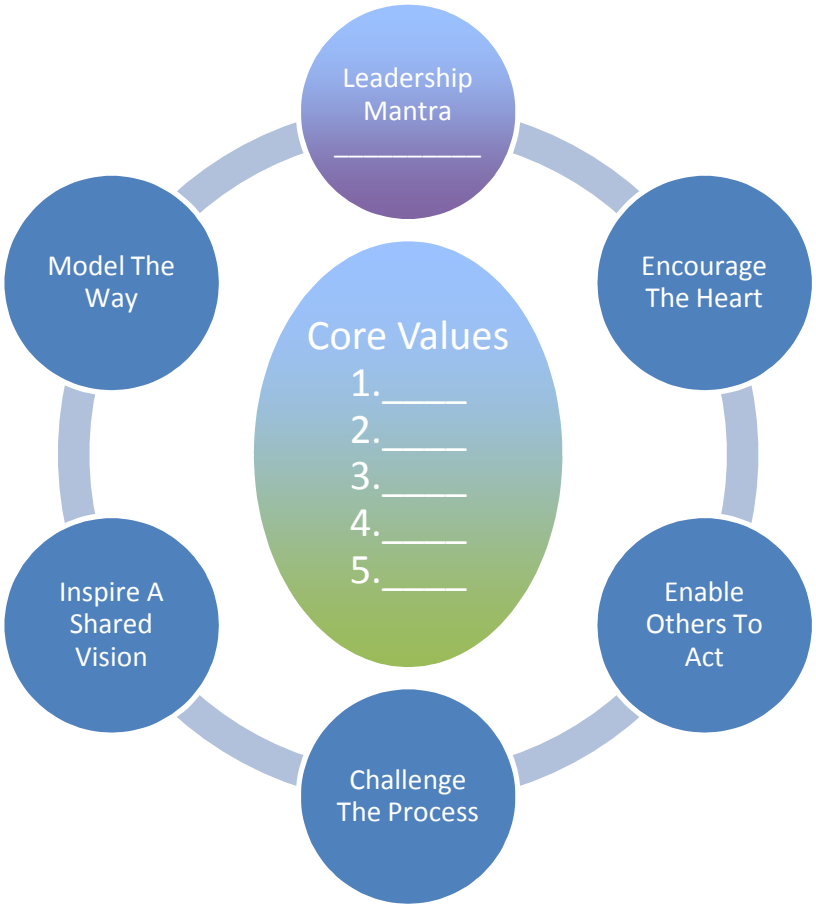
Second Session

This class included a presentation of the remaining principles of Inspire a Shared Vision, Challenge the Process, Enable Others to Act, and Encourage the Heart. This was followed with activities related to these three principles using YouTube videos and Kouzes and Posner leadership articles. Additionally, the participants were placed in groups to demonstrate and act out each of the five principles using props and building blocks. Homework was given to the participants that included continued work on their Action Plans, planning a meeting or a lunch with a colleague or staff member to begin a mentoring relationship with them, writing a thank you card to someone they work with, and sharing the YouTube clips and leadership articles with their staff.

Third Session

During the last class day all five Kouzes and Posner Leadership Principles were reviewed and participants were asked to give examples of how they demonstrated those principles over the past month. Additionally, individual action plans were reviewed. During the class, participants were asked to determine and rank their own Core Values as well as write down their 'Leadership Mantra.' These Core Values along with the Leadership Mantra were placed on a diagram and integrated into the Kouzes and Posner Leadership Principles through the pairing of these principles and each participant's Core Values (Figure 1).

Figure 1. Core Values and Leadership Mantra Schematic



YouTube videos were again used to illustrate the leadership principles and inspire deep thought into each person's leadership skill set. At the end of the class, each participant was asked to articulate their own personal take-away from this leadership course.

