A Case Study Investigating The Development, Implementation, And Perceptions Of Transformational Leadership Practices Of The Clinical Nurse Leader

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Abstract

The hospital setting is a complicated, challenging, and complex environment in which to deliver high-quality, lower-cost care. It is particularly vulnerable to what is often termed "care fragmentation." The Clinical Nurse Leader (CNL), the first new nursing role advanced nationally in decades, is an innovative strategy uniquely positioned to address teamwork and strengthen leadership at the bedside to improve patient outcomes for a reduced cost at the microsystem level. The CNL is less than 5 years old and limited research has been conducted, particularly around the development, implementation, and perceived transformational leadership aspects of the role. Consequently, to address the research gap, this study investigated the above aspects on 5 inpatient units. Qualitative findings regarding the role reveal the perception and alignment of a complex role for complex times, and the "pull of polarity" on multiple levels (organization, unit, staff and each other). Quantitative results suggest licensed personnel and those with higher educational preparation as group perceive the transformational leadership practices of the CNL to be higher than those unlicensed personnel and those with less education. Furthermore, it generally appears the longer the CNL has been practicing on the unit, the higher the perceptions of their transformational leadership practices.

Keywords: clinical nurse leader, transformational leader, *Leadership Practice Inventory*

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CHAPTER ONE: INTRODUCTION

The Current State of Healthcare

Healthcare in the United States needs a radical makeover. Escalating costs, fragmented delivery processes, inequitable access, and quality variances plague the system (Nelson, Batalden, Godfrey, & Lazar, 2011). The mounting burden of disease chronicity, technological and drug advancements, societal mores of "cure at all cost," a rapidly expanding aging population, and a looming healthcare workforce shortage creates a system on the edge of implosion (Harris & Roussel, 2010).

Current healthcare reforms are focused on covering the uninsured, slowing the rate of cost of increases, and redesigning care models to reduce unwarranted variations for better outcomes, which are framed in the context of value (Salvador, 2010). Value in healthcare is described as the relationship of quality, safety, and outcomes divided by costs over time (Nelson, Batalden, Godfrey, & Lazar, 2011). Value discussions in healthcare reforms are ubiquitous, yet the United States lacks an agreed upon process or strategy to best attain value within healthcare.

Medical errors (both minor and significant) are unfortunately more prevalent than previously known, negatively impacting value as defined above. In fact, The Institute of Medicine (IOM) Report (1999), *To Err is Human: Building a Safer Health System*, estimated that up to 98,000 patients die each year due to medical mistakes, with Leape and Berwick (2005) suggesting that this number might be even higher. These errors cost the society, patients, and hospitals billions of dollars (Harris & Roussel, 2010), which is money that could be utilized in a far more productive manner. Furthermore, errors create significant

negative non-monetary (physiological as well as psychological) impact on individuals and families creating additional and undeserved burdens to those impacted by errors.

Contributing to errors are system structures and processes causing fragmentation of care. Years ago, healthcare was far simpler. Care was perceived as being delivered by an omnipotent and omniscient solo provider rendering treatment in an intimate, personal, and unhurried manner (Nelson, Batalden, Godfrey, & Lazar, 2011). Today, with the proliferation of medical knowledge, the explosion of technology, and increasingly complicated infrastructures, the model of care has transitioned from a single pseudo-heroic provider caring for a patient to a model of multiple providers lacking personalized care and being pushed for time in treating a patient (Nelson, Batalden, Godfrey, & Lazar, 2011).

The hospital is a complicated, challenging, and complex environment used to deliver high-quality, lower-cost care and is particularly vulnerable to the care fragmentation spoken of above. Continued constraints on resources due to economic pressures and health care reforms make it nearly impossible to add personnel, even with increased complexity and reduced lengths of stays. Additionally, the current model of care delivery requires a patient-centered team and system approach to provide efficacious care to patients. However, current team structure(s) within the hospital utilize a variety of roles, having various schedules and limited continuity. Shift work has replaced the continuity of care, creating fragmented communication and insufficient teamwork that provides less than optimal patient care (Salas, Rosen, & King, 2007).

Lack of teamwork and communication are impediments to coordinated care, but system failures impact the quality of care as well. In fact, the 2001and 2004 IOM Reports, *Crossing the Quality Chasm*, and *Keeping Patients Safe* respectively indicate valuable time is

consumed with system failures that harm patients. Additional IOM Reports (2003, 2005), the Institute for Health Care Improvement (IHI) web site, along with The Joint Commission and Robert Wood Johnson Foundation (RWJF) (2011) challenge the healthcare industry to fundamentally and innovatively reform structures, processes, and education for maximum responsiveness, ensuring that all people receive care that is equitable, safe, patient-centered, and efficacious.

Clinical Microsystem Improvement Methodology

As noted earlier, the US has no agreed upon improvement methodology to attain value in healthcare. Value in healthcare, as previously described, is the relationship of quality, safety, and outcomes divided by costs over time (Nelson, Batalden, Godfrey, & Lazar, 2011). That being acknowledged, the Clinical Microsystem methodology is gaining prominence as a process to achieve excellence and value. Microsystem improvement methodology actually arose from original research in the service sector by James Brian Quinn (1992), who discovered that the best service performers had many similarities. They focused improvement efforts on what he labeled "the smallest replicable unit" (SRU).

Effective SRUs passionately pursued perfection at the frontline, recognizing that value and loyalty originated at the consumer-provider interface. Frontline processes wove quality, efficiencies, service, and innovation throughout, with information flows structured to give real time information facilitating quick and necessary modifications. Highly successful SRUs created and tracked performance measures over time and were rich in information to ensure that the correct information was available at the right place, the right time, and the right level. These systematic improvement processes could then be easily replicated in other settings (Quinn, 1992).

After reading Quinn's work, Eugene Nelson, Paul Batalden, and Marjorie Godfrey recognized the applicability of the SRU concept to healthcare (Nelson, Batalden, & Godfrey, 2007) and labeled it the "clinical microsystem" where participants (providers and patients) intersect and which is the locus of value in healthcare. The formal definition of a clinical microsystem is as follows:

> Small groups of people (including health professionals and care receiving patients and their families) who work together in a defined setting on a regular basis (or as needed) to create care for discrete subpopulations of patients. As a functioning unit it has clinical and business aims, linked processes, a shared informational and technological environment, and produces services which can be measured as performance outcomes. The clinical microsystem evolves over time and is often embedded in larger systems or organizations. As a living, complex adaptive system, the microsystem has many functions, which include (1) to do the work associated with core aims, (2) to meet member needs, and (3) to maintain itself over time as a functioning clinical unit. (Nelson, Batalden, Godfrey, & Lazar, 2011, pp. 3-4)

To understand the unique features of any microsystem, one needs a structured and organized method of evaluation, which Nelson, Batalden, and Godfrey (2007) called the "5P Framework," developed out of Toyota's LEAN principles (Toyota web site, 2009). The 5Ps are purpose, patients, professionals, processes, and patterns. One must identify the purpose of the clinical microsystem and know the details of the patients served (e.g., age distribution, most frequent diagnosis, and patient satisfaction). Additionally, one must ascertain professional information such as specific full-time equivalents (FTEs), schedules, meeting times, and hours of operation. Processes must be discovered and patterns (demand, cultural, communication, outcome, and financial) must be examined. Completing an assessment applying the 5P Framework allows for a deep understanding of the clinical microsystem and lays the groundwork for meaningful improvements.

Leaders of clinical microsystem research maintain that an inpatient unit within the hospital is a clinical microsystem (Nelson, Batalden, Godfrey, & Lazar, 2011). Thus, if the clinical microsystem is the building block of excellence and value in the healthcare system, one must focus efforts of improvement at the unit level. Consequently, the subsequent discussion will focus on describing an innovative nursing role called the Clinical Nurse Leader (CNL), specifically situated within the clinical microsystem as a mechanism to improve teamwork and patient outcomes at the bedside.

Purpose of this Research

The Clinical Nurse Leader (CNL), the first new nursing role advanced nationally in four decades (American Association of Colleges of Nursing [AACN], 2007), is an innovative strategy uniquely positioned to address teamwork and strengthen leadership at the bedside to improve patient outcomes for a reduced cost at the microsystem level (Haase-Herrick & Herrin, 2007; Harris & Ott, 2008; Harris, Stanley, & Rossiter, 2011). My interest in the CNL role originated from an organizational request to investigate this new role as a potential option to utilize within the organization.

In early 2009, the organization's Chief Nursing Officer (CNO) submitted a Health Resources and Service Administration (HRSA) grant to create a healing environment for the nursing staff utilizing Jean Watson's *caritas theory* (Watson, 2008), a philosophy of care emphasizing the importance of caring relationships and the interconnectedness of all with the implementation of the CNL role, to be piloted on a unit exhibiting a variety of low quality, and satisfaction metrics coupled with higher costs. This grant was not accepted, and in the summer of 2009, the Chief Operating Officer (COO) determined that a CNL "role exploration" would proceed embedded into the Patient and Family Centered Care Division

initiatives of which I, the researcher, am the executive. Upon receiving this assignment, the researcher spent the summer and early fall of 2009 completing an initial literature review along with investigating the role to more fully understand its potential application. An investigation revealed multiple positive outcome measures with the implementation of the role in areas of cost containment, quality, improved staff, and patient satisfaction (Bowcutt, Wall, & Goolsby, 2006; Gabuat, Hilton, Linnaird, & Sherman, 2008; Harris, Tornabeni, & Walters, 2006). Due to the positive outcome measures outlined above, the organization decided to implement the role and asked me, the researcher, to function as the executive sponsor for this process.

While acknowledging positive outcome measures, as I delved more deeply into the published literature, I became intrigued about perceptions of the labels of the CNL, and the lack of process measures related to the role. Recognizing the CNL was less than 5 years old (AACN, 2007), limited research examining the development, implementation, and transformational leadership aspects of the role was discovered. Consequently, this study focuses on the development, implementation, and the perceived transformational leadership practices utilizing Kouzes and Posner's *Leadership Practices Inventory* (*LPI,* 2003) of nine CNL's practicing on five inpatient units at a hospital in the Upper Midwest.

As I began this research journey, I initially perceived action research as the method best suited for this project for a number of reasons. Greenwood and Levin (2007) define action research as a collaborative interdependent partnership between researcher and participants aimed at increasing self-determination and wellness. This relationship creates blurred boundaries between the researcher and client, generating theory-grounded action (Greenwood & Levin, 2007). Susman and Evered (1978) support action research as a viable

approach in situations such as this because it is future orientated with the purpose of creating enhanced conditions, holistic, integrates system development, and recognizes that outcomes and consequences cannot be fully identified at the inception of the process. Upon deeper reflection as the investigation began to coalesce, there were definitely components of action research in this investigation; however, the more suitable method of approach was determined to be a case study approach.

The purpose of this study was not to demonstrate the validity or efficacy of the development and implementation, but rather to describe the "lived" experience (Kvale, 1996). This study incorporates a case study approach. Yin (2009) supports case study research as an appropriate method when the primary question is "how" or "why" and there is interest in understanding the phenomenon in its real-life context, and believes this in-depth examination of a case or cases offers invaluable and deep understanding, which will hopefully result in "new learning about real-world behavior and its meaning" (Yin, 2012, p. 4). Additionally, he believes the case study approach aligns with process investigations similar to the development and implementation of the CNL role described above (Yin, 2012).

Stake (1995) advocates the use of the case study because of its adaptability and flexibility, and it can be effectively utilized when one seeks a greater understanding of the uniqueness (particularity) and complexity of the case along with recognizing potential interrelationships that might exist. He deliberately utilizes the term "understanding" as being much richer than explanation because it incorporates contextual meaning and significance.

A unique strength of the case study approach is the utilization of multiple sources of evidence. This study incorporated planning activities, meeting minutes, emails, and workout sessions around role development and implementation. Another key contributing source of

information is an interview with each of the nine CNL/CNL-fellows. According to Weiss (1994), interviews are a valuable tool in research since they encourage participants to tell their own story and allow others to experience certain phenomena through the lens of the storyteller. Lastly, a survey was included to more fully understand perceptions of leadership styles of the CNL/CNL-fellows to offer potential insights to the role and implementation process.

Yin (2009) indicates that "how" and "why" questions are essential components of the case study approach and constitute a very high level and preliminary portion of the process. He suggests that if the researcher does not take significant and deliberate time gaining precision in formulating insightful "how" or "why" question(s), the study will take an undisciplined trajectory and be of limited value. The following research questions are the result of considerable contemplation to give both direction and discipline to this study.

Research Questions

The central research question is; *How does an institution develop and implement the Clinical Nurse Leader (CNL), a new leadership role in nursing, on five inpatient units in a major hospital?* Subquestions associated with the overarching question are

1. What are the similarities and differences of development and implementation on the five different units?
2. How does each CNL/CNL-fellow perceive the development and implementation process including their role in the process? Are there any common themes? Facilitative activities? Barriers?
3. What are the perceived transformational practices of the nine CNL/CNL-fellows using Kouzes and Posner's *Leadership Practice Inventory* (2003)?

4. What can we learn that might contribute to the development and implementation efforts of other healthcare institutions?

Definitions

Clinical Nurse Leader: A Clinical Nurse Leader (CNL) is defined as a leader at the point of care functioning at the microsystem level. The CNL is a graduate (master's) prepared generalist possessing national certification, responsible for managing both the care environment and patient outcomes. Dimensions of the role include team manager, outcomes manager, advocate, information manager, risk anticipation, system analyst, and educator (AACN, 2007). Fundamental to the role is multidisciplinary lateral integration reflecting horizontal influence versus a traditional hierarchical line of authority.

Clinical Nurse Leader Fellow: A registered nurse currently enrolled in an accredited CNL program functioning under the direction of a certified CNL.

Leadership: "The process whereby an individual influences a group of individuals to achieve a common goal" (Northouse, 2010, p.3). To expand on Northouse's definition for the purpose of this study, Kouzes and Posner's interpretation of leadership (2007) will be utilized. For them, leadership is not about being a hero, having a title, or having organizational authority; it is about "relationships, and credibility and what you *do*" (Kouzes & Posner, 2007, p. 338). Their premise is that "leadership is *an observable set of skills and abilities*" (Kouzes & Posner, 2007, p. 339) that can be tested, learned, and taught.

Transformational Leader*:* Kouzes and Posner define a transformational leader as an exemplary leader demonstrating five essential practices: (a) models the way, (b) inspires a

shared vision, (c) challenges the status quo, (d) creates a strong sense of community and collaboration identified as enables others to act, and (e) encourages the heart. These practices will be elaborated on in future sections.

Assumptions and Limitations

This study assumes leadership is more about skills and abilities versus possessing a specific set of traits. Additionally, this study assumes each CNL/CNL-fellow is potentially able to demonstrate transformational practices. Lastly, the study assumes the CNL's will freely and openly communicate both their positive and negative perceptions of the development and implementation process.

This study also acknowledges several limitations. Since it is substantively qualitative in nature, discoveries may be subject to alternative interpretations. Additionally, case study research by its very essence makes it challenging to appropriately identify any generalizations. Moreover, the study will be conducted incorporating only nine CNL/CNL-fellows, who are all Caucasian women, at a single institution, thus certain aspects may not be generalizable to other organizations. The process of development and implementation spanned almost 24 months; therefore, it is possible the CNL/CNL-fellow's recollection may potentially be altered with time. Furthermore, since the topic of research is so new, initial findings should not be expected to fully prove or resolve questions at hand and additional studies addressing limitations are encouraged.

Summary

While the CNL role is exciting and demonstrates great potential, much more research is needed to fully understand the role to efficaciously leverage it in the clinical setting. Due to

the current volatile healthcare milieu, this study is not only timely, but can contribute to the body of knowledge to aid in minimizing care fragmentation and enhancing patient outcomes.

CHAPTER TWO: REVIEW OF THE LITERATURE

For this study, the literature review will be organized in the following manner: The discussion will begin exploring the rationale for the development of the Clinical Nurse Leader (CNL) in the context of current nursing challenges within healthcare. It will then transition to an overview of transformational leadership, followed by an examination of transformational leadership studies using the *Leadership Practice Inventory (LPI)* in nursing as a profession, and close with an exploration of transformational leadership and the CNL.

The Development of the Clinical Nurse Leader Role

Nursing has been in existence for hundreds of years, and as a profession is focused on the promotion and optimization of health, prevention of illness and injury, and the alleviation of suffering (American Nurses Association, 2010). Nursing is a highly regarded profession and, until the last decade or two, offered great job satisfaction (Robert Wood Foundation, 2011). However, current pressures afflicting the healthcare system impact nursing as well.

Nursing, a vital component in the healthcare system, faces its own distinctive challenges. One issue plaguing the profession is retention. Nurse retention is multifaceted, including vacancy rates, high turnover rates, job dissatisfaction, and high levels of burnout. Gelinas and Bohlen (2002) submit that the high vacancy rates and continuous turnover of staff are stressing the financial and cultural fabric of healthcare. The Bureau of Labor Statistics' National Employment Matrix identified a need for 22% more nurses, or approximately 581,000 new registered nurses from 2008-2018 (RWJF Human Capital, n.d.). The vast majority of nurses practice in a hospital setting, but due to intensifying demands at the bedside, nurses are leaving the profession at far faster rates than nurses entering the profession (RWJF, 2011).

Retaining nurses on a medical/surgical unit, an unrecognized specialty, is especially difficult. Many nurses, especially new employees, serve a year or two on a medical/surgical unit, acquire the required skill sets associated with working on the unit, and then choose to leave for a different specialty area. This lack of continuity, combined with nurses feeling stress and dissatisfaction, also has a negative impact on patient care.

Negative patient outcomes have been well documented as a result of nursing shortages. Needleman, Buerhaus, Mattke, Stewart, and Zelevinsky (2002) demonstrated lower nurse staff ratios were associated with higher urinary tract infections, more instances of pneumonia, longer lengths of stays, and "failure to rescue," whereby patients' statuses deteriorated undetected by staff. Aiken, Clarke, Sloane, and Sochalski (2002) noted that lower nurse-to-patient ratios correlated with higher risk-adjusted 30-day mortality. Kalisch, Landstrom and Williams (2009) observed that, while studies may differ in methods, they all indicate the healthcare environment has significant "impact on patient outcomes" (p. 1510).

Another concern besides the looming nursing shortage is the need for improved nursing preparation. Nurses require enhanced knowledge and skills to negotiate the demands of sicker patients and an increasingly complex healthcare system (Bartels & Bednash, 2005; Monaghan & Swihart, 2010). Enhanced knowledge and skills are needed at all levels and all settings within the profession, but particularly at the bedside (Baernholdt & Cottingham, 2010). Historically, a nurse obtaining graduate training generally has limited career opportunities for advancement at the bedside; consequently, s/he utilizes advanced knowledge and skills in another setting. This out-migration is detrimental for patients. Aiken, Clarke, Sloane, and Sochalski (2002) demonstrated a correlation between the level of

education and patient outcomes: As the educational level of the nurse rose, so did positive patient outcomes such as reduced mortality rates.

Recognizing the critical issues facing nursing, representatives from academia, practice, and policy formed a national task force comprised of curriculum/regulation and implementation arms in early 2000 to envision a role that could meet current challenges (AACN White Paper, 2007). The CNL role conceived by the task force after approximately 3 years of work is an innovative strategy specifically situated to address teamwork and strengthen leadership at the bedside to improve patient outcomes for a reduced cost at the microsystem level (Monaghan & Swihart, 2010). This role is uniquely positioned to promote enhanced intra- and inter-professional collaboration, connecting system resources in a way not utilized before and offering a new dimension to clinical improvement as a lateral integrator of care (Appendix A). The CNL's accountability for outcomes is achieved through point-of-care practices including planning, implementing, and evaluating individual patients as well as a group of patients (Bowcutt & Goolsby, 2006).

The national task force felt the CNL role could foster quality patient care and staff retention by positively influencing the work environment. The task force generated the AACN CNL White Paper (2007), considered by CNLs to be the Bible as a mechanism to guide development activities. This is reflected in the 10 assumptions created by the national oversight committee as the role was being developed (AACN White Paper, 2007). They are

1. Practices at the microsystem level.
2. Client care outcomes are the measure of quality practice.
3. Practice guidelines are based on evidence.
4. Client-centered practice is intra-interdisciplinary.

5. Information will maximize self-care and client decision-making.
6. Nursing Assessment is the basis for theory knowledge and development.
7. Good fiscal stewardship is a condition of quality care.
8. Social justice is an essential nursing value.
9. Communication technology will facilitate the continuity and comprehensiveness of care.
10. The CNL must assume guardianship of the nursing profession.

(Harris & Roussel, 2010, p. 8)

Furthermore, recognizing the CNL's unique role, the AACN, along with various stakeholders, created role and scope statements along with specific curriculum (Appendix B) focusing on nursing leadership, clinical outcomes management, and care environment management (Harris & Roussel, 2010). The CNL curriculum helps develop key components of the role: (a) leadership and change grounded in systems thinking, (b) interdisciplinary relationships, (c) knowledge transfer, (d) outcomes management, (e) point of care, and (f) professional development and mentoring (Monaghan & Swihart, 2010). By developing competencies in the above, the CNL has the opportunity to improve patient outcomes as a reduced cost at the microsystem level. Appendix B offers a pictorial representation of the CNL role and its impact on the healthcare team.

