THE RELATIONSHIP BETWEEN EDUCATION AND LEADERSHIP BEHAVIORS IN
NEW GRADUATE BACCALAUREATE EDUCATED NURSES AND NEW GRADUATE
ASSOCIATE DEGREE EDUCATED NURSES

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ABSTRACT

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Using a concurrent mixed method design, this study examined if there was a relationship between the education of nurses and their use of leadership behaviors. A purposive criterion sampling of 7 expert nurse managers from 7 different hospitals in Northwest Ohio was selected for the qualitative strand. Using a semi-structured questionnaire each of the 7 nurse managers was asked to identify behaviors they wanted in their leaders and behaviors they wanted in their staff nurses. Data analysis showed behaviors they wanted in their staff nurses including interpersonal skills, communication, compassion and caring, independent decision-making and critical thinking were similar to those they wanted in leaders.

Purposive criterion sampling of 145 new graduate nurses who worked in medical surgical units completed the 40-item Self Assessment Leadership Instrument measuring leadership behaviors on a Likert scale of 0 to 4. A MSN and a PhD nurse ranked each leadership item for complexity. A t-test analysis showed no significant difference in the means of self-reported leadership behaviors by ADN nurses and BSN nurses, however, analysis of the percentage of nurses that reported doing each item more than half the time showed that BSN nurses reported using more complex items than ADN nurses. A second t-test analysis measuring past hospital work experience showed there was no significant difference in the number of leadership behaviors used and the amount of past hospital work experience the nurse had.

The leadership behaviors identified by the 7 nurse managers were used to categorize the leadership items on the instrument. Analysis of this data showed that both ADN nurses and BSN nurses used the category compassion and caring the most often and the category of

communication the least often. Further analysis of the data showed that BSN nurses reported using more items in the category of critical thinking than ADN nurses.

While all nurses use leadership behaviors, communication is not one that is being used often and should be integrated more into the curriculum. Education of nurses does appear to have a positive effect on critical thinking, therefore differentiated practice should be considered for implementation in the hospitals.

This manuscript is dedicated to my husband and children, Fred, Dawn Weaver and Dr. Christopher Bernheisel whose love and support throughout my many years of education has been my guiding light. This final educational journey has required many sacrifices by each of them, but they remained by my side supporting and encouraging me the whole way. Fred, my loving husband, taught me about self-discipline and determination to achieve my goals, without him none of this would have been possible.

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TABLE OF CONTENTS

Page

LIST OF FIGURES

LIST OF TABLES

CHAPTER I. INTRODUCTION

The following chapter will provide a brief review of the background of the problem, an introduction of the changes that have occurred over time in health care and the characteristics of patients. The chapter continues with the purpose of the study and concludes with the study's definitions of concepts.

Background

Throughout history people have been injured or have become sick and infirmed, requiring the help of another person. Among the individuals that provided care to the sick, injured, and infirmed were nurses. Historically the role of the nurse was limited to maintaining the hygiene of the suffering person or to sit with them as they died (Kalisch & Kalisch, 2004). Nursing the sick and injured at nursing's inception was not a coveted job and was done primarily by family members, friends, physicians, priests, and nuns. Knowledge of health and health care issues was minimal and often included the use of exorcism to expunge an evil spirit (Kalisch & Kalisch, 2004). As the knowledge and understanding about health and the causes of illness advanced, so did the duties and expectations of the nurse. Today a student preparing to become a nurse is educated in the sciences, including, but not limited to, anatomy and physiology, chemistry, pharmacology, nutrition, pathophysiology of disease processes and normal progression for healing after an injury (National League for Nursing Accrediting Commission, 2004). Students are also educated in the art of nursing such as treatment regimens for many diseases and ideal nursing interventions for diseases or injuries. The nurse of today must also have skills and knowledge in the use of computers and a plethora of technological devices used in patient care. Modern day nurses must be intelligent and flexible because the one thing a nurse can be sure of is that change will continue to impact the practice of nursing (Nelson, 2002).

Changes will occur in how care is given, how care is documented, and how and what to teach patients and families (Fagin, 2001). All areas of nursing practice are subject to change and will no doubt undergo sporadic, if not continuous, metamorphosis to ensure the patient has the best possible nursing care.

Changes in the knowledge, skills, and technology in health care are not the only changes that have occurred over time: there has also been a transformation in the characteristics of the typical patient in the healthcare institution (Bartels & Bednash, 2005). The change in the characteristic of the patient is directly related to an increased number of older people in the population. In 2004, The Administration on Aging identified that there was one in eight Americans over the age of 65 years and it estimated that by 2030 as the United States' largest generation, the baby boomers, continue to age, there will be approximately one in five people who will be at least 65 years of age. It is predicted that one result of this aging of the American population will be an increase in chronic illnesses and a resultant increase in hospitalizations (US Department of Health and Human Services, 2000). The impact on health care institutions and the already taxed medicare and medicaid programs has the government, health care insurance companies, and the American people demanding that the cost of health care be reduced.

One of the ways the government and many private insurance companies are attempting to force a decrease in health care cost is by agreeing to pay a predetermined amount of money for a specific diagnosis; if the patient requires a longer time in the hospital, the hospital will have a loss in income. In order for the hospitals to maintain solvency, they must work to balance the length of time a patient remains in the hospital, the equipment utilized, and the delivery of nursing care. Medicare and private insurance companies have identified how long a person should remain in the hospital for a particular illness or particular type of surgery and they usually

will not pay the hospital for a longer stay, so the hospital must cover the cost for that patient's longer stay. Hospitals have employed nurses and educated them in medicare, medicaid, and private insurance hospitalization requirements. These nurses are called utilization review nurses. Utilization review nurses spend their day communicating with insurance companies and physicians and reviewing patients' charts to ensure each patient meets the required criteria for hospitalization according to the health insurance company's guidelines. The utilization review nurse notifies the patient's doctor when the patient no longer meets the criteria for hospitalization and strongly encourages the doctor to discharge the patient. The patient, however, may not be discharged because of a variety of problems that may occur such as nosocomial infections, inability to defecate, or the development of a decubitus ulcer. The insurance company probably will not pay for the increased length of stay by the patient and as a result the hospital will be left to cover the cost of that patient's care during those extended days. The hospital, in an effort to try and counter-balance the extended length of stay of some patients, encourages doctors to discharge patients as soon as they are stable and do not require the rigorous nursing care provided in the hospital.

Discharging patients that are not totally healed may require they be discharged with a visiting nurse who will go to their home and provide wound care, intravenous medications, or other skilled care. An alternative to the patient having a visiting nurse in the home is that the patient may be discharged to a skilled nursing facility or rehabilitation center where the patient will continue to receive nursing care, but not at the same intensity as they received in the hospital. Admissions the day of surgery and speedy discharges of patients have resulted in an increase in the acuity of patients who are hospitalized: patients are more critically ill today than those hospitalized in the past (Fagin, 2001; Goode et al., 2001). As a result of the increased

acuity of the patient and the increased use of community care nurses, the National Advisory Council on Nurse Education and Services (NACNES) has advised that two-thirds of all nurses working in hospitals be prepared at the Bachelor's in Nursing (BSN) level to ensure they have the knowledge and leadership required to meet the needs of today's patients (National Advisor Council on Nursing Education and Services, 1996).

Adding to the health care problem is a nation-wide shortage of registered nurses. The American Association of Colleges of Nursing (AACN) developed a fact sheet concerning the nursing shortage and projected that the shortage would continue for decades complicated by a concurrent shortage of qualified nursing faculty (Fagin, 2001). Schools of nursing are limited in the number of students they can admit into a nursing program because of the lack of qualified faculty (Fagin, 2001). Faculty, like the nurses working in hospitals, are getting older: the average age in 1997 of full time nursing faculty was 53.5 years old (American Association of Colleges of Nursing, 2005).

2004-2005 Enrollment and Graduations in Baccalaureate and Graduate Programs in Nursing by the AACN reported 32,797 qualified students were denied entry into the nursing programs because there was an inadequate supply of qualified faculty. Shortages of qualified faculty are not limited to baccalaureate programs: Associate Degree programs are experiencing similar problems with aging faculty and have also established waiting lists for admission into nursing programs for qualified students.

The nursing shortage will increase as qualified nursing faculty and current registered nurses enter retirement. Registered nurses are providing care to patients who are more critically ill than they were in the past and they must be experts at time management, problem solving, critical thinking, decision-making, and crisis management.

Statement of the Problem

Increased acuity of hospitalized patients, the nursing shortage, and the advancements in medical technology have resulted in the need for better-educated nurses (Fagin, 2001). Nurses providing care to hospitalized patients today, and in the future, will need to be experts in the arts of nursing and technology and be able to provide complex nursing care to very sick patients (Bartels & Bednash, 2005; NACNES, 1996). Nurses of today and in the future will need to be experts in managing crisis, time management, and be able to navigate through the complex health care organization with strong interpersonal skills (Goode et al., 2001). The health care organization is a large complex culture including: hospitals, physicians, outpatient care services, rehabilitation care services, and skilled nursing care facilities. Determining what the educational level of the nurse should be to develop these critical leadership behaviors is difficult today with a registered nurse shortage that promises to worsen over time (Murphy, 2001). The two-year associate degree programs profess to educate registered nurses in a shorter time, thereby helping to relieve the shortage. Since the associate degree programs are substantially shorter than the bachelors degree programs there are two questions that need to be investigated: 1) Are associate degree nurses adequately prepared and educated to meet the needs of today's sicker patients and 2) Can they practice well in a health care environment that requires the registered nurse to be self-directed and autonomous in decision making? (Fagin, 2001).

Historically nurses were educated in the hospital in an apprentice type of educational program culminating in a nursing diploma (Kalisch & Kalisch, 2004). Studies conducted during the 1940's and early 1950's supported the move of nursing education from the hospital to the college campus (Burns & Grove, 2001; Ellis & Hartley, 1995). The result of these studies was the development of the associate degree in nursing (ADN) and strong support for the

baccalaureate degree in nursing (BSN) (Kalisch & Kalisch, 2004). Diploma programs, set often in hospitals, also continued to educate nurses providing three educational entries into the practice of nursing. The ADN nurse was intended to be a technical nurse and the BSN nurse was expected to be the professional nurse within a differentiated practice (Montag, 1959). The differentiating of nursing practice, however, never came to fruition and the three degrees, diploma, ADN, and BSN became blurred (Fagin, 2001).

Nurses, the professional with the least restrictive educational requirement for entry into practice (Nelson, 2002), are the first line of care-givers to patients in the health care setting. Nurses are most likely to be the leaders in the interdisciplinary team of health care providers including physicians, pharmacists, physical therapists, respiratory therapists, occupational therapists and nutritionists because they are with the patient more frequently during hospitalization. Each of these health care professions requires a minimum of a baccalaureate degree and most requires a master's degree or an earned doctorate degree (Nelson, 2002).

Discussion of mandating a minimum educational standard for entry into the practice of nursing is fraught with dissention among the different educational institutions and among nurses themselves (Nelson, 2002). The debate is usually focused on the ADN and the BSN, as the number of diploma programs has been steadily decreasing. The debate concerns whether the educational entry level should be at the BSN or continue at the ADN. The argument revolves around the current nurse shortage and the need for nurses at patient's bedsides. The ADN supporters argue it is the quickest way to educate nurses to relieve the current nurse shortage. Furthermore, the supporters state that the ADN provides opportunities for women who may not be willing or financially able to attend college for four years to obtain a BSN (Bartels & Bednash, 2005). Supporters of the BSN as entry into practice argues that BSN nurses are more

professional in their behaviors, have stronger critical thinking skills and demonstrate good leadership skills (Goode et al., 2001). They also provide evidence that BSN nurses have a higher job satisfaction rate and remains in nursing longer than ADN prepared nurses (Anderko, Robertson, & Lewis, 1999).

As a set the literature encourages the registered nurse to be able to demonstrate leadership behaviors including professional communication, development of trusting interpersonal relationships with patients, families and other health care providers, critical thinking and crisis management. Heller et al. (2004) identified six essential skills every nurse manager should have: interpersonal skills, communication skills, organizational navigation skills, crisis management, time management, and an appropriate leadership style. However, it could be argued that every nurse providing direct patient care requires these same competencies. George et al. (2002) discuss the need for every nurse providing care at the bedside to have leadership behaviors. George et al. (2002) proposes that nurses must be able to act independently, communicate professionally, critically analyze and make decisions on the correct nursing action. These skills parallel those identified by Heller et al. (2004) as core competencies of leadership for nurse managers.

Increasing the educational requirement for nurses to ensure nurses are able to function competently in order to meet the demands on today's nurses, however, is difficult to achieve in light of the current nursing shortage crisis. Nurses are the first line of care for the patient, the primary communicators, crisis managers and organizers for the patient, the physician, and other health care members on the interdisciplinary team. Nurses assume the team leader role and require adequate education to develop and model important leadership behaviors including skillful communication, crisis management, critical thinking, problem solving, motivation, and

development of trust in interpersonal relationships. Countries other than the U.S. have identified

this and have moved to require a bachelor's degree in nursing for licensure (Nelson, 2002).

Studies, such as the Aiken et al. (2003) study provide data to support the premise that the ADN-

prepared nurse is not adequately prepared to meet the needs of today's seriously ill patients;

however, data is still needed to substantiate whether the leadership behaviors in the registered

nurse are the defining behaviors needed to meet the needs of today's seriously ill patients and if

increased education from ADN to BSN will ensure the development of these leadership

behaviors.

<div align="center">Overview of the Nursing Leadership Conceptual Framework</div>

The conceptual framework for the study is a combination of a leadership theory and a

nursing theory that has been interwoven to create a nursing leadership framework specifically for

this study. The House-Mitchell Path-Goal Theory of Leadership is combined with Dorthea

Orem's Self Care Deficit Theory of Nursing and the nursing process to emphasize the

proposition that leadership behaviors are both desired and required in nurses who provide direct

patient care. Both theories require the nurse or leader to identify a common goal with the patient

or organization and ensure a clear pathway to achieve the goal or to reach a successful outcome.

The combined framework of House-Mitchell and Orem is referred to as the Nurse Leadership

framework.

Leadership discussions usually revolve around an organization and how leaders of these

organizations influence the followers to achieve an organizational goal. In health care, nursing

specifically, leadership discussions are blurred with management discussions. In this study,

leadership does not examine leadership behaviors in managers but examines leadership

behaviors in the nurse providing direct patient care. Nurses have two factions they need to

influence: the health care institution and the patient. Patient is defined as an individual, family or community unable to meet their self-care demands and requiring interventions by an educated licensed registered nurse. Health care institution is defined as a hospital, nursing home, home health care organization, or rehabilitation center.

The House-Mitchell Path-Goal Theory is based on two important concepts found in leadership: motivation and goal attainment. The theory proposes that people are goal oriented when there is a desirable reward obtained following the achievement of the goal (Hersey, Blanchard & Johnson, 2001). The reward received may be an intrinsic award, such as satisfaction for a job well done, or for the patient, the cessation of a health problem. The reward may also be an extrinsic reward, such as a job promotion, an increase in pay or discharge from the hospital or other healthcare institution. The leader's role in the path-goal theory is to both motivate the follower and to clear the pathway toward the goal to ensure the successful accomplishment of the goal (Hersey, Blanchard & Johnson, 2001). The pathway toward the goal may be blocked by several different entities. Lack of a clear understanding of the goal, lack of systems or technology needed to achieve the goal, or lack of motivation by the follower to accomplish the goal are some of the blockades the leader will need to identify and remove for the follower. Identification and removal of these barriers will empower the person to successfully achieve the identified goal (Hersey, Blanchard & Johnson, 2001).