At the conclusion of each class, participants were instructed to complete evaluation forms which were then given to the American Nurses Credentialing Center activity sponsor from Norton Healthcare. Nine Continuing Education credits approved by the American Nurses Credentialing Center were given to the participants upon completion of the program.

Data Collection

An initial session was held with participants to explain the purpose of the study and to collect pre-intervention data. Instructions were given on how to complete the LPI. Envelopes were marked with an identification number known only to the researcher and were distributed to each participant. Each envelope contained: seven LPI's marked Self (1), Manager/Supervisor (1), Observer (2), and Direct Report (3); envelopes for each LPI that were sealed for privacy; consent form; sociodemographic form; and instructions on how to return the completed forms to the designated LPI Champion at CRH. The LPI Champion was the internal contact for the staff at CRH if the participants needed assistance. The LPI Champion was chosen due to their location in the administrative office and their knowledge of this research project. Both the consent form and the sociodemographic form (Appendix G) were collected at the end of this initial meeting. The participants were given two weeks to complete and return the other LPIs to the CRH Champion.

The first class session began two weeks after this initial session. Participants completed a second LPI 3 months after the conclusion after the last session. This session with the leadership group lasted about an hour and they were given two weeks to return the LPI's to the LPI champion at CRH.

Data Analysis

The researcher processed each of the participant's pre and post LPI survey forms and entered them into a purchased database from Kouzes and Posner. This database generated each participant's pre leadership course LPI results and it was given to the participants on the first day of the course. Three months after the conclusion of the course the post LPI was given and those results were calculated using the database. The participant received a report that demonstrated the changes in their leadership scores in each of the five Kouzes and Posner constructs.

Data were analyzed using SPSS version 17.0. Paired samples t-test was used to compare the leadership practices of the sample before and after the leadership course intervention. Descriptive statistics were used to determine sample characteristics.

Sample Characteristics

A total of 41 healthcare leaders completed the pre-LPI survey. Post-LPI surveys were completed by all 37 of the reminding 39 participants in July of 2014. Data were categorized based on four cohorts of leadership positions:

- 'senior leaders' were the most senior management roles reporting to the hospital president
- 'directors' were the administrative and clinical leaders reporting to the Chief Nursing Officer
- 'managers' were the middle managerial level reporting to directors who had direct reports
- 'leaders in operational roles' were the coordinators or leaders who spanned the organization and who did not have direct reports

Two leaders left the organization during the course of the study. Two leaders did not complete their post LPI survey, 20 of the participants did not have a Manager complete the post

LPI survey, 4 of the participants did not have their Co-worker complete the post LPI survey, and only 16 of the participants had Direct Report LPI's completed.

The age range of the healthcare leaders in all job stratifications was between 29 and 64 years with the mean age of 49. The entire sample had an average of 25 years of experience within healthcare, 19 years of experience at CRH, and six years of experience in their current position. While most of the leaders in the sample were female, the manager cohort had the largest male percentage (16.7%). Baccalaureate degrees were more prevalent in operational role leaders and accounted for 51% of the total sample. Fifty nine percent of the sample held a certification and 69% of the sample had leadership training in the past (Table 2).

Table 2

Sample Charateristics

	Senior leaders	Director	Managers	Leaders in Operational Roles
Pre-course data	(n = 2)	(n = 5)	(n = 18)	(n = 16)
Age (mean/SD)	53 5	51 6	47 11	50 10
Gender Count (%)				
Female	2 (100%)	5 (100%)	15 (83%)	16 (100%)
Male	0	0	3 (17%)	0
Highest credential count (%)				
PhD	0	1 (20%)	0	0
Masters	2 (100%)	1 (20%)	3 (17%)	3 (19%)
Baccalaureate	0	1 (20%)	10 (56%)	11 (69%)
Diploma	0	1 (20%)	3 (17%)	1 (6%)
Other	0	1 (20%)	2 (11%)	1 (6%)
Years worked in profession (mean/SD)	32 9	31 5	24 10	25 12
Years worked at CRH (mean/SD)	4 3	21 14	20 13	18 11
Years worked in current job (mean/SD)	4 3	12 13	7 7	5 6
Certification held				
Yes	2 (100%)	1 (20%)	9 (50%)	12 (75%)
No		4 (80%)	9 (50%)	4 (25%)
Previous leadership course				
Yes	2 (100%)	5 (100%)	16 (89%)	5 (31%)
No			2 (11%)	11 (69%)