The CNL role appears to be an innovative strategy uniquely positioned to address teamwork and strengthen leadership at the bedside to improve patient outcomes for a reduced cost at the microsystem level. While strengthening leadership at the point of care or bedside is an acknowledged component of the CNL role, little to no research has been conducted

investigating that aspect of the role. Consequently, including leadership exploration into the study is both relevant and important.

Transformational Leadership Overview

The idea of leadership has captured people's interest for centuries and is perceived as a highly coveted commodity. Interest and investigation involving leadership have intensified in recent years. Due to its complexity, multiple conceptualizations, various definitions, numerous instruments exploring the topic of leadership have been advanced. For the purpose of this study, leadership will be described as a "process whereby an individual influences a group of individuals to achieve a common goal" (Northouse, 2010, p. 3). Northouse's description reflects the idea that leadership is a process, not an event, and connotes the bi-directional impact of leaders and followers on each other.

Recognizing the complexity of leadership, it is understandable that different approaches to leadership have emerged. Transformational leadership, coined by Downton (1973) and developed by political sociologist Burns (1978), is one such approach having gained popularity over the last few decades because it is suggested to be a very effective leadership style, especially in times of great uncertainty (Northouse, 2010). This is significant for today's healthcare system due to its current volatile milieu. The interest in such an approach is so strong that Lowe and Gardner (2001) discovered that approximately one-third of leadership research investigated some aspect of transformational leadership (TL).

Burns (1978) described the two leadership styles that he identified as transactional and transformational. He considered the majority of leader/follower interactions transactional, operating under the premise of exchange. Transactional leader(s), comfortable with

established structures and focused on self-interest, seek to motivate follower(s) with "x" to attain "y" from follower(s), incorporating more of a punishment and reward system. Burns (1978), in turn, defined transformational leadership as "leaders inducing followers to act for certain goals that represent the values and the motivations—the wants and needs, the aspirations and expectations—*of both leaders and followers*" (Burns, 1978, p. 19). Burns (1978) admits to the complexity of TL, but posits it as far more effective than transactional leadership.

Burns (1978), the first to introduce a moral/ethical dimension to leadership, sees TL not as a specific set of behaviors but a process by which the leader and follower are inextricably connected and raise each other to a higher level of morality and motivation. He believed TL is fundamentally about values, purpose, and meaning. Influenced by Maslow and Kohlberg, Burns (1978) recognized people's vast array of needs and suggested that performance is linked to the extent that needs and wants are fulfilled.

Kouzes and Posner (2007) believe that leadership is not about being a hero or having positional power; it is about personal connections and credibility. Their premise is that "leadership is *an observable set of skills and abilities*" (Kouzner & Posner, 2007, p. 339) that can be tested, learned, and taught.

Kouzes and Posner (2007) propose five practices demonstrated by transformational or exemplary leaders that have been linked to effectiveness. The first practice is "modeling the way." This is accomplished by having clarity of one's own beliefs and values and setting high standards for others to be able to emulate. Kouzes and Posner (2007) imagine values as enduring beliefs that serve as a guide giving direction and meaning to action, and a transformational leader must demonstrate unwavering commitment and passion to a clear set

of principles or values. Exemplary leaders set a personal example and act as role models for others. Furthermore, transformational leaders use storytelling as a mechanism to reinforce preferred behaviors and teach others to model desired values.

The second practice, "inspiring a shared vision," ignites excitement and helps others see a positive future. It is far more than executing a leader's aspirations; it is about imagining possibilities for the common good appealing to followers' values, hopes, and dreams (Kouzes & Posner, 2007). To help others "see" a future full of potential, a transformational leader reflects on the past and attends to the present to better construct a future incorporating vivid word pictures and symbolic language. The alignment of leader and follower vision fosters strong team spirit and commitment.

The third practice is called "challenging the process." Transformational leaders act like pioneers, take risks, and challenge the status quo; "they are fundamentally restless" (Kouzes & Posner, 2007, p. 168). They take initiative and view every assignment as an opportunity while encouraging the same in others. Challenges are energizing versus demoralizing and foster resilience in all. They constantly experiment, innovate, and generate small wins setting the stage for ongoing success. Transformational leaders are active learners and gain knowledge from experiences to help themselves as well as other team members learn and grow.

Developing a strong sense of community and promoting collaboration is the fourth practice described as "enabling others to act." Extraordinary leaders cultivate engagement, creating a climate of trust, empowerment, and ownership by sharing information and promoting creativity. They encourage face-to-face interactions and structure activities

cultivating joint efforts (Kouzes & Posner, 2007). They coach to develop competence and confidence in followers.

The fifth and last practice of a transformational leader is to "encourage the heart." This is accomplished by expecting the best in team members and offering personalized praise/recognition in an authentic manner (Kouzes & Posner, 2007). Additionally, exemplary leaders promote having fun and weave public celebrations into corporate life.

To help assess the five practices of a transformational leader, Kouzes and Posner developed and revised (2003) the *Leadership Practice Inventory (LPI)* tool through a triangulation of qualitative, quantitative research methods and studies (Kouzes & Posner, 2010). The *LPI* tool is a 30-item instrument integrating six questions focused on each of the five transformational practices. It has been used extensively throughout the world (more than a million respondents) and in various organizational settings. Discussion on the psychometric aspects of the tool is addressed in Chapter 3 in the quantitative instrumentation section.

Transformational Leadership in Nursing

Acknowledging the plethora of studies supporting the positive benefits of transformational leadership (TL) in various settings, the literature review was narrowed to focus on transformational leadership research in nursing as a profession, followed by an examination of research focusing on the transformational practices of nurse leaders specifically using the *LPI* tool.

A number of nursing studies have shown TL practices of leaders having a positive impact on followers in areas of loyalty to the organization, staff members' decision to leave their job, enhanced job satisfaction along with higher levels of empowerment, increased patient satisfaction, and reduced adverse events (Drenkard, 2005; Morrison, Jones, & Fuller,

1997; Searle Leach, 2005; Wong & Cummings, 2007). Kohler (2010) finds a positive impact on turnover and work-related stress when exploring the perceived leadership impact of CNLs on a clinical unit.

While nursing literature is rich with the benefits of transformational leadership, fewer studies exploring TL practices using the *LPI* have been conducted within the profession. McNeese-Smith (1993, 1995) appears to be the first with her two studies investigating the nurse managers' TL practices and employee outcomes (job satisfaction, productivity, and commitment). The studies indicated a positive correlation between the perception of TL practices of leaders and the employees' attachment and loyalty to the organization. Additionally, McNeese-Smith (1993, 1995) reported *LPI* internal consistencies between the two studies ranging from .84-.85 for the subscales reflecting the five leadership practices.

Bowles and Bowles (2000) utilized the *LPI* to identify perceived TL practices of nurse mangers in a Nursing Development Unit (NDU) in England – a clinical setting specifically targeted to incorporate innovative leadership styles. The study demonstrated that the leadership provided by the nurse managers in the NDU was evaluated more highly than the non-NDU managers. Loke (2001), replicating McNeese-Smith's work in Singapore, found similar correlations of TL practices and follower outcomes. George et al. (2002) investigated the TL practices of those involved in a shared leadership program, and Houser (2003) examined issues around the care environment. Both demonstrated the positive correlation between perceived TL practices by the leader and outcomes. Duygulu and Kublay (2011) studied TL practices of charge nurses in Turkey participating in a leadership development program. Results indicate positive perception of charge nurses' transformational leadership practices post-education.

Transformational Leadership and the CNL

Since its inception 5 years ago, numerous descriptors have been applied to the CNL, but one of the most ubiquitous has been "transformational leader." A number of resources were reviewed to gain a better understanding of the intersections of CNL and TL practices: the CNL White Paper (AACN, 2007), journal articles and dissertations published to date, information offered at 2009-2011 CNL national summits including poster presentations, and abstracts describing breakout sessions along with key note and plenary lectures. Additionally, CNL certification literature and two books published to date on the CNL were examined.

The AACN CNL White Paper (2007) acknowledged the complexity of the current healthcare setting and outlined the development of the CNL, including fundamental aspects of the role, values, preparation assumptions, and core competencies. The report (AACN, 2007) described the CNL as innovative, a lateral integrator, a horizontal leader at the point of care, and a change agent; however, no reference to the CNL being a transformational leader could be found in the 26-page report. While the authors surely situate the CNL as potentially impactful, the only specific practice of TL clearly outlined was challenging the process (Kouzes & Posner, 2007).

The White Paper (AACN, 2007) addresses certain practices of TL tangentially and one could offer some of the TL practices are inferred; however, the White Paper falls short of creating clear and distinct alignment between TL practices and the CNL role. For example, "development and leverage of human resources" (AACN, 2007, p. 11) appears, but the context appears CNL determined and lacks any reflection of the mutuality of the leader (CNL) and follower(s). The White Paper also shares that the CNL must "engage in self-

reflection… and demonstrate creative problem solving" (AACN, 2007, p. 17), but the statement is leader-directed, lacking the inclusion of leader facilitation/mentoring of those same aspects with the follower(s).

Furthermore, the report mentions that the CNL must adapt style of interaction to meet client (patient) needs and desires, but remains silent on adapting style to meet other follower needs and wants. The White Paper (AACN, 2007) indicates the CNL should have a clear set of values, but lacks clarity on how one might be an effective role model.

A literature search using Pub Med, EBSCO host comprised of CINAHL, CINAHL Plus with full text, Academic Search Premier, Medline, and Health Source: Nursing /Academic Edition was conducted. Key words utilized for the search were "clinical nurse leader," "transformation," "TL," and "*LPI*." There were no non-English journals to be filtered, thus 57 articles were identified through January of 2012.

The majority of articles were descriptive in nature, outlining the genesis of CNL development, operationalization, and evaluative components (Baernholdt & Cottingham, 2011; Tornabeni, 2006; Tornabeni & Miller, 2008; Tornabeni, Stanhope, & Wiggins, 2006). A few common themes emerged from the review. The first theme acknowledged the increasing complexity of healthcare, financial constraints, and quality variability. The second theme reflected a sense of urgency to create innovative nursing education and practice partnerships/models to address issues (Long, 2004; Maag, Buccheri, Capella, & Jennings, 2006; Radzyminski, 2005; Wurmser, 2008). A third theme suggested nursing as a profession was uniquely positioned to solve current healthcare issues and functioned as a call to action both nationally and internationally.

Of the articles examined from reviewed journals, 18 included empirical or qualitative data. Thirteen included empirical data related to outcomes, with Stanhope and Turner (2006) offering empirical data regarding the distribution of CNL practice and academic partnerships across the nation. Four qualitative studies were reported: Stanley et al. (2008) incorporated case studies, while Bombard et al. (2010), Sherman (2010), and Sorbello (2010) utilized a phenomenological approach to understand the CNL role and its transition. Stanton, Lammon, and Williams (2011) explored how CNL functioning aligned with AACN recommended components of the role.

Nine hospitals comprised the total number of sites producing/reporting empirical data, reflecting cost, quality, and satisfaction outcome information (Bowcutt & Goolsby, 2006; Gabuat, Hilton, Linnaird, & Sherman, 2008; Harris, Tornabeni, & Walters, 2006; Hartranft, Garcia, & Adams, 2007; Hix, McKeon, & Walters, 2009; Ott et al., 2009; Poulin-Tabor et al., 2009; Sherman, 2008; Sherman, Edwards, Giovengo, & Hilton, 2009; Smith & Dabbs, 2007; Smith et al., 2006; Smith, Manfredi, Hagos, Drummond-Huth, & Moore, 2006; Stanley et al., 2007; Tachibana & Nelson-Peterson, 2007; The hospitals represented for profit, non-profit, and government sectors. These facilities included academic teaching as well as community-based designations. Several different units were investigated integrating diverse patient populations and sizes. Sherman, Clark, and Maloney (2008) published outcomes utilizing a role called a "patient care facilitator" having overlapping concepts to CNL, but lacking comprehensive alignment to the CNL role.

Fourteen references posit the CNL role/activities as transformational (Bartels, 2005; Begun, Tornabeni & White, 2006; Bender, Mann, & Olsen, 2011; Drenkard, 2004; Gabuat et al., 2008; Haase-Herrick, 2005; McKeon, Norris, Webb, Hix, Ramsey, & Jacobs, 2009;

Norris, Webb, McKeon, Jacob, & Herrin-Griffith, 2012; Porter-O'Grady, Clark, & Wiggins, 2010; Rosseter, 2009; Rusch & Bakewell-Sachs, 2007; Seed, Torkelson, & Karshmer, 2009; Stanley, Hoiting, Burton, Harris, & Norman, 2007; Wiggins, 2006). Seven of these 14 articles cited were authored by individuals participating in national task force activities and represent academia, practice, and policy sectors.

Interestingly, five were published before the AACN White Paper (2007) or empirical data were published and were more of a position or promotional type of article. None of the articles referring to the CNL as a transformational leader included a definition, conceptual framework, or transformational leadership measurement tool to substantiate such a claim. Two studies (Drenkard & Cohen, 2004; Sherman, Clark, & Maloney, 2008) published data on roles similar to the CNL, but lack comprehensive alignment; one was identified as team coordinator and the other was identified as a patient care facilitator. No studies to date have been replicated.

Guillory (2011) examined the relationships between the leadership style of nurse managers and CNLs with the leadership behaviors of staff nurses using the *Multifactorial Leadership Questionnaire Form* (MLQ-5X short). In her dissertation, she writes "The results indicated that the perceived full range leadership style of the Nurse Managers predicted the perceived full range leadership style of the CNL's, and the perceived full range leadership style of the CNL's predicted the perceived leadership behaviors of staff nurses" (Guillory, 2011, p. vi).

Other points of interest gleaned from reviewed published material were uncovered. Certain authors support the role and see its development as complimentary to existing nursing roles across the care continuum (Karshmer, Seed, & Torkelson, 2009; Kennedy,

2004; Spitzer, 2010; Thompson & Lulham, 2007). Some question whether the CNL really is the answer to the current healthcare challenges (Ebright, 2004; Erickson & Ditomassi, 2005; Girard, 2005; McCabe, 2006). Others (Grindel, 2005; Tanner, 2005) voice concern about adding a new nursing role with intense faculty shortages plaguing the system. Goudreau (2008) opposes the development of the CNL and believes it overlaps with an already established role, the Clinical Nurse Specialist.

Articles included cost, quality, and patient satisfaction outcome metrics, but only Rosseter (2009) and Stanley et al. (2007) include data from follower(s) perspective (e.g., staff satisfaction metric). The Advisory Board (2009) outlines how staff satisfaction metrics do not reflect engagement and personal commitment of followers, a vital tenet of TL practice, clearly making the TL claim even more rash. Moreover, while the above-identified articles labeled the CNL as transformational, they interestingly juxtaposed a comment reflecting the need for research to ascertain its impact.

Another disconcerting aspect of the articles arose out of the lack of detailed exploration of process. Virtually all articles were silent on specifically how or what the CNL did to demonstrate TL practices. If one concurs that leadership is a process, not an event, then it becomes challenging, if not impossible, to substantiate the TL claim from current research.

Two books have been published to date about the CNL outside of educational preparation or curriculum information: *Clinical Nurse Leader: Transforming Practice, Transforming Care* (Monaghan & Swihart, 2010) and *Initiating and Sustaining the Clinical Nurse Leader Role* (Harris & Roussel, 2010). Monaghan and Swihart (2010) utilize a descriptive approach incorporating practical suggestions on how the CNL can act as a

transformational leader. The authors acknowledge the complexity of transformational leadership, and offer techniques for the CNL to generate a shared vision, develop trust, increase collaboration, and improve communication with other team members. They support that leadership is about what one does and take the approach of skill development similar to Kouzes and Posner. While they do not use the exact terminology used by Avolio (1999) and Bass and Avolio (1990, 1994) or Kouzes and Posner (2007), they generally align suggestions conceptually with the basic tenets of TL. For example, CNLs should "create, influence and track positive changes with those they work with to help them develop into confident leader-practitioners….they challenge others to optimal performance by understanding individual strengths and weaknesses" (Monaghan & Swihart, 2010, pp. 27-28). One area, the inextricable relationship of the CNL- follower(s), could have been developed further. But generally speaking, the book effectively demonstrates how a CNL could be a transformational leader. Because Monaghan and Swihart (2010) apply a descriptive approach, it is important to note that the lack of empirical data proving that the CNL is a transformational leader is a shortcoming of the book.

Harris and Roussel (2010) devote a chapter to leadership, but focus on transactional (autocratic, democratic, and laissez-faire) styles of leadership. They align more philosophically with trait theorists and state "Effective leaders are different from other people in key respects. The key traits are…. a drive that includes accomplishment, energy, persistence and initiative" (Harris & Roussel, 2010, p. 68). Only one statement in the chapter, "An effective leader is driven to develop and support each member of the group as he or she grows into his or her highest potential" (Harris & Roussel, 2010, p. 79), comes

close to reflecting TL practice. This chapter falls short in creating connection(s) between TL and the CNL.

Professional Summit Information

After performing an extensive literature review, it was still not clear how TL had become such a ubiquitous label for the CNL, since the research did not appear to substantiate such a claim. Consequently, a review of the 2009-2011 national CNL summits transpired to identify potential connections. Table 1 offers information on the inclusion of the term "TL" in either a poster presentation or an abstract describing a breakout session. The only discernable difference observed from the data was a substantial reduction in the utilization of TL in 2011 poster presentations. Much more investigation is needed to uncover the range of reasons for such a change, or even to determine the significance of the change. That being acknowledged, conceivably as understanding and critical analysis of the role continues to mature, professionals are more sensitive to the nuances of CNL labels.

Table 1

Inclusion of Transformational Leader Language at CNL National Summits

Type of Information	2009	2010	2011
Poster Presentation	6/25	5/33	2/52
Abstract Content	6/23	5/30	8/37

In regards to summit keynote addresses, the 2011 summit included two: one identified as the opening keynote and the other identified as just keynote. Three (Godfrey, 2009; Gibson, 2010; Bleich, 2011) of four keynote speakers specifically referenced the CNL as a

transformational leader. Gibson (2010) made a single reference to the CNL being a transformational leader and Bleich (2011) made two; however, neither wove the concept into their presentation, nor did they give examples supporting such a statement. Of the presentations, Godfrey (2009) spent the most time creating connections between TL and the CNL.

Godfrey, one of the founders of the clinical microsystem quality improvement methodology, is internationally recognized as a leading expert on quality improvement in healthcare. Her comments identifying the CNL as a TL at the microsystem level undoubtedly influenced participants' perspectives and strengthened mental alignment of TL and the CNL. While the lecture did not include a definition of TL, Godfrey (2009) offered examples from her perspective supporting such a declaration. Godfrey's illustrations specifically substantiated three CNLs' transformational leadership practices: (a) challenging the process, (b) enabling others to act (Kouzes & Posner, 2007), and (c) inspirational motivation (Bass & Avolio, 1994).

Plenary sessions were a bit more difficult to evaluate regarding TL and the CNL. Two of the sessions (Blakewell-Sachs, 2009; Salvador, 2010) referenced the CNL as a transformational leader. However, this author could not access PowerPoints or tapes of the other four sessions. As with the keynote speeches, it appears the term TL was applied more informally versus scholarly.

It is interesting to note that the CNL certificate in 2009 contained a black-and-white tag line of "Excellence, Recognition, Leadership and Knowledge;" but in 2010, this was changed to its current tag line of "TRANSFORM. LEAD. EXPERIENCE" while incorporating a

holographic pattern. Not only are these different word choices, but there is an increased font size and pattern change.

Conclusion

In summary, as one reviews the literature and professional conference information, the CNL is showing great promise in helping to solve issues challenging the current healthcare system and the nursing profession to advance teamwork and improve patient outcomes. Initial publications outlined the perceived need and origins of the role in more of a narrative manner. Approximately a third of the articles reviewed from journals included empirical or qualitative data. Of this group, 13 empirical studies contributed to the body of knowledge related to the positive impact of the CNL role in quality, cost, and satisfaction arenas. None of these 13 studies to date have been replicated.

While acknowledging the preliminary positive empirical data and the role's possibilities, it appears the term "transformational" has found its way into the lexicon of the CNL conversation with very little research to support such a bold statement. Articles (14) and summit addresses, particularly Godfrey's (2009) inaugural lecture, appear to have created mental connections between TL and the CNL, yet correlations between the two have not been clearly demonstrated with scholarly research.

As was noted earlier, the current volatility of the healthcare milieu creates great stress and chaos. Revolutionary economic, technological, and generational forces require traditional hierarchal leadership styles to transition to more of an influential and horizontal approach integrating a high degree of networking (Northouse, 2010), tenets of the CNL role. The need for highly effective or transformational leaders who understand and leverage the

connections between personal practices and employee performance (Bass, 1985, 1990) in these times of great uncertainty continues to escalate.

The paucity of research outlined in this chapter challenges those interested in championing the CNL as an innovative approach positioned to positively impact healthcare challenges and as a transformational leader to further investigation. This both relevant and necessary study explored here addressed the above-identified knowledge gap.