Dorthea Orem's theory of self-care deficit is similar to the House-Mitchell goal-path theory as it proposes patients have a common goal to be able to care for themselves, or their

Figure 1. Nursing Leadership Conceptual Framework.

Nursing Leadership Conceptual Framework demonstrating the communication and flexibility between the nursing leadership behaviors, reflected in the outer rings, the nursing process, reflected on the spokes and the ultimate goal of self-care ability.

dependents. This self-care goal may require assistance from a nurse, the leader in patient care, to clear the pathway for the patient. This desire to achieve self-care will require nursing interventions for a person who is experiencing a self-care deficit due to illness or injury (Orem, 2001). The patient who is suffering from an illness or injury will have self-care demands that they are unable to meet due to the illness or injury. The nurse leader would be responsible for meeting the self-care demands of the patient, thereby clearing the pathway of barriers, until the patient is able to meet their self-care demands and achieve self-care. The tools required for the nurse leader to help the patient meet self-care demands are similar to the House-Mitchell tools. The pathway to self-care agency may be blocked by lack of education concerning the health care problem, motivation to make needed changes for health, or the lack of physical or cognitive ability to work toward the goal of self-care.

The nurse leader framework is an open communication system in which the leadership behavior adopted by the nurse is determined by the situation. These nursing leadership behaviors have an impact on the nurse's ability to perform the steps of the nursing process. Nursing process includes nursing assessment, nursing diagnosis, goal development, nursing interventions, and evaluation to aid the patient in achieving the mutual goal of self-care agency. The nursing process is represented by the spokes of the wheel and is the direct line to successful achievement of the goal of self-care agency, (See Figure 1). It is important to remember in nursing, the patient may be the person suffering from self-care deficit, or the patient may be the care provider for another person, such as a mother for a child or a child of an older parent. The goal of self-care agency will be positively or adversely affected by the nurse's ability to utilize the nursing process, which is positively or adversely affected by the nurse leadership behavior adopted by the nurse.

Purpose Statement

The purpose of this concurrent mixed methods study is to better understand leadership behaviors in registered nurses by converging both numerical ratings data of the Self Assessment Leadership Instrument (Smola, 2001) and qualitative interview data from expert nurse managers. The first strand of the study involved qualitative interviews with expert nurse managers. Exploration was focused on leadership behaviors desired in staff nurses by nurse mangers at a variety of hospitals in Northwest Ohio. During the second strand of the study numerical ratings data of the Self-Assessment Leadership Instrument (SALI) was used to measure the relationship between the education of the nurse, ADN or BSN, and the self-reported use of identified leadership behaviors. The last strand of the study mixed the findings of the qualitative strand and the quantitative strands and compared the leadership behaviors identified by the expert nurse managers with the leadership behaviors identified in the literature and the leadership behavioral categories established by Yura in 1970. During the final part of the mixed strand the results of the qualitative strand with the results of the quantitative strand was mixed to identify if there were differences in the leadership behavior categories ADN nurses and BSN nurses used more frequently according to education level.

Research Questions

1. Is there a difference in the number of leadership activities self-reported as being done by the ADN registered nurse and the BSN registered nurse working on a general medical surgical unit?

2. Are leadership behaviors wanted by expert nurse managers in their staff nurses?

3. Are the leadership behaviors identified in the SALI comparable to the behaviors identified by nurse managers as behaviors desired in staff nurses?

4. Is there a difference in the complexity of leadership behaviors self reported in the SALI by registered nurses with a four-year college degree and the complexity reported by registered nurses with a two-year college degree?

5. Does a new graduate registered nurse's past experience working in a hospital patient care area as a licensed practical nurse or a nurse's assistant increase leadership behaviors modeled in that new graduate registered nurse?

6. Is there a difference in the category of leadership behaviors completed by ADN educated nurses compared to BSN educated nurses using the leadership categories identified by the expert nurse managers?

Significance of the Problem

Studies comparing the differences in the performance of technical nursing skills of the ADN and BSN nurses have been done; however, studies examining and comparing leadership behaviors between the ADN and BSN have not been directly examined. Aiken et al. (2003) examined the educational level of hospital nurses and surgical patient mortality. The study examined the mortality and morbidity rates of patients who had orthopedic or vascular surgeries and compared the ratio of ADN prepared nurses with BSN prepared nurses staffing the post surgical care units in the hospitals. Protocols were developed to ensure the complications were from the surgical procedures and not from preexisting chronic illnesses. 168 hospitals were used for the study. In order to control known extraneous variables that could have impacted the outcome of the study, the hospitals were categorized by size, medical residents available, and technology. Aiken et al. (2003) also recognized that experienced nurses could have biased the study, so they incorporated this into the analysis. Another extraneous variable that could bias the study was the nurse patient ratio. Aiken et al. (2003) recognized that nurse patient ratios do affect

patient outcomes and accounted for the workload of the nurses in the analysis. Hospitals that had a lower ratio of BSN prepared nurses had a higher level of mortality and morbidity rates. Aiken et al. (2003) proposes that the ADN prepared nurses did not identify the subtle changes indicating surgical complications as readily as the BSN prepared nurse. Assessment skills are required in all registered nurses although the ADN prepared nurse may receive education in assessment differently than the BSN prepared nurse. The ability to critically evaluate the assessment data or ability to make independent decisions based on the assessment findings could impact the outcomes, but Aiken et al. (2003) does not propose why there are differences in morbidity and mortality rates other than the difference in educational preparation. The behaviors and skills of assessment, critical thinking and independent decision-making are required skills in nurses at the point of patient care to ensure patient safety and achievement of self-care. Montag (1959) established the ADN education program for preparation of a technical nurse, with good technical skills. But she stated the ADN should not be placed in a leadership position, as the ADN nurse is not trained for that. We must now examine our health care system as it has changed since the ADN program was established and leaders are not separate from health care providers. Perhaps it is now time for a differentiated practice.

A shortage of nurses, increased complexity of patient care, and the need for the nurse at the bedside to ensure good patient outcomes in the shortest possible time combined with new computerized documentation requirements and new computerized medication administration systems have added new dimensions to the required knowledge and skills of today's nurse. The nurse is the first person the patient and family see and the nurse is their primary source for seeking answers concerning health care. Communication skills aid the nurse's ability to establish a trusting therapeutic relationship with the patient and family in a relatively short time frame.

The nurse acts as the liaison for the patient and the other departments the patient may need during the course of the patient's hospitalization. Therefore, the nurse must have the knowledge and skill to navigate the health care system.

The nurse, who is the first line of care for patients, must to be able to identify the subtle changes that may indicate a complication or deterioration of the patient. The nurse who is able to identify these patient changes is able to intervene for the patient quicker (Aiken, Clarke, Cheung, Sloane, & Silber, 2003). The quick response of the nurse may result in less impact of the problems and perhaps result in saving a patient's life. The skills of assessment, analysis and implementing the correct intervention for a patient who is deteriorating rapidly are primary examples of Heller et al.'s leadership qualities of acting independently and crisis management in bedside nursing. Organizing and prioritizing care needed by other departments are examples of Heller et al.'s leadership quality of navigating the health care system.

Nurses must be masters of professional communication. Arnold and Boggs (2003) identify communication as a complex, multifaceted system that involves both verbal and non-verbal skills for the purpose of sharing information between two or more individuals. The nurse patient relationship is one built on trust and confidence that is developed through the use of professional communication by the nurse to the patient and the family. Communication mastery aids the nurse in educating the patient about the health care regimen required for obtaining a satisfactory outcome. Patient education is a required nursing standard identified by the Joint Commission on Accreditation of Hospital Organizations and the American Nurses Association (Arnold and Boggs, 2003). Education in the hospital environment presents a complexity to the educational process and may include the patient and/or the family. Developing a trusting relationship with the patient and family is a prerequisite to the educational process. Development

of a trusting therapeutic relationship with the patient and the family by using professional

communication skills is not the only area these skills are required. Nurses must communicate

with physicians, other departments in the health care institution and in the community.

Information sharing between the physician and the nurse is a critical component for the

patient's successful progress toward self-care. Physicians may see a patient in the hospital for a

few brief minutes each day and is dependant on the nurse to communicate the progress of the

patient, patient symptoms of deterioration and other complications. Patients frequently depend

on the nurse to communicate their fears, questions and requests to the physician. They also

expect the nurse to act as an interpreter of what the physician has said to them and to interpret

the physician's plan of care. Communication between the nurse and the physician occurs in both

oral and written formats, therefore the nurse must develop both professional oral communication

skills and written communication skills. Interpersonal and communication skills are examples of

other leadership behaviors identified by Heller et al. (2004) as required behaviors for leaders.

The call for leadership qualities in nurses is not new. Fifty years ago Steward voiced the

need for leadership behaviors in nurses in her 1953 book, *The Education of Nurses*. In her book

Steward identifies many of the same problems we are facing today, including a nursing shortage

and bewilderment in the multiple avenues of nursing education. When Steward wrote her book

there were three avenues of education for a student to choose from: diploma, associate degree,

and baccalaureate degree. Today students have five levels of education for entry into the nursing

profession: diploma, ADN, BSN, entry level master in nursing degree (MSN) and an entry level

doctorate in nursing (ND). All five of these educational opportunities will prepare the new

graduate to sit for the National Council Licensure Examination (NCLEX). The three most

common avenues for basic undergraduate nursing education are the diploma, the ADN and the

BSN (Ellis & Hartley, 1995). The educational avenues of focus that are debated for either entry into practice or for differentiated practice are between ADN education and BSN education because the diploma programs are slowly closing and will probably not be an option for nursing education in the future (Nelson, 2002). Using the concept of leadership and the identified core competencies of nursing leadership identified by Heller et al. (2004) will help to validate which educational route develops these behaviors in their graduates.

The leadership qualities of independent decision making, critical thinking, creative problem solving, interpersonal skills, communication, navigation of the health care system, and time management are behaviors identified by chief nursing officers as qualities required in the staff nurse of today (Goode et al., 2001; Manfredi & Valiga, 1990). Comparing the desired behaviors of leadership noted above and the technological skills required of a nurse in today's health care environment, with the behaviors and skills of the nurses from the different educational programs, ADN and BSN, would provide a better understanding of the strengths and weaknesses of nurses with different educational backgrounds. Understanding these different strengths and weaknesses in the ADN and BSN nurses will help the health care institutions in the United States identify the staffing mix that is the safest and most cost effective for the patient and the health care institution.

<div align="center">Definitions of Key Terms</div>

For the purpose of this study the following operational definitions will be used to describe the meaning and the application of the terms.

Creative Problem Solving – An act of identifying a problem or difficult situation and developing a innovative resolution to the problem or situation. Developing new ideas or resources to resolve a problem (Bernheisel, 2006).

Communication – The effective professional oral, written, body language or sign language used for the purpose of persuading, motivating or sharing information to another person or a group of people (Bernheisel, 2006).

Crisis Management – the nurse's ability to identify a crisis situation and provide appropriate patient care safely and quickly, delegate activities appropriately and communicate appropriate information to physicians, superiors, other health care departments, families and patients (Bernheisel, 2006).

Critical Thinking – The ability of a nurse to reflect on the data obtained in an assessment of a situation, problem or a patient and to analyze, compare, and clarify the data in order to make an appropriate decision about the interventions required (Hahn, Bryant, Peden, Robinson & Williams, 1998).

Expert Nurse Managers – Nurse managers who have a minimum of five years of nurse management experience in an acute care hospital, consistently meet identified goals and or outcomes and have a low turnover rate of staff compared to other managers in the same institution (Bernheisel, 2006).

Independent Decision Making – The act of identifying something that needs to be done to improve a situation, knowledge, skill or environment and taking the required steps to meet that need without being directed to do so (Bernheisel, 2006).

Interpersonal relationship – Professional, caring, trusting relationships between nurses and their peers, nurses and physicians, nurses and other departments or health care agencies, nurses and patients, and nurses and patients' families (Bernheisel, 2006).

Junior college -A community or technical college requiring two to three years of full time study to complete an associate degree (Bernheisel, 2006).

Leadership behaviors – leadership behaviors are: independent decision making, critical thinking, creative problem solving, interpersonal skills, communication skills, navigation of the health care system, time management and crisis management (George et al., 2002; Good et al., 2001; Heller et al., 2004).

New Graduate Nurse – An ADN or BSN registered nurse who has been licensed to practice nursing for not less than six months and not more than two years (Bernheisel, 2006).

Nurse-a registered nurse licensed to practice nursing (Bernheisel, 2006).

Nurse Leader – a registered nurse who has the ability to motivate patients, subordinates, peers and others to work toward a shared goal, demonstrates critical thinking, creative problem solving, good communication skills, crisis management, develops good interpersonal relationships with patients families and other health care providers, and makes independent decisions (Bernheisel, 2006).

Nursing – A direct human health service provided by a qualified person to help persons to continuously know and meet their own or their dependent's therapeutic self-care demands and to regulate the exercise or development of their self-care or dependent-care agency whenever their limitations for action are associated with their own health states or that of their dependents (Orem, 2001, p. 517-518).

Patient – An individual or family who requires nursing intervention to achieve therapeutic self-care demands (Orem, 2001).

Self care – "The practice of activities that maturing and mature persons initiate and perform, within time frames, on their own behalf in the interest of maintaining life, healthful functioning, continuing personal development, and well-being, through meeting known requisites for functional and developmental regulations." (Orem, 2001, p.521-522)

Self-care agency – "The complex acquired ability of mature and maturing persons to know and meet their continuing requirements for deliberate, purposive action to regulate their own human functioning and development" (Orem, 2001, p.522).

Senior college- Colleges requiring a minimum of four years to complete with a curriculum consisting of two years of general/liberal arts education and two years professional practice education resulting in a bachelors degree (Bernheisel, 2006).

Therapeutic self-care demands – The summation of care measures necessary at specific times or over a duration of time for meeting all of an individual's circumstances, using methods appropriate for (1) controlling or managing factors identified in the requisites, the values of which are regulatory of human functioning, for example, sufficiency of air, water, food; and (2) fulfilling the activity element of the requisite, for example, maintenance, promotion, prevention, and provision" (Orem, 2001, p. 523).

<center>Organization of the Study</center>

Chapter 2, the Literature Review, is divided into three sections: Retrospective Look at Nursing Education, Nursing Leadership Conceptual Framework and Nursing Leadership. Chapter 3 describes the study design and provides the research questions and hypothesis. The method of data collection, including the quantitative instrument the SALI, is discussed. Chapter 4 provides the analysis of the Qualitative Strand of the study. Chapter 5 gives a statistical analysis of the Quantitative Strand of the study and Chapter 6 mixes the results of the Qualitative and Quantitative Strands. The final chapter, Chapter 7, discusses the findings and provides the conclusions.