LPI

Paired samples t-tests of the LPI pre/post intervention are displayed in Table 3. All five subscales of the LPI increased significantly for both participant ratings (Self LPI) and the manager/supervisor (Manager LPI). Two additional subscales reached significance: ‘enable others to act’ assessed by co-workers (Co-worker LPI) and ‘inspire a shared vision’ assessed by direct reports (Direct Report LPI).

Table 3.

Paired Samples t-tests of Pre- and Post-LPI Scores (n= 37)

Subscale	Pre - LPI Mean (SD)	Post - LPI Mean (SD)	*t value*	*p*
Self LPI (*n* = 37)				
Model the way	7.7 (1.1)	8.2 (0.9)	-2.26	**0.03**
Inspire a shared vision	7.0 (1.4)	7.6 (1.2)	-2.21	**0.03**
Challenge the process	7.0 (1.3)	7.7 (1.0)	-3.19	**0.00**
Enable others to act	8.1 (0.9)	8.5 (0.8)	-2.90	**0.00**
Encourage the heart	7.3 (1.5)	7.8 (1.0)	-2.05	**0.04**
Manager LPI (*n* = 21)				
Model the way	8.1 (1.0)	8.7 (1.0)	-3.55	**0.00**
Inspire a shared vision	7.5 (1.1)	8.5 (1.1)	-5.14	**0.00**
Challenge the process	7.7 (1.2)	8.4 (1.2)	-4.46	**0.00**
Enable others to act	8.1 (0.9)	8.9 (0.9)	-3.88	**0.00**
Encourage the heart	7.8 (1.2)	8.9 (1.1)	-4.80	**0.00**
Co-worker LPI (*n* = 35)				
Model the way	8.3 (0.9)	8.6 (1.3)	-1.50	0.14
Inspire a shared vision	8.0 (0.9)	8.4 (1.1)	-1.28	0.20
Challenge the process	8.1 (1.0)	8.4 (1.4)	-1.20	0.24
Enable others to act	8.2 (0.9)	8.8 (1.0)	-2.01	**0.05**
Encourage the heart	8.1 (1.0)	8.5 (1.6)	-1.23	0.23
Direct Report LPI (*n* = 16)				
Model the way	8.4 (1.1)	8.7 (0.8)	-1.09	0.29
Inspire a shared vision	7.4 (1.8)	8.4 (1.0)	-2.63	**0.02**
Challenge the process	7.8 (1.3)	8.4 (0.7)	-2.05	0.06
Enable others to act	8.8 (0.7)	8.7 (0.8)	0.16	0.87
Encourage the heart	8.5 (1.3)	8.7 (0.7)	-0.60	0.56

SD, Standard Deviation
Statistical significance set at $p \leq 0.05$. Significant results are in bold

Participant Feedback

Participant feedback from the leadership class was very positive and demonstrated understanding of the five leadership principles described by Kouzes and Posner. The importance of knowing oneself and one's core values was a common feedback theme throughout the program and was discussed in-depth during the last session. This is represented by the Core Values and Leadership Mantra Schematic that was introduced in Session Three. It was suggested that the leaders post this schematic in their offices as a constant reminder of their values and leadership mantra.

Another key theme involved understanding the difference between being a leader and a true authentic leader via the teachings of Kouzes and Posner. Actually implementing and improving upon the five principles of leadership allowed participants to move past functioning as a leader by title to employing a transformational leadership style. Participants appreciated understanding their own blind spots and being able to develop a plan to work on them. The Kouzes and Posner workbook with the pre-LPI survey results provided a framework for participants to use during the program to improve in their low scoring constructs.