CHAPTER THREE: RESEARCH APPROACHES AND METHODS

Introduction

The Clinical Nurse Leader (CNL) role, as noted in prior chapters, is new and complex, yet poised to potentially assist in addressing current healthcare struggles. As with any new phenomenon, it is both understudied and lacks robust understanding, requiring considerable investigation. Since this study largely operated in uncharted or new territory, significant deliberation ensued to determine an appropriate research trajectory. The literature review revealed little to no research about process aspects such as role development, implementation, or transformational leadership practices. Thus, recognizing the breadth of the above mentioned knowledge gap, it became apparent that integrating both qualitative and quantitative aspects to the study would lend a greater degree of clarity and comprehension to the future development of the role, along with advancing the body of knowledge and practice.

Design

This research study employed a descriptive case study approach integrating qualitative and quantitative methods. Case study approach is a valid research design due to its flexibility (Rosenberg & Yates, 2007) in addition to being useful when the questions at hand are focused on either "how" or "why" and/or when phenomena and real-life context have blurred boundaries (Yin, 2009).

The case study approach is gaining popularity in nursing and the social sciences; however, it can be challenging to conceptualize clear and appropriate procedural steps to demonstrate methodological rigor (Rosenberg & Yates, 2007). Rosenberg and Yates (2007)

offer a schematic representation of case study processes as a visual map outlining the research question, theoretical underpinnings, contextual setting, phenomenon of interest, and an overview of data collection and strategies of analysis. The elements of this case study have been situated into Rosenberg and Yates's (2007, p. 449) schematic to offer the reader a visual map of this particular study in *Figure 1*: Case Study Schematic. It is important to note that Rosenberg and Yates (2007) identify these steps as being very interrelated, and the schematic is not intended to reflect a sequential nature of these procedural steps.

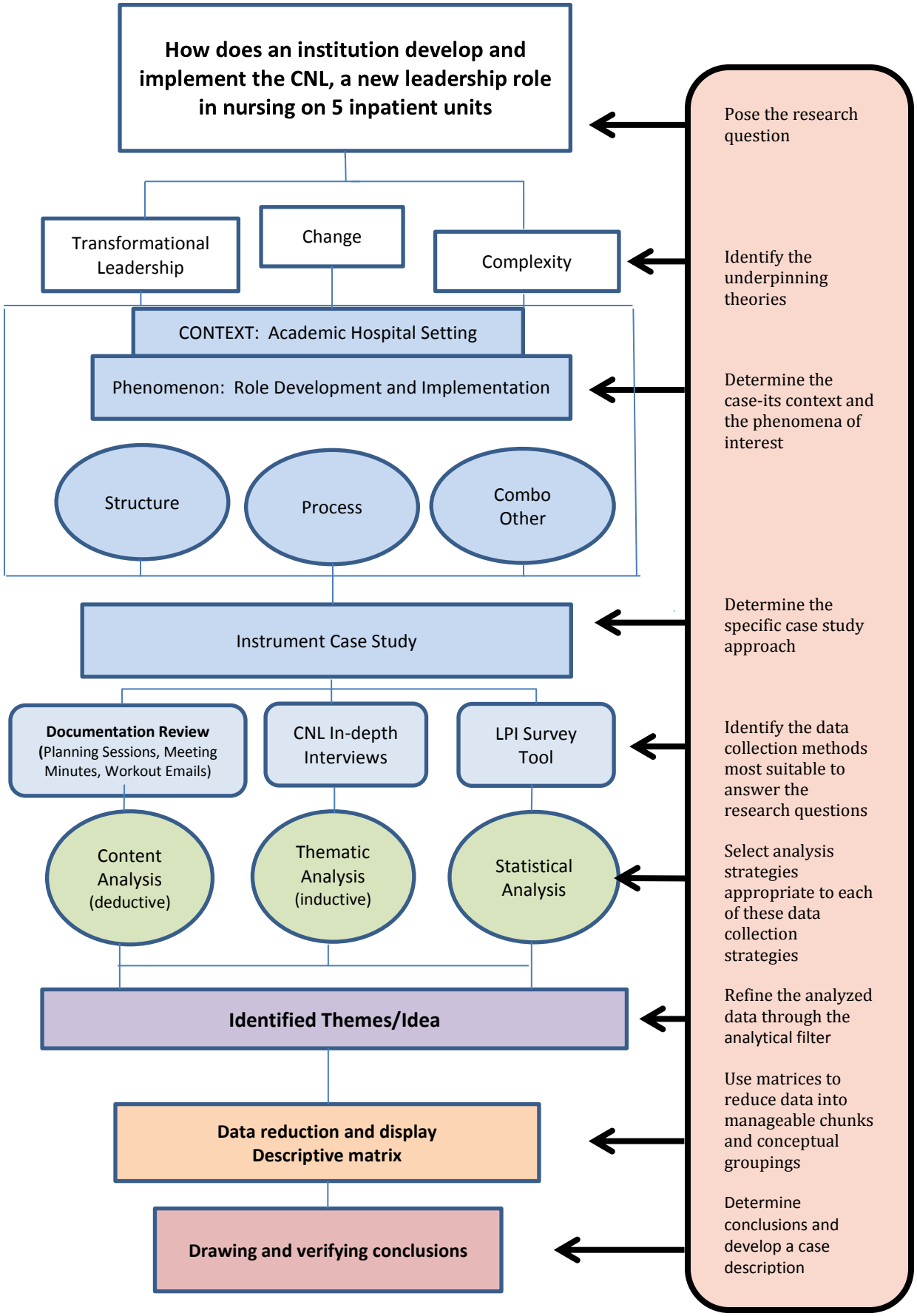

Figure 1. Case Study Schematic

Multiple sources of evidence were incorporated, including archival research into documents containing planning sessions, meeting minutes, emails, and workout sessions that Greenwood and Levin (2007) label as "search sessions," in which content analysis was applied.

Another source of data was interviews with participating Clinical Nurse Leaders/Clinical Nurse Leader–fellows (CNL/CNL-fellows). At their ongoing weekly Thursday planning meeting, an overview of this study was provided, with a subsequent email sent inviting participation. Informed consent (Appendix C) was obtained by each CNL/CNL-fellow agreeing to participate in an interview. The interviews included both structured and unstructured dialogue and occurred individually to minimize peer influence. Interview questions were compiled from the literature review, pilot study, and personal experience (Appendix D).

Additionally, questions were asked in an informal or conversational manner, structured to begin with more of an objective focus before transitioning to questions of more personal nature to increase comfort and trust. Anticipated interview length was 60-90 minutes. Upon completion of the interview, a summation of the interview was sent to each participant who had the opportunity to review the summation and delete comments they did not care to have shared. Additionally, each participant had the opportunity to modify comments to more accurately reflect their meaning. Approval of summation (Appendix E) was obtained before any analysis began. To address the concern that CNL/CNL-fellows might not be comfortable sharing less than positive perspectives with someone they perceive was intimately involved in the development and deployment of the role, each participant was offered the opportunity to confidentially offer additional comments via an institutionally approved survey tool.

Data were analyzed for patterns incorporating both deductive and inductive approaches. Both documentation and CNL/CNL-fellow interview information were situated in separate and individual matrixes as a filter to refine data and reduce material into manageable portions. Information was subsequently coalesced into conceptual groupings to create the foundation for drawing and verifying conclusions that will be reported in the following chapter.

To more fully understand the transformational leadership aspects of this case study, five medical surgical units participated in the quantitative element of this study. Participants were comprised of licensed nurses as well as unlicensed personnel. Participants completed a Demographic and General Information Section (Appendix F) incorporating demographic data including age, gender, educational preparation, role, shift, overtime, and work experience to describe the population sample of participants responding to the survey. Following the General Information Section, participants completed either a *LPI OBSERVER* or *SELF* developed by Kouzes and Posner (Appendix G). The *LPI OBSERVER* tool was completed by staff and the *LPI SELF* was completed by each CNL/CNL-fellow. Each tool contained identical questions; the only difference between the two tools is that an "I" was substituted for the "he/she" connoting the leader in the *LPI SELF* tool.

The tool assessed the five essential leadership practices of transformational leaders previously described as "Models the Way," "Inspires a Shared Vision," "Challenges the Status Quo," "Enables Others to Act," and "Encourages the Heart." The *LPI* tool is a 30-item instrument integrating six questions focused on each of the five transformational practices using a 10 point Likert scale including the following frequency scale responses: 1-*almost*

never, 2-*rarely*, 3-*seldom*, 4-*once in a awhile*, 5-*occasionally*, 6-*sometimes*, 7-*fairly often*, 8-*usually*, 9-*very frequently*, and 10-*almost always*.

Participants utilized an institutionally approved online method to complete the survey to assess the staff's perception of the transformational practices of the CNL/CNL-fellows and correlations to CNL/CNL-fellows' *LPI SELF* reports. The *LPI OBSERVER* survey was in the format of self-reporting and is anonymous. Each CNL/CNL-fellow was given access to their own information obtained from the *LPI SELF* survey tool. This data will help guide and direct future research activities at the institution where the research took place related to TL and the CNL role. Additionally, a copy of any reports, papers, or other publications that might arise out of the utilization of the tool will be shared with Kouzes and Posner per their request.

Ethical Considerations

No quantitative data collection instruments contained any identifiers for the *LPI OBSERVER*. All staff participants remained anonymous. Quantitative data collection via the institutionally approved online tool was returned to the Nursing Research repository without email addresses to ensure anonymity for participants completing the *LPI OBSERVER*. The principal investigator and each CNL/CNL-fellow completing a *LPI SELF* survey tool had access to their own assessment data. For aggregate reporting purposes, individual CNL/CNL-fellow names were removed and assigned an alphabetical identifier (A-I) to maintain confidentiality. This study posed no known risks to participants.

Population and Sampling for Quantitative Portion

The sample for completing the *LPI* survey tool was non-probability and purposive in nature. Approximately 300 RNs and unlicensed personnel identified as Certified Nursing Assistant (CNA) and Hospital Unit Clerk (HUC) were recruited to participate in completing the *LPI OBSERVER* (Appendix G). CNL/CNL-fellows on each unit were recruited to complete the *LPI SELF* (Appendix G) at their weekly staff meeting. Staff personnel were recruited during staff meeting(s). Additionally, an email with a link to the survey tools located on Survey Monkey (organizational approved survey database) was distributed to staff personnel soliciting participation (Appendix H). Excluded from the research were individuals who float to the unit (e.g., non-unit RNs/unlicensed personnel), and consultants such as pharmacists, physicians, physical therapists, and so on.

Data Collection

Qualitative

Information was gathered, as previously noted, from archival documents including planning sessions, meeting minutes, and workout sessions. Content analysis (deductive) was applied to this documentation review. Interviews with each CNL/ CNL-fellow were taped. Each interview was transcribed within 2 weeks of interaction by a transcriptionist. Summation information was returned to each participant for review, and they had 2 weeks to verify and modify information. Three of the nine CNL/CNL-fellows requested and were granted a 2 week extension. Each participant's information had their name removed and was only referred to by an alphabetical identifier (A-I) to maintain confidentiality. As noted earlier, all information was housed in a secure location where only the primary researcher had access.

Quantitative Instrumentation

Transformational leadership practices in this study were investigated using the *LPI SELF* and *OBSERVER* survey tools (Kouzes & Posner, 2003). Kouzes and Posner developed the *LPI* tool through a triangulation of qualitative, quantitative research methods and studies (Kouzes & Posner, 2010). The tool assesses the five essential leadership practices of transformational or exemplary leaders identified previously as "Models the Way," "Inspires a Shared Vision," "Challenges the Status Quo," "Enables Others to Act," and "Encourages the Heart."

The *LPI* tool (Kouzes & Posner, 2003) is a 30-item instrument described above. It has been used extensively throughout the world (more than a million respondents) and in various organizational settings (Kouzes & Posner, 2010). Comprehensive analysis of the psychometric properties for the *LPI* were reported in 2000 with data analyzed from approximately 18,000 test takers. In September 2010, further psychometric testing for the *LPI OBSERVER* confirmed ongoing reliability and validity with data collected from over 1.3 million respondents. Internal reliability was demonstrated with consistent Cronbach alpha coefficients greater than .80 (a range of .85 to .92 across the five subscales); (www.leadershipchallenge.com). Convergent validity was shown by consistent statistically significant differences in subscale results of the *LPI* for weak, moderate, and strong positive workplace groups as categorized by the *Positive Workplace Attitude (PWA)* scale. Statistically different leadership practices across the five subscales were documented as predicted for gender and ethnicity.

The *LPI* has been used internationally with respondents from a large variety of functional work areas including construction, engineering, finance, human resources, informational systems, management, manufacturing, marketing, operations, research and

development, and sales. These areas represent the following industries: aerospace, automotive, banking, computers, education, government, hospitality, petroleum, pharmaceuticals, publishing, retailing, real estate, telecommunication, transportation, social services, and in particular, the medical/healthcare industry. Geographical regions reflected in the psychometric testing include the United States, Canada, Latin America, Europe, and Asia (www.leadershipchallenge.com).

Kouzes and Posner's confirmatory research on the *LPI* has been supported by other research (Bowles & Bowles, 2000; Fields & Herold, 1997; Shoemaker, 1999; Tourangeau & McGilton, 2004). As with most tools, there are those researchers who dispute some findings and conclusions, as is the case of Carless (2001) and Patton (2002). Carless (2001) concluded specific and distinct transformational leadership practices demonstrated high intra-correlations, and it was challenging to distinguish between the individual practices. Patton (2002) observed a high degree of cross over in the Model and Inspire practices, questioning if followers could actually differentiate between specific practices. Overall, there appears to be far more research supporting the current claims of the psychometric properties of the *LPI* tool, than does challenge the current claims.

In the process of psychometric testing, the average time taken to complete the instrument was 10 minutes. Permission to use the survey tool was granted by the developers and the publishing company who distributes the tool (Appendix I).

Data Analysis

Qualitative

Data from the documentation review incorporated deductive content analysis. Information obtained from each unit's planning and implementation was positioned in a

designated color in Appendix J: Unit Similarities and Differences Matrix to give consistency to the investigation. The matrix outlined nine different components examined that related to the role development and implementation process for each unit. These nine components were task force membership and attendance, time to implement the role, length of planning meetings, planning endeavors undertaken by the unit, launching and closing activities, communication strategies, educational elements, content of meetings/emails, and a miscellaneous section to capture information not easily categorized by the other eight components. Each unit's data were then transferred to a large poster board correlating with each of the nine investigated components to ascertain similarities and differences. Coalesced information only obtained the label of "theme" if four of the five units demonstrated similar findings. Specific findings related to commonalities and variations will be discussed more fully in subsequent chapters.

Qualitative data obtained from the interviews were examined inductively. Transcripts as a whole were read at least 14 times, and individual transcripts were read many more times. Important to note is a deliberate attempt on the principal investigator's part to objectively listen in a thoughtful manner. This is important for any interview process, but doubly so for this study due to the principal investigator's close involvement with the development and implementation process. As a mechanism to ensure the CNL/CNL-fellows had the opportunity to share less than positive information with the primary researcher, a confidential survey link was established to capture confidential comments.

After interviews were completed and CNL/CNL-fellows approved content, each verbatim comment was situated in an analytical filter identified as a Descriptive Matrix (Appendix K); (Rosenberg & Yates, 2007). Comments were situated into level of impact,

ranging from macro or organizational, unit to self with further classification into structure, process, or combo /other foci. Comments were further delineated into categories perceived as a facilitator or a barrier. A matrix was completed for each interviewee in an assigned and different color.

Comparable comments obtained from individual matrixes were clustered together on a large poster board outlining a particular subset of the matrix. For example, one poster board contained all interview comments related to organizational, unit, and self level of influence whose focus was structure and perceived as facilitative. Another poster board included all interview comments associated with organizational, unit, and self level of influence comments whose focus was structure and perceived as a barrier.

A total of six poster boards were populated (Appendix K), and boards began to look like a patchwork quilt with all the various and different colored comments. Discrete poster boards allowed for a specific and concentrated examination with a narrower focus to identify possible patterns or concepts. They also facilitated easier intra/inter subset comparisons. Additionally, this process forced me to toggle back and forth between minute details and the "big-picture," analogous to changing the aperture on a camera lens. Data on poster boards were reviewed at least four times, with the first and second review producing some movement in the location of verbatim comments (both within the poster board and to another poster board).

To help verify accuracy of comment positioning and clustering, after the third review, I connected with a colleague, not employed by the organization where the study was conducted nor who had any connection to the project. The anonymity of the responses was maintained by sharing only color-coded comments but no names or alphabetical identifier.

This colleague, confirming all but one comment location, was not paid, but used this work/analysis to partially meet educational requirements in a graduate program.

Clustering of verbatim comments functioned as a mechanism to uncover any potential relationships or themes. A theme was identified as such only after a minimum of seven of nine respondents offered comparable observations. Three kinds of themes emerged with this process (role, implementation, and operational), which will be more fully discussed in ensuing chapters. The Descriptive Matrix (Appendix K) along with the color-coded poster boards functioned as an analytical filter, providing a systematic and rigorous method to organize and refine significant volumes of data. This also created a traceable audit trail (Rosenberg & Yates, 2007).

Quantitative

Quantitative data analysis included the use of descriptive and inferential statistics incorporating one-way analysis of variance (ANOVA). A pilot study on one of the participating units was conducted in March 2012 as a mechanism to test the instrument and procedures of distribution and collection. Only two minor recommendations of change emerged from the pilot study. One was to slightly modify observer directions, and the other arose around location of CNL/CNL-fellow names in relationship to the LPI questions. The layout change was not recommended for additional clarity, but rather allowed observers to more efficiently complete the *LPI* tool. Data collected with the *LPI* tool will be shared with the developers and publishing company per agreement (Appendix I) to enhance the development of these instruments and to contribute to the body of knowledge. All identifying information will be deleted prior to the data being shared.

Summary

This case study investigation, integrating both qualitative and quantitative facets, contributed to the understanding about this complex and highly contextualized phenomenon by examining the role development, implementation activities, and perceived transformational leadership practices of nine CNL/CNL-fellows at a healthcare institution in the Upper Midwest.

Qualitative data obtained from document review along with CNL/CNL-fellow interviews were situated in analytical matrixes or filters to identify concepts, detect relationships or patterns, and reveal potential themes. Perceived transformational leadership practices of the CNL/CNL-fellows were measured using the *LPI Tool* (Kouzes & Posner, 2003), applying descriptive and inferential statistics. Subsequent chapters will explore in detail the study's findings, results, and implications as a mechanism to enhance practice and improve patient outcomes.

CHAPTER FOUR: FINDINGS AND RESULTS

The purpose of this research, questions to be investigated, and the instrument tools and methodology were outlined in prior chapters. This chapter will present discoveries of overall findings along with the statistical methods employed. The information will be presented in a sequential manner aligning with the order of research questions previously delineated in Chapter 1.

Exploring Similarities and Differences of the CNL Role Development and Implementation

The first research question sought to examine the similarities and differences of role development and implementation on each of the five inpatient units. To accomplish this, a variety of documentation materials were reviewed and included emails, meeting minutes, planning sessions, educational sessions, and communication information. Document review spanned 28 months beginning October 2009 until February 2012, which was 2 months after the last unit implemented the role. An acknowledgement regarding email review and meeting minutes is necessary to note.

While participating individuals were willing to share emails regarding the development and planning processes (more than 500), in all likelihood the emails obtained did not reflect the entire body of emails exchanged. Moreover, it is recognized that while a consistent meeting minute and planning session template was utilized, variation with content and details documented potentially might occur related to different facilitators' personal perceptions.

The data were initially overwhelming in both content and volume. To give structure and consistency to the investigation, each unit's meeting minutes, planning sessions, and pertinent emails were placed in Appendix J: Unit Similarities and Differences Matrix

offering content analysis of a deductive nature. Nine components examined for each unit's development and implementation process included task force membership, roles and attendance, time to implement the role, length of planning meetings, activities in addition to planning meetings, launching and closing activities, communication and educational strategies on both organizational and unit level, content analysis of discussion topics of planning meetings/emails, and a miscellaneous section.

The content analysis was divided into two categories, role development and implementation, to help the researcher ascertain the focus of the conversations. A miscellaneous section for other notables was incorporated to capture important topics that might not directly be related to either role development or implementation. To offer clarity to the reader, the term "task force" will be used interchangeably with the term "planning group," and refers to the interdisciplinary group facilitated by the CNL/CNL-fellow overseeing the development and implementation process on each unit. Task force members were solicited by the unit manager and represented the following roles: bedside RN, discharge RN, certified nursing assistant, health unit coordinator, social worker, unit educator, and unit manager.

Similarities

Similarities of units' role development and implementation processes will be discussed first, followed by an exploration of unit differences with the same processes.

Being Chosen

All of the CNL/CNL-fellows were selected or appointed, rather than participating in an application process. Due to the newness of the role nationally, the range of role applications, and the magnitude of the project, the executive leadership (Chief Operating

Officer (COO), hospital Vice President, Chief Nursing Officer (CNO), and researcher) felt that designating the right people for these roles would be essential for success. A few statements obtained from meeting minutes recognized, but did not discuss, that some staff viewed this practice as unfair, feeling an application process would have been more appropriate. In reviewing documentation to more fully understand the scope of dissatisfaction with this process, emails reveal the concern arising not from bedside nurses but from other nursing personnel such as educators, quality nurses, and advanced practitioners. On the other hand, CNL/CNL-fellows articulated in interviews that they "Felt honored to be approached" (CNL, F), were "So excited to be solicited to participate" (CNL, D), felt "Validated as a practitioner" (CNL, H), and were "Proud to be asked" (CNL, B).