CHAPTER II. REVIEW OF RELATED LITERATURE

The following review of the literature for nursing leadership will begin with an exploration into the history of nursing education and differences in the practice of nursing in nurses with an associate degree (ADN) and nurses with a baccalaureate degree (BSN). The focus of this historical exploration will be the development of the diploma program, the ADN educational program and the BSN educational program. These three approaches into the profession of nursing are the major educational routes taken by nurses for licensure to practice nursing. Following the education section a discussion will be provided about nursing leadership and leadership behaviors. The changing roles and responsibilities of nurses will be discussed in this section of the literature review, providing support for the proposition that all registered nurses should demonstrate leadership characteristics and behaviors in every nursing role but especially in the direct patient care role. The chapter will conclude with a summary and analysis illustrating the connection between the educational level of the nurse and the development of leadership behaviors in the nurse, thereby clarifying for the reader the source of the research questions and the study hypothesis.

Retrospective Look at Nursing Education

The diploma programs are the earliest form of nursing education. The diploma form of nursing education historically is a hospital based, apprentice type of education. Florence Nightingale, the founder of modern day nursing education, established the first hospital based nursing program in 1860 in London, England: The St. Thomas Hospital School of Nursing (Kalisch & Kalisch, 2004). Nightingale held the belief that nurses required a formal nursing education in order to learn the skills and rationale for the skills (Nightingale, 1860/1969). She believed experienced nurses in the hospital setting should provide the formal education of nurses,

however, physicians during her time did not share in the belief that nurses required formal

education (Nightingale, 1860/1969). The philosophy of physicians during Nightingale's time was

that nurses were little more than house-maids and that they only needed to incorporate the

required personal hygienic care for patients into their normal house keeping duties (Kalisch &

Kalisch, 2004). Nightingale disagreed with this philosophy and in her 1860 book, *Notes on

Nursing,* she writes:

> The everyday management of a large ward, let alone of a hospital-the knowing what are
>
> the laws of life and death for men, and what the laws of health for wards-(and wards are
>
> healthy or unhealthy, mainly according to the knowledge or ignorance of the nurse)-are
>
> not these matters of sufficient importance and difficulty to require learning by experience
>
> and careful inquiry, just as much as any other art? (p. 134)

Observation of a patient and the patient's environment was a major focus of training for nurses in

her curriculum. She advocated observation and reflection on what the nurse had observed in a

patient because, as she explains, it would help the nurse decide on the correct intervention for the

patient. Observation and reflection, Nightingale argued, required formal training to be mastered

(Nightingale, 1860/1969).

The Nightingale hospital-based nurse-training program was the foundation for the

modern day diploma schools of nursing in the United States (Kalisch & Kalisch, 2004). The

primary and central difference between Nightingale's vision of nursing education and the

diploma programs in the United States was the role of the hospital and the hospital's

administration. Nightingale's nursing school was under the auspices of the Nightingale Fund; the

role of the hospital was simply to provide the nursing student with opportunities to work with

patients (McCloskey & Grace, 1997). Students were not directly connected to the hospital and

the hospital did not have the responsibility of educating the student nurse. They were two separate and distinct entities. This is an important concept to understand in order to recognize the opportunistic pursuit of hospitals in the United States establishing schools of nursing within the hospital.

The first diploma school in the United States was established at the New England Hospital for Women in 1872 (Ellis, & Hartley, 1995; Kalisch and Kalisch, 2004). The impetus for opening the school of nursing came from the success of the Nightingale school in Britain and an influx of patients with a corresponding exodus of nurses following the civil war. The hospitals were in great need of nurses to provide care for patients (Ellis & Hartley, 1995). Hospitals recognized the benefit of having a nursing school at the hospital but unlike the Nightingale school of nursing, the United States schools had the students directly under the auspices of the hospital administration. The results of this proved detrimental to the student nurses and their education (Kalisch & Kalisch, 2004).

Diploma schools in the United States trained nurses by having the students do the work of nursing in the hospital under the watchful eye of senior nursing students and experienced nurses (McCloskey & Grace, 1997). The curriculum was a rough duplicate of the Nightingale curriculum, however, the staffing needs of the hospital took priority over educating the new nurses. Student nurses would work unpaid for 12 to 16 hours on the clinical unit with the main focus of education being on skills and subservience to authority, and very little on theory (McCloskey & Grace, 1997).

Theory classes about the whys of nursing, disease processes, nursing interventions and basic sciences were held arbitrarily and were taught by physicians (Ellis and Hartley, 1995). Having physicians teach the student nurses may not have been the best design, as most

physicians were still not convinced nurses needed to have formal education. The majority of

physicians of that time held the belief that a good nurse did what she was told without question,

hence the focus of subservience to authority in the nurse's education. This pattern of belief was

epitomized in a novel written in 1913 by Eleanor Hallowell Abbott, *The White Linen Nurse,* in

the following statement by a physician character in the book talking to the head nurse:

> There goes my best nurse! Oh no, not the most brilliant one…but the most reliable! The
>
> most nearly perfect human machine that it has ever been my privilege to see turned out, -
>
> that one girl….has always done what she was told,-when she was told,-and the exact way
>
> she was told,-without questioning anything, without protesting anything, without
>
> supplementing anything with some disastrous original conviction of her own (p. 31).

Nursing education during the early years in the United States did not have specific

educational requirements, standards or guidelines and the result of this lacking was the under

education of nursing students and the over utilization of nursing students for staffing the

hospitals (Nieswiadomy, 1993). As a result of the various ways nurses were being educated,

nursing education became a focus for research in the early part of the 20th century. One of the

first studies during this time was the Nutting study in 1913. The Nutting study resulted in the

development of educational standards for nursing education (Polit & Hungler, 1995). The

National League of Nursing Education (NLNE) established the "Standard of Curriculum for

Schools of Nursing" in 1914. The standards established minimum educational requirements for

nursing schools, however, these standards of education were recommended, they were not

required (Polit & Hungler, 1995).

The 1913 Nutting study did not receive as much notoriety as it deserved, however, the

Winslow-Goldmark report in 1923 received both recognition and praise. One of the premier

studies completed in 1923, *Nursing and Nursing Education in the United States*, also known as

the Winslow-Goldmark Report, was commission by the Rockefeller Foundation (Ellis & Hartley,

1995; Kalisch & Kalisch, 2004; Polit & Hungler, 1995). The original study was commissioned to

examine the education of public health nurses and to make recommendations for improvement in

the education process, however, before that section was completed the Rockefeller Foundation

requested the study be enlarged to include all nursing education programs (The Committee for

the Study of Nursing Education, 1923/1984).

The Winslow-Goldmark Report provided recommendations about minimal educational

requirements of students. During the early part of the century it was uncommon for women to

have high school degrees, and hospitals required only one year of high school for entry into

nursing school. The Winslow-Goldmark Report recommended the minimum requirement be four

years of high school education and a minimum age of 18 years (The Committee for the Study of

Nursing Education, 1923/1984). The report recommended a curriculum that included theory

classes to be held during the first four months of nursing education, during that time no clinical

courses were to be offered. A recommendation for a decrease in the workload of the nursing

student to eight hours per day, with not more that 44 hours in one week, was given with a

realization of the initial impact it would have on the hospitals and the general health of the

population.

The recommendation of the Winslow-Goldmark Report took into account the financial

burden hospitals would have implementing the recommendations for change. Hospitals would

need to replace the free, or minimally paid, students with paid nursing staff (The Committee for

the Study of Nursing Education, 1923/1984). This would have a substantial impact on the cost of

health care in the United States. The recommendation by the committee was to make the required

changes gradually. The committee also recommended that the smaller hospitals that do not have the financial means to meet the standards of nursing education should be closed (The Committee for the Study of Nursing Education, 1923/1984).

The final recommendation of the committee that has had lasting implications on nursing education and patient care was the recommendation for state licensure laws that would set minimum standards for nurses and anyone who provided care to the sick. The argument for the licensure was that similar professions had established licensure laws such as doctors, dentists and pharmacists. These professional licenses protected the public by ensuring minimal standards of education and by applying penalties for fraudulent use of the titles (The Committee for the Study of Nursing Education, 1923/1984).

Following World War II problems with nursing competence combined with an ongoing nursing shortage caused the health care institutions and the country great concern. During the war there was a concentrated effort to recruit and train nurses and nurse's aides in the shortest time possible. To help cover the cost of the education and encourage women to enter the profession of nursing funds in the form of grants were provided by the government, the end of the war, however, also marked the end of the financial support for nursing education (Brown, 1948; Kalisch & Kalisch, 2004). Many of the nurses and nurse aides that had been trained during the war left nursing after the war and returned home to provide care for their families. The resultant nursing shortage developed into a critical health care problem for the country (Brown, 1948; Kalisch & Kalisch, 2004). The National Nursing Council believed there was a chronic problem with the way nurses were being educated. Nursing education, once again, became the focus of nursing research and the National Nursing Council requested financial support from the Carnegie Corporation of New York to examine the nursing education process (Brown, 1948).

The resultant study is known as The Brown Report. Brown (1948) stated the question to be examined in this study was: "Who should organize, administer, and finance professional schools of nursing?" (p. 10). Brown was provided a Professional Advisory Committee and a Lay Advisory Committee to be used for consultation. The welfare of the people in the United States was of primary importance, so Brown and the advisory committees made the decision that whenever there was a conflict between nursing and the societal good, the decision would always support what was best for society (Brown, 1948). The guiding ethical principle of beneficence proved to be an important, although debatable, influence in the conclusion of the study.

The conclusion of Brown's study was that nursing education required both an academic and professional focus and the only types of institutions equipped to meet the two distinct kinds of education was in the higher education environment. She recommended nursing education be removed from hospitals and placed in colleges and universities. The recommended time of study was four years, and the graduate should be granted the degree of Bachelor of Science in Nursing (BSN). Brown emphasizes the need for colleges and universities to have working relationships with hospitals for the clinical education piece of the nursing education. She did warn, however, against colleges and universities supplying students to the hospitals in order to fill staff nursing needs at the expense of the student nurse's education (Brown, 1948).

Brown (1948) was the first to introduce the idea of accreditation of nursing schools within the college or university setting. The idea of accreditation of nursing schools was a new concept, but was welcomed by nurses and nursing leaders (Ellis & Hartley, 1995). Brown recommended the standards set by the Association of Collegiate Schools of Nursing (ACSN) as minimum requirements and the ACSN as the governing body for nursing programs (Brown, 1948). The ACSN standards governing nursing faculty included: educational qualifications,

teaching load of faculty, numbers of faculty necessary to run a nursing program and the status of

the nursing faculty within the college or university (Brown, 1948). The Brown Report resulted in

several changes in nursing education including accreditation of nursing education programs, state

licensure examinations for nurses and standards of minimal educational requirements for nursing

schools of all types. The recommendation of the BSN as entry into the profession of nursing by

Brown (1948), however, has not been accepted and has been debated by nurses for the past 50

years.

Hospital based diploma programs have not ceased to exist but they are diminishing in

numbers and are not major contributors to nursing education today (Ellis and Hartley, 1995).

Diploma programs that have continued to provide nursing education have undergone many

changes in curriculum and design. They have developed standardized nursing education

curriculums and many of them have partnerships with colleges to provide theory classes in

anatomy, physiology and other sciences (Ellis and Hartley, 1995). The change was a forced

change with the advent of accreditation, required minimal educational standards, and

implementation of state licensure examinations required to practice nursing. The changes that

were implemented and the advent of ADN programs have had a devastating impact on the

diploma apprentice forms of hospital based nursing schools. Diploma schools are graduating

fewer students and many of the schools are closing (Ellis and Hartley, 1995). According to the

American Association of Colleges of Nursing's 2001 report: *Nursing Shortage Fact Sheet*, there

was a 36.5% decrease in diploma graduates between 1995 and 2000.

Diploma schools of nursing were the first type of formal nursing education, the second

formal type of nursing education was the senior college or university based nursing education

programs. The first university based nursing program was established in 1909 at the University

of Minnesota, several years before the Brown study (Catalano, 2000). The University of

Minnesota's nursing program was a hybrid with two years of college education and three years

of diploma nursing school education. Since it was a blended form of nursing education it is not

considered a true autonomous university based program (Catalano, 2000). In 1923 two schools

of nursing at the university level began to admit students, Yale School of Nursing, considered the

first true autonomous university level school of nursing, and Western Reserve University School

of Nursing. Although both were established in 1923 Yale began to admit students into the

nursing program before Western Reserve University (Catalano, 2000; Dolan, 1973; Kalisch &

Kalisch, 2004). The defining characteristic of these two schools of nursing setting them apart

from the University of Minnesota's school of nursing was the lack of any attachment to a

hospital based nursing program. Yale and Western Reserve University designed their nursing

curriculum around a liberal arts foundation with a professional nursing core. Professional skills

of nursing were taught in college based nursing skills laboratories and students were provided

opportunities to practice these skills in community hospitals with which the universities had

contracts (Catalano, 2000). The focus on the hospital or clinical education was teaching and

learning and not staffing of that hospital.

The growth of the university based schools of nursing, compared to the other forms of

nursing education, was slow due to the lack of qualified faculty. There were few BSN prepared

nurses, fewer nurses educated at the master's degree level and no doctorate in nursing degrees

were established (Catalano, 2000). Most of the nurses during that time were hospital based

diploma graduates and were not qualified to teach at the senior college level. To counter the

nurse faculty shortage problem, the senior college based nursing curriculum had a major focus

on nursing education, thus educating and developing their own nursing faculty. Yale, whose

undergraduate nursing program was doing very well, developed the first master's in nursing degree and graduated the first class of masters prepared nurses in 1929 (Burns & Grove, 2001; Catalano, 2000). The establishment of the master's in nursing degree helped with the development of nursing research and also helped with the problem of unqualified nurses to fill the role of nursing faculty (Burns & Grove, 2001; Catalano, 2000; Ellis & Hartley, 1995).

Following the Brown Report in 1948, and the recommendation that nurses should be trained at the BSN level, there was a marked expansion in the establishment of university based nursing programs (Catalano, 2000; Dolan, 1973). An increase in the number of masters prepared nurses to fill faculty positions was an important factor that occurred that enabled the increase in university based nursing programs. A second factor that had a positive affect on the their development was the recognition and growth of nursing research with government grants supporting the research. These important factors combined with Brown's study were the impetus needed for the development of an increased number of senior college nursing programs. The growth of the university level nursing programs, however, has been overshadowed by the development of the ADN, a two-year nursing education program.

The associate degree of nursing education programs were introduced in 1952. The associate degree in nursing is a two-year nursing education program located in a community college or junior college. According to Ellis and Hartley (1995) the move to two-year nursing education programs was due in part to the nurse cadet program implemented during World War II. Nurses were educated in less than the three years of a diploma program, and much less than the four years recommended by the Brown Report. The community colleges would meet one part of the Brown Report, as community colleges were not affiliated with hospitals, however, the education was only half of what was recommended by Brown.

There was a severe nursing shortage following World War II, and as a result of the nursing shortage, concern for the public's health grew. The absence of a sufficient number of nurses to staff the hospitals and maintain the public's health became the focus of a nursing leader, Louise McManus (Ellis & Hartley, 1995; Kalisch & Kalisch, 2004). McManus noted that the education of nurses in the nurse cadet program took less than the three-year diploma programs required and the four years recommended by the Brown Report. McManus hypothesized that the community or junior colleges could educate nurses at a reasonable price and in a shorter period of time. The result of this education, McManus hypothesized, would be a quick fix for the nursing shortage and an opportunity for women to earn a college degree (Ellis & Hartley, 1995; Kalisch & Kalisch, 2004). McManus did not address the incompetence of the nurses following World War II, which had been identified by Brown as one of the reasons for the study. Perhaps there was a belief, as it is today, that the incompetence is a result of poor nurse staffing due to the nursing shortage.