Finally, participants realized that in order for leadership growth to occur, they need to enjoy the leadership journey and celebrate the successes that not only they achieve, but what their team accomplishes as well. Participants found support within the group and enjoyed completing the course together, developing relationships with colleagues, and initiating friendships. They felt like each session was a 'gift' and a nice break from the daily busyness of their units.

Ethical Considerations

Participation in this project was voluntary. All participants signed an informed consent. In order to protect anonymity and strengthen the study, code numbers were used to identify questionnaires. This allowed for linking sequential responses while maintaining anonymity. Full transparency about the data collection process was discussed with participants during the introduction of the LPI assessment. The results of each participant's LPI assessment were kept confidential, with only the researcher having the code list. This list was kept in a locked file cabinet in the researcher's office and was destroyed at the completion of data analysis. Only aggregate data was reported. Final results of the study were shared with participants.

Resources Needed and Estimated Costs

This leadership program was estimated to cost approximately $8,235. Factored into these costs were the donated student and facilitator costs, which made up 77% of the total cost of the program. Columbus Regional Hospital purchased the LPI workbooks, the Kouzes and Posner LPI Facilitators Guide, and office supplies needed for the sessions. CRH provided the meeting space and computer/projector needs for each session at no cost (Figure F).

Discussion

The results of this project indicate that transformational leadership skills can be successfully taught and integrated into leadership practice. For ratings by both leaders and managers, each subscale of the LPI improved significantly following the leadership development program. The mean scores for subscales rated by co-workers and direct reports increased except for one ('enable others to act' rated by direct reports), and two reached significance: 'enable others to act' rated by co-workers and 'inspire a shared vision' rated by direct reports. It may be

that a longer period of time is needed for co-workers and direct reports to observe changes in their leader's behaviors.

The course was successful due to the high engagement of the leadership staff at CRH. They were engaged during each of the sessions and actively gave feedback to the instructors. The participants took the course seriously as reflected in the return rate of the surveys as well as the positive feedback post-course. The YouTube videos that were used during the course were the most successful tool used during the sessions as these were then shared with the staff members of the participants.

Limitations

The current study was limited by an absence of probability sampling with reduced generalizability. All leaders within CRH were encouraged to participate in the course and all opted into the study. Future studies with larger sample size are needed to determine generalizability.

Challenges

Attrition was an issue during the leadership course. The Chief Nursing Officer left the organization between the third session and the post-LPI survey, possibly affecting some of the participant responses. Additionally, two of the participants moved on to other organizations during the study timeframe.

During each of the three sessions, 3-6 of the participants were absent indicating the need for make-up sessions. These make-up sessions were completed via conference call. The structure of the make-up sessions could have limited participant understanding of the concepts and thus affected the post-LPI scores. Other researchers have identified these difficulties in planning time away from the unit to commit to a leadership program (O'Neil, Morjikian, Cherner, Hirschkorn,

& West, 2008; Stichler, 2008). Nurse leaders and their supervisors plan for the time away from the unit in order for successful completion and to ensure that optimal learning can occur.

The results of this study may be difficult to sustain, especially with the turnover in administration at CRH. New administrators must be committed to the growth and development of their leaders through purposeful planning of monthly, quarterly, and annual exposure to these leadership principles. This support will be needed to sustain the momentum, energy, and motivation of this group and to see continued growth in their transformational leadership skill set.

Recommendations for Future Leadership Courses

A recommendation from participants is to include assistant nurse managers and those nurses identified as 'high potential's' in future leadership courses. The participants felt that this would help develop these emerging nurse leaders by giving them exposure to these principles. Stichler (2008) points out that in many organizations very little attention is dedicated to succession planning and the development of emerging nurse leaders at the point of care.