"One of Us" Attire

During development sessions, the original task force determined that the CNL/CNL-fellows would wear the uniform of the registered nurse rather than street clothes and a white lab jacket, which other organizations preferred. Rationale for this emerged out of the desire to send a message of being part of the team and in the "trenches" with the staff. Review of documentation and session participation indicated strong staff support for this decision on all units.

Confluence is Created by Central Colocation and Collaboration

Promoting CNL/CNL-fellow visibility and access to bedside staff was deemed important by the initial task force. Consequently, space in the center of each unit was converted to situate the CNLs/CNL-fellows. This move was contrary to established organizational philosophy, which historically supported leadership personnel (except for the unit manager) to be close to the unit, but not "in" the unit. Similar to the attire decision, documentation

review and attendance at multiple communication and educational sessions indicate all units embraced this decision, with staff extending only positive comments.

Just a few examples reflecting support obtained from meeting minutes and affirmed in interview information were noted: “I love that I can quickly get them if I need them,” “They will be just steps away,” and “I won’t have to waste time hunting for them.” Centrally locating the CNL/CNL-fellows was viewed so positively that the initial unit CNL/CNL-fellow pair suggested other leadership positions (quality and education) be co-located in the same central office space as well to further promote accessibility and collaboration. Subsequently, all units centrally co-located support leadership personnel in the unit. While this office matter was not in the original planning scope, this organic development was integrated on all units, garnishing unanticipated positive consequences.

School is Work and Work is School

During initial planning activities, it quickly became apparent that the role required full-time status. That being acknowledged, this requirement posed some real challenges for the certified CNLs and CNL-fellows. Multiple semesters requiring hundreds of practicum hours per semester necessitated the CNL-fellow to be away from the unit a minimum of 2 days a week and sometimes more. Besides the CNL-fellow not being able to participate fully in the development and planning activities, in addition to experiencing financial burdens due to a reduction of paid hours, these educational requirements created an undue burden on the certified CNL to take on additional responsibilities.

To address institutional and CNL/CNL-fellow concerns regarding this issue, the “work is school and school is work” philosophy was adopted for all units. The institution collaborated with an academic partner to create a plan allowing current CNL-fellow planning and

implementation activities to partially meet practicum hours while being paid at a full-time status. Additionally, with an academic partner, the institution modified some of the development and implementation activities to better align with established curriculum creating win-wins for all.

Leap Frog Implementation Approach

Since the role was so new and complex, and there were not enough certified CNLs to fill all needed positions, it was determined by the researcher and administrative director that the best way to maintain a level of standardization and continuity was to implement a leap frog approach to the expansion of the role versus a big bang singular implementation. The term "leap frog implementation" was coined by the organization and reflected a process whereby an experienced and certified CNL would move (or leap) to a new unit only after a CNL–fellow was orientated on the current unit. Consequently, for those units large enough to have two CNLs (four of five units), a certified CNL would move to another unit only after a CNL-fellow was trained and oriented.

The length of orientation for the CNL-fellows varied from unit to unit based on their experience and how far along in the CNL curriculum they were. This allowed each unit to have a pairing of an experienced certified CNL with a CNL-fellow. CNL/CNL-fellow interviews (to be discussed in future section) indicated all eight affected by the leap frog approach believed this to be a strong facilitative factor. This approach was not part of original planning sessions on the pioneering unit but arose organically due to the speed of positive results.

Similarities with Differences Woven Throughout

Preliminary investigation revealed multiple similarities; nevertheless, a deeper probe of emails and facilitator meeting minutes (their own copies versus published minutes) and personal planning notes uncovered both obvious and subtle differences woven throughout the similar aspects of development and implementation. The following are specific illustrations depicting this assessment.

Discharge Nurse Role Phased Out

All units phased out the discharge nurse role, but the process and timeline for doing so varied from unit to unit. Just prior to the CNL initiative, an institutional LEAN investigation (efficiency efforts focused on enhancing processes) reviewed roles and functions within the hospital setting focusing on potential efficiencies. One role, the discharge nurse, received significant scrutiny. The discharge nurse's purpose as the title connotes was to ensure the details of discharge were completed.

While on the surface this sounds like a necessary role, the examination revealed the role actually functioned like a "sweeper" for multiple disciplines, not consistently completing required discharge activities, or as LEAN would label as non-value add (Marchwinski, Schroeder, & Shook, 2008). Additionally, the investigation uncovered that this role unintentionally mitigated some of the bedside nurses' coordination and accountability, thus fragmenting patient care.

The initial unit phased out the discharge role 4 weeks after the CNL implementation went live, with various timelines noted on other units: almost simultaneously with CNL go live, 6 weeks, and 11 weeks after go live date. The time frame allotted for phasing out the discharge role was the responsibility of the unit manager, based on her assessment of staff readiness to undertake certain functions of the discharge role. From document review and

conversations with unit managers, it appeared unit managers did not formally discuss rationale and timelines in peer management meetings, but made this decision independently.

Unsolicited and impromptu staff comments revealed a great deal of anxiety around the elimination of the discharge role. Reviewing meeting minutes of planning sessions, it appeared that only the initial unit discussed staff's concerns regarding the phasing out of the discharge nurse role with specific actionable items. Subsequent unit meeting minutes were silent on this particular topic. Interestingly, over 150 emails (approximately 30%) involved discussion or comments of some kind regarding the elimination of discharge nurse. Further dialogue on this will be offered in the thematic discussion.

CNL/CNL-Fellow Observations

To help ground CNL/CNL-fellows to the complexity and interconnectedness of multiple disciplines caring for patients, along with understanding the current state at a deep unit level, CNL/CNL-fellows completed observations of various roles. The intent of the experience was to share observations with unit staff as a mechanism to gain input on improvement opportunities identified and to begin to prioritize CNL/CNL-fellow future work. A template for observations was created outlining purpose and rationale along with identification of specific roles to be observed. This template was shared with all supervisors accompanied by a request to discuss with affected staff. Some supervisors shared information with staff and others did not. CNL/CNL-fellows disclosed that staff members who did not receive information and context to the observation experience voiced confusion and appeared less willing to share perspectives. One role, pharmacy, was not included in the observations, which in retrospect would have been beneficial due to the greater than anticipated interaction between CNL/CNL-fellows and pharmacy.

While CNL/CNL-fellows demonstrated consistent use of the template and all expressed the value of the experience, the timing required to complete observations varied. Four CNL/CNL-fellows completed all observations before the official first day of role implementation, and five completed observations after going live. Times to complete varied, but 11 weeks appeared to be the longest. Those completing observations after go live indicated planning and implementation responsibilities took more time than anticipated.

The mechanism and timing to share observations with staff differed unit to unit. The initial unit's CNL/CNL-fellow created a comprehensive document (30 pages) organized thematically that was sent to staff members with the idea that the document would prompt discussions at future planning sessions. Even though the staff members knew the purpose of the observations (information was sent via email and shared at staff meetings), the document created a great deal of angst and was perceived very negatively. Staff shared that when they saw 30 pages of potential opportunities for improvements, they were overwhelmed and demoralized, questioning the current quality of care rendered. After discussion, staff better understood that while excellent care was being provided, the purpose of sharing observations was to explore improvement opportunities.

Observation feedback for subsequent units was modified, with some modifications planned and others evolving more organically. No information was sent to staff members prior to information session(s) focused on potential future improvement opportunities. Additionally, prior to the face-to-face distribution of the observation document, CNL/CNL-fellows expressed appreciation for the staff's effort and carefully framed purpose and content. Furthermore, the observations were condensed to just a few pages, reflecting a much higher-level overview with an offer of more details if staff expressed an interest. A few

units had some unforeseen issues arise, so sharing of the observations did not occur until after the unit went live.

Differences

Though many similarities existed in role development and implementation activities on each of the five units, several meaningful differences in these processes were detected as well.

Implementation Timeframes

Timeframes varied for participating units. The initial unit's planning spanned approximately 10 months. Subsequent units incorporated 3 months of planning with the last units' preparation time condensed to 8 weeks. The rationale for abbreviated planning time frames was that multiple philosophical and operational details had been determined by prior units' activities. While the condensed time frame initially made sense, interview information revealed the abbreviated time frame limited the CNL/CNL-fellows' ability to build trusting relationships and foster staff engagement in this initiative. It also appeared to hamper the ability to help staff understand and leverage this role.

The initial unit's "go live" timeframe was intentionally identified as "living" versus cast in stone to accommodate any potential unforeseen difficulties. The initial unit's "go live" was in fact extended by 3 weeks because of such an issue. All other unit "go lives" reflected more of a cast in stone mentality, with planning timeframes established and communicated to the organization a minimum of 7 to 12 months prior to each "go live." Each unit went live singularly, except for the last two units, which went live simultaneously.

From review of written material and conversations with a variety of personnel, only the initial unit appeared to have had a formal celebratory gathering commemorating the efforts of

the planning group. All other units just phased out the CNL planning task force by ceasing to meet. Possible rationale for this will be discussed in the Pioneering Unit: Creative Force section.

Planning Task Force

CNL/CNL-fellows chaired each unit's planning task force, but both the membership and size varied somewhat from unit to unit. Probably the most palpable difference was executive participation. In the initial unit, meeting attendance for executive and mid-level personnel was close to 100%, with multiple debriefing and mentoring sessions occurring with CNL/CNL-fellow between unit planning sessions. In the second and third unit, executive personnel (Chief Nursing Officer [CNO] and researcher) attended the introductory planning session but attended sporadically throughout the following planning sessions, and in the last two units' planning sessions, the executive personnel was not present except for the kick-off planning meeting. Mid-level operational leadership's participation in planning diminished with each unit's implementation as well, but not quite to the same degree as did executive participation.

Clinical mangers solicited staff to participate on the planning task force. Units had similar roles present, but the initial unit had a few more people in each role represented. If one excludes executive and mid-level personnel, initial unit task force had three more members. Average attendance of planning sessions for the pioneering unit was slightly higher (approximately 72%) than subsequent units, which averaged around 60%. Each unit's "go live" meeting minutes overall got shorter and shorter throughout the planning process. Initial unit's meetings generated 6-7 paged documents, tapering off to 2-3 paged documents, while other units began with 4-5 paged documents tapering to 1-2 pages.

The lengths of planning sessions were generally 90 minutes for all units except the last two, which were closer to 60 minutes. The first unit's planning sessions occurred twice a month for a number of months, transitioning to weekly for 2 months immediately preceding unit go live. Other units, due to the condensed planning time, met weekly for the duration of the planning sessions. For those units with additional initiatives added, it appeared at least half of the planning times were allocated to those initiatives, reducing the actual planning for the CNL role by approximately one half.

Pioneering Unit: Creative Force

Likely the most significant difference in role development and implementation between units arose with the concentration of role development activities by the initial unit. Investigation clearly supports the initial unit, at a fundamental level, functioned as the primary creative force in role development, with subsequent units applying developmental elements to individual unit implementation. For example, CNL C shared "Didn't plan lots of the initial things like the 12 bed model, office, and uniform, I just tweaked for our unit." CNL A stated that, "Most of the details were figured out, [we] just needed to put our unit slant on the information."

Furthermore, the initial unit demonstrated a much broader professional and organizational awareness during the planning process. It was not uncommon during initial unit planning sessions to hear questions posed inquiring about organizational or professional impact of proposed ideas. Efforts were intentionally positioned not only to meet unit needs, but also to address organizational and professional responsibilities. To the researcher's recollection, and from personal notes taken throughout this journey, only one other unit

raised organizational questions during planning sessions, and no other units discussed professional obligations.

Task force members in the initial unit created a set of guiding principles and list of over 200 questions to be investigated related to the role, ranging from philosophical to operational in nature. Just a few examples of philosophical discussion topics include, What does 24-hour accountability for practice issues mean, and how would the interpretation practically be applied? What should the CNL/CNL-fellow wear to best reflect the intent of the role? Examples of operational questions include, How are other institutions utilizing this role and what can we learn from them? What is the reporting structure for these roles? Will this new model change staffing patterns? Executive (researcher and CNO) along with operational (director) leadership gave guidance and direction to these discussions with the first 5 months of planning dedicated to addressing questions. Task force member comments reflect both gratification and fulfillment with this process.

Multiple other activities undertaken by the initial unit task force personnel give additional credence to the notion that this unit functioned as the creative force in role development. Job descriptions were created to align CNL/CNL-fellow role and responsibilities as outlined in the AACN's white paper (2007). Quality, cost, and satisfaction metrics were identified and as discussed earlier, and unit personnel participated in workout sessions establishing efficacious care flows.

The CNL role was so new nationally that at the beginning of this journey, no hospital to date in the upper Midwest region had implemented the role, and the institution began to be inundated with requests seeking information about the journey. Consequently, the CNL/CNL-fellow on the initial unit developed and taped short vignettes that were located on

the institution's internet site that could be accessed by both internal and external personnel. Some topics covered include, What is a CNL?; What does a day in the life of a CNL look like?; Exploring Metric Development; Implementation Journey Details; and testimonials describing how the role impacted patients and staff. These resources functioned to help educate internal staff, but also served as a time saving mechanism to answer other institutions' questions.

Based on observations, the pilot CNL/CNL-fellow co-partnered with information services to create technological tools to enhance the interdisciplinary discharge process and aid them in efficaciously managing and coordinating care. These tools also assisted other facilities (e.g., nursing homes) in obtaining information they deemed necessary without making multiple telephone calls. Other units utilized these tools, but to date few enhancements have been integrated into those original tools. Lastly, when expansion was accelerated, the initial CNL/CNL-fellow created orientation guidelines as well as educational and communication templates for other units.

The first unit held scheduled weekly debriefing sessions including a few unscheduled gatherings for 6 weeks after go live with the CNL/CNL-fellow, executive sponsor (researcher), mid-level director, and unit manager as a mechanism to do rapid cycles of change as needed. Subsequent units incorporated very limited (as needed), less formal debriefing sessions with the operational director incorporating no executive participation. It appeared that the unit manager's attendance at these debriefing sessions was somewhat less consistent than the pilot unit.

A 5P Twist: The Possibilities, Pitfalls, and Perseverance Required to Pioneer in One's Own Profession

While the document review offered considerable information about the CNL role's development and implementation processes on five units, CNL/CNL-fellow interviews were conducted to offer additional insights and functioned to address the second research question: How does each CNL/CNL-fellow perceive role development and implementation including their role in the process? Are there any common themes? Facilitative activities? Barriers? The title of this section reflects a twist on the microsystem method of evaluation previously outlined on pages 3-5. The "P's" outlined above on a very general level comprised the broad spectrum of thoughts and emotions expressed by CNL/CNL-fellows during their interviews regarding role development and implementation.

Nine individual CNL/CNL-fellow interviews were conducted, augmenting documentation information to enhance understanding of the CNL role development and implementation process. Interviews occurred in April and May 2012, lasting from 55 minutes to 105 minutes, incorporating questions outlined in Appendix D to maintain consistency and allow for comparisons. A few open-ended questions were included to permit each CNL/CNL-fellow to tell her own story related to the development and implementation. Each interviewee reviewed her own transcript for accuracy, making modifications as desired before any analysis began.

One interview tape broke approximately three-fourths of the way through transcription and could not be recovered. The impacted staff was asked to recall to the best of her knowledge her responses related to those questions that could not be retrieved. To maintain confidentiality of responses, each CNL/CNL-fellow going forward will only be identified by a randomly assigned alphabetical letter A-I. Furthermore, future discussions incorporating

verbatim comments will only designate responses by the assigned CNL alphabetical letter, rather than differentiate CNL/CNL-fellow, to add an additional layer of confidentiality.

Details regarding interviews were delineated earlier; however, another aspect of the process necessitates discussion. Recognizing the researcher's close involvement with this project and CNL/CNL-fellows' potential unwillingness to share thoughts or ideas that would not shed a positive light on the process, a confidential survey link was established as a mechanism to obtain comments they might not feel comfortable sharing face to face with the researcher. The author shared this option with each CNL/CNL-fellow during the interview process and within a day emailed the link to them. No responses were submitted within the first month; consequently, the researcher re-sent the email invitation to share comments and the survey link to all. This confidential survey opportunity remained open for 10 weeks, but no feedback via this survey link was submitted.

To give consistency and coalescence to the process of thematic inductive analysis, a Descriptive Matrix (Appendix K) was utilized to capture interview data. Three levels of influence were identified representing macro (organizational), micro (unit) and self, along with three focus options (structure, process, or combination). Additionally, facilitative and barrier categories were established to capture CNL/CNL-fellow perceptions. Each CNL/CNL-fellow's verbatim comments were color-coded and positioned in a separate individual matrix. The researcher reviewed placement of interview comments at least four times to ensure consistency and accuracy.

Comparable comments obtained from individual matrixes were clustered together on a large poster board outlining a particular subset of the matrix. A total of six poster boards were populated (Appendix K), and boards began to look like a collage with all the various

and different colored comments. As noted in the methodology chapter, discrete poster boards allowed for a specific and concentrated examination with a narrower focus to identify possible patterns or concepts. They also facilitated easier intra/inter subset comparisons. Additionally, this process forced me to toggle back and forth between minute details and "big-picture" analogous to changing the aperture on a camera lens. Data on poster boards were reviewed at least four times, with the first and second review producing some movement in the location (both within the poster board and to another poster board) of verbatim comments.

Comparison and analysis occurred to identify patterns or relationships with comments. Labels/titles of themes occurred only if a minimum of seven of nine interviewees verbalized analogous comments and required a great deal of thought to accurately portray both the content and intent of CNL/CNL-fellow comments. As a mechanism to adequately address research question 2, three categories of themes will be explored: role, implementation, and operational. Role themes arising out of this process will be discussed first, followed by implementation themes, and concluding with a conversation integrating a general operational theme.

Role Themes

The CNL role is clearly in the embryonic stages of development, as outlined in earlier chapters. That being acknowledged, it is important to investigate various aspects of the role to understand how individual perceptions and interpretations of the role are constructed within the context of this new phenomenon. Three themes were identified related to role development: generalist to a point, the pull of polarity or the dissonance of duality, and complex role for complex times.

Generalist Only to a Point

The AACN's White Paper (2007) clearly positions this role as a generalist in the care environment; however, interview comments offer a somewhat different perspective on that interpretation. Interviewees (8/9) indicated that it would be a challenge to practice effectively in an arena where one had no clinical background and offered the following comments: CNL G shared, "I don't think I would be as effective on a unit that I knew nothing about." CNL D said, "My perception is that when you have limited clinical expertise, and you are not a known entity, doing the work can be a struggle." CNL B disclosed that, "It helped that staff knew us, and we didn't have to develop relationships from ground zero."

Imbedded into the generalist comments was that relationship building takes patience, perseverance, and more time than anticipated. CNL B indicated that a "couple of nurses are hard to break through and make connections. They see us trying to take something away versus lightening the load, but we just have to keep at it." CNL D shared that, "It takes lots of time to cultivate relationships." CNL E said, "Even though I have great relationships with staff, it's always a work in progress, and it's not an issue that goes away."

Pull of Polarity or the Dissonance of Duality

This role is situated at the microsystem level by the AACN (2007); however, all participants voiced challenges practicing horizontal leadership in a traditional hierarchical structure. They articulated struggles attempting to solve unit problems creatively within the context of organizational constraints. The CNLs understood the negative implications of a primarily decentralized system, but felt that too much emphasis on organizational "sameness" or standardization decreased personal accountability and stifled innovation. In fact, CNL I used the words "[I feel] pulled in opposite directions." CNL D felt "at times

constrained to implement creative solutions because the organization is so focused on standardization—[the organization] really only desires to implement a single solution, even if it doesn't make sense sometimes."

This duality pertained to perceived pressures of organizational initiatives as well as organizational standardization. All but one CNL indicated that sometimes competing initiatives created challenges in prioritization. CNL G's comment, "Some days I struggle with what I should focus my efforts on," summarizes the group struggles.

The pull of polarity theme extended to staff issues as well. All interviews articulated being pulled in many directions, not infrequently questioning themselves to ascertain if they were doing the right thing at the right time to create the best outcomes. CNL H indicated, "I'm always trying to balance right level of superficiality and deep dives." CNL D shared that she tries to "balance when to teach, when to do, when to lead. Important for staff to see all three, but the trick is doing each one at the right time."

The dissonance theme applied to one another as peers as well. While they recognized each CNL/CNL-fellow as unique, interviewees revealed various degrees (depth) and need for self-reflection to compare and contrast how each individually address practice issues on respective unit(s). Additionally, it appeared from comments that stylistic approaches varied, which created angst with some CNL/CNL-fellows and less so with others. CNL B shared the overall feelings, articulating, "We're a work in progress as a group, [we] haven't fully figured out when [it matters] that we are all approaching the problem the same way, and when [it doesn't] really matter."

Complex Role for Complex Times

All participants verbalized the increased complexity of the care environment and the rapid speed of change. They felt this role was uniquely positioned to elevate the bedside nurses' practice and improve patient outcomes. CNL I said, "I now look at problems differently, more focused on the intricacies of professional relationships." CNL C said, "I kept getting farther and farther away from the bedside; this role pulled me back. I love being able to plant seeds and watch them grow." One CNL, when discussing the role, referred to a school project where she likened the CNL role to a spider and a web: "CNLs, like spiders, sit in the center and can differentiate causes of vibration…. webs take great energy and patience to build….semi-permeable circular thread portrays CNLs' fluidity of practice."