McManus developed a five-year pilot study at seven community colleges to develop associate degree nursing programs. To oversee the study McManus assigned Mildred Montag, an assistant professor of nursing education at Teachers College, as the project coordinator (Ellis & Hartley; Kalisch & Kalisch, 2004; Montag, 1959). The community colleges were selected around the country and were of various sizes to ensure a sample that could be generalized to all community colleges around the country. The curriculum, however, was standardized in that 75% of the educational time was to be spent in nursing courses and 25% on general education courses (Kalisch & Kalisch, 2004, Montag, 1959). The graduates received an associate degree in nursing and were able to write the state licensure examination (Kalisch & Kalisch, 2004; Montag, 1959).

The emphasis of the two-year ADN nursing education program was on physical skills or technical aspects of nursing and Mildred Montag proposed the ADN nurse would not be the professional nurse, but the technical nurse (Montag, 1959). The result of the five-year study supported the hypothesis that skilled technical nurses could be trained in less time than the four years that the 1948 Brown study had proposed. Montag (1959) further recommended nursing practice be differentiated according to the nurse's educational level and that ADN nurses should never be placed in a leadership role for which they had not been educated (Montag, 1959).

The success of the ADN programs has been historic. In a review of the origins and rise of the associate degree education Haase, 1990, states, " a new ADN program was opening somewhere in the country every week" (P. 86). The success of the ADN programs have continued as evidenced by the fact that 61% of new RN's graduate from ADN programs while only 36% graduate from the BSN programs (Aiken et al., 2003). The reason for the success of these programs is two fold: 1) cost for the ADN program is less than the BSN program and 2) the ADN program is a two year commitment while the BSN program requires a four year commitment. It is reasoned by the American Association of Community Colleges that the two year, cost effective program unlocks an educational door for individuals who would not otherwise be able to attend college (American Association of Community Colleges, 1999).

The rapid change of health care and the demands on nurses providing care has impacted the ADN program's curriculum. Many nurse educators in senior colleges refer to the ADN program as having "curriculum creep". Curriculum creep is the increased requirements for nursing education by the primary accreditation body of ADN programs, the National League of Nursing (NLN). The NLN maintains that all nurses should be prepared to practice in any work setting regardless of educational preparation (National League of Nursing, 1983). The result has

been an expansion in the number of course requirements for the ADN. The impact of the increased program requirements has resulted in the ADN, in many community colleges, taking three years or more to complete instead of the two years that was originally established (Nelson, 2002).

The key difference between the two major types of nursing educational programs, ADN and BSN, revolve around the liberal arts/general education. A liberal arts/general education combined with the professional education of nursing results in a nurse who is intelligent, of good character and moral (Polet, 2002). The liberal arts/general education received in the BSN program develops the student's ability to function effectively as a person, a citizen and as a professional (DeYoung, 1976). Goode et al., 2001, completed a study of chief nursing officers and their preference to hire BSN nurses. Goode et al. (2001) found the nurse leaders perceived BSN prepared nurses, or nurses with an educational foundation in the liberal arts have stronger critical thinking skills, are less task oriented, demonstrate more professionalism, are more focused on continuity of care and outcomes, have a greater focus on psychosocial components, are better communicators and demonstrate more leadership skills.

The increasing acuity of patients in the hospital today combined with the increase autonomy of the staff nurse signifies the need for a greater emphasis to be placed on the nurse's ability to problem solve, critically think, use complex medical technology, and have an acute understanding of assessment and pathophysiology. These mental skills may not be adequately developed in the education received in a two-year associate degree program and without the differentiated practice recommended by Montag. Patient health may be negatively impacted and result in a higher morbidity and mortality rates. The general education courses required in senior colleges and universities develop the student's ability to critically analyze situations, develop

resolutions to problems, to be inventive and creative in problem solving and to communicate with other people orally and in written formats. These are leadership behaviors and they are both valued and needed in the direct patient care nurse.

<div align="center">Nursing Leadership Conceptual Framework</div>

The Nursing Leadership conceptual framework is a hybrid that combines a theory of leadership with a theory of nursing. The House Mitchell Path-Goal Leadership Theory and Dorothea Orem's Self Care Deficit Theory of Nursing are the two contributing theories for the hybrid Nursing Leadership conceptual framework. The House/Mitchell theory of leadership identifies four leader behaviors: supportive, directive, achievement-oriented, and participative (Hersey, Blanchard and Johnson, 2001). These four leader behaviors are similar to Orem's three nursing systems: wholly compensatory, partly compensatory and supportive-educative (Orem, 2001).

Orem's theory of nursing is developed around three linking theories, 1) theory of self-care deficit, 2) theory of self-care and 3) theory of nursing systems. Orem's five premises and her presuppositions connect the three theories. The five premises are:

1. Human beings require continuous deliberate inputs to themselves and their environments in order to remain alive and function in accord with natural human endowments.

2. Human agency, the power to act deliberately, is exercised in the form of care of self and others in identifying needs for and in making needed inputs.

3. Mature human beings experience privations in the form of limitations for action in care of self and others involving the making of life-sustaining and function-regulating inputs.

4. Human agency is exercised in discovering, developing and transmitting to others the way and means to identify self care needs or and make inputs to self and others.

5. Groups of human beings with structured relationships cluster tasks and allocate responsibilities for providing care to group members who experience privations for making required deliberate input to self and others (Orem, 2001 p. 140).

Premises 1 and 2 relate to the theory of self-care, premise 3 to theory of self-care deficit and premises 4 and 5 to the theory of nursing systems. Individuals act purposefully to meet self-care demands in order to maintain health (premises 1 and 2), when there is an injury or illness that inhibits a person from being able to meet self-care demands a self-care deficit (premise 3) occurs. Nurses, who are educated to help individuals meet self-care demands (premise 4 and 5), will intervene when the person is unable to meet self-care demands and will either provide the required self-care demands or remove the obstacles that are preventing the person from meeting them. The theory of nursing, and the concept of nursing as defined and outlined by Orem are the core components of the nursing leadership conceptual framework.

Orem (2001) describes nursing as a helping service that requires specialized education and training to meet self-care demands of those who are unable to meet their own self-care demands. Nurses have five methods for meeting self-care demands of others:

1. Acting for or doing for another

2. Guiding and directing

3. Providing physical or psychological support

4. Providing and maintaining an environment that supports personal development

5. Teaching (Orem, 2001, p.56)

Which of the five helping methods required for successful achievement of self-care agency

depends on the situation. Nurses utilize the skills of assessment, diagnosis, and goal development

to identify which of the methods or combination of methods will be the most appropriate for the

situation (Hanucharurnkul, 1988; Orem, 2001). In the *acting for or doing for another*

methodology, the nurse must assist with all the activities of daily living required for life because

individuals in this category are unable to meet any of their self-care demands. Individuals

requiring this methodology may be in a coma, quadriplegic, or developmentally unable to meet

their own needs, like a child, a baby, or an elderly person with dementia (Orem, 2001).

Individuals requiring *guiding and directing another* methodology may only require

guidance or advice about achieving self-care demands. A person who is newly diagnosed with a

chronic illness may need information about new self-care demands the illness has caused and

how to meet those self-care demands in order to manage the disease. Another example is

providing information about community resources such as meals on wheels or support groups

(Orem, 2001).

Providing physical or psychological support is utilized with patients who need

encouragement or a helping hand to complete a physical task (Orem, 2001). The nurse will often

be required to use both physical and psychological support with individuals who recently had

joint replace surgery. Patients experience pain with activity and will need motivation and

encouragement to follow the rehabilitation requirements of walking, sitting, or bending the knee.

They will also need physical support such as a guiding arm as they relearn how to walk, bend, or

sit.

One of the most difficult nursing methods is *providing and maintaining an environment*

that supports personal development. The reason this method is so difficult is because it involves

change. It may mean motivating someone to lose weight, follow an exercise program or give up

smoking, drinking or drugs. Nurses working with individuals needing this methodology will help

them identify appropriate goals and develop the steps needed to achieve the goals. Ensuring the

successful achievement of the goals requires that nurses assess all areas, including the person's

physical and psychological development and the environment of person. Orem (2001) states that

the successful implementation of this nursing methodology requires nurses to be creative,

knowledgeable, and empathetic. Nurses will have to have genuine respect for the person needing

this methodology or goals may not be achieved (Orem, 2001).

The final helping method proposed by Orem (2001) is *teaching another*. Nurses are

required to be educators for patients by the Nurse Practice Act, Standards of Nursing Care and

The Joint Commission on Hospital Accreditation. Ensuring success with this helping

methodology the nurse needs to have some knowledge of pedagogy and androgogy. Education

about new medications, new diagnosis and treatment regimens that may be required for self-care

agency, and education of families or other care givers about treatment regimens for dependent

persons are some of the more common areas of nurse patient education.

The nurse must be able to communicate and be able to develop a strong interpersonal

relationship with the person(s) in need of nursing intervention. In order to successfully

implement any of the helping methods noted above, nurses would have to identify what the

patient needs, integrate multiple health care specialties, and interact with all the participants

involved in the care of the patient (Orem, 2001). Excellent communication skills, critical

thinking ability, creative problem solving and an ability to develop trusting interpersonal

relationships with patients and families are critical competencies for nurses and these

competencies are the same leadership behaviors identified throughout leadership and nursing literature.

Assessment, diagnosis, goal setting and choosing the best helping method strategy are common themes in Orem's Theory of Nursing and the House-Mitchell Path Goal Theory (HMPG). Leadership textbooks classify House-Mitchell's theory of leadership as a situational approach to leadership. Situational leadership proposes that leaders require specialized education, training and experience and is strongly dependent on the leader's ability to communicate and develop an interpersonal relationship with followers and/or subordinates (Hersey, Blanchard & Johnson, 2001). Situational leaders require specialized education in order to perform a leadership type of assessment and diagnosis to determine the appropriate leadership behaviors for a given situation (Hersey, Blanchard & Johnson, 2001). Leadership behaviors may be directive or supportive (Hersey, Blanchard & Johnson, 2001).

House-Mitchell's leadership theory is organized around motivation and task performance (Hersey, Blanchard, & Johnson, 2001; House & Mitchell, 1974; Sullivan & Decker, 1997). The successful achievement of goals depends on the leader's ability to motivate followers to work toward achieving the goals willingly and happily (Hersey, Blanchard, & Johnson, 2001; House & Mitchell, 1974; Sullivan & Decker, 1997). Workers will not be motivated to achieve goals if there are no rewards for achievement; if there are obstacles blocking the progress toward the goal, or if the follower does not have a clear understanding of the goal (House & Mitchell, 1974). Leaders must perform an assessment of the workers to determine what is needed to achieve the goal and implement the correct leadership behavior. House and Mitchell identify four leadership behaviors:

1) Directive leadership

2) Supportive leadership

3) Participative leadership

4) Achievement-oriented leadership (House & Mitchell, 1974).

Directive leadership is the leadership style needed when the follower does not understand the goal or the process required to achieve the goal (Sullivan & Decker, 1997). The leader will communicate clearly the what, how, where, and when of a goal. Followers who need to have this type of leadership are normally those who are new to an institution or have limited education, training and experience that will impede the progress of achieving the goal (Sullivan & Decker, 1997). The follower may be fearful due to the lack of knowledge of the process or unsure who to go to for problems. An example of this type of leadership in nursing would be a person who has just been diagnosed with diabetes mellitus. The person does not know what to eat, how to measure their blood glucose levels, if they can exercise, what the signs and symptoms are for hypoglycemia or hyperglycemia. The nurse would take on the House-Mitchell leadership behavior of *directive leadership.*

Supportive leadership is an empathetic and caring form of leadership behavior. The leader would use this style of leadership when the followers are experienced, self-directed and the tasks are very familiar to them (Sullivan & Decker, 1997). The leader demonstrates concern and compassion for the followers, for their health and their families. This form of leadership establishes a friendly and welcoming environment for the follower (Sullivan & Decker, 1997). An example of this type of leadership in nursing would be preferred when working with a patient and family who were just admitted into the hospital. The nurse would strive to ensure the patient and family are comfortable and as relaxed as one could be under the circumstances. The nurse

may also use this form of leadership when communicating to subordinates or when communicating with other members of the health care team.

Participative leadership requires a substantial amount of communication between the leader and the follower. Goals are mutually identified and the process needed to achieve the goal will be developed as a team. Both the follower and the leader will have an active role in the goal achievement. The leader will ask for ideas, suggestions and opinions from the follower before a decision about a goal or process is made (Sullivan & Decker, 1997). Followers requiring this type of leadership style have some skill level and work in an area that may have more than one way to do the job, the job activities may be somewhat vague requiring critical thinking and problem solving (House & Mitchell, 1974; Sullivan & Decker, 1997). An example of a nurse adopting this type of leadership behavior is when the nurse is working with someone who has had a chronic illness for a long time and is learning to make decisions about adapting the dosage of their medications when specific symptoms appear. For example a patient with congestive heart failure may learn to decrease their fluid intake and increase their diuretic when they notice edema and shortness of breath with minimal activity.

The final leadership behavior described by House and Mitchell (1974) is *Achievement-oriented leadership.* Followers who are intrinsically motivated by challenging work and are competitive are the ideal followers for this form of leadership behavior. Followers who are very self directed and enjoy opportunities to grow with the possibility of advancement in the organization require very little direction from the leader. The leader's role in this instance is that of a strong motivator (Sullivan & Decker, 1997). Nurse leaders would need to identify the patient who meets this description and motivate them to succeed in achieving the goal of self-

care agency. This behavior could be combined with any of the other leadership behaviors in the nursing environment.

Orem's theory of nursing and House-Mitchell's theory of leadership not only complement one another but also have multiple commonalities. Both Orem and House-Mitchell recognize the need for specialized education and training, Orem for nursing and House-Mitchell for leadership. The true connection, however, between Orem's nursing and House-Mitchell's leadership are the interventions. Both recognize guidance and direction, education, support, environmental factors for success, and motivation. Orem uses different terms to represent these concepts than House-Mitchell, but the definitions and actions required are very similar in both theories. This is not really surprising to find that the nursing theory would resemble a leadership theory because, nurses at every level must be, and are, leaders. No studies were found that conducted a comparison of leadership behaviors with nursing behaviors to validate this premise; however, it is quite evident that Orem's theory of nursing is synonymous with the House-Mitchell path goal theory of leadership behaviors.

The development of the nursing leadership framework for this study uses the commonalities and the best ideas of these two theories and the nursing process for a unique framework. The nursing process includes a nursing assessment, nursing diagnosis, goal development, nursing interventions and evaluation of goal attainment. The unstated goal is self-care ability, however, each situation will have a specific nursing goal that is specific for each patient.

The proposed nursing leadership framework recognizes that nurses at every level have multiple roles, including patient care and leading and directing subordinates. Orem states in her 2001 book, "It (nursing) includes continuous efforts to bring about and maintain association,

integration, and interaction among participants in the nursing situation" (p. 368). This statement demonstrates she clearly recognizes the complexity of patient care management at the caregiver level.

The nurse leadership framework has the following assumptions:

1) Nursing leadership is a form of situational leadership that is outcome focused.

2) Nurses have multiple roles and must be able to transition between the roles smoothly, adopting the appropriate leadership behavior for the situation.

3) Nursing leadership is a learned skill developed with specialized education in nursing and liberal arts.