A second recommendation is to meet more frequently than the three class days in order to have shorter meeting times, thus improving the participant attendance. Although make-up sessions were completed via conference call, twice monthly shorter sessions may help improve attendance for the next leadership course.

Additionally, since nurses are located in positions throughout the healthcare setting, it would be important to offer this course in settings outside the acute care space. Transformational nurse leaders are needed in all areas of healthcare including long-term care, insurance and process improvement.

Conclusion

In the present study, a leadership development course led to increases in Self, Manager, Co-worker, and Direct Report-assessed transformational leadership practices. The leadership course gave the participants an opportunity to define their own core values and understand their leadership style. It also helped foster the participant's relationships among each other and improve the camaraderie with the CRH leadership team. It is critical for nurse leaders who are responsible for the daily operations of nursing units to possess the transformational leadership characteristics outlined by Kouzes and Posner's Five Leadership Principals. An effective and successful nurse leader is invaluable to the retention of satisfied and professional nurses and is a key player in the successful operation of a healthcare organization. Positive results such as nurse retention, patient and staff satisfaction, effective work environments and quality patient outcomes have all been shown to be linked with leadership that engages in these behaviors (Heuston & Wolf, 2011). Leadership programs need to be embraced and employed. Strong, developed leaders can position an organization to be a viable and admired healthcare organization during these tenuous financial times. With an end to the nursing shortage nowhere in sight, nursing does an injustice to itself by not preparing more nurses for leadership roles. In this new era of healthcare, nursing must make a committed and faithful effort to foster and encourage its young to develop into effective, motivating and authentic nurse leaders (Valentine, 2000).

Appendix A
Review Matrix

Review Matrix

Citation (Authors and year)	Purpose / Aims	Study Design/ Instrument(s)	Sample size	Results	Conclusions / Recommendations	Quality of Evidence *
Crosby, F. & Shields, C. (2010) Preparing the next generation of nurse leaders: An educational needs assessment. *The Journal of Continuing Education in Nursing 41*(8) 363-368.	To determine the educational needs of a nurse leader through a questionnaire, describing items that facilitate or are a barrier to leadership development.	Convenience Sample, Questionnaire	N=85	Themes: people skills or a mentoring environment were positive. Increased communication, creating a trusting environment, and encourage new ideas from their staff	Leaders are more likely to be successful (i.e. positive outcomes) if they were skilled communicators, create a trusting environment, and encourage new ideas	Level V
Cathcart, E., Greenspan, M., & Quin, M. (2010) The making of a nurse manager: the role of experiential learning in leadership development. *Journal of Nursing Management 18*, 440-447.	To articulate the experientially acquired knowledge, skill and ethics embedded in NM practice	Convenience sample, First person narratives	N=32	Reflection is important to the NM development	Journaling (writing down experiences) is important for the NM herself, but can also be beneficial to others to learn from mistakes or a situation was handled	Level VI
Nielson, K., Randall, R., & Brenner, S. (2008) The effects of transformational leadership on followers' perceived work characteristics and psychological well-being: A longitudinal study. *Work & Stress 22*(1) 16-32.	To examine the mechanisms through which transformational or "inspiring" leadership behavior influences employee well-being.	Longitudinal Design, Global Transformational Leadership Scale (2000)	N=188	Transformational leadership and an employee well-being were linked	Followers experience a meaningful work environment, role clarity, and opportunities for development with leaders that generate awareness and the commitment of individuals to the mission of the group.	Level V
Spinelli, R. (2006) The applicability of Bass's model of transformational, transactional, and laissez-faire leadership in the hospital administrative environment. *Hospital Topics: Research and Perspectives on Healthcare 84*(2). 11-18.	To evaluate empirically in the hospital setting the relationship of leadership behaviors to subordinates perceived outcomes	Purposeful sampling, Multifactor Leadership Questionnaire	N=101	Leader effectiveness, willingness to exert extra effort and self reported satisfaction was correlated with transformational leadership. Trust is also important.	Findings support the Full Range Leadership Theory, CEO's had both transformational and transactional qualities	Level V
Heuston, M. & Wolf, G. (2011) Transformational leadership skills of successful nurse managers. *Journal of Nursing Administration 41*(6). 248-251.	To use Kouzes and Pozners Five Practices of Exemplary Leadership to measure a leaders skill	Convenience sample, Questionnaire, Kouzes &Posner's 360 leadership assessment	N=35	Themes: Tell the staff the "why" behind the "what", role modeling is important (walk the walk), have nursing staff 'own' the issue and the solution, coach and mentor staff, personal recognition.	Leadership behaviors can be learned and strengthened.	Level V
McCloughen, A., O'Brien, L. & Jackson, D. (2009) Esteemed connection: creating a mentoring relationship for nurse leadership. *Nursing Inquiry 16*(4) 326-336.	The study aimed to identify whether mentoring relationships contribute to the development of nurse leaders	Purposeful Sampling, Face to face interviews	N=13	Themes: considering each other with positive regard, developing respectful boundaries, honoring key human characteristics	Mentoring was present both inside and outside of nursing. Nurse leaders were both mentors and mentees	Level VI
Malloy, T. & Penprase, B. (2010) Nursing leadership style and psychosocial work environment. *Journal of Nursing Management 18*, 715-725	This study examines the relationship between leadership style and the psychosocial work environment of registered nurses.	Convenience Sample, Multifactorial Leadership Questionnaire	N=122	Themes support the Full Range Leadership Theory, created a positive work environment	The results of this study suggest that there would be an improvement in the nursing psychosocial work environment by implementation of transformational and contingent reward leadership behaviors.	Level V