All acknowledged that complexity issues make the role very challenging. CNL F shared, "I had no clue how much emotional, mental, and physical energy doing the role would actually take…. and it's not always clear how/when to be independent." CNL G disclosed that, "This role is trying to do things differently and in ways that makes some uncomfortable…sometimes hard to navigate those waters." CNL I articulated, "Blurred boundaries can create blurred responsibilities, but not sure the organization is ready for this kind of thinking… makes the role really challenging sometimes."

Implementation Themes

While one might have similar perceptions of the CNL role, as was delineated in the prior section, it is possible that perceptions of the implementation of the role may vary somewhat. Interview comments revealed a number of implementation commonalities: appreciation of organizational support, support of the leap frog approach coupled with right unit partnerships, staff's fear and grief with the elimination of the discharge role, and

frustration with appending additional initiatives to the CNL role's development and implementation.

Appreciation of Organizational Support

Interviews (8/9) contained comments voicing appreciation of organizational support for this undertaking. CNL C articulated that, "The support and responsiveness amazed me." CNL I said, "I have been here my whole career, and I don't remember universal support before this." CNL A said, "I feel really lucky when I talk to other CNLs, and I hear the political battles they get caught in. One person tells them they need to do this, and another one comes and gives them completely different directions. I feel here, we're pretty much on the same page."

Support of the Leap Frog Approach Coupled with Selecting Right Unit Partnerships

All interviews referenced the benefit of the leap frog approach and successful pairings, with some offering more effusive praise. CNL G shared, "I loved the leap frog approach; I couldn't imagine a better way to spread this role." CNL H disclosed that, "I have no idea how you guys did it, but you selected the exact right partners." CNL I said, "My partner and I have complementary skills and approaches. It was really hard to implement this, but I couldn't imagine doing it with anyone else or differently than the leap frog way." A synopsis of comments indicated that the leap frog approach allowed units to learn and leverage; however, it was also recognized that greater leverage of learnings could have occurred which will be discussed in the subsequent chapter.

Staff's Fear and Grief with the Elimination of the Discharge Role

Most participants (7/9) talked about the staff's frustration and fear caused by the elimination of the discharge role as a result of the implementation of the CNL role. As was

previously noted, the discharge role had already come under scrutiny prior to the implementation, but staff struggled to recall that aspect. Interviewees by and large felt the organization offered multiple means of communication to share information about the rationale for eliminating the discharge role.

Some (3/9) felt the organization could have been more effective in communicating the role, while the remaining (4/9) recognized the difficulty of staff "hearing" information that they might not want to hear. CNL I said, "Popcorns of fear popped up, not so much about our role, but with the elimination of the discharge role." CNL B shared, "At first all they could think about is how would they even do this." CNL F said, "At first staff were hoping this role would just replace the discharge role, took them awhile to understand it was much bigger than that."

Frustration with Appending Additional Initiatives to CNL Role Development and Implementation

The institution where this work was being conducted has a documented track record of undertaking multiple significant initiatives simultaneously with little appreciation for the impact of those mandates. To more fully understand the rationale and impact of this cultural mores, the organization contracted with an external consultant to help devise solutions to appropriately prioritize strategic efforts to minimize competing agendas and situations. These consultant activities occurred closer to the end of implementation, so this initiative reaped little benefit regarding the balancing of competing projects.

Consequently, a number of interview comments reflect the frustration of appending additional organizational initiatives to the implementation process. Those multiple units having additional initiatives added to the CNL implementation process expressed greater

frustration with implementation and voiced more concerns with the ability to complete necessary activities than those units without additional initiatives. CNL D indicated, "I felt very frustrated when they added____. It sent a message that the role development and implementation was somehow not as big as it really was." CNL F shared, "I was stressed already with all that needed to be accomplished. When they told us we needed to _____, I really questioned how could we get it all done and do a really good job." CNL I verbalized, "Holy cow, will we never learn when enough is enough?"

Importance of Storytelling and Use of Language to Convey Partnership Messages

Although all interviewees used different words, 8/9 talked about creating personal connections with the staff to be able to understand and utilize the role to the fullest. CNL H indicated that she "incorporated stories on how the role could help the staff, gave them examples of how the CNL worked with other disciplines, [and] created pictures." CNL G said, "I wanted them to have an 'ah ha' moment about the role, so I shared other 'ah ha' moments from their peers." CNL C revealed, "I didn't talk much about what the role was; I shared specific stories about what the role could do for patients and staff."

Closely aligned with storytelling was the deliberate use of language to convey the messages of partnership. One CNL coined the phrase "guide by the side," and shared that she specifically did not use the word "help," instead intentionally using the phrase "Where are your hot spots?" CNL A asked staff, "What needs to be taken off your plate for you to be able to give the best care that you want today?" CNL G said, "What's getting in your way today of giving the best care you can?"

General Operational Theme

Development of Unit Leadership Team

This theme actually incorporates both structure and process aspects. Eight interviewees articulated unit leadership team dynamics as an enhancement opportunity. CNL H shared that the "leadership team doesn't always feel like a cohesive group, which is not good for staff." CNL B felt there are "different levels of accountability in team members." A few ideas were brought forth trying to uncover potential explanations for the lack of cohesiveness:

1. CNLs challenge acceptance of current state, generally requiring additional work for other team members: "We say that is not reality or that's not how it really is – sometimes they just don't want it hear it" (CNL B).
2. Unintentionally uncovered gaps in others' leadership skills, and "managers are unsure how to leverage our skills" (CNL A).
3. "Members not comfortable with ambiguity, not OK with talking out who will do what in what circumstance. They want it all lined up. It doesn't work like that anymore" (CNL D).
4. "There might be a bit of professional envy since the CNL role has received such positive accolades in the organization" (CNL B).

Transformational Leadership Exploration

Prior sections incorporating a qualitative focus advanced a number of findings related to the CNL role development and implementation activities. To offer additional understanding to this highly contextualized phenomenon, the conversation will transition to a quantitative emphasis addressing research question 3: What are the perceived transformational practices of the nine CNL/CNL-fellows using Kouzes and Posner's *Leadership Practice Inventory*?

Sample Characteristics

Surveys (Appendix G-Observer) accompanied by a demographic and general information section (Appendix F) along with consent forms (Appendix H) were distributed and available to 300 staff on five units having implemented the CNL role to complete from June 4, 2012 to June 29, 2012 via system approved electronic survey tool. The process was mimicked for the nine CNL/CNL-fellows, substituting *LPI* -Self (Appendix G) in place of *LPI*-Observer. Data were verified and inspected three times for outliers and irregularities to ensure accuracy. Total initial response was 252, and 43 surveys displaying identical responses to all questions were discarded per developers' recommendations; thus, the usable survey response total equaled 209. When reported *n* totals are less than that, it reflects missing data. Additionally, a minimum of four responses in any specific observer category was required to apply statistical calculations and to ensure anonymity of responders. Unit response rates ranged from 26%-61%. To maintain confidentiality of unit responses, unit names have been randomly replaced with a numerical identifier having no correlation to "go live" sequencing (Table 2: Usable Survey Totals and Unit Response Rates). Usable response rate for CNL/CNL-fellows was 100%.

Table 2

Unit Totals and Response Rates

Unit	Total Responses	Response Percentage
Unit 1	14	26%
Unit 2	44	40%
Unit 3	59	61%
Unit 4	47	46%
Unit 5	45	45%

Gender and age distribution of the sample is outlined in Table 3: Clinical Nurse Leader and Observer Gender and Age Distribution.

Table 3

Clinical Nurse Leader and Observer Gender and Age Distribution

	Clinical Nurse Leader		Observers	
Gender	Percentage	Totals	Percentage	Totals
Female	100%		96%	200
Male	0%		4%	8
Missing data	0%		0%	1
Age				
Less than 25			16%	33
25-34	78%	7	43%	89
35-44	11%	1	15%	31
45-54	11%	1	14%	29
55-64	0%		12%	25
Missing data				2

The overwhelming majority of responses were female, and demographic information obtained from the institution's Human Resources Department indicates a primarily Caucasian ethnicity of personnel working on participating units. There appears to be a much greater percentage of CNL/CNL-fellows in the 25 to 34-year-old age bracket compared to observers; however, for both groups the 25 to 34- year- old cohort represented the largest subcategory of survey participants. Among CNL/CNL-fellows, 56% had a graduate -level education compared to staff observers reporting less than 1% graduate -level education.

Statistical Analysis

Data were transferred from the electronic survey tool to a personal computer on which the *Leadership Practice Inventory (LPI)* software was downloaded. A review of the data was completed three times to verify correctness. A one-way analysis of variance (ANOVA) was the statistical approach completed utilizing the Statistical Package for the Social Sciences (SPSS), software specifically designed for behavioral research. For the purpose of this study, statistical significance was identified as $p<.01$.

Internal reliability as measured by Cronbach's alpha is .968, which was very high and consistent with other published studies (Duygulu & Kublay, 2011; Houser, 2003; Loke, 2001; Searle Leach 2005), and focused on nursing personnel. The validity of the *LPI* measurement tool has been well established within the nursing field and across numerous other industries (www.leadershipchallenge.com). Because of the extensive use of the tool and the widely accepted results, the *LPI* tool passes the face validity test of measuring the leadership constructs described by the tool's usage.

The LPI ratings for CNL/CNL-fellows were tested against numerous demographic and behavioral variables including age, licensure, educational preparation, years of experience, shift worked, overtime worked, unit worked, process to attain CNL education/certification, an indication of intent to leave position on unit, and the length of time the role had been implemented on each unit. Mean scores and standard deviations for each of the five leadership practices (Models the Way, Inspires a Shared Vision, Challenges the Process, Enables Others to Act, and Encourages the Heart) as well as specific variables were identified for CNL/CNL-fellows and follower responses.

For the remainder of this chapter, the following one-name descriptors will be used to describe each of the leadership practices: Models the Way- Model, Inspires a Shared Vision-

Vision, Challenges the Process- Challenge, Enables Others to Act-Enable, and Encourages the Heart- Heart. The discussion will commence with exploring variables appearing to have meaningful impact on perceived CNL leadership practices as reported by observers, followed by a discussion of variables not appearing to impact perceptions of CNL leadership practices as reported by observers.

Variable Discussion

Significant Variables

After analysis, a number of observer variables reflected statistically significant perceptions of CNL/CNL-fellow transformational leadership practices.

There is a significant difference in means across age for the "Challenge" practice category outlined in Tables 4 and 5. It also appears that those under 25 and those ages 35 to 54 tend to rate leaders higher on the "Challenge" practice category, while those in the 25 to 34 and over 54 rate them lower. The other four practice categories fail to show a statistically significant difference in ratings. However, the same age rating trend found in the "Challenge" category consistently appears in the other four practice categories, just not at a statistically significant level.

Table 4

Observer Mean Responses, Sample Distribution Examining Age Variable

Age	Model	Vision	Challenge	Enable	Heart	*n*
<25	46.54545	41.78788	44.93939	46.87879	42.15152	33
25-34	42.38636	39.38636	40.52273	44.42045	39.96591	88
35-44	46.36667	42.7	44.93333	49.73333	44.73333	30
45-54	48.1	44.76667	47.3	49.56667	46.2	30
55+	41.45833	37	39.5	45.66667	42.25	24

Table 5

One-Way ANOVA Investigating Age Variable

		Sum of Squares	df	Mean Square	F	Sig.
Model	Between Groups	1411.551	5	282.310	2.073	.070
	Within Groups	26960.370	198	136.163		
	Total	28371.922	203			
Vision	Between Groups	1185.528	5	237.106	1.412	.221
	Within Groups	33247.982	198	167.919		
	Total	34433.510	203			
Chal-lenge	Between Groups	1709.517	5	341.903	2.267	.049
	Within Groups	29858.420	198	150.800		
	Total	31567.936	203			
Enable	Between Groups	1188.024	5	237.605	1.841	.106
	Within Groups	25550.383	198	129.042		
	Total	26738.407	203			
Heart	Between Groups	1400.044	5	280.009	1.394	.228
	Within Groups	39777.618	198	200.897		
	Total	41177.662	203			

Tables 6 and 7 demonstrate a significant difference in means in the experience variable of the observer responses is demonstrated in all five practice categories. Those with 2 to 5 years in their current role rate their leaders higher in every category. Those serving in the same role for over 10 years consistently rate their leader high as well. Those serving less than 2 years and from 5 to 10 years in their current role appear to rate their leaders lower in all five practice categories.

Table 6

Observer Mean Responses, Sample Distribution Examining Experience Variable

Experience	Model	Vision	Challenge	Enable	Heart	*n*
< 6mths	44.33333	39.83333	39.16667	47.66667	33.83333	6
6mths-2yrs	41.675	37.425	39.25	42.975	37.35	40
>2yrs-5yrs	48.26415	44.83019	46.58491	49.49057	46.88679	53
>5yrs-10yrs	41.33898	38.01695	40.37288	44.52542	40.20339	59
>10 yrs	46.06383	42.59574	44.85106	48.42553	44.59574	46

Table 7

One-Way ANOVA Examining Experience Variable

		Sum of Squares	df	Mean Square	F	Sig.
Model	Between Groups	1703.727	4	425.932	3.178	.015
	Within Groups	26668.195	199	134.011		
	Total	28371.922	203			
Vision	Between Groups	1863.926	4	465.982	2.847	.025
	Within Groups	32569.584	199	163.666		
	Total	34433.510	203			
Chal-lenge	Between Groups	1838.849	4	459.712	3.077	.017
	Within Groups	29729.087	199	149.392		
	Total	31567.936	203			
Enable	Between Groups	1335.840	4	333.960	2.616	.036
	Within Groups	25402.567	199	127.651		
	Total	26738.407	203			
Heart	Between Groups	2988.081	4	747.020	3.893	.005
	Within Groups	38189.581	199	191.907		
	Total	41177.662	203			

All five practice categories between RNs and unlicensed personnel display statistically significant results as displayed in Tables 8 and 9. The data strongly suggest Nursing Assistants rate leaders much lower in every leadership practice category than do RNs.

Table 8

Observer Mean Responses, Sample Distribution Examining Licensed and Unlicensed Variable

	Model	**Vision**	**Challenge**	**Enable**	**Heart**	***n***
licensed	45.77852	41.87919	43.95302	47.94631	43.77852	149
unlicensed	39.88333	36.66667	38.61667	41.93333	36.71667	60

Table 9

One-Way ANOVA Examining Licensed and Unlicensed Variable

		Sum of Squares	df	Mean Square	F	Sig.
Model	Between Groups	1452.500	1	1452.500	10.718	.001
	Within Groups	27916.264	206	135.516		
	Total	29368.764	207			
Vision	Between Groups	1132.703	1	1132.703	6.622	.011
	Within Groups	35235.408	206	171.046		
	Total	36368.111	207			
Chal-lenge	Between Groups	1194.136	1	1194.136	7.667	.006
	Within Groups	32084.859	206	155.752		
	Total	33278.995	207			
Enable	Between Groups	1515.766	1	1515.766	11.994	.001
	Within Groups	26034.004	206	126.379		
	Total	27549.769	207			
Heart	Between Groups	2107.838	1	2107.838	10.438	.001
	Within Groups	41600.427	206	201.944		
	Total	43708.264	207			

Tables 10 and 11 display a significant difference in means of observers across educational level for Model, Challenge, Enable, and Heart practices. The data strongly suggest that the higher the education level of the observer, the higher the average rating of the CNL/CNL-fellow leader. Vision follows this trend as well; however, the difference is not statistically significant.

Table 10

Observer Mean Responses, Sample Distribution Examining Level of Education Variable

Education	Model	Vision	Challenge	Enable	Heart	*n*
HS	39.7381	37.04762	38.35714	42.38095	35.7381	42
Associate	44.4058	40.44928	42.95652	47.18841	42.7971	69
Bachelor	46.64368	42.94253	44.93103	48.11494	44.78161	87
Graduate						2

Table 11

One-Way ANOVA Examining Level of Education Variable

		Sum of Squares	df	Mean Square	F	Sig.
Model	Between Groups	1349.069	3	449.690	3.235	.023
	Within Groups	26829.459	193	139.013		
	Total	28178.528	196			
Vision	Between Groups	1080.577	3	360.192	2.108	.101
	Within Groups	32978.144	193	170.871		
	Total	34058.721	196			
Chal-lenge	Between Groups	1315.336	3	438.445	2.844	.039
	Within Groups	29751.334	193	154.152		
	Total	31066.670	196			
Enable	Between Groups	1148.498	3	382.833	2.932	.035
	Within Groups	25200.598	193	130.573		
	Total	26349.096	196			
Heart	Between Groups	2545.033	3	848.344	4.255	.006
	Within Groups	38476.267	193	199.359		
	Total	41021.299	196			

To offer supplemental information related to the educational variable, an analysis of registered nurses' educational preparation was conducted and presented in Tables 12 and 13. While the results do not identically reflect the data in Tables 10 and 11, results reveal the leadership practices of Model, Vision, and Challenge demonstrate a statistically significant difference between the Diploma/ADN prepared nurse and the BSN prepared nurse. Enable and Heart practice show a similar pattern but one that is not statistically significant.

Table 12

Observer Mean Responses, Sample Distribution and One-Way ANOVA Examining Educational Preparation of Nurses Variable

Degree	Model	Vision	Challenge	Enable	Heart	*n*
Diploma/ADN	43.39726	39.21918	41.86301	47	42.09589	73
BSN	47.90141	44.53521	46.02817	49.08451	46.14085	71

Table 13

One-Way ANOVA Examining Educational Preparation of Nurses Variable

		Sum of Squares	df	Mean Square	F	Sig.
Model	Between Groups	653.566	1	653.566	5.207	.024
	Within Groups	17445.597	139	125.508		
	Total	18099.163	140			
Vision	Between Groups	896.243	1	896.243	5.654	.019
	Within Groups	22033.728	139	158.516		
	Total	22929.972	140			
Chal-lenge	Between Groups	535.943	1	535.943	3.975	.048
	Within Groups	18738.865	139	134.812		
	Total	19274.809	140			
Enable	Between Groups	104.224	1	104.224	.915	.340
	Within Groups	15833.691	139	113.911		
	Total	15937.915	140			
Heart	Between Groups	493.061	1	493.061	2.899	.091
	Within Groups	23641.549	139	170.083		
	Total	24134.610	140			

Tables 14 and 15 offered, for all five practice categories there is a significant difference in mean ratings by those planning to leave within 12 months versus those with no immediate plans to leave their unit. The data suggest that those observers planning on leaving their department within the next year rate their leaders significantly lower than those with no immediate plans to leave their unit.

Table 14

Observer Mean Responses, Examining Plans to Leave Position Variable

	Model	**Vision**	**Challenge**	**Enable**	**Heart**	***n***
Plans to leave in next 12 months	40.88889	36.97778	38.51111	41.95556	37.11111	45
No plans	45.19136	41.65432	43.83951	47.58642	43.41975	162

Table 15

One-Way ANOVA Examining Plans to Leave Unit Variable

Model	Between Groups	1015.857	2	507.929	3.721	.026
	Within Groups	27707.580	203	136.491		
	Total	28723.437	205			
Vision	Between Groups	1329.425	2	664.712	4.012	.020
	Within Groups	33630.502	203	165.667		
	Total	34959.927	205			
Chal-lenge	Between Groups	1531.404	2	765.702	5.133	.007
	Within Groups	30284.013	203	149.182		
	Total	31815.417	205			
Enable	Between Groups	1533.526	2	766.763	6.085	.003
	Within Groups	25580.965	203	126.015		
	Total	27114.490	205			
Heart	Between Groups	2000.058	2	1000.029	5.101	.007

Unit and individual variation display statistically significant differences in all five practice categories as exhibited in Tables 16 through 19. Unit 4 provides their leaders the highest ratings across all five categories. Unit 5 consistently reports the lowest ratings for their leaders in all five categories. Thus, it appears that there are great differences in leadership practice perceptions among units (Tables 16 and 17). For all five transformational leadership practices, there are significant differences in mean ratings by observers between the individual CNL/CNL-fellows as well; in fact, these differences appear to have the greatest level of significance of all variables investigated as shown in Tables 18 and 19.