4) Nursing leadership is a required skill in professional nurses at every level of practice.

5) Nursing behaviors are the same behaviors identified in any successful leader.

6) The leadership behaviors expert nurse managers want in staff nurses include, critical thinking, creative problem solving, good communication skills, ability to develop good interpersonal relationships, and are self-directed.

Leadership and Nursing

Leadership and management are terms often used interchangeably in the nursing literature and in health care facilities. The term leadership is used in a health care facility and in many nursing journals and books to reflect the administration or management of the health care facility. These individuals may in fact be leaders but being an administrator or manager does not make a person a leader. The positions of administrator and manager give the individual positional power and authority, how they use these attributes is the key to their leadership abilities. The consistent misuse of the words leader and leadership to represent administration and managers demonstrates a wide spread confusion and knowledge deficit of the concepts of

leaders and leadership. Burns (1978) stated, "leadership is one of the most observed and least understood phenomena on earth" (p. 2). Although the concept of leader has multiple definitions there are certain commonalities that can be identified.

Leaders may be found in any position and is not directly linked to authoritative positions (Grossman & Valiga, 2005). Two forms of leaders and leadership have been identified; informal leadership and formal leadership. Informal leaders are those found in the work place, staff nurses, who are able to influence those around them to willingly follow them. Formal leaders are leaders in a position of authority, a manager or administrator, who is able to influence others, to willingly follow them (Hersey, Blanchard & Johnson, 2001; Tappen, Weiss & Whitehead, 1998). Hersey, Blanchard, and Johnson (2001) define a leader as "a person who is able to influence the behavior of an individual or group, regardless of the reason" (p. 9). This definition lacks one of the basic components of a true leader-the willingness of a follower. A true leader does influence the behavior of others, however, one could argue that the Hersey, Blanchard and Johnson definition could be a person of authority who does not model leadership behaviors. The authority figure may influence the behavior through their position of power over the follower and a true leader is able to bring about a behavior in a follower without having power. Tappen, Weiss and Whitehead (1998) provide the following definition of power: "the ability to influence other people or other things despite resistance on the part of the other person or object" (p.83). Comparing the Hersey, Blanchard and Johnson (2001) definition of leader with that of Tappen, Weiss and Whitehead's (1998) definition of power a common theme of influence over another's behavior is identified; however, a leader influences the behavior of another in such a way the follower chooses to adapt to the leaders request. The follower is not forced to adapt as insinuated in the definition of power. There are excellent examples of leaders who did not have positional

power but influenced the behavior of millions of individuals. Jesus, Gandhi, King and Mother Theresa are examples of influential leaders who did not have positional power, but influenced the behaviors, thoughts and actions of millions of individuals.

Leadership is an active process (Hersey, Blanchard & Johnson, 2001; Kouzes & Posner, 1987). To become a leader a person must be willing to lead, to accept the responsibility and accountability of being a leader. Leaders do not hide among the followers, but must step up to the podium and motivate followers, subordinates or patients to achieve a common goal. This may require a person to volunteer to work on a committee, accept a management position, or to run for office in a professional organization (Grossman & Valiga, 2005; Hersey, Blanchard & Johnson, 2001).

Leaders do not accept the status quo; they look beyond what is to what may be. Nursing leaders who looked beyond what was and made changes in nursing are numerous, Florence Nightingale, however, is one of the most visionary leaders in nursing history. Her leadership transformed nursing and nursing education. Leaders are willing to invest substantial amounts of their human capital to realize their vision (Grossman & Valiga, 2005; Hersey, Blanchard & Valiga, 2005; Kouzes & Posner, 1995).

Leaders are change agents. Leaders observe and notice the subtle signs of change in the patient, health care facility, or community and they take an active approach to intervene, making the changes required to achieve success. They approach change as a challenge and are not afraid to fail, but welcome the challenge and the opportunity change brings with it. A good leader is able to energize people to embrace the change and keep them moving forward (Grossman & Valiga, 2005; Hersey, Blanchard & Johnson, 2001; Kouzes & Posner, 1995).

Leaders are excellent communicators. It is ineffective to have a vision and be unable to communicate it clearly to people. Leaders must be able to communicate clearly, enthusiastically and in the follower's language. Clarke and Crossland (2002) discuss the importance of using the follower's language when communicating to ensure the follower interprets the message accurately. Clarke and Crossland (2002) provide an excellent example of communication using the language of a unique follower in their book *The Leaders Voice.* They are talking to one of the great communicators, Monty Roberts, better known as the horse whisperer. Monty Roberts has mastered communication with his "followers" which are horses. The language is the language of the horse:

> A look in the eye, Roberts explains, means "go away from me." The horse moves to the other side of the corral. He moves a horse around the edge of the corral by gently tossing a cotton rope at the horse's hindquarters. The horse trots in "I no longer want to flee" (p. 13).

Effective communication with patients is achieved when nurses are able to adapt their language and communication style to the same level as their patients. Using "nurse speak" would be an ineffective communication language for most patients. Communication will be different when communicating with peers, physicians and other health care providers than it will be with patients. Patients have a range of communication language that changes according to the education level of the patient, highly educated to illiterate. The nurse will need to communicate using the patient's unique language, which may include utilizing slang terms for bodily functions to achieve success in reaching self-care agency.

Hersey, Blanchard and Johnson (2001) identify three competencies of a leader:

1. *diagnosing*-understanding the situation you are trying to influence;

2. *adapting*-altering your behavior and the other resources you have available to meet the contingencies of the situation; and

3. *communicating*-interacting with others in a way that people can easily understand and accept (p.11).

Each of these competencies correlates with the role of the staff nurse. Nurses must complete a thorough assessment of the patient and identify the patient's self-care deficit; they must understand the situation where they will need to intervene. After completing the assessment and nursing diagnosis, the nurse will need to develop a plan of care that is specific for that patient, thus aiding the patient in achieving self-care agency. This may require the nurse to be creative and utilize tools available to her. An example of this adaptation is when a nurse must teach a patient with diabetes how to administer insulin injections. It is a simple process unless the patient has lost the use of one side of the body due to an accident or stroke. Creativity may be necessary if the patient has a financial obstacle inhibiting the person from purchasing tools that are available. The nurse may develop a tool to hold the insulin vial for the patient, such as a table drawer or a suction cup device used to hold razors for shaving found at a local store.

Communication is vital for the nurse as communication is a continual process in the health care environment. Communication occurs with the patient, family, physicians, peers, subordinates, other departments and community resources. Communication in the health care arena is oral and written. Each form of communication used by the nurse will require the nurse to adapt the communication to the correct voice, or language (Clarke & Crossland, 2002). There have been many changes in the area of communication in the health care field. Many technological advances have been adopted to help the nurse and other health care providers with the process of communication to decrease the amount of time spent on documentation.

The practice of nursing has experienced many changes throughout history. The earliest nurses practiced primarily in the community as public health nurses, a shift away from the community nursing environment to the hospital environment occurred following World War II. In the late 1970's nursing practice shifted back to the community as one of the major practice areas (Kalisch & Kalisch, 2004). The cause of the latest shift away from the hospital is the result of managed care that impacted hospital's finances. This move has resulted in most hospital units becoming mini intensive care units and patients being discharged before they have achieved total self care ability thereby requiring the knowledge and skills of a visiting nurse (Flanagan, 1997).

In conjunction with the changes in the area of nursing practice, other changes have occurred in the hospitals practice structure impacting patient care and nursing. Registered nurses (RN) are the largest group of employees in a hospital; as a result of this they are the first line of caregivers to be cut in any downsizing action of a hospital (Flanagan, 1997). As the number of RNs working in hospitals due to the nurse shortage or downsizing, results in them being replaced with licensed practical nurses (LPN) and unlicensed assistive personnel (UAP) to meet the basic needs of the patient. LPN's have a very limited one-year education program and must work under the guidance and direction of the RN in the hospital setting. The UAP's are also under the supervision and direction of the RN and may have six weeks of education or less. UAP's working in skilled nursing facilities, such as nursing homes, are required to have education and pass a test for certification, however, this rule does not apply to UAP's working in a hospital (Fagin, 2001). The LPN's and UAP's are limited in the skills and tasks they may perform and as a result the RN must be knowledgeable about the skills and tasks each may perform competently and legally prior to delegating to these individuals. The LPN and the UAP may not, by law, be

the primary care provider for a patient in a hospital, however, there is evidence they are filling the role of primary care provider in today's RN shortage and staff cuts.

Spilsbury and Meyer (2004) implemented a study in the United Kingdom (UK) to describe the work of UAP's called health care assistants and to find how their work is defined and shaped in the health care organization. Although the study took place in the UK, there are many similarities with the health care assistant's role and the UAP role in the United States. Many of the skills completed by the health care assistants are skills that are normally in the domain of the RN; however, the skills are frequently delegated to the health care assistant by the RN in the hospital setting. The health care assistants do not have formal training. Health care assistants in the UK have an estimated 300 different titles; similarly the UAPs in the United States have as many different titles as there are hospitals (Spilsbury & Meyer, 2004).

I have witnessed the use of LPN's in hospitals as primary care givers. The hospital unit manager justified the use of these individuals to provide care as primary care givers because they were under the direction of the charge nurse. I found, however, that the charge nurse was not aware that she was responsible for the patients these individuals had in their assignment. Further complicating that was that the charge nurse would be responsible for the basic unit activities as well as eight to ten patients. Aiken et al. (2003) found the mortality and morbidity rates of patients increase when there is a high ratio of RN's with ADN education acting as the primary care giver for patients, how much greater is it with individuals who have even less education such as the LPN as a primary care giver?

The Spilsbury and Myer (2004) study provided support that the health care assistants were being used to provide direct patient care as nurses at the bedside in the health care setting without the proper training and education. The findings cannot be generalized to all health care

settings, as it was limited to only one health care setting and the practice of the health care assistants and RN's in that setting.

The current nursing shortage combined with added responsibility of the RN to supervise and manage subordinates on the hospital unit requires the RN to understand principles of management and leadership. Nursing leadership is required at every level due to the changes that have and continue to occur in the profession of nurses (Heller et al., 2004). The National League for Nursing (NLN), one of the national accrediting groups for nursing education, identified this need and included leadership and management content as required in nursing curriculum in 1983. The criteria states "provides for the development of skills in leadership and management for beginning professional practice" (NLN, 1983, p. 7). The criteria established a requirement for all schools of nursing, ADN and BSN, to incorporate leadership and management into the curriculum. It is important to remember that the ADN was established as a technical nurse and Montag explicitly stated the ADN should not be placed in leadership positions for which they have no training (Montag, 1959). The requirement of leadership and management content added to the requirements of the ADN programs again increased the time required to complete the ADN course of study. Nursing education programs could integrate the leadership and management concepts throughout the program or, as most programs have done, develop nursing leadership and management courses.

Manfredi and Valiga (1990) questioned whether BSN nursing programs understood the differences in leadership and management and as a result were training nurse managers and not nurse leaders. They completed a descriptive study to identify if BSN education programs were teaching leadership development and management concepts or if the nursing programs were only teaching management concepts. Ten activities of leadership and ten activities of management

were identified and utilized to develop a form with a dichotomous scale for data collection. Inter-rater reliability of 89.2% was established prior to the data collection process. The reviewers reviewed leadership and management content in the NLN Self-Study Reports of ten accredited BSN nursing programs. Manfredi and Valiga (1990) concluded that there was a greater emphasis on management principles than on leadership development and that the terms of leadership and management are used interchangeably in the nursing programs. Manfredi and Valiga further conclude that distinctions must be made between leadership and management to ensure the development of nurse leaders.

Manfredi and Valiga (1990) did not observe BSN nurses or measure the leadership behaviors in the BSN nurse to identify whether leadership behaviors were present in the nurse. Reviewing the self studies of the nursing programs for content on leadership development failed to recognize the impact of a liberal education that is combined with the leadership and management content. The liberal education the BSN nurse receives helps the student develop the skills of critical thinking, creative problem solving, self-directedness and leadership (Polet, 2002). Joel (1972) elaborates further that a liberal education removes the barrier of fear from ones self in the individual allowing the person to be creative and think outside the norm.

Heller et al. (2004) also recognized the need for improved leadership development in the nursing curriculum and proposed a curriculum change for the BSN curriculum, especially in the curriculum for the RN returning to school to earn a BSN. Heller et al. (2004) explains that the associate degree programs are not providing enough attention to the development of leadership and management content and there is a need for leadership characteristics and behaviors in every level of nursing practice. Developing leadership behaviors would require teaching of these

behaviors at the basic, pre licensure, level of nursing education, not just for those RN's returning to school to earn their BSN.

Chandler (2005) also recognized the increased need for leadership behaviors in every nurse and developed a teaching assistant program to help with the development of these leadership behaviors throughout the BSN nursing education program. Chandler (2005) proposes that the problem of nurses not modeling leadership behaviors may be due to the fact that most leadership and management courses are typically offered during the last semester of the curriculum. The lateness of the course may be inhibiting the student from mastering these behaviors prior to graduation (Chandler, 2005).

The health care environment today is faced with problems of rising costs, sicker patients, rapid changes and complex technology requiring nurses to act autonomously and professionally at the point of care for patients (Chandler, 2005; Manfredi and Valiga, 1990). Staff nurses who demonstrate good communication skills, critical thinking, creative problem solving, self-direction and the ability to develop professional interpersonal relationships can overcome these challenges. Bennis and Nanus (1985) speak to the differences of managers and leaders in a simple yet powerful statement: "managers are people who do things right and leaders are people who do the right thing." (p. 21) Leaders stand above the fray and motivate others to work toward the achievement of common goals (Grossman & Valiga, 2005). Nurses, who demonstrate leadership behaviors are able to motivate patients to follow the prescribed health care regimen needed to achieve self-care ability, creatively solve problems, mentor other nurses and subordinates and manage crisis situations.

Nurse executives across the United States value leadership behaviors in the nurses they hire to provide care to patients. Goode et al. (2001) completed a survey of Nurse Executives who

were members of the University Health System Consortium Chief Nursing Officer Council. The

survey provided support that BSN prepared nurses are preferred over ADN or Diploma nurses.

The Nurse Executives voiced their opinion that BSN prepared nurses have better critical thinking

skills and stronger leadership skills than the ADN or Diploma nurses (Goode et al., 2001). In

April (2005) the American Organization of Nurse Executives (AONE) provided additional

support of the Goode et al. study when they released a statement of preference for BSN nurses

over ADN or Diploma nurses. The 2005 statement released by the American Organization of

Nurse Executives states:

> The educational preparation of the nurse of the future should be at the baccalaureate
>
> level. This educational preparation will prepare the nurse of the future to function as an
>
> equal partner, collaborator and manager of the complex patient care journey that is
>
> envisioned by AONE (p. 1)

There is supporting evidence of differences in nursing practice at the different levels of

nurse education. Aiken et al. (2003) completed a study of nurses with varied levels of education

working in post-operative hospital units and the mortality and morbidity rates of patients in these

different post-operative units. Aiken et al. (2003) address the extraneous variable of patient nurse

staffing ratio that could have had an impact on the studies results as well as the size of the

hospital and the acuity of the patients. They discovered that hospitals with a higher ratio of BSN

prepared nurses to ADN prepared nurses had lower mortality and morbidity rates. A 10%

increase of BSN prepared nurses, or higher degree, decreased the mortality and morbidity rates

by 5%. Aiken et al. (2003) does not address the reason for the differences. Results of other

studies found in the literature suggest that BSN prepared nurses are better communicators,

demonstrate more professional behaviors, have a strong ability to solve complex problems and are able to perform complex functions.