Appendix B

Gantt Chart for Project Implementation Timeline

	By	Jan	Jan 1,	Jan	Jan	Feb	Apr	July	Aug

	Dec 30, 2013	15, 2014	2014	20, 2014	22, 2014	26, 2014	22, 2014	23, 2014	1, 2014
Travel to CRH to discuss LPI with leadership group. Distribute LPI for completion									
Have Nursing Leadership group at CRH complete LPI and study consent form and return to KP									
Develop curriculum for Nursing Leadership Development course using Kouzes & Posner									
Complete 360 reports for each participant									
First Leadership Course at CRH									
Second Leadership Course at CRH									
Final Leadership Course at CRH									
Distribute final LPI to leadership group at CRH									
Collect and analyze first and final LPI from leadership group									

Appendix C
Proposed Evaluation Plan

Instruments/ Indicators used for measurement	Data Collection Plan	Rationale for Measure Selection	Plan for Data Analysis	Timeline for Monitoring Objective Accomplishment	Plan for Addressing Problems
LPI (Kouzes & Posner)	LPI will be administered to all leadership class attendees before the first class day. LPI will be administered to the leaders' staff members, colleagues and direct supervisor before the first class. A 360 view of each leaders leadership ability will be formulated via Kouzes & Posner's LPI tool from each of the respondents answers Total of 7 assessments per participant will be collected by a 'LPI Champion' at CRH. Surveys will be collected by researcher.	Assesses the effectiveness of an entire organization's leadership. Valid across cultures and types of organizations. Easy to administer and requires 15 minutes to complete. Extensively researched and validated.	Compare the means of the pre and posttests of the LPI for each of the 5 leadership categories. Perform a paired t t-test to detect whether there are any statistically significant differences between the means.	Introduce LPI to CRH leaders and have group begin LPI process by December 4, 2013. Collect LPI results and formulate 360 reports for each participant by January 15, 2014. Complete repeat LPI by August 30, 2014. Complete data analysis by October 30, 2014.	Name a 'LPI Champion' at CRH to answer any questions during completion time. Provide email address for respondents to send questions to during completion period.