Table 16

Mean Scores of Different Units Examining Unit Variability

	Model	**Vision**	**Challenge**	**Enable**	**Heart**
Unit 1	46.90909	41.90909	43.09091	50.18182	42.18182
Unit 2	41.98	38.02	40.24	47.12	41.72
Unit 3	45.71429	42.23214	45.42857	46	43.19643
Unit 4	51.36585	49.60976	49.4878	52.58537	51.53659
Unit 5	37.90196	32.92157	35.43137	39.60784	32.23529

Table 17

One-Way ANOVA Examining Unit Variability

		Sum of Squares	df	Mean Square	F	Sig.
Model	Between Groups	4474.962	4	1118.740	9.123	.000
	Within Groups	24893.802	203	122.630		
	Total	29368.764	207			
Vision	Between Groups	6714.778	4	1678.695	11.492	.000
	Within Groups	29653.333	203	146.076		
	Total	36368.111	207			
Chal-lenge	Between Groups	5216.842	4	1304.211	9.435	.000
	Within Groups	28062.153	203	138.237		
	Total	33278.995	207			
Enable	Between Groups	4022.696	4	1005.674	8.677	.000
	Within Groups	23527.073	203	115.897		
	Total	27549.769	207			
Heart	Between Groups	8616.932	4	2154.233	12.462	.000
	Within Groups	35091.332	203	172.864		
	Total	43708.264	207			

Table 18

Observer Mean Scores of Individual CNL Examining Individual Variable

CNL	Model	Vision	Challenge	Enable	Heart
1	39.36	35.48	37.56	45.68	39.64
2	35.88462	30.80769	33	38.23077	30.03846
3	44.6	40.56	42.92	48.56	43.8
4	51.75	52.4	49.85	52.2	53.85
5	46.90909	41.90909	43.09091	50.18182	42.18182
6	42.71429	39.78571	43.14286	40	37.67857
7	51	46.95238	49.14286	52.95238	49.33333
8	40	35.12	37.96	41.04	34.52
9	48.71429	44.67857	47.71429	52	48.71429

Table 19

One-Way ANOVA Examining Individual Variable

		Sum of Squares	df	Mean Square	F	Sig.
Model	Between Groups	5547.063	8	693.383	5.792	.000
	Within Groups	23821.702	199	119.707		
	Total	29368.764	207			
Vision	Between Groups	7928.752	8	991.094	6.935	.000
	Within Groups	28439.359	199	142.911		
	Total	36368.111	207			
Challenge	Between Groups	6188.483	8	773.560	5.682	.000
	Within Groups	27090.512	199	136.133		
	Total	33278.995	207			
Enable	Between Groups	6246.557	8	780.820	7.294	.000
	Within Groups	21303.212	199	107.051		
	Total	27549.769	207			
Heart	Between Groups	10996.745	8	1374.593	8.362	.000
	Within Groups	32711.519	199	164.379		
	Total	43708.264	207			

Currently, there are multiple ways to attain CNL education and certification. Three master's-prepared nurses either completed or are in the process of completing a certificate program incorporating abbreviated curriculum based on possessing an existing advanced degree. Four were BSN-prepared nurses that have either obtained certification or are enrolled in a traditional 3-year CNL Master's degree. Of the nine CNL/CNL-fellows investigated, two advanced practice nurses having adjunct faculty status were selected to sit for the certification exam with no additional course work. Data indicate no significant relationship in the process to attain CNL education except in the "Enable" practice, as

offered in Tables 20 and 21. While this analysis might possibly be premature, since just under half of the CNL-fellows have not yet completed full course work or attained certification at the time of this study, it is surely worthwhile to have an introductory conversation around the process of attaining CNL education and certification.

Table 20

Observer Mean Scores Related to Obtaining CNL Education and Certification Process Variable

	Model	Vision	Challenge	Enable	Heart	*n*
Master's, Certification	46.79688	42.59375	45.04688	50.34375	45.67188	64
Master's, Adjunct status	45.22222	42.8	43.24444	46	43.11111	45
BSN, traditional 3-year	41.8400	37.8800	40.3700	43.6800	38.6300	100

Table 21

One-Way ANOVA Examining Process to Attain CNL Education and Certification

		Sum of Squares	df	Mean Square	F	Sig.
Model	Between Groups	124.453	2	62.227	.436	.647
	Within Groups	29244.311	205	142.655		
	Total	29368.764	207			
Vision	Between Groups	7.551	2	3.775	.021	.979
	Within Groups	36360.560	205	177.369		
	Total	36368.111	207			
Challenge	Between Groups	68.580	2	34.290	.212	.809
	Within Groups	33210.415	205	162.002		
	Total	33278.995	207			
Enable	Between Groups	994.618	2	497.309	3.839	.023
	Within Groups	26555.152	205	129.537		
	Total	27549.769	207			
Heart	Between Groups	514.233	2	257.117	1.220	.297
	Within Groups	43194.031	205	210.703		
	Total	43708.264	207			

To situate survey information in the context of the entire *LPI* database investigating millions of leaders, survey responses were entered into the proprietary *LPI* software, which in turn assigned a percentile score for each practice category compared to others in the entire *LPI* database as shown in Table 22. It appears CNL/CNL-fellows position their perceived leadership practices at a higher level than do observers. This leader higher self-perception is consistent with other study findings utilizing the *LPI* tool outlined at www.leadershipchallenge.com.

Table 22

Percentile Ranking Scores of Self and Observer Responses Compared to Others In LPI Data Base

	MODEL		**INSPIRE**		**CHALLENGE**		**ENABLE**		**ENCOURAGE**	
CNL	Self	Obs	Self	Obs	Self	Obs	Self	Obs	Self	Obs
A	32	13	68	16	37	12	18	26	18	17
B	76	16	63	17	78	13	70	14	26	12
C	19	34	14	32	28	31	70	42	13	33
D	74	42	71	81	69	68	77	65	51	79
E	53	47	64	37	69	32	78	53	74	37
F	69	26	83	29	73	33	84	6	52	13
G	58	69	58	58	47	66	82	70	69	59
H	97	14	96	13	98	12	92	7	87	6
I	93	57	98	48	98	58	98	63	74	55

The *LPI* software subsequently categorized percentile scores into high (70% or greater), medium (30-69%), and low (0-29%) groupings for each perceived leadership practice compared to others in the entire *LPI* data base presented in Table 23.

Table 23

CNL and Observer Percentile Ranking Scores Assigned to High, Medium, and Low Categories Compared to Others in the Entire LPI Data Base

	MODEL		**INSPIRE**		**CHALLENGE**		**ENABLE**		**ENCOURAGE**	
CNL	Self	Obs	Self	Obs	Self	Obs	Self	Obs	Self	Obs
A	M	L	M	L	M	L	L	L	L	L
B	H	L	M	L	H	L	H	L	L	L
C	L	M	L	M	L	M	H	M	L	M
D	M	H	H	H	M	M	H	M	M	H
E	M	M	M	M	M	M	H	M	H	L
F	M	L	H	L	H	M	M	L	H	L
G	M	M	M	M	M	M	H	H	M	M
H	H	L	H	L	H	L	H	L	H	L
I	H	M	H	M	H	M	H	M	H	M
% H SELF	33		44		44		78		44	
% H OBSERVER		11		11		0		11		11
% H/M SELF	89		89		89		89		67	
% H/M OBSERVER		56		56		67		56		44

Another variable appearing to be significant is the length of time the role has been implemented on each unit as revealed in Table 24. Units having implemented the role greater than 12 months, all categories besides "Challenge" had 20% of observer responders identify leadership practices in the high category as defined by Kouzes and Posner compared to 0% in the high category for those units having implemented the role for 6 months or less. Furthermore, when including a moderate rating, the same general trend of observers ranking the leadership practices higher in those units where the role was implemented longer is evident.

Table 24

Observer Perceptions of Leadership Practices Integrating Length of Time the CNL has Been Practicing on the Unit

	MODEL	**INSPIRE**	**CHALLENGE**	**ENABLE**	**ENCOURAGE**
% H LENGTH Observer					
18/14/12 Month*	20	20	0	20	20
6 Month (2 units)	0	0	0	0	0
% H/M LENGTH Observer					
18/14/12 Month	80	80	100	80	60
6 Month (2Units)	25	25	25	25	25

*time reflects the amount of months CNL/CNL-fellows had been practicing on designated units at the time the survey was conducted. H designates high category, M designates moderate category.

Non-significant Variables

While there were a number of variables that demonstrated significant difference across observer mean responses, a number of variables investigated did not appear to have statistically significant impact on observers' perceptions of the CNL leadership practices as outlined in Tables 25 through 32. It intuitively makes sense that there would be no significance in the examined variables related to the number of overtime hours worked, the length of shift worked (8 or 12 hours), or part-time versus full-time. However, the same logic cannot be applied to the shift (day, evening, nights) worked variable. Since the CNL/CNL-fellows work predominantly (but not exclusively) day shifts, one would have assumed those observers who work the day shift would have far more contact or interaction with the CNL/CNL-fellow and would potentially view their leadership practices differently from those observers who had less direct interaction. This aspect is addressed more fully in the subsequent discussion chapter.

Table 25

Observer Mean Responses, Sample Distribution Examining Hours Worked / Week Variable

Hours/Week	Model	Vision	Challenge	Enable	Heart	*n*
<30	46.08333	41.47222	43.05556	47.88889	43.75	36
>30	43.95266	40.53846	42.6213	46.01775	41.79882	169

Table 26

One-Way ANOVA Examining Hours/Week Worked Variable

		Sum of Squares	df	Mean Square	F	Sig.
Model	Between Groups	143.026	1	143.026	1.015	.315
	Within Groups	28473.601	202	140.958		
	Total	28616.627	203			
Vision	Between Groups	29.412	1	29.412	.171	.680
	Within Groups	34824.877	202	172.400		
	Total	34854.289	203			
Challenge	Between Groups	6.949	1	6.949	.044	.834
	Within Groups	31785.032	202	157.352		
	Total	31791.980	203			
Enable	Between Groups	110.496	1	110.496	.827	.364
	Within Groups	26996.264	202	133.645		
	Total	27106.760	203			
Heart	Between Groups	117.883	1	117.883	.574	.450
	Within Groups	41481.744	202	205.355		
	Total	41599.627	203			

Table 27

Observer Mean Responses, Sample Distribution Examining

Shift Worked (Days, Evenings, Nights) Variable

Shift Worked	**Model**	**Vision**	**Challenge**	**Enable**	**Heart**	***n***
Days (8/12)	43.66667	40.57471	41.95402	45.93103	42.54023	87
Evenings	46.25	40.5	42.33333	51.41667	46.16667	12
Nights (8/12)	42.5	37.83333	39.58333	46.5	42.91667	12
Rotates	44.78723	41.12766	43.60638	46.08511	41.19149	94

Table 28

One-Way ANOVA Examining Shift Worked (Days, Evenings, Nights) Variable

		Sum of Squares	df	Mean Square	F	Sig.
Model	Between Groups	155.546	3	51.849	.368	.776
	Within Groups	28202.390	200	141.012		
	Total	28357.936	203			
Vision	Between Groups	119.958	3	39.986	.231	.875
	Within Groups	34626.449	200	173.132		
	Total	34746.407	203			
Challenge	Between Groups	253.352	3	84.451	.540	.656
	Within Groups	31291.054	200	156.455		
	Total	31544.407	203			
Enable	Between Groups	339.285	3	113.095	.848	.469
	Within Groups	26676.259	200	133.381		
	Total	27015.544	203			
Heart	Between Groups	295.404	3	98.468	.479	.697
	Within Groups	41092.532	200	205.463		
	Total	41387.936	203			

Table 29

Observer Mean Responses, Sample Distribution Examining Length of Shift Worked (8 or 12 hours)

Shift	Model	Vision	Challenge	Enable	Heart	*n*
8 hour	45.15278	42.26389	42.93056	47.08333	42.33333	72
12 hour	43.78358	39.74627	42.4403	46.06716	41.87313	134

Table 30

One-Way ANOVA Examining Length of Shift Worked (8 or 12 hours)

		Sum of Squares	df	Mean Square	F	Sig.
Model	Between Groups	99.335	2	49.668	.349	.706
	Within Groups	28724.645	202	142.201		
	Total	28823.980	204			
Vision	Between Groups	570.600	2	285.300	1.662	.192
	Within Groups	34683.478	202	171.700		
	Total	35254.078	204			
Challenge	Between Groups	227.885	2	113.942	.716	.490
	Within Groups	32160.339	202	159.210		
	Total	32388.224	204			
Enable	Between Groups	40.978	2	20.489	.154	.858
	Within Groups	26905.101	202	133.194		
	Total	26946.078	204			
Heart	Between Groups	40.805	2	20.403	.098	.907
	Within Groups	42231.195	202	209.065		
	Total	42272.000	204			

Table 31

Observer Mean Responses, Sample Distribution Examining Overtime Variable

OT hrs/mnth	Model	Vision	Challenge	Enable	Heart	*n*
none	44.98276	40.84483	42.7069	46.36207	42.15517	58
Up to 12	44.24409	40.90551	42.50394	46.76378	42.83465	127
12 or more	42.25	38.3	43.85	44.35	36.75	20

Table 32

One-Way ANOVA Examining Overtime Variable

		Sum of Squares	df	Mean Square	F	Sig.
Model	Between Groups	111.795	2	55.897	.393	.676
	Within Groups	28603.558	201	142.306		
	Total	28715.353	203			
Vision	Between Groups	115.621	2	57.811	.333	.717
	Within Groups	34843.962	201	173.353		
	Total	34959.583	203			
Challenge	Between Groups	34.730	2	17.365	.110	.896
	Within Groups	31773.559	201	158.077		
	Total	31808.289	203			
Enable	Between Groups	94.551	2	47.276	.352	.703
	Within Groups	26960.875	201	134.134		
	Total	27055.426	203			
Heart	Between Groups	630.388	2	315.194	1.540	.217
	Within Groups	41146.568	201	204.709		
	Total	41776.956	203			

Summary

In reflecting broadly on findings revealed from this case study research, multiple facets on the Clinical Nurse Leader role development, implementation activities, and transformational leadership practices were uncovered. Reviewing documentation of planning sessions, meeting minutes, emails, and other activities, focused on nine specific components, involved a qualitative approach, and revealed that the pioneering unit functioned as the primary creative force in the CNL role development efforts. Many similarities across units came to light: CNLs were chosen (appointed), attire was determined to be the RN uniform, office was centrally located and shared with other support leadership roles, "school is work and work is school" philosophy was applied to fellows, and the leap frog implementation approach was consistently utilized. A number of meaningful differences were discovered as well: implementation timelines, planning task forces' membership and focus, and CNL observation timelines.

CNL interviews identified various role, implementation, and operational themes. The participants somewhat challenged the AACN's current position that the CNL functions as a generalist. They recognized the dissonance of duality, and concurred that this complex role is right for these complex times in healthcare. Additionally, the CNLs as a whole expressed gratitude for organizational support with the initiative, showed frustration with appending additional initiatives to the project, thoroughly embraced the leap frog implementation approach, and recognized the importance of storytelling and messages/language portraying partnership. All concurred in seeing that further development of unit leadership teams is an enhancement opportunity.

The investigation of transformational leadership practices using the *LPI Inventory* offered important insights as well. Multiple variables such as experience, licensure versus unlicensed, plans to leave unit, and individual/unit variability demonstrated statistically significant means in observer perceptions in all five leadership practices. Observers with higher levels of education appeared to statistically significantly rank the leadership practices of the CNL higher in all practice categories except "Vision." Age as a variable offered a statistically significant difference in mean responses in the "Challenge" practice category with process to attain CNL education and certification, demonstrating a statistically significant difference in mean responses in the "Enable" practice.

While a number of variables exhibited statistically significant differences in observer perceptions of CNL leadership practices, a number of variables did not appear to statistically influence observer perceptions. The number of hours staff worked (part-time or full-time), the shift worked (days, evenings, or nights), length of shift (8 or 12 hours), or the amount of overtime staff work did not appear to impact perceptions of leadership practices of the CNL.

The subsequent chapter will explore the implications of reported findings and results to give context and meaning to this complex and developing new role.

CHAPTER FIVE: DISCUSSION

This chapter will begin with a discussion related to the documentation review, followed by reflections on interviews with the conversation transitioning to transformational leadership. The chapter will close with what was learned through the lens of the scholar-practitioner.

Documentation Review

A number of observations came to light with the documentation review, which focused primarily on research question 1, exploring the similarities and differences of role development and implementation. In reflecting broadly on the similarities and differences aspects, it appeared that role development and implementation for four of the five units overall had multiple similarities, with the pioneering unit's efforts standing out as substantively different.

The initial unit functioned as the creative force in role development and implementation, and demonstrated an equal balance of integrating organizational, unit, and professional perspectives during this initiative. Interestingly, the original CNL/CNL-fellow pair have presented at a national conference and a research symposium, activities that other CNLs have yet to participate in.

Another notable observation surfaced during the review. Processes arising more organically versus being part of the original plan were embraced very quickly and produced significant and sustained positive results with little negative repercussions. One example supporting the above observation was moving all unit leadership personnel together in the center of the unit on all units.

The leap frog approach was another example of the benefits of being open to integrating unplanned opportunities. During planning sessions on the first unit, it was communicated that expansion of the role to other units would be determined by the attainment of established quality, cost, and satisfaction metrics. No specific timelines were offered publicly; however, executive leadership members in informal discussions were hopeful to see improved metrics in approximately a year, at which time subsequent units' planning would commence. Quality, safety, and cost metrics improved far quicker than anticipated, and at six months, executive leadership (Chief Operating Officer [COO], hospital Vice President, Chief Nursing Officer [CNO] and researcher) determined that expansion of the role to other units needed to be expedited. Sequencing of successive unit implementation arose out of CNL/CNL-fellow practice preferences, not as a result of being dictated by the executive leadership. This approach was consistently cited as being both creative and effective.

A third observation arose around change activities and emotions, particularly with the elimination of the discharge role coinciding with the implementation of the CNL role. An elevator speech was fashioned and consistently distributed to create a single uniform message of communication regarding the rationale for eliminating the discharge role with the implementation of the CNL. Intentional effort was directed at focusing the message on practice issues, versus a budgetary focus. Within 2 weeks of the elevator speech being shared with staff on the first two units, the researcher rounded and asked staff members what they had heard to date regarding the discharge role. Interestingly, staff easily recalled the budget aspect of the message, but took some prompting to recall the elevation of practice aspects of the message. The elevator speech was modified for subsequent units de-

emphasizing the budget aspect even further, but rounding on units implementing the CNL role later demonstrated only moderate improvement in message recollection. In reviewing the elevator speech, it is noteworthy to recognize that the modifications did not specifically address the emotional aspects of the discharge role being eliminated; it was predominantly focused on the cognitive and rational realms of the message.

Research indicates that change is experienced both cognitively and emotionally. Emotions are an important part of adaptation and structure meaning during change (Liu & Perrewe, 2005). In reviewing the documentation, especially the emails related to the anxiety and fear of the discharge role being eliminated, in all likelihood role development and implementation activities did not leverage the research on emotions and change strongly enough.

While on the surface it appeared the similarities were more numerous than the differences, the differences (planning timeframes, pace of the discharge role being eliminated, additional initiatives, and observational variances) on non-pilot units (four of five) were far more impactful on staff than were the similarities, with the shortened planning timeframe and discharge role elimination being the most impactful. The shortened time for planning seemed reasonable at the time due to efforts completed by the initial unit; however, it was noted that in all likelihood there was not enough time to build trusting relationships with staff, which is key to an influential or horizontal leadership role like the CNL role. As a general rule, units that delayed the elimination of the discharge nurse until the CNL role was implemented for a longer period of time overall experienced less staff angst as reported in emails.

Interview Synthesis

As noted earlier, CNL/CNL-fellows experienced a cacophony of thoughts and emotions during this journey, but overall, interviewees believed that the development and implementation process was what they anticipated and articulated perceptions of the process had not changed over time. They were excited and honored to be part of these innovative activities, and shared a common belief this role could elevate practice at the bedside and enhance patient outcomes. All expressed the desire to cultivate a more robust peer colleague group and the opportunity to observe CNLs in other organizations to glean further knowledge related to variances in the application of the role.

Another common notion emerged around the need to more fully and deliberately leverage technology as a mechanism to facilitate efficacious care processes. With their integrative perspective, many of the CNL/CNL-fellows were bombarded with care fragmentation issues that could possibly be rectified with enhanced electronic tools. Many had given a great deal of thought to what electronic tools could or should be developed; it was just a matter of trying to carve out time to partner with information systems to execute these ideas.

Overall, the CNL/CNL-fellows articulated fairly similar joys. Most believed this role allowed them to stay at the bedside interacting with staff and patients in a manner they had always desired to, but wasn't an option before this role was implemented. Furthermore, they felt they were empowering staff by "planting seeds" of change and encouraging professional development by teaching them to "fish," and were inspired by the staff's growth to date. CNL D expressed the group's thoughts when she shared, "I love being in the trenches; it's important that I fully understand what the staff's issues are so I can help effectively problem solve. This role lets me see things differently."

Many CNL/CNL-fellows vocalized common struggles as well. Several commented on the lack of a well-established peer group since limited organizations have implemented the role, and each organization utilizes the role a bit differently. Many of the interviewees were somewhat surprised with the amount of time and effort it took to build trusting relationships with staff, especially given the fact that they were "known" entities. Most had anticipated relationship building would take time, but not quite so much time and effort.

Other challenges became apparent around the intersections of complexity science and the CNL role. Reductionist thinking and the belief in deterministic causality have permeated scientific thinking since Galileo times (McWhinney & Hutchison, 2005). Healthcare is just beginning to understand and apply open systems thinking incorporating linear and nonlinear connectivity, both tenets of complexity. Interview comments situate the CNL role as employing complexity science principles, challenging long-standing assumptions and ways of thinking, creating uneasiness for some.

Interestingly, facilitative comments were more equally distributed amongst the three levels of influence (organizational, unit, self), and most of the interviewee perceptions of barriers were situated around the unit leadership opportunities, not at the macro (organizational) or self level. Far more comments were offered related to process components versus structure components, and facilitative comments far outnumbered barrier comments. Initially it appeared that interview participants offered conflicting messages about what I perceived as structure issues within the unit leadership team, but further investigation revealed the structure of the unit leadership team was not the issue; it was process components related to the prioritization of issues, responsibilities, and follow through of team members, and the inability to have healthy conflict.