Giger and Davidhizar (1990) compared the conceptual and theoretical approaches to patient care between the ADN prepared nurse and the BSN prepared nurse. They were interested in learning if there was a difference in the education of the nurse and the nurse's understanding and utilization of the nursing process and leadership abilities. Nursing process includes development of a nursing diagnosis, patient outcome and the identification and implementation of nursing interventions to help the patient achieve the nursing outcome. Nursing diagnosis and identification and implementation of nursing interventions require that the nurse have critical thinking ability and creative problem solving skills. Both of these skills are behaviors found in leaders. Giger and Davidhizar's (1990) study supported the premise that ADN prepared nurses are technical nurses. They found the ADN prepared nurse was more involved in the technical aspects of patient care such as the maintenance of equipment and direct nursing care. The BSN nurse, Giger and Davidhizar's (1990) concluded that there are two important areas of nursing activity that are impacted by the educational preparation of the nurse: the BSN was more process-oriented and had a better understanding and utilization of nursing process and demonstrated stronger leadership skills.

Young, Lehrer and White, (1991) examined whether human capital investment in nursing education impacted the productivity of the registered nurse. Young et al. (1991) proposed that the investment of time into higher levels of education would increase the productivity of the registered nurse. The results of the study supported Giger and Davidhizar (1990) study conclusions that BSN prepared nursed performed higher-level care than the ADN prepared nurse. The study also lends support to Aiken et al.'s (2003) study conclusions that the BSN is

better prepared to provide the intense, higher level of care needed by today's patients. Young et al. (1991) also had a revelation they had not intended: BSN prepared nurses are less likely to leave the nursing profession. Registered nurses who invest more time and money into their education are less likely to leave their chosen profession. That is an important finding in today's evolving nursing shortage.

Further support of the differences in practices between the BSN and ADN nurse is given by a report of Fagin in the 2001 report, *When Care Becomes a Burden*. Fagin (2001) reports that the impact of hospital restructuring and decreased RN staffing for patient care has had a deleterious impact on the mortality and morbidity rates in the hospital. She continues to share that the RN staffing mix of BSN and ADN nurses also impacts the quality of care. Medication errors are one of the largest problems in hospitals and Fagin provided evidence that it is impacted by educational preparation of the nurse. Fagin (2001) provided results of reports submitted by New York State Education Department Survey that showed: "nurses who had only an associate degree as their basic preparation were nine times as likely as those with a bachelor of science degree to be charged with violations" (p.10).

In summary, patients in today's health care environment are in the hospital fewer days than they have ever been in the past, and those in the hospital are much sicker. Because patients are more acutely ill nurses providing care to them must be able to perform nursing care at a higher level than in the past. Nurses need to have the ability to communicate, embrace change, problem solve, critically think, handle crisis situations, and notice the subtle changes in the patient condition.

Hassmiller (2006) states: "Nurses' clinical duties routinely thrust them into leadership roles. In addition to providing direct patient care, nurses educate patients and families and act a

liaisons to doctors, pharmacists, administrators and many others in our increasingly complex health care system" (p. 25). Leadership behaviors could be argued, however, as needed in every nursing role. Leaders have the qualities needed to develop trusting interpersonal relationships with people around them. They demonstrate competence in their profession. Good leaders have a propensity for communication and the need to share patient information with a team of health care providers makes communication one of the most important skills a nurse has. Interpersonal relationships, competence in practice and communicating critical information are important but that's not all a nurse needs to provide safe and effective patient care. The nurse must have the ability to critically think, to assess a situation and identify both what interventions are needed now and what may be needed later. None of these will occur, however, if the nurse is not self-directed. Self-direction is a major leadership behavior. Leadership is not passive, but it is active and requires the person to be self-directed. Self-direction is the ability to see what needs to be done, how it can be done, and then takes the steps to do it without being told or directed by someone else. These are the leadership behaviors that are wanted in nurses providing care at the bedside by nurse executives. Nurse executives want these leadership behaviors in the staff nurse to ensure good outcomes in patients.

CHAPTER III. METHODOLOGY

In this study I explored the differences in educational preparation of registered nurses and their integration of major leadership behaviors including a) decision-making, b) critical-thinking, c) creative-problem solving, d) interpersonal skills, e) communication, f) mediator for change, g) navigation of health care system, h) time management, and i) crisis management. I used a complementarity mixed methods research approach. In the following section a discussion of the research design including the population and sampling technique, data collection instruments, data collection procedures and proposed data analysis will be given.

Mixed Methods Research Design

The term *mixed methods* research is a term used among researchers to indicate the use of both qualitative and quantitative methodologies in one study. The actual process of mixing research designs has been done throughout the 20th century and the 21st century (Tashakori & Teddlie, 2003). Johnson and Onwuegbuzie (2004) define mixed methods research as, "the class of research where the researcher mixes or combines quantitative and qualitative research techniques, methods, approaches, concepts or language into a single study" (p.17). The mixed methods research process known as triangulation has been commonly used as a research design in the social, educational, and nursing studies (Tashakori & Teddlie, 2003). Researchers in the social, educational and nursing disciples used the triangulation design to add to the understanding of phenomena and to strengthen a study's validity (Polit & Hungler, 1995; Sale, Lohfeld & Brazil, 2002; Viadero, 2005). There is concern by many, that the attempted mixing of very different points of view, or paradigms is inappropriate. (Johnson & Onwuegbuzie, 2004; Tashakori & Teddlie, 2003).

Sale et al. (2002) argues that the mixing of quantitative and qualitative research does not strengthen nor does it add validity to a study because qualitative and quantitative studies have different questions, purposes and paradigms. Their argument is in the purist sense. Typical quantitative research designs are built around a positivist paradigm. The positivist paradigm has strict rules with tight controls. The researcher who adopts the positivist paradigm in the purist sense holds that there is only one reality and that the truth is absolute (Burns & Grove, 2001; Johnson & Onwuegbuzie, 2004; Sale et al., 2002). The quantitative researcher studies phenomena using attributes that can be assigned numbers that are absolute to identify the one truth with the purpose of identifying what, if any, relationships exist between an independent variable and a dependent variable (Sale et al., 2002).

Typical qualitative research designs are built around the naturalistic or humanistic paradigm. The naturalistic paradigm is much more open to interpretation in research. The purist qualitative researcher who supports the naturalist paradigm believes there are multiple realities and multiple truths, which are developed through the lived experiences of individuals (Burns & Grove, 2001; Johnson & Onwuegbuzie, 2004; Sale et al., 2002). The qualitative researcher argues that the lived experience of individuals molds the individual's realities just as the experiences of the researcher will mold the researcher's realities. To gain the greatest understanding of a phenomenon a researcher needs to understand the reality, the lived experience, of the study participants (Burns & Grove, 2001). The researcher seeks to understand the participant's perceptions of a specific phenomenon and may actually become part of the research study (Burns & Grove, 2001). Self proclaimed purists in these two primary schools of thought believe these paradigms are so fundamentally different that they cannot be combined or mixed (Howe, 1988; Johnson & Onwuegbuzie, 2004).

One could argue that the true scientist, the extreme positivist purist, would not study any human phenomena because it would require that the researcher apply a value to the phenomena in order to measure it and achieve the one truth. If a researcher assigns a numerical value to the phenomena, it would most likely be based on the researchers past experiences with the phenomena or the researcher's values. In this study a Likert Scale will be used, similar to the Self Assessment Leadership Instrument (SALI), requiring the respondent to assign a value to a concept. That value will be the result of the respondent's experience. That one truth would be, in reality, influenced by the researcher's bias, or the respondent's bias, toward the phenomena as soon as the researcher or participant assigns a numerical value to it. True positivist are those individuals that only study scientific principles such as chemical interactions, or phenomena that is naturally occurring and does not require that a numerical values be assigned to it; the numerical attributes are naturally occurring and only requires that the researcher do the counting.

The debate between the purists continues. However, mixed research methodologies are becoming more acceptable in the social sciences and textbooks have been written discussing the benefits of using mixed designs and the similar aspects of qualitative and quantitative research designs. Sechrest and Sidana (1995) propose that both qualitative and quantitative research have many similarities. They state both research designs "describe their data, construct explanatory arguments from their data, and speculate about why the outcomes they observed happened as they did" (p. 78). It could be argued, however, that although both research designs have these similarities they are asking different questions, they have different purposes, and they have different forms of data, words versus numbers (Sale, Lohfeld, & Brazil, 2002).

Mixed design research has been used in nursing research for many years. It has typically been referred to as triangulation and touted by researchers as providing greater validity and

credibility to the research (Twinn, 2003). Nursing researchers have acknowledged the many

ways research can be mixed, or triangulated: data triangulation, investigator triangulation, theory

triangulation and method triangulation (Polit & Hungler, 1995). Greene et al. (1989) suggest the

use of the term *triangulation* for all mixed methods designs muddies the actual purpose of

triangulation and results in the loss of value in the other types of mixed methods designs. The

term mixed methods has gained in acceptance and recently there has been an increase in the

number of nursing research texts that have a mixed methods chapter and in these chapters the

typology of mixed methods had advanced beyond the word triangulation. Greene et al. (1989)

propose determining the purposes for the mixed study can control these differences.

Greene et al. (1989) completed a study for the purpose of developing a framework for

mixed methods research. The study involved a review of the theoretical literature and analysis of

57 mixed method evaluations. Greene et al. (1989) identified five purposes for completing a

mixed methods study: triangulation, complementarity, development, initiation, and expansion.

Each of these purposes will be discussed briefly in the following paragraphs.

Triangulation is utilized by researchers to corroborate or converge on the interpretation

of the results of a research study. The investigator may use the triangulation design to "increase

the validity of the constructs and inquiry results…" (p.259). The two different methods of the

triangulation study must be measuring the same conceptual phenomenon (Greene et al., 1989).

Development is used by a researcher to aid in the development of the second phase of the

study. The development may be an instrument for data collection, a sampling decision or a study

implementation decision. This type of mixed methods will increase the validity of the

instruments constructs being studied (Greene et al., 1989).

Initiation is used when the researcher is attempting to discover contradictions or to

develop new perspectives of a phenomenon. The initiation mixed methods approach will

"increase the breadth and depth of inquiry results and interpretations" (Greene et al., 1989,

p.259). Many times the researcher may not have planned an initiation mixed method approach,

but during a mixed methods study the researcher discovers contradictions or a paradox in the

analysis of the study. The initiation method provides for discovery and the development of new

insights and perspectives of a phenomenon (Greene et al., 1989).

Expansion is used for a study when multiple methods and multiple components are

needed. It is a multitasking form of study design. Different methods are used to study different

aspects or components of a study. The example provided by Greene et al. (1989) is the use of

expansion for program outcome assessment and implementation.

The *Complementarity* mixed method design is used to study two different aspects of a

phenomenon. The different aspects complement one another and provide a more thorough

understanding of the phenomenon. The purpose is to elaborate, clarify and enhance the findings

of one method of a study with the other method of the study (Greene et al., 1989).

For the purposes of this study Greene et al. (1989) complementarity design was used (see

figure 2, p. 61). A qualitative interview with expert nurse managers and a quantitative survey of

new graduate nurses was completed concurrently. The decision to use a mixed methods research

design for this study was made in order to study the many different facets and areas of leadership

behaviors in nursing. The mixed method design provided valuable information and

understanding of the importance of leadership behaviors in staff nurses and the desire for staff

nurses to have these behaviors by expert nurse managers A second reason for using the mixed

methods design is to confirm the leadership behaviors measured in the SALI are equal to the

Figure 2. Tashakkori and Teddlie's sequential multitrait-multi-method matrix.

Qualitative Question: Are the leadership behaviors measured in the SALI comparable to the leadership behaviors identified by expert nurse managers, as behaviors desired in nurses?

Quantitative Question: Is there a relationship between education and leadership behaviors in new graduate BSN prepared nurses and new graduate ADN prepared nurses?

Data Collection: Taped interviews with seven expert nurse managers about desired behaviors of leaders and nurses

Data Collection: SALI completed by 145 new graduate nurses licensed nurses in Ohio

Data Analysis:
Constant Comparison
Member Checking
Identify Themes
Peer Checking

Data Analysis:
Descriptive Statistics
T-Test

Qualitative Inference

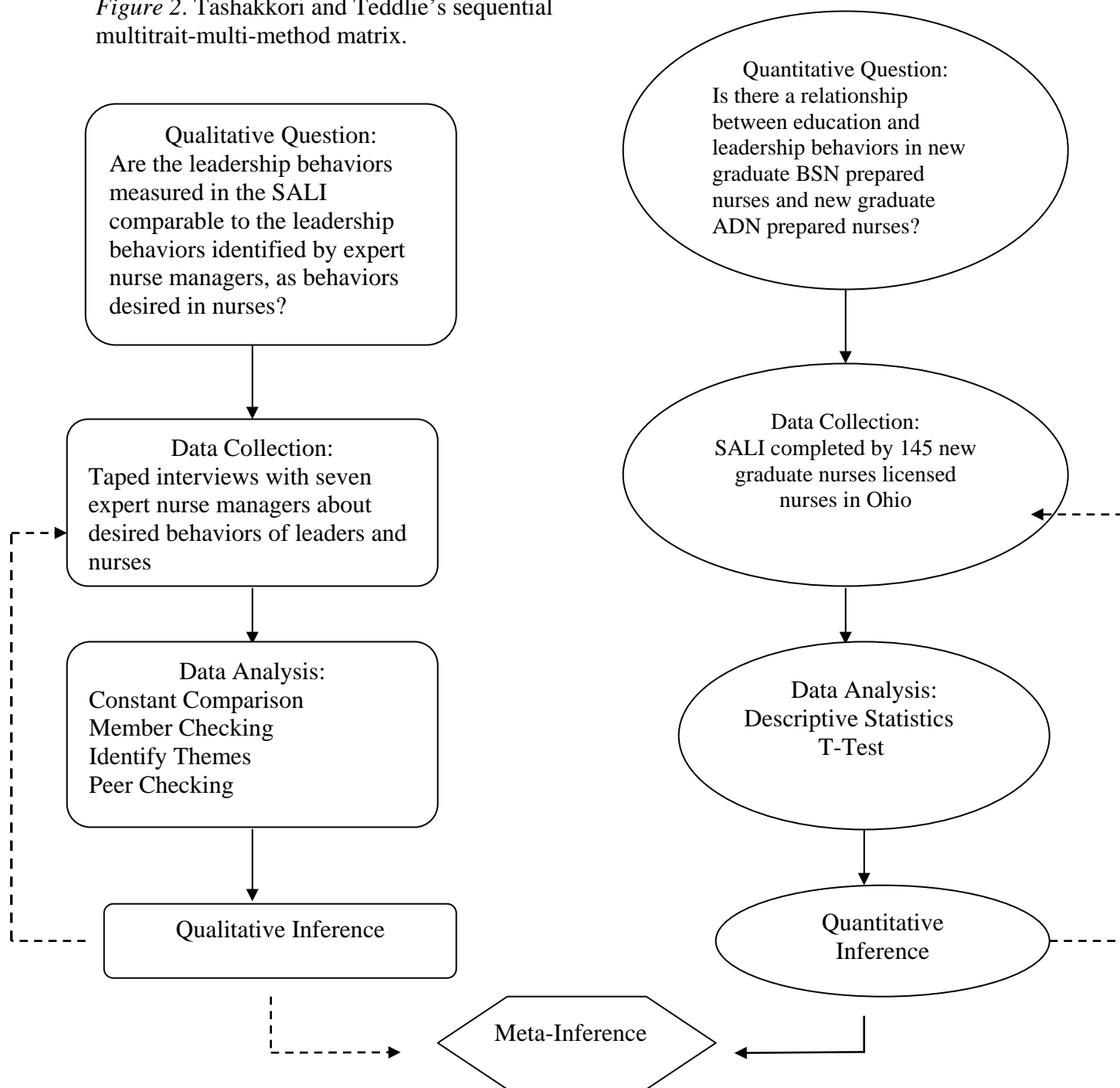Quantitative Inference

Meta-Inference

Diagram of the leadership study using the complementarity design

behaviors desired by expert nurse managers in their nurses, thereby supporting the premise of the researcher that leadership behaviors are desired in nurses at every level of practice.