Appendix D
Leadership Class Schedule

Class Date	**Length**	**Topic Covered**
December 4, 2013	1 hour	1. Instruction on completion of the LPI, who to return to, LPI Champion and timeline
January 22, 2014	3 hours	1. Review of individual 360 LPI 2. Model The Way 3. Homework/Evaluations
February 26, 2014	3 hours	1. Inspire A Shared Vision 2. Challenge The Process 3. Enable Others To Act 4. Encourage The Heart 4. Homework/Evaluations
April 22, 2014	3 hours	1. 360 Action Plan Review 2. Core Values/Leadership Mantra Schematic 3. Wrap Up Course 3. Evaluations
July 23, 2014	1 hour	1. Complete repeat LPI instruction, timeline

Appendix E
Cost Breakdown of Leadership Program

Category	Cost	Total
Student/Facilitator Time	$48/hr. @ 100 hours $75/hr. @ 20 hours	$4,800 $1,500
LPI/Workbooks LPI Facilitator Materials	$25/book @ 42 books $225	$1,050 $225
Office Supplies (paper, copies, binders)	$5/leader @ 42 leaders	$210
Statistician	$25/hr. @ 8 hours	$200
Miscellaneous	Unforeseen expenses	$250
Room/Computer/Projector	Donated by CRH	$0
		$8,235

Appendix F

Leadership Practice Inventory (LPI)

Your name: _____

To what extent do you engage in the following behaviors? Choose the response number that best applies to each statement and record it in the box to the right of that statement.

1.	I set a personal example of what I expect of others.	
2.	I talk about future trends that will influence how our work gets done.	
3.	I seek out challenging opportunities that test my own skills and abilities.	
4.	I develop cooperative relationships among the people I work with.	
5.	I praise people for a job well done.	
6.	I spend time and energy making certain that the people I work with adhere to the principles and standards we have agreed on.	
7.	I describe a compelling image of what our future could be like.	
8.	I challenge people to try out new and innovative ways to do their work.	
9.	I actively listen to diverse points of view.	
10.	I make it a point to let people know about my confidence in their abilities.	
11.	I follow through on the promises and commitments that I make.	
12.	I appeal to others to share an exciting dream of the future.	
13.	I search outside the formal boundaries of my organization for innovative ways to improve what we do.	
14.	I treat others with dignity and respect.	
15.	I make sure that people are creatively rewarded for their contributions to the success of our projects.	
16.	I ask for feedback on how my actions affect other people's performance.	
17.	I show others how their long-term interests can be realized by enlisting in a common vision.	
18.	I ask "What can we learn?" when things don't go as expected.	
19.	I support the decisions that people make on their own.	
20.	I publicly recognize people who exemplify commitment to shared values.	
21.	I build consensus around a common set of values for running our organization.	
22.	I paint the "big picture" of what we aspire to accomplish.	
23.	I make certain that we set achievable goals, make concrete plans, and establish measurable milestones for the projects and programs that we work on.	
24.	I give people a great deal of freedom and choice in deciding how to do their work.	
25.	I find ways to celebrate accomplishments.	
26.	I am clear about my philosophy of leadership.	
27.	I speak with genuine conviction about the higher meaning and purpose of our work.	
28.	I experiment and take risks, even when there is a chance of failure.	
29.	I ensure that people grow in their jobs by learning new skills and developing themselves.	
30.	I give the members of the team lots of appreciation and support for their contributions.	

LPI: LEADERSHIP PRACTICES INVENTORY SELF

Appendix G
Sociodemographic Data

1. Age:_____
2. Gender: M ____F_____
3. Position:_____
4. Length of time in position:_____
5. Length of time at Columbus Regional Hospital: _____
6. Length of time in healthcare:_____
7. Education: ADN ___ BSN ___ MSN ___Other _____
8. Certifications obtained: _____
9. Have you ever had formalized leadership training classes/courses? Y____ N____

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