Transformational Leadership Appraisal

The discussion on the aspects of transformational leadership practices and the CNL role will commence with a dialogue focused on specific investigated variables displaying meaningful differences, followed by observations noted in the interviews focusing on transformational leadership, and concluding with a brief synopsis.

Variables Dialogue

There is research that might prove beneficial to give context to the age and experience results. Literature exploring multiple aspects of job satisfaction, of which leadership is an important aspect, is rich. Numerous studies (Drenkard, 2005; Morrison et al., 1997; Searle Leach, 2005; Wong & Cummings, 2007) demonstrate positive correlations of job satisfaction with higher perceptions of effective leadership. Acknowledging the richness of the data, one must also acknowledge the plethora of results when specifically examining the relationship of age and job satisfaction, a proxy for the leadership component in this discussion.

Until a few decades ago, it was believed work satisfaction and age demonstrated a slightly positive relationship (Bellou, 2009). Clark, Oswald, and Warr (1996) challenged that established thinking, offering research supporting a U-shaped distribution of age and job satisfaction with the low point correlating with age 31, which is similar to the CNL leadership survey results.

Clark, Oswald, and Warr (1996) hypothesize that young workers just entering the work force perceive opportunities for personal growth and feel valuable. Terjesen, Vinnicombe, and Freeman (2007) found in times of economic hardship, younger people rate job satisfaction higher primarily based on the fact they were able to find a job rather than any specific attributes of the job or the job environment. The low point in job satisfaction is

reached when employees in their late 20s and early 30s experience increasing levels of boredom and the perception of diminishing opportunities. Older workers (this study identified them as 40+) transition to higher levels of satisfaction, either coming to terms with the job or choosing to move on to another one (Clark, Oswald, & Warr, 1996).

The greatest number of observer respondents fell into the 25-34 age categories, aligning with Clark, Oswald, and Warr's (1996) age category demonstrating the lowest job satisfaction. While only the "Challenge" practice category demonstrated significant statistical difference, the data also support an overall trend in that age category with lower perceptions of transformational leadership in the remaining four practice categories: Model the Way, Inspire a Shared Vision, Enable Others to Act, and Encourage the Heart.

Other life cycle, professional cycle research exploring a tangential but supporting line of reasoning espousing different age categories has a different lens with which appraisal of job aspects are evaluated and might help to give further context to some of these results. Kearney (2008) examined the age difference between team leaders and followers as a moderator between transformational leadership and performance. A positive relationship was found when the leader was older than followers, but nonsignificant when the leader's age was closer to the mean of the followers. Kearney (2008) argues transformational leadership practices will give rise to positive performance only if followers regard the leader as competent and extraordinary (transformational), and perceives that the leader legitimately occupies a special and privileged position within the team. He posits that situations where leader and followers share similar job-related criteria (age), followers will less likely deem the leader's position as legitimate and challenge their practices either overtly or covertly. In

other words, the leader might be demonstrating transformational leadership, but followers are not open because they view the leader as being similarly qualified as themselves.

As recognized earlier, the greatest number of observer respondents fall in the same age category as the majority of CNL/CNL-fellows. It is possible, based on the research mentioned above, that this age category views the transformational practices of the CNL/CNL-fellow lower because they do not view their position as legitimate. Additional research is needed to offer more robust answers to the age variability.

Another meaningful outcome is the statistically significant relationship between transformational leadership perceptions of CNL/CNL-fellows and the length observers have served in their current position (experience variable). It appears that those who have been in their current position from 2 to 5 years and for longer than 10 years perceive stronger transformational leadership practices of the CNL/CNL-fellows than those with less than 2 years and those serving from 5 to 10 years, offering a similar U-shaped distribution as was discussed with age.

Results also indicated significant relationships between observer perceptions of transformational leadership practices of CNL/CNL-fellows related to the level of education and licensing. Those with more education and possessing licensure tend to more positively rate CNL's as transformational leaders.

Contemplating these results, a number of possibilities come to mind. As previously noted, the CNL role is a very complex role with a broad and high-level scope (Appendix B). Its purpose and focus, applying tacit knowledge, is to proactively plan and problem solve as a mechanism to improve patient outcomes. It takes a great deal of sophistication to understand

the intricacies of horizontal integration/influence, the hallmark of the CNL role, and to truly see how this role can best be leveraged.

These results speak to the educational preparation that might be needed to understand the complexity of the CNL role. Historical research reported by the American Nurses Association (2010) offers the generally accepted notion that the ADN (associate degree in nursing) and diploma prepared nurse tends to focus more on the technical and task activities of care, while the baccalaureate (BSN) prepared nurse generally demonstrates a higher level of critical thinking and problem solving. Within the context of that research, it is not surprising that those with higher levels of education viewed the leadership practices higher than those with less education.

Unlicensed personnel (Certified Nursing Assistants, CNAs) whose mindset is task oriented might not understand or even recognize the scope of the role, and when they do not observe the CNL/CNL-fellow completing tasks, they possibly might have less than positive perceptions of transformational leadership practices. It is also possible the CNAs perceive the CNL/CNL-fellows predominantly interacting with the RN, who functions as the team leader in care delivery, and interacts differently (both in content and amount) with them, unknowingly creating a sense of team exclusion versus team inclusion. Expounding on this theme, the CNAs' lower perception of all five leadership practices might arise out of a perceived lack of power or lack of empowerment requiring additional investigation.

Evidence also suggests that higher perceptions of transformational leadership practices of CNL/CNL-fellows by observers reflect a lower percentage of observers planning to leave their unit within the next 12 months. Concurrently, low perceptions of

transformational leadership practices of CNL/CNL-fellows by observers reflect a higher percentage of observers planning to leave their unit within 12 months.

This outcome is consistent with previous research suggesting that those viewing their leaders as transformational leaders possess greater attachment and loyalty to the organization (Searle Leach, 2005; McNeese-Smith, 1993, 1995). Going even further, Drenkard (2005) and Houser (2003) suggested turnover would be reduced with the implementation of transformational leadership. Results support those findings since the unit providing the highest leadership rating to their leaders also has the lowest rate of those planning to leave (unit 4 = 15%), while the unit with the highest number of followers planning to leave (unit 5 = 31%) provided the lowest leadership ratings for their CNL/CNL-fellows. This strongly suggests that successful CNL/ CNL-fellow leaders, if one considers commitment, attachment, and lower turnover of personnel important, are those recognized as demonstrating transformational leadership skills to their followers. It is important to note, however, that no causal relationship should be attributed between this variable and leadership practices, since other factors might also be contributing to observer responses.

Perceptual variations of CNL/CNL-fellows' transformational leadership practices arose both on unit and individual levels. From a unit perspective, it appears that the longer the CNL/ CNL-fellow practices, the higher the observers' perception is of transformational leadership. This supports the concept of the length of time it takes to build trusting relationships, how complex the role really is, and the amount of time it takes for observers to fully grasp the scope and functioning of this new role.

Another equally viable possibility contributing to these differences might be around the potential impact of co-creation. It is possible that observers from the pioneering unit

offered high TL practice scores not solely related to the length of time the role had been implemented, but potentially related to the fact that the unit personnel functioned as the creative force in role development activities. The co-creation process allowed staff to understand the intricacies of the leadership practice aspects of the role on a deeper level than other unit personnel.

For all five transformational leadership practices there are significant differences in mean ratings by observers between individual CNL/CNL-fellows. In fact, these individual variances reflected the highest level of statistical significance of all the variables investigated. One would have conjectured that it would be reasonable to expect those CNLs having completed CNL educational training and attained certification would be perceived by observers as demonstrating overall higher levels of transformational leadership practices than those fellows enrolled in school, but that was not the case. This finding reveals unique characteristics and/or behavioral differences of CNL/CNL-fellows impact observer perceptions requiring more research to understand.

Since there are multiple ways to attain CNL education and certification, it is important for nursing as a profession to begin to understand whether a particular pathway produces higher perceptions of transformational leadership practices by followers. The "Enable" practice displayed significant results with preliminary investigation revealing observers perceive those master's prepared nurses obtaining CNL education through the certification process (condensed curriculum) as demonstrating stronger transformational leadership practices compared to other groups attaining CNL education and certification. While this conversation might be premature, and no recommendations or conclusions can be offered at this time, it is important to begin the discussion.

Data show a number of variables investigated did not have a significant impact on observer perceptions of CNL/CNL-fellow leadership practices: hours worked (part-time versus full-time), shift worked (days, evenings, nights), length of shift worked (8 or 12 hours) or the amount of overtime worked. Only shift worked (days, evenings, nights) proved unexpected. One would have surmised those individuals having more interaction (primarily day shift personnel) with CNL/CNL-fellows might have a higher perception of leadership practices due to increased contact, but that was not the case. A literature review proved to be of little assistance in giving context to this variable, since most transformational leadership investigations assumed physical interaction between leaders and followers, and did not include the quantity of exposure. Furthermore, in reviewing documentation information and interview transcripts, the researcher was unable to ascertain any specific behaviors or communication components specifically targeted to those individuals on off shifts. It is entirely possible "word of mouth" or informal conversations amongst staff influenced perceptions of off shift observers. This would be an excellent trajectory for future transformational leadership research.

Interview Reflections Specifically Related to Transformational Leadership

During interviews, the researcher asked each CNL/CNL-fellow if they thought this role was transformational and to share their definition of a transformational leader. Interestingly, they all affirmed that they thought this role was transformational, but definitions only very loosely aligned with published research on the topic, mirroring similar results uncovered in the literature review whereby perceptual beliefs that the CNL role was transformational, but lacked substantiating research to make such a claim. All interviewees shared a participation in limited formal education on transformational leadership, and

responses were based more on personal perception and instinct. This was a bit unsettling revealing the power of perceptions not necessarily rooted in research as well as the lack of educational preparation occurring in established curriculum.

Furthermore, to uncover whether CNL/CNL-fellows might intuitively be applying transformational leadership practices, individual interview comments were identified as meeting the definitional requirements for each of the five leadership practices. For example, in reviewing comments related to the Model practice, CNL C indicated that, "I need to lead by example." CNL H shared, "I have to model the way, I have to walk the talk" with both of those comments meeting definitional parameters. Other examples of CNL/CNL-fellow interview comments meeting definitional guidelines of transformational leadership arose in the "Encourage the Heart" practice. CNL I stated, "I try very hard to recognize the great work of each individual and the group." CNL B verbalized the need to "celebrate even the littlest of successes." Based on their interview comments, none of the CNL/CNL-fellows met the definitional guidelines for possessing all five transformational leadership practices. The "Challenge" practice had the most CNL/CNL-fellow comments (6/9) meeting definitional guidelines, while the "Vision" practice lacked any comments meeting definitional guidelines, with the other three practices falling in between.

The "Challenge" practice produced the most alignment with definitional parameters, which is not unexpected. The organization has frequently heard how it is pioneering and creating a new reality that is shared with staff (observers). Additionally, staff members know that the organization has been contacted by numerous institutions, and institutional personnel have been asked to present regionally as well as nationally about role development and implementation processes.

The lack of vision statements made by the CNL/CNL-fellow somewhat parallel the results of the survey, reflecting that observers as a whole generally perceived the "Vision" practice as the least demonstrated practice of the CNL/CNL-fellows. In reflecting on the data, it is not surprising since having a conversation that ignites excitement and helps others to see future possibilities takes a fair amount of time and effort, and mostly does not occur spontaneously. The pace of activities occurring on an inpatient unit creates a milieu not conducive to having such conversations. Additionally, with the uncertainty of healthcare reform, coupled with the decreasing reimbursement constraints, it is challenging to create a positive and compelling image of the future.

Interestingly, the CNL who had the highest perceived leadership practices noted by observers did in fact appear to have the most comments aligning with the five transformational leadership practices definitions (4/5); however, the same trend did not apply to the CNL with the lowest perceptions of transformational leadership practices by observers. This variation continues to support the concept of the complexity of the role combined with the unique characteristics of CNL/CNL-fellows impact perceptions.

One tenet of transformational leadership, the inextricable connection of leader and follower to raise each other to a higher level of morality and motivation (Burns, 1978), was not expressed in any interview. Comments reflected what the CNL/CNL-fellow could do to raise up the staff (unidirectional efforts), but lacked any verbalization of the impact that staff (followers) had on the CNL/CNL-fellows. One cannot presume mutuality was not transpiring, just that the CNL/CNL-fellows did not articulate that particular aspect of transformational leadership in the interview.

Synopsis of Transformational Leadership and the CNL Role

Some variables appeared to demonstrate statistical significance in observer perceptions. Age as a variable offered a statistically significant difference in means in the "Challenge the Process" leadership practice. The process to attain CNL education and certification exhibited statistically significant differences in means in the "Enable Others to Act" leadership practice. Those with higher educational preparation displayed statistically significant differences across the means in all leadership practices except for the "Inspires a Shared Vision" leadership practice. Experience, licensed versus unlicensed, plans to leave the unit, and unit/individual variables revealed a statistical significance in means across all five leadership practices.

While a number of variables exhibited statistically significant differences in observer perceptions, a number of variables did not appear to influence observer perceptions. The number of hours staff worked (part-time or full-time), the shift worked (days, evenings or nights), length of shift (8 or 12 hours), or the amount of overtime staff work did not appear to impact perceptions of leadership practices of the CNL/CNL-fellow.

One of the most disconcerting aspects of this study actually transcends the study itself, and centers on the power of perceptions or one's sense of knowing. As noted in the literature review, mental connections of the CNL role and transformational leadership have been fostered with little research to substantiate such a claim. Jeremy Shapiro, in a session on Epistemologies of Scholar-Practitioner Approaches said, "Be careful what you believe because it's true." Beliefs are "truths" which guide action(s). They are powerful, tend to be self-sustaining, and are at times irrational and unconscious (Bentz & Shapiro, 1999). Beliefs precede knowledge, filtering and shaping the assimilation (or not) of new information. Uncovering the unconfirmed assertions of the CNL as a transformational leader challenges

me to develop a deeper level of personal awareness related to perceptual assumptions and reflection as a scholar practitioner.

Scholar-Practitioner Reflections

Research question 4 addresses what we can learn that might contribute to the body of knowledge, and at a fundamental level, the scholar-practitioner relationship. Prior to this work, I perceived scholar-practitioner activities having a connection and impacting each other, but conceptually I visualized each as quite distinct and separate. This journey has influenced me to reconceptualize these endeavors more like an estuary, where scholar-practitioner pursuits are inextricably linked and the boundaries between the two are blurred. This reconceptualization acknowledges that the concentration of fresh water (scholarly efforts) and salt water (practitioner efforts) can vary based on a variety of factors, but also acknowledges that the amalgamation creates a rich fertile environment ripe for new growth not possible when the efforts remain separate.

The following scholar-practitioner "lessons learned" insights are not intended to reflect a hierarchical ranking of importance, but rather demonstrate the "constant dialogue between scholarship and practice" (Pearce, Appelbaum, & Agger-Gupta, 2003) where knowledge is generated, not solely for its own sake, but to serve as a vehicle of change and enhancing practice. Likewise, informed practice expands the body of knowledge creating a synergistic two-way relationship (Pearce, Appelbaum, & Agger-Gupta, 2003).

A number of "lessons learned" were discovered from this endeavor. First is the understanding that the CNL role is not the answer to solving every issue. As positive quality, cost, and satisfaction metrics came to light, the organization had a tendency to assign issues to CNLs that were out of their scope, challenging the researcher to maintain "purity" of the

role and keep CNL activities focused. Additionally, personnel filling these new roles should have organizational exposure before accepting the position (e.g., participate in organizational committees, engage in system wide initiatives). CNLs accepting this role without organizational exposure initially expressed both frustration and inability to give context to conversations or problems, and required a great deal more mentoring.

An unintended consequence of developing and implementing this new role was uncovering gaps in competencies of some managers and their inexperience at collaborative pursuits. While unit managers fully participated in role development and implementation activities, having these high-functioning individuals, who were their peers (not direct reports) lead or facilitate the CNL change process created a level of dissonance for some. While multiple informal discussions and mentoring occurred between managers on each unit as the role was implemented, a more formal and standardized process exploring the intersections of unit leadership roles would have proved beneficial.

Organizations tend to be action biased and put a premium on speed of implementing changes, but avoid the inclination to appendage other initiatives to the process since it dilutes efforts and sets up competing agendas. Furthermore, in times of great uncertainty, as is the case in healthcare today, organizations tend to fall back on what is comfortable territory, such as command and control behaviors (Wheatley, 2007). Conformity and compliance under the label of standard work is demanded in times of uncertainty, yet what is really needed is creativity. The CNL role at its essence fundamentally challenges those traditional power behaviors and fosters participation and creativity by building trusting relationships. Wheatley (2007) believes the impact of cultivating relationships cannot be underestimated and relationships are “the pathways to the intelligence of the system” (p. 40). Those leaders who

cultivate relationships are building what scholars call communities of practice (Hendry, 1996) where new knowledge is generated by the sharing and connections/bonds of many professionals. It is important for executives to remove organizational barriers to allow CNLs the time to build effective relationships and to help them lead with curiosity within the framework of possibilities.

Action-oriented bias or pressures exhibited by organizations must be counter balanced with an immersion of the literature and research. As was noted in the literature review and interviews, some perceptions of the CNL role were not necessarily supported by research. Critical analysis grounded in research can function as an effective conduit impacting perceptions to guide appropriate actions.

Limitations of the Findings

This study also acknowledges several limitations. Since it was substantively qualitative in nature, discoveries may be subject to alternative interpretations. Moreover, case study research by its very essence makes it challenging to appropriately identify any generalizations. Additionally, the study was conducted incorporating only nine CNL/CNL-fellows, who are all Caucasian women, at a single institution, thus certain aspects may not be generalizable to other organizations. The process of development and implementation spanned almost 24 months; therefore, it is possible the CNL/CNL-fellows' recollection was potentially altered with time. Lastly, leadership in this study is defined as a process; the survey results reflect just a point in time and must be interpreted as such. One must be cautious to draw any definitive conclusions from this work. Initial findings should not be expected to fully prove or resolve questions posed, but rather use the information as a

springboard for additional research to more fully comprehend the facets and dimensions of transformational leadership and the CNL role.

Future Research Trajectories

There are a number of future research trajectories to further investigate the CNL role. One such direction could be to investigate how patients and families view the CNL role. Another could be to investigate how medical providers perceive and or leverage this role. A third direction would be to include the unit leadership team members in studies to better understand relationships. Lastly, if one supports that leadership is a process, it would be appropriate to administer the LPI in a longitudinal manner.

Conclusion

Healthcare is facing formidable challenges with unsustainable escalating costs and decreasing reimbursement. It is in the midst of exponentially changing structures and processes. Healthcare historically has applied mechanistic closed systems thinking with an emphasis on control and predictability. Einstein said, "No problem can be solved with the same level of thinking that created it" and healthcare is just beginning to think differently by incorporating complexity science to help solve problems. Complexity science challenges the traditional way of conceptualizing boundaries, and produces great uneasiness related to the lack of control and the inability to predict with any degree of certainty (Daneke, 1990). The CNL role is fundamentally rooted in the tenets of complexity science, and at its essence has the opportunity to be the conduit of bridging the old way of command and control (black and white) or "driving" change to creating and building systems through horizontal influence that are adaptable, resilient, and creative (grey). The role has the potential of changing perceptions and ways of thinking to elevate practice and improve patient outcomes.

Furthermore, it has the ability to translate uncertainty and chaos into curiosity and opportunities.

The role has so much potential, but this investigation exploring the CNL role's development and implementation on five inpatient units, along with examining the perceived transformational leadership practices of the role, demonstrates how much more research is needed to ascertain whether it will actually live up to its potential billing. This study applied broad strokes of inquiry to aid in expanding the knowledge of this complex and highly contextualized phenomenon, functioning as a prologue to the investigation and a deeper understanding of the CNL role. Much more research is needed to truly optimize and leverage the role to its fullest capacity.