<div align="center">Qualitative Strand</div>

Trustworthiness of Data

Polit and Hungler (1995) define trustworthiness as an assessment of the data obtained in a study using the four criteria of credibility, transferability, dependability, and confirmability. Transferability is the ability to apply the findings to other individuals within similar cultures or groups (Lincoln & Guba, 1985). Lincoln & Guba (1985) discuss the requirement of the researcher to provide thick description of data so the consumers of the research can make an informed decision concerning transferability. Transferability of the findings is a decision the consumer of the research must make. The final report of this study will provide descriptive data about the participants, the interview process and thick descriptions of the interview data to enhance the consumer's ability to make the decision on transferability.

Dependability is a measure of stability of the data over time (Lincoln & Guba, 1985). Confirmability refers to the objectivity of the data and this can be established by using a peer review of the data and the analysis. This study used a doctorally prepared colleague who is not in the nursing profession to review the completed interview data and analysis to establish confirmability. Credibility examines how credible or believable the data is (Lincoln & Guba, 1985). Two different methods to increase the credibility of the data have been identified in the literature, prolonged engagement and triangulation.

Triangulation is the use of multiple methods, multiple data sources, multiple investigators, and multiple theories (Denzin, 1989). The multiple data sources triangulation design will be used in this study to increase the credibility of the inferences. The multiple data

sources were seven expert nurse managers from a variety of hospitals in northwest Ohio and the SALI.

Seven expert nurse managers were selected from hospitals that are located in rural, urban, and suburban settings in Ohio. Interviews with the expert nurse managers occurred in their offices at their respective hospitals. These interviews were used to identify the behaviors most desired in their leaders and the behaviors they wanted in their staff nurses. The behaviors the expert nurse managers identified as those they wanted in their leaders and the behaviors they wanted in their nurses were compared to discover commonalities between them. These behaviors were then compared to the categories originally set by Yura in 1970 in her Self Assessment of Leadership Instrument (SALI). Interviewing nurse managers from different hospitals ensured diversity of the nurse managers due to the difference in hospital cultures, hospital sizes and hospital acuities. Interviews were conducted and data collected from the seven expert nurse mangers until data saturation occurred as identified by using the constant comparison method.

When data saturation occurred a summary of the information was developed with categories identified. Each of the interviewees was given a copy of their data summary to review to ensure accuracy of interpretation and analysis. The interview data and analysis was given to a doctorally prepared colleague to review in order to ensure confirmability of findings.

Participant Selection

A criterion sampling plan was utilized for the study to ensure each interviewee met the expert nurse manager definition (Creswell, 1998). This type of purposive sampling is used in a study when random sampling is not possible. Random sampling is not possible when the study requires specific characteristics in the participants (Brockopp and Hastings-Tolsma, 2003; Burns & Grove, 2001). The participants in this strand of the study were expert nurse managers. Expert

nurse mangers are nurse managers with a minimum of five years of experience and evidence of leadership skills. Identification of leadership skills by the expert nurse manager was accomplished by demonstrating a history of successful completion of identified unit goals and outcomes, a consistent low turn over rate for staff on the unit compared to the other units in the hospital and staff contentment with the leadership skills of the nurse manager. The educational background of the expert nurse manager was not a determining factor for inclusion in the study and identification as an expert nurse manger.

A minimum of one expert nurse manger was interviewed from seven different hospitals in Northwest Ohio, for a total of seven participants. Interviewing nurse mangers from different hospitals provided the study with different perspectives, as each hospital varies in size and expertise. Each hospital and hospital unit is a culture onto itself, and did; therefore provide greater variability in the perspectives of the participants. The interview process continued with as many participants as necessary to achieve saturation of data. Saturation of data occurred when there were no new themes or information gleamed from the interviews (Polit & Hungler, 1995).

Nurse administrators at each of the Toledo area hospitals were asked to provide the names of potential nurse manager participants. The rationale for asking the nurse administrators for potential candidates is that the nurse administrators are the supervisors of the nurse managers and are the individuals with the greatest working knowledge of the skills and successes of the nurse mangers in the hospital. They are, therefore, the most appropriate source for providing references for potential participants. An e-mail was sent to each of the nurse administrators identifying the researcher, the purpose of the study, the time commitment of the participants, the qualifications of expert nurse managers, and a request for the names of managers who meet these requirements and would be willing to be interviewed (see Appendix A).

A list of potential nurse manager candidates was developed from the names provided by the nurse administrators The list with the names was cut and the names representing each hospital were placed in a bag with the associated hospital's name on it. Two of the hospitals provided only 1 name for inclusion into the study, so each of those managers was included in the study. The remaining five candidates were selected by random drawing of names, one name out of each of the bags representing the hospitals. The candidates were sent an e-mail letter describing the study and inviting them to participate in the study (see Appendix B). One week following the e-mail invitation a follow up phone call was made to confirm the nurse managers willingness to participate in the study and to set the interview appointment time and place.

Participant Safeguards

Confidentiality and anonymity are important ethical concepts noted in the ethic of justice, right to privacy (Polit & Hungler, 1995). Anonymity is when the participants cannot be identified by anyone, including the researcher. A qualitative study does not easily allow for that type of strict protection since the researcher in most qualitative studies meets the participants and interacts with them, thus eliminating anonymity (Polit & Hungler, 1995). To protect the participants in a qualitative study confidentiality is important. Confidentiality is achieved when the information given by the participant cannot be identified with the participant (Polit & Hungler, 1995). A promise of confidentiality can be difficult to achieve in a qualitative study due to the small sample size used, however, there are steps that can be taken in order to protect confidentiality of the participants. Polit and Hungler (1995) advise the following steps to safeguard the confidentiality of the participants.

- Obtain identifying information (e.g., name, address, etc.) from participants only when it is essential to do so.

- Assign an identification (ID) number to each participant and attach the ID number rather that other identifiers to the actual research information.

- Maintain any identifying information and lists of ID numbers with corresponding identifying information in a locked file.

- Restrict access to identifying information.

- Enter no identifying information onto computer files.

- Destroy identifying information as quickly as feasible.

- Have all research personnel who have contact with the research information or identifiers sign pledges of confidentiality.

- Report research information in the aggregate; if information for a specific subject is reported, take steps to disguise the persons identify, such as through the use of a fictitious name together with sparing use of descriptors of the individual (p. 125).

A promise of confidentiality was given to the participants of this study. Steps proposed by Polit and Hungler (1995) were instituted to protect the participants. To protect the participants from being identified as the individual who provided specific information in the study the participants were assigned a pseudonym. The pseudonyms with the corresponding participant names are kept in a secure computer flash drive that requires a password for access. A flash drive is not the same as a computer file. Others may access a computer file but the flash drive is a removable drive and a secure flash drive requires a password for access. The flash drive is being kept in the possession of the researcher in a file cabinet with the research data. Identification of the participants was not revealed to anyone. Research information was reported in an aggregate report using only the identifying numbers for the participants.

Interview Process

Data for the qualitative strand of the study was obtained through face-to-face interviews with expert nurse managers using a semi-structured questionnaire (see Appendix D). The researcher, prior to the interview process, completed a review of the research study with the nurse manager and answered any questions the manager had about the study. The nurse manger was requested to sign a hard copy of the consent to participate form prior to the interview process. The semi-structured questionnaire provided the researcher some control over the interview process (Maxwell, 2005). The face-to-face interview technique enabled the researcher to clarify answers and probe deeper when necessary thereby increasing the researchers understanding of the interviewee's responses (Creswell, 1998; Maxwell, 2005). The interview protocol was used to help the researcher maintain a set of organized notes and thoughts about the interview (see Appendix D).

The interviews were audio-recorded using two tape recorders, one micro cassette and one digital recorder. Using two recorders provided backup in case of a technical failure of one of the recorders. Taping the interviews ensured accuracy and clarity in transcription of the interviews, plus it allowed the researcher to take written field notes on the responses of the participant without missing important information (Creswell, 1998). The tapes were erased after successful completion of the study.

Interview notes were transcribed and analyzed for the first time within eight hours following the face-to-face interview. A summary of the interview was written with notes for further clarification and questions were developed following the transcription and initial analysis. Transcription of interview notes immediately after the interview ensured the accuracy of the interview data and the memory of the researcher of any events that occurred during the interview

process (Burns & Grove, 2001). Follow up questions that were identified during the transcription was asked during a second follow up interview with the nurse mangers. The initial interview process took approximately 45 to 60 minutes; the follow up interview took approximately 15 to 30 minutes.

Analysis of Data

Analysis of the interview data began immediately following the first interview and continued throughout the study using a constant comparative technique. Constant comparison is used to help the researcher identify when data saturation has occurred (Creswell, 1998). While listening to the taped interviews the researcher read the transcripts of the interviews to ensure accuracy of transcription and to gain an overall impression of the interview data. Notes' concerning the interview responses and an initial sorting out of the data by the researcher was completed during this review. A summary of the interview with the interpretation was written and e-mailed to the nurse manager for confirmation and verification. Creswell (1998) proposed that verification is a critical step in qualitative analysis. Any corrections noted by the manager will be incorporated into the data and a second analysis will be completed with a summary of the data interpretation.

Interview data was continually analyzed for themes and commonalities to develop categories for the data. Data was reduced into the categories and the categories were counted for frequency noted in the interviews. When saturation occurred, the categories were compared to the behaviors of leadership noted in Yura's 1970 SALI. To ensure trustworthiness of the qualitative results, a peer debriefing of the interviews was conducted. The results of both analyses were compared to ensure accuracy of interpretation of the interviews, themes and conclusions.

Quantitative Strand

The quantitative strand of the study is a nonexperimental descriptive study of leadership behaviors in new graduate nurses. The study utilized a self-report instrument, the SALI to measure leadership behaviors employed by nurses with different nursing educational backgrounds. The independent variable is the educational background of the nurse ADN or BSN, and the dependent variable is the self reported leadership behaviors that are employed by the nurse when giving care to patients. The purpose was to determine if there are differences in the number of leadership behaviors reported as being used by nurses with different educational backgrounds. The null hypothesis of the study was: There are no differences in the leadership behaviors displayed by ADN new graduate nurses and BSN new graduate nurses working in a general medical surgical hospital unit.

Participants and Data Collection

The population for the quantitative strand of the study was new graduate registered nurses working in a hospital on medical surgical units. Nurses working in the intensive care unit and nurses working in the emergency department were omitted from the study. New graduate registered nurses are registered nurses with an ADN nursing education or a BSN nursing education that were licensed to practice registered nursing for the first time between December 2004 and July 2006. Newly licensed nurses with higher degrees in nursing or another field, such as an ADN in nursing with a bachelor's in education, was included in the study with the BSN nurses since they had a bachelors education and the general education is the critical difference between the ADN and the BSN. The study examined if there was a difference in the two-year ADN education and the four-year BSN nursing degree on leadership development. Nurses with advanced degrees were not used to prevent bias the results.

The sample for the study was taken from two counties in Ohio, Lucas County and Hamilton County. Limiting the sample to two counties in Ohio decreased the cost of the study. Lucas County is in the northern part of the state and has nurses from a variety of schools located in and around Toledo, Ohio. Hamilton County is in the southern part of the state and has nurses from a variety of schools in and around Cincinnati, Ohio. The sample provided participants with education from a variety of schools increasing the diversity of the sample. Nursing education from a variety of schools also aided in limiting potential bias in how students are taught which may impact leadership development.

The names and addresses of potential participants were obtained through the Ohio Office of Information Technology in Columbus, Ohio. Names and addresses of every person who are licensed to practice registered nursing are maintained in the Office of Information Technology and are available upon request to the public. The Office of Information and Technology reported that there are 1,232 registered nurses in these two counties that met the specified criteria for inclusion into the study. The 1,232 names included newly licensed nurse practioners and nurses who had just moved into Ohio resulting in 906 potential participants. Each of these 906 registered nurses were mailed a letter of invitation to participate explaining who the researcher is, what the study is about, the risks and benefits to the participants, the time commitment required to participate and a promise of anonymity along with a copy of the SALI and a demographic form (See Appendices E and F). Return of the completed SALI implied consent to participate in the study.

Participant Safeguards

A promise of anonymity was given to the participants in the quantitative strand of the study. To ensure anonymity the participants were instructed to not put their name or other

identifying information on any of the SALI forms. A stamped addressed return envelope was

included in the mailing with instructions to the participants to leave the return address blank.

These steps ensured that the researcher and others were not able to identify the participants.

Instrument

The instrument used in the study was Yura's Self Assessment of Leadership instrument

(SALI) developed in 1970 (see Appendices E and F). Yura developed the 70-item instrument

using leadership literature and Halpin's 1957 Leadership Behavior Description Questionnaire

(LBDQ) to explore leadership behaviors in BSN students (Smola, 2001). Yura had designed the

instrument so that the leadership behaviors were categorized into six areas: (a) self, (b) critical

thinking, (c) decision-making, (d) interpersonal relationships, (e) group relations and (f) job

relations (Smola, 2001). The categories first identified by Yura were compared with the five

behaviors identified by the seven expert nurse managers as those they wanted in staff nurses. The

five categories identified are, (a) independent decision-making, (b) critical thinking, (c)

interpersonal relationships, (d) communication, and (e) compassion and caring.

Yura completed a study of 90 nursing students to test for internal consistency. A Kuder-

Richardson formula showed a .93 internal consistency score (Smola, 2001). Utilizing the

information from the internal consistency results Yura completed an item analysis by

determining item difficulty and discrimination indices. The result of this analysis was a decrease

in the original instrument from 70 items to 46 items (Smola, 2001).

Reliability of the SALI was measured using a test-retest with 24 nursing students. The

nursing students were given the SALI and repeated it 10 days later. The result of this test-retest

was a Cohen's K coefficient of only a 55% agreement (Smola, 2001).

Five doctorally prepared expert leaders examined the SALI for content validity using modified semantic differential scales. The leaders did not agree on the fit of the items in the categories, as a result the categorization was eliminated and six items were eliminated. The result is a 40-item SALI (Smola, 2001).

Data Analysis

The three null hypotheses corresponding to the research questions that were tested included:

1. There are no differences in the number of leadership behaviors self reported as being done by new graduate ADN nurses and new graduate BSN nurses working in hospitals on medical surgical patient care units.

2. There are no differences in the complexity of leadership behaviors self reported by new graduate ADN nurses and new graduate BSN nurses working in hospitals on medical surgical patient care units.