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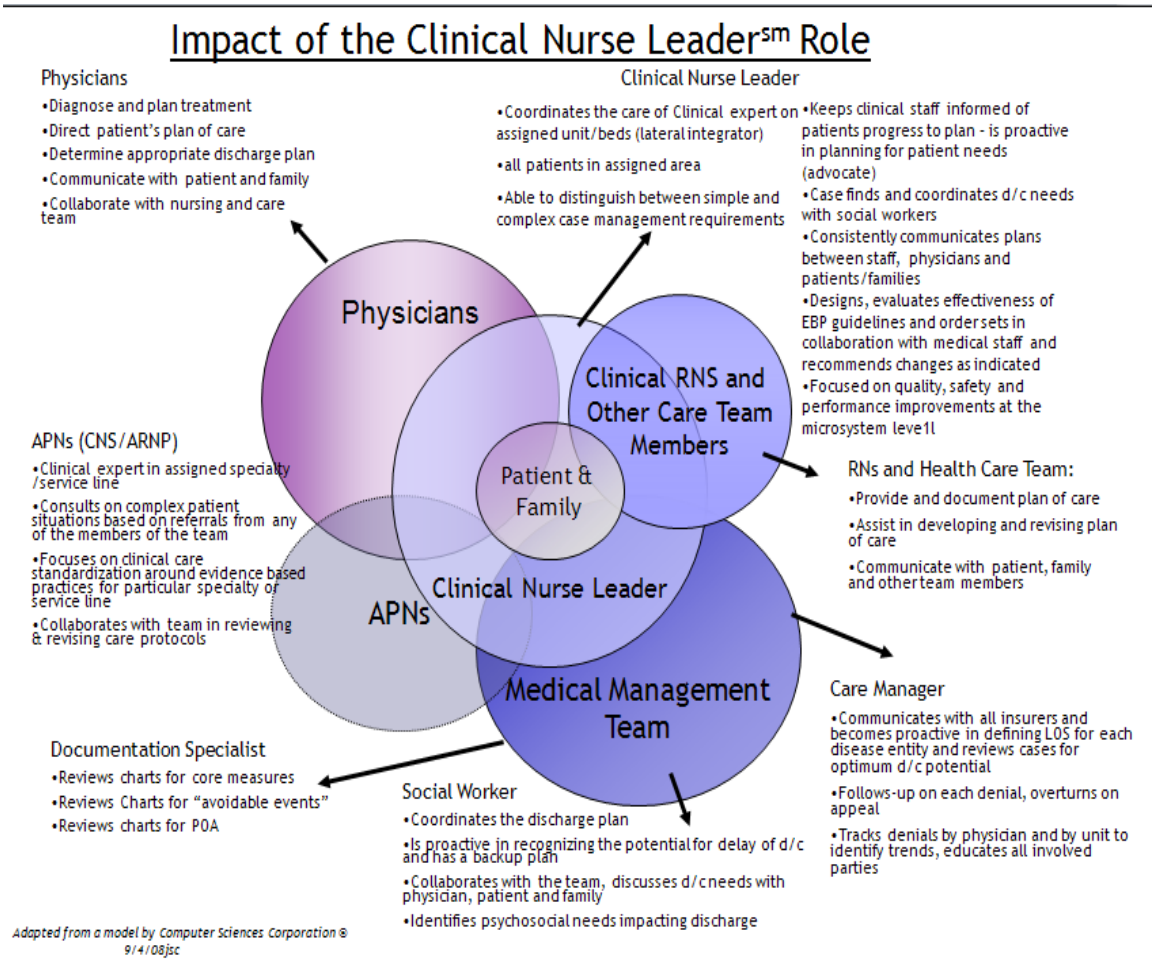
Appendix A


Impact of the Clinical Nurse Leader℠ Role
Physicians
•Diagnose and plan treatment
•Direct patient's plan of care
•Determine appropriate discharge plan
•Communicate with patient and family
•Collaborate with nursing and care team
Clinical Nurse Leader
•Coordinates the care of Clinical expert on assigned unit/beds (lateral integrator)
•all patients in assigned area
•Able to distinguish between simple and complex case management requirements
•Keeps clinical staff informed of patients progress to plan - is proactive in planning for patient needs (advocate)
•Case finds and coordinates d/c needs with social workers
•Consistently communicates plans between staff, physicians and patients/families
•Designs, evaluates effectiveness of EBP guidelines and order sets in collaboration with medical staff and recommends changes as indicated
•Focused on quality, safety and performance improvements at the microsystem leve1l
Physicians
Clinical RNS and Other Care Team Members
Patient & Family
Clinical Nurse Leader
APNs
Medical Management Team
APNs (CNS/ARNP)
•Clinical expert in assigned specialty /service line
•Consults on complex patient situations based on referrals from any of the members of the team
•Focuses on clinical care standardization around evidence based practices for particular specialty or service line
•Collaborates with team in reviewing & revising care protocols
RNs and Health Care Team:
•Provide and document plan of care
•Assist in developing and revising plan of care
•Communicate with patient, family and other team members
Care Manager
•Communicates with all insurers and becomes proactive in defining LOS for each disease entity and reviews cases for optimum d/c potential
•Follows-up on each denial, overturns on appeal
•Tracks denials by physician and by unit to identify trends, educates all involved parties
Documentation Specialist
•Reviews charts for core measures
•Reviews Charts for "avoidable events"
•Reviews charts for POA
Social Worker
•Coordinates the discharge plan
•Is proactive jn recognizing the potential for delay of d/c and has a backup plan
•Collaborates with the team, discusses d/c needs with physician, patient and family
•Identifies psychosocial needs impacting discharge
Adapted from a model by Computer Sciences Corporation ®
9/4/08jsc

Appendix B

Adopted from AACN White Paper (2007)

- **Clinical Nurse Leader ROLE/SCOPE**
    - Master's-prepared nurse practicing as a "Generalist"
    - Possesses System knowledge, deals with system barriers
    - Accountable to improve patient outcomes
    - Acts as a lateral integrator
    - Guides and coordinates Interdisciplinary Team
    - Consistent and expert communicator, improves communication
    - Promotes Teamwork
    - Has a patient/family centered focus
    - Improvement expert at micro-system level
    - Leads and manages care at the bedside
    - Works closely with clinical manager
    - Improve patient outcomes
    - Oversees patient plan of care
    - Assures evidence based practice
    - Assures individualization
    - Deals with barriers at the point of care
    - Assures core measures and compliance
    - Immunizations, pressure ulcer reduction, patient education, documentation
    - Promotes application at the bedside
    - Patient safety

- Restraints, falls reduction, medication safety
- National patient safety goals
- Hand hygiene, critical lab results, patient identifiers, suicide screening, etc
- Quality improvement initiatives
- Improve patient satisfaction
- Coordinate/integrate healthcare team
- Be a consistent nurse for patient
- Improve staff satisfaction
- Guide at the side
- Engages and empowers
- Cost effectiveness and efficiency
- Can be modeled many ways
- Needs to stay true to the intent of the role
- Transforms care at the bedside (TCAB) – Robert Wood Johnson Fdtn
    - Advanced level of nursing leading the nursing team
    - Helps to move the practice of bedside nurse beyond task orientation
    - Role models and mentors
    - Advocates for change, institution and at the bedside
    - Assists staff to think and make decisions at the bedside while incorporating best practice
    - Applies evidence that challenges current policies and procedures

MEASUREMENTS OF SUCCESS RELATED TO ENHANCED TEAMWORK

- Reduced readmissions
- More effective new graduate transition
- Improved physician satisfaction
- Increased use of evidenced based practice
- Improved nursing professional self-image
- Improvement of individualized pt/family care plans
- Reduced first year RN turn-over
- Improved staff engagement
- Identified recruitment characteristics (what attracts new staff)
- Absence of lateral violence
- Improved performance on CMS core measures
- Reduction in length of stay
- Reduction in hospital acquired pressure ulcers
- Reduction in patient falls
- Improvement in patient throughput
- Reduction in nosocomial infection
- Improved staff retention and satisfaction
- Improved patient and family satisfaction
- Fewer errors

CNL CURRICULUM FRAMEWORK FOR CLIENT-CENTERED HEALTHCARE

Nursing Leadership

I. Horizontal Leadership
II. Effective Use of Self
III. Advocacy
IV. Conceptual Analysis of the CNL Role
V. Lateral Integration of Care

Clinical Outcomes Management ⟷ **Care Environment Management**

I. Illness/Disease Management
- Care management
- Client outcomes
- Builds on and expands the baccalaureate foundation in:
  1. Pharmacology
  2. Physiology/ pathophysiology
  3. Health Assessment

II. Knowledge Management
- Epidemiology
- Biostatistics
- Measurement of client outcomes

III. Health Promotion and Disease Reduction/ Prevention Management
- Risk assessment
- Health literacy
- Health education and counseling

IV. Evidence-based Practice
- Clinical decision making
- Critical thinking
- Problem Identification
- Outcome measurement

I. Team Coordination
- Delegation
- Supervision
- Interdisciplinary care
- Group process
- Handling difficult people
- Conflict resolution

II. Healthcare Finance/Economics
- Medicare and Medicaid/ Reimbursement
- Resource allocation
- Healthcare technologies
- Healthcare Finance & Socioeconomic Principles

III. Healthcare Systems & Organizations
- Unit level healthcare Delivery/microsystems of care
- Complexity theory
- Managing change theories

IV. Healthcare Policy
V. Quality Management/Risk Reduction/Patient Safety
VI. Informatics

Major Threads integrated throughout curriculum

I. Critical Thinking/Clinical decision making
II. Communication
III. Ethics
IV. Human diversity/cultural competence
V. Global Healthcare
VI. Professional development in the CNL role
VII. Accountability
VIII. Assessment
IX. Nursing technology and resource management
X. Professional Values, including social justice

AACN. (February 2007). *White Paper on the Education and Role of the Clinical Nurse Leader™*

Appendix C

CNL Participation Informed Consent

Investigating the Development and Implementation of the CNL role

Dear_____

Date_____

I am conducting research on the development and implementation of the CNL on five units. You are being asked to participate as one the nine CNL/CNL-fellows practicing on five units. Granting your informed consent would indicate:

You agree to have the interview taped and notes to be taken by the principle investigator. Information gleaned from the taping and notes will be summarized. You will be provided with a summation of the interview collated from the tape and notes. You will be asked to review for both accuracy and to remove any information you do not wish to be shared in the research. You will be asked to give separate written authorization of summation material. Your information will be kept confidential and anonymous. Your name and any information that could identify you will be eliminated. You have the right to decline participation. If you choose not to participate, there will be no negative consequences. Tapes will be locked in a secure location to which only I will have access. All written data will be stored on a computer in a secure location to which only I will have access. After completion and approval of the dissertation all information will destroyed in an appropriate manner.

The Gundersen Lutheran Institutional Review Board (IRB) as well as the Fielding Graduate University IRB have approved this project. IRB approval indicates that appropriate measures

have been taken to ensure that your answers are anonymous. You will be provided with the results as requested and the information will be made public through my dissertation. Additionally, the results might be used for publishing and will also be shared with Wiley Publishing, the owners of *the Leadership Practice Inventory* (LPI). In accordance with IRB standards, any identifying information will be removed before publishing or sharing data with Wiley.

If you have questions about this research project, please call Beth Smith-Houskamp at 608-775-1080.

Additionally, if you have any questions regarding your rights as a study participant please feel free to contact Dr. Bud Hammes, Chair of Gunderson Lutheran's IRB at 608-775-2412.

Thanks for your participation

Beth Smith Houskamp

Printed Name

Of Participant_____

Date_____

Signed Name

Of Participant_____

Date_____

Appendix D

CNL Interview Questions

1. Please share a brief general perceptual overview of the development and implementation of the CNL role from:
    a. organizational level
    b. unit level
    c. individual level
2. Was the development and implementation process what you envisioned? Why or why not?
3. Was there any thing (personally or professionally) that helped prepare you for this experience? Probe was this a solo or group activity, realms –cognitive, emotional or spiritual??
4. Was there anything you feel you should have done to prepare that didn't happen?
5. Please identify barriers and facilitators to the role development and implementation.
6. Has your view of the development and implementation process has changed over time?
7. What were some of your greatest joys during this process?
8. What were some of you greatest struggles?
9. Sounds like your professional life has changed with participating in this process. Tell me more about this…
10. Are there any questions you think I should ask other CNL/ CNL-fellows?
11. Is there any advice you desire to share with others?
12. Can you share your definition of a transformational leader?

13. What do you think the CNL role does (or could do) that would be considered transformational?

Plan to include open ended statements like: can you please tell me more about……

Appendix E

Approval of Summation Information

I have attached a copy of the transcript obtained from your interview and notes. I would like to request you review these notes and strike out any material that you do no wish to be included. Additionally, please modify any statements you feel do not accurately reflect your comments. I would ask that you complete this in the next two weeks. If you have any questions, please don't hesitate to give me a call at 775-1080.

I hereby authorize Beth Smith Houskamp to use enclosed summation (except for the indicated deletions) as part of her doctoral research project. I have reviewed these notes and marked all material that I wish to be deleted and modified comments to reflect greater accuracy. I understand all deletions and modifications will be made prior the inclusion of this information in the research project.

Printed Name

Of Participant_____

Date_____

Signed Name

Of Participant_____

Date_____

Appendix F

Demographic and General Information

1. **Name of the unit** you work on: _____

2. I spend **the majority of my working time** on this unit**:** _____ yes _____ no

3. **Highest education level:**

    1) _____ Grade school

    2) _____ High School Graduate (or GED)

    3) _____ Associate degree graduate

    4) _____ Bachelor's degree graduate

    5) _____ Graduate degree

    6)

4. **If you are a nurse, what is the highest degree:**

    1) _____ LPN Diploma

    2) _____ RN Diploma

    3) _____ Associate's degree in nursing (ADN)

    4) _____ Bachelor's degree in nursing (BSN)

    5) _____ Bachelor's degree **outside** of nursing

    6) _____ Master's degree (MSN) or higher in nursing

    7) _____ Master's degree or higher **outside** of nursing

5. **Gender:** _____ Female _____ Male

6. **Age:**

1) _____ Under 25 years old (<25)
2) _____ 25 to 34 years old (25-34)
3) _____ 35 to 44 years old (35-44)
4) _____ 45 to 54 years old (45-54)
5) _____ 55 to 64 years old (55-64)
6) _____ Over 65 years old (65+)

7. **Job Title/Role:**

1) _____ Staff Nurse (RN)
2) _____ Staff Nurse (LPN)
3) _____ Nursing Assistant (e.g., nurse aides/tech)
4) _____ Nurse manager, assistant manager (e.g. administrators on the unit)
5) _____ Unit Clerk/Secretary
6) _____ Other [Please specify: _____]

8. Number of **hours usually worked per week** (check only one)

1) _____ less than 30 hours per week
2) _____ 30 hours or more per week

9. **Work hours** (check the one that is most descriptive of the hours you work)

1) _____ Days (8 or 12 hour shift)

2) _____ Evenings (8 or 12 hour shift)

3) _____ Nights (8 or 12 hour shift)

4) _____ Rotates between days, nights or evenings

10. **Experience in your role:**

1) _____ Up to 6 months

2) _____ Greater than 6 months to 2 years

3) _____ Greater than 2 years to 5 years

4) _____ Greater than 5 year to 10 years

5) _____ Greater than 10 years

11. **Experience** on your **current patient care unit:**

1) _____ Up to 6 months

2) _____ Greater than 6 months to 2 years

3) _____ Greater than 2 years to 5 years

4) _____ Greater than 5 year to 10 years

5) _____ Greater than 10 years

12. Which **shift** do you most often work?

1) _____ 8 hour shift

2) _____ 10 hour shift

3) _____ 12 hour shift

4) _____ 8 hour and 12 hour rotating shift

5) _____ Other [Please specify: _____]

13. In the past 3 months, how many hours of **overtime** did you work?

    1) _____ None

    2) _____ 1-12 hours

    3) _____ More than 12 hour

14. In the past 3 months, how many days or shifts did you **miss work** due to illness, injury, extra rest etc. (exclusive of approved days off)?

    1) _____ None

    2) _____ 1 day or shift

    3) _____ 2-3 days or shifts

    4) _____ 4-6 days or shifts

    5) _____ over 6 days or shifts

15. Do you plan to **leave your current position?**

    1) _____ in the next 6 months

    2) _____ in the next year

    3) _____ no plans within the year

Appendix G

LPI – OBSERVER

He or She:
1. Sets a personal example of what he/she expects of others.
2. Talks about future trends that will influence how our work gets done.
3. Seeks out challenging opportunities that test his/her own skills and abilities
4. Develops cooperative relationships among the people he/she works with.
5. Praises people for a job well done.
6. Spends time and energy making certain that the people he/she works with adhere to the principles and standards that we have agreed on.
7. Describes a compelling image of what our future could be like.
8. Challenges people to try out new and innovative ways to do their work.
9. Actively listens to diverse points of view.
10. Makes it a point to let people know about his/her confidence in their abilities
11. Follow through on promises and commitments he/she makes.
12. Appeals to others to share an exciting dream of the future.
13. Searches outside the formal boundaries of his/her organization for innovative ways to improve what we do.
14. Treats others with dignity and respect.
15. Makes sure that people are creatively rewarded for their contributions to the success of the project.
16. Asks for feedback on how his/her actions affect other people's performance.
17. Shows other how their long-term interests can be realized by enlisting in a common vision.
18. Asks "What can we learn?" when things don't go as expected.
19. Supports the decisions that people make on their own.
20. Publicly recognizes people who exemplify commitment to shared values.
21. Builds consensus around a common set of values for running our organization.
22. Paints the "big picture" of what we aspire to accomplish.
23. Makes certain that we set achievable goals, make concrete plans, and establish measurable milestones for projects and programs that we work on
24. Gives people a great deal of freedom and choice in deciding how to do their work.
25. Finds ways to celebrate accomplishments.
26. Is clear about his/her philosophy of leadership
27. Speaks with genuine conviction about the higher meaning and purpose of our work.
28. Experiments and take risks, even when there is a change of failure.
29. Ensures that people grow in their jobs by learning new skills and developing themselves.
30. Gives the members of the team lots of appreciation and support for their contributions.

LPI – SELF

1. I set a personal example of what I expect of others.
2. I talk about future trends that will influence how hour work gets done.
3. I seek out challenging opportunities that test my own skills and abilities.
4. I develops 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
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 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 other 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.

Appendix H

Data Collection for the Clinical Nurse Leader Role Initiative

Information and Consent Form

Subject line for email: We Need Your Feedback

The implementation of the CNL role is an initiative to improve nursing care for hospitalized patients that has been implemented on the _____ Unit. You are being asked to provide your perceptions of the leadership practices of the CNL as a mechanism to enhance the development of the role.

Your perceptions will be collected in the survey attached to this email. Survey Monkey is the electronic tool that delivers the survey. Your responses will be anonymous. There will be no link between your answers on Survey Monkey and your Gundersen Lutheran login identification.

The attached survey includes information on your age category and role, your perceptions of the practices of the CNL. Since there are two CNL's practicing on the unit a second survey will follow the first. Please do not forget to identify each specific CNL. The survey will take 10 to 15 minutes to complete. There is no right or wrong answers.

You are invited to complete this survey if you are a nurse or CNA working on the _____hospital unit; and will be one of approximately 300 nursing staff members taking the survey. The decision not to participate will result in no negative consequences.

The Gundersen Lutheran Institutional Review Board (IRB) has approved this project. IRB approval indicates that appropriate measures have been taken to ensure that your answers are anonymous.

By completing this survey you are giving the Department of Nursing permission to use this information for research. Data from this survey will be shared with you at the Nursing Staff Meetings, used for CNL role development, and possibly published.

If you have questions about this survey or would like to know more about this research project, please call Beth Smith-Houskamp at 608-775-1080.

If you have any questions regarding your rights as a study participant please feel free to contact Dr. Bud Hammes, Chair of Gundersen Lutheran's IRB at 608-775-2412.

Please complete the survey by

Thank you for your participation, The Department of Nursing

Appendix I

JOSSEY-BASS™
An Imprint of WILEY

News

December 16, 2011

Beth Houskamp
2340 Gladstone Cove
Onalaska, WI 54601

Dear Ms Houskamp:

Thank you for your request to use the Leadership Practices Inventory (LPI) in your dissertation. We are willing to allow you to ***reproduce*** the instrument in written form, as outlined in your request, at no charge. If you prefer to use our electronic distribution of the LPI (vs. making copies of the print materials) you will need to separately contact Lisa Shannon (lshannon@wiley.com) directly for instructions and payment. Permission to use either the written or electronic versions requires the following agreement:

(1) That the LPI is used only for research purposes and is not sold or used in conjunction with any compensated management development activities;
(2) That copyright of the LPI, or any derivation of the instrument, is retained by Kouzes Posner International, and that the following copyright statement is included on all copies of the instrument; "Copyright 8 2003 James M. Kouzes and Barry Z. Posner. All rights reserved. Used with permission",
(3) That one (1) **electronic** copy of your dissertation and one (1) copy of all papers, reports, articles, and the like which make use of the LPI data be sent **promptly** to our attention; and,
(4) That you agree to allow us to include an abstract of your study and any other published papers utilizing the LPI on our various websites.

If the terms outlined above are acceptable, would you indicate so by signing one (1) copy of this letter and returning it to me either via email or by post to; 1548 Camino Monde San Jose, CA 95125. Best wishes for ever success with your research project.

Cordially,

Ellen Peterson
Permissions Editor
Epeterson4@gmail.com

I understand and agree to abide by these conditions:

(Signed) Beth Smith Houskamp Date: 12/19/2011

Expected Date of Completion is: 12/2012 – 4/2013

Appendix J

Unit Similarities and Differences

Unit _____

Components		**Other Notables**
1. *Task Force (membership-roles and attendance)* ***2.*** *Time to implement role* ***3.*** *Length of Planning Mtgs* ***4.*** *Planning activities besides meeting minutes* ***5.*** *Launching and Closing Activities* ***6.*** *Communication strategies (Organizational, unit)* ***7.*** *Educational Activities* ***8.*** *Content of Discussion (reflected in mtg minutes and other documentation)*	**Role Development**	**Implementation**

Miscellaneous		

Appendix K

Descriptive Matrix

LEVEL OF INFLUENCE	FOCUS	FACILITATIVE	BARRIERS
Organization (Macro) Unit (Micro) Self	Structure	**1***	**2**
Organization Unit Self	Process	**3**	**4**
Organization Unit Self	Other (combo)	**5**	**6**

*Numbers 1-6 reflect Poster Board content focus

Modified from Rosenberg & Yates 2007, p. 450