3. A new graduate's past experience working in a hospital patient care unit does not increase the number of self-reported leadership behaviors as being done.

Data obtained from the participants during the quantitative strand of the mixed method study was organized using frequency distributions. The purpose of organizing the data with the use of frequency distribution enabled the researcher to identify which leadership behaviors are used most often by new graduate nurses. Each of the three hypotheses was tested using a 2-sample t-test ($\alpha = 0.05$). Frequency distribution helped to organize the raw data and provided some basic understanding of the new graduate nurses and their corresponding educational preparation, however, the t-test allowed for a deeper analysis to determine if there was a

relationship in the educational preparation of the nurse or the past experience of the nurse and the self reported use of leadership behaviors measured in the SALI.

A measurement of variance was used to measure average dispersion of the data, the measures of variance that was used is the standard deviation (SD) (Brockopp & Tolsma, 2003). The SD is an important measure to aid in the understanding of the distribution of scores. Analysis continued with the use of the t-test comparing the means of the ADN prepared nurse's self-reported use of leadership behaviors and the means of the BSN prepared nurse's self-reported use of leadership behaviors. The t-test was used to determine the probability (*p)* value to aid in the determination of the difference occurred by chance (Brockopp & Tolsma, 2003).

Conclusion

The change in the practice of nursing has occurred over time due to the changes in health care and patient acuity. Nurses with more advanced nursing skills and leadership behaviors are needed to ensure the patient is able to meet their self-care demands in a safe and efficient way. The education of nurses continues to have multiple educational entry levels into the profession and the same licensure exam for all the educational programs.

Studies have shown the increased morbidity and mortality rates of patients in hospital with low BSN to ADN ratio of staff nurses providing care to patients. There have not been any studies examining the development of critical leadership behaviors in nurses related to educational preparation. This study was a mixed methods study of behaviors modeled by new graduate nurses of differing educational preparation and those behaviors that are desired by expert nurse managers in acute care settings.

CHAPTER IV. RESULTS FROM QUALITATIVE STRAND

The following chapter provides the data analysis and results of the qualitative strand of the study. The first section of the chapter introduces the seven expert nurse managers who participated in the qualitative strand of the study. The second section of the chapter will present the themes of leadership behaviors identified in the expert nurse manager interviews as those wanted in their leaders. The third section of the chapter will examine the identified behaviors the expert nurse managers want in staff nurses. The chapter will conclude with a comparison of the behaviors the expert nurse managers want in their leaders with the behaviors they want in their staff nurses.

Background of Interviews

Seven expert nurse managers were invited to participate in the study. Information about the study was provided to the managers before asking them to participate in the study. After the manger agreed to participate in the study they were asked to sign the consent to participate form. The participants received a copy of the consent form prior to beginning the taped interviews. The seven expert nurse managers (ENM) who participated in the study had diverse management and educational backgrounds. Four of the expert nurse managers had diplomas from hospital schools of nursing; two of these had additional formal nursing education. One of those four expert nurse mangers had, in addition to the diploma, a bachelors in psychology (BA), a BSN and a master in nursing (MSN). The second expert nurse manager who had additional nursing education beyond her diploma had a BSN and a MSN with two post-graduate certifications. There was one expert nurse manager who started into practice with an ADN and continued her education to earn a BSN and a master's in business (MBA). There were two expert nurse managers that began their practice with the BSN and continued their education to earn a masters degree, one earned the

MSN and the other earned the MBA. Each of the managers had more than five years of leadership experience. The manager with the least management experience had been a manager for 11 years. The manager with the greatest management experience had been a manager for 30 years. All seven of the managers had low nursing staff attrition rates and a history of achieving institutional and unit goals. Each of the expert nurse managers had additional continuing education in leadership and management from their individual hospital employers.

Management and leadership courses were offered by six of the seven hospitals that employed the individual expert nurse managers. The leadership and management developmental courses offered in the health care institutions included topics in budget preparation, change theory, team building, mentoring and human resource management. Some of the hospitals that provided these leadership educational programs made the programs mandatory for all managers in the hospital. The one manager that was employed by the hospital that did not offer continuing education in leadership development had attended similar programs at another hospital where she had previously worked.

The expert nurse managers represented seven hospitals in Ohio. The hospitals varied in size, services, and location. Three hospitals were urban and four were in the suburban areas of Ohio. The smallest of the seven hospitals had 92 inpatient beds and the largest of the hospitals had 671 inpatient beds. The seven managers who will be introduced in the following section have been given pseudonyms to ensure their anonymity and confidentiality.

<div align="center">Expert Nursing Manager Profiles</div>

Caren

Caren is a nurse manager in a 103 bed suburban hospital. She began her nursing career

after graduating from a School of Nursing with a nursing diploma. While she waited for the results of her licensure exam she worked in a tertiary care facility as a new graduate nurse. After receiving her license she left the tertiary care facility and joined the Army Nurse Corp for two years. During that time she specialized in psychiatric nursing. Upon leaving the Army Nurse Corps she began a new practice area in orthopedic nursing. She did not stay with orthopedic nursing for very long and went back to psychiatric nursing.

Caren found a lot of differences between the psychiatric nursing practice in the military and the psychiatric nursing practice in civilian life. She felt that civilian psychiatric units were too harsh and judgmental.

Civilian and military psych are a lot different, I prefer military, and they don't necessarily have you locked behind doors all the time and treating you like your more of a prisoner, or that people are afraid you're going to go out on some psychotic rage…

Caren left the psychiatric nursing specialty after 4 years because of the stress of going through a divorce. She felt she could not provide the mental support that was needed in the psych unit when she was under so much stress in her personal life and returned to the orthopedic nursing specialty.

I went back during the time of divorce. I found I could not do justice to what was needed for psych because I had too much going on in my own head, so I went back to orthopedic nursing and stayed there for a little bit.

She began to teach in a licensed practical nursing school (LPN) during the same time she was working on the orthopedic unit at the hospital. She discovered she enjoyed teaching but she did not like orthopedic nursing. Caren transferred off the orthopedic unit and moved to a medical surgical unit. Following the move to the medical surgical unit she decided to make a change in

the area where she was teaching. She decided to move from teaching LPN students to RN students. She moved her teaching role from the LPN school to an ADN school.

Caren left her position in the medical surgical unit and took a position at another hospital working in the critical care area. She continued to work in critical care for approximately 7-8 years before leaving the hospital environment entirely for a job in a private company. The private company provided educational programs to help new graduate nurses succeed in passing the nurse licensure examination. Caren was given training in test development and designing educational programs.

I went to the Medical College because I wanted to change. So I went to the Medical College and started putting my 13 years of experience, that I had at that point, in together into a different picture. So I started working critical care. …I was working the medical coronary ICU there and I did that for about 7-8 years. I took a position with a private company that belonged to a friend I knew in the military.

Caren enjoyed the position in the private company. She felt she had to leave that position for the good of her children. The job required her to travel and be gone from home for long periods of time. In 1988 she saw an advertisement for a Staff Development Educator at a small suburban hospital and she applied for it and was hired.

In 1995 she accepted a management position on the medical surgical and oncology specialty unit. She left her Staff Development position and began her nursing management experience. During the years of being in the management position she has been the manager of the medical surgical oncology unit, intensive care unit, and the administrative supervisors. The week prior to our interview she had been assigned a second unit to manage, a short stay medical surgical unit on another floor of the hospital.

Caren has been in management for 20 years, 12 years in the civilian hospital and about 8 years in the military:

>I was a manager in a military nursing center. Add those years to the 12 years and it will increase about 5-8 years, so about 20 years. I became a manager in the mid 80's if we count that and it is also nursing.

Caren's educational background is as varied as her professional experience. She returned to school a few years after completing her diploma in nursing and earned a Bachelor's in Psychology in 1974. In 1978 she decided the BA was not sufficient to secure her career in nursing and she returned to earn her BSN. She continued on with her education after obtaining the BSN and earned her MSN in 1988.

>because of my divorce and because of other things going on, if I wanted to secure and ensure my position professionally, especially as a single parent responsible for two children, I needed to make sure that degree was more recognizable, which it would be as a BSN. I took another little side trip through my insane moments and went aback and got my masters in nursing. I got that in June of '88.

The master's degree in nursing Caren earned had a dual focus, adult health and nursing administration. She had a variety of leadership and management courses in the administrative tract of her MSN program. These courses provided her with leadership and management concepts; however, an important contributor to her leadership and management development came from her service in the military.

Valerie

Valerie is a nurse manger of two units, a critical care unit and a critical care step down unit in a 342 bed suburban hospital. She has been in nursing for 26 years. Valerie began her

career with an ADN working as a float nurse. She floated through the medical surgical unit, the psychiatric unit, pediatric and obstetric units. She found that the critical care area was the specialty she preferred and focused her time on critical care. She has remained in the critical care area.

> Originally I started out as a float nurse on nights, went through all the units, from psych to peds and OB and decided critical care is where I really wanted to be. I went into critical care and I have stayed there.

Valerie worked her way up from a staff nurse to the charge nurse on the unit. The same year she completed her BSN she was promoted to the role of unit manger. She was asked if the BSN was a requirement for the manager role. She said the role did not require the BSN but it was "…highly suggested to have your BSN to go into that role."

Valerie made the decision to continue her education and earn the master's degree immediately following her attainment of the BSN. She began in the MSN program and took approximately five courses at the Medical College of Ohio in the MSN program. She decided the MSN was not what she really wanted and she began to investigate other avenues for a master degree. After careful thought and consideration she chose to work toward a master's in business administration (MBA). She graduated from the University of Tiffin with the MBA in 2003.

Leadership and management courses were included in her BSN education as well the MBA program. The leadership and management courses that she was required to take in the BSN and MBA programs provided very little education on the concepts of management and leadership. The majority of her leadership and management development came from mandatory leadership education courses. These core courses were mandatory for all nurse mangers. The Director of Nursing at the hospital was instrumental in developing the leadership and

management skills of the nurse managers in hospital. She held a Nursing Leadership Academy that provided six to eight courses on leadership development. Every manger was expected to attend these courses.

Alice

Alice is the manager of an outpatient oncology and medical radiology unit in a 533 bed suburban hospital. She has been in the nursing profession for 21 years and 20 of those years have been in management. Alice earned her BSN in 1984 and began working in an intermediate care unit as a new graduate nurse. The transitional care unit under went a downsizing her sixth month of employment and she was laid off. Her professional goal had always been to work with the oncology population so she took this time to focus on obtaining a position in this specialty. She began to seek out opportunities for the oncology specialty, "I still wanted to work in the oncology area, so when I was laid off I sent out resumes and inquiries to all the oncologists in the area until one of the doctors hired me."

The experience working with an oncologist opened up an opportunity to work in a hospital inpatient unit at a large urban hospital. During the time she worked on the oncology unit the hospital had an opening for a shift supervisor on the oncology unit. Alice applied for the position and after the interview process she was offered the position of 3-11 oncology unit supervisor. She continued in that role until she saw an advertisement for a unit manager at a local suburban hospital. She explained why she applied for the position; "I thought it would give me some good experience interviewing for a management position so I applied." In 1987 she was offered the unit manager position at the suburban hospital and even though it was not oncology, she accepted. Oncology continued to be her primary focus and she never lost sight of her goal. During a time of change and downsizing at the hospital, Alice was required to add another unit to

her responsibilities, she requested the oncology unit and it was given to her. She left the small

suburban hospital in 1990 after being offered a position as a unit manger of an oncology unit in a

large 671 bed urban hospital.

Alice's educational background includes the BSN and an MSN with a dual focus of adult

health and administration. Both the BSN and the MSN had content in leadership and

management. She was asked about the concepts of leadership and management and if these

concepts were delineated in her nursing education courses as different concepts or if they were

used interchangeably. Alice stated, "They used them interchangeably, like they were the same,

but I don't see them that way." She went on to explain her definition of management and

leadership:

> A Manager supervises the nursing unit; they develop budgets, reports, delegates tasks to
>
> others, and ensures the unit has the supplies needed to function. A leader will do all those
>
> things as well, but they are also a mentor, a coach and a teacher. They empower their
>
> employees and they care about them. Leaders want their employees to learn and grow.

Alice was asked to describe the behaviors of a leader she respected and would like to be

like. She explained she had the opportunity to work with two great leaders. The leaders she

described had common behaviors that included: mentoring, communication, strong interpersonal

relationships, vision, and professional goals. Alice shared an interesting story about one of the

leaders that showed the persons ability to develop strong interpersonal relationships with people:

> We were at a conference once and she ran into someone she knew. The person was
>
> genuinely happy to see her and came running over and gave her a hug. Later she
>
> whispered she had let that person go a couple of years earlier. I laughed and said she was

the only person I knew who could let someone go and they would still be happy to see her and give her hug.

Alice identified that a good leader wanted her staff to be successful and to learn. She also discussed the importance of communicating with the staff in a way that does not result in the staff feeling like, "they were verbally attacked for something." Caring and developing supportive interpersonal relationships with the staff are key leadership behaviors for Alice.

Sally

Sally is the manager of an emergency department in a small, 126 bed urban hospital. She has been in nursing for 37 years and has been in the management role for 20 of those 37 years. Sally has a diverse background in her nursing and management experiences; however, she has never worked in any other hospital system. She began her career in a small urban hospital which was merged with a larger system. The small hospital was closed in 2002 and the staff was moved to a new health care facility located in the outskirts of the city.

Sally began her nursing career in 1970 after earning the nursing diploma from the same hospital that hired her as a medical surgical staff nurse. She moved from the medical surgical area into the surgical area as a surgical staff nurse. Sally was promoted to charge nurse and the experience of working in the surgical unit combined with her experience as charge nurse helped to prepare her for the major task of opening an outpatient surgical facility.

Sally's management experiences are very diverse. After opening the outpatient surgical unit she moved away from the patient care area to managing the central supply department. She managed the central supply department for 5 years before moving to the emergency department as a manager. Sally has been the manager of the emergency department for 7 years.

I was a med-surg charge nurse. I worked in surgery as a surgical staff nurse and then a

charge nurse for 20 some years. I opened an outpatient surgical facility. I've been in

charge of central supply as the director of central supply for 5 years. I've been in charge

of the ER for 7 years. So I've done a lot.

Sally has a diploma of nursing she earned from the same hospital she has dedicated her

nursing career to. She has started a bachelors program in Health Care Administration and hopes

to have it completed in another year. Sally was asked if she had any education in leadership and

management. "Leadership, we've done a lot of leadership education over the years. We currently

do the LDI's which has been going on now for, what 3 years." LDI is the acronym for

Leadership Development Institute and all the managers in this health care system are required to

attend these courses. Sally was asked if she had received any management or leadership

education in her diploma or undergraduate studies. She explained the diploma program was

primarily focused on clinical skills and clinical work. There were no courses or topics offered on

leadership and management. The Health Care Administration program has provided some

leadership and management courses, but the primary source for her leadership and management

education has been in her work place.

Kelly

Kelly graduated in 1980 with a diploma from a hospital school of nursing. She has

specialized in women's health her entire career and is currently the Director of Women's Health

in a small, 92 bed suburban hospital. In her role she manages the labor and delivery unit and is

developing a women's health department. Her experiences in nursing, in women's health

specifically, and her varied education have prepared her for her current role.

Kelly began her nursing career at a large, 671 bed, urban hospital as a float nurse in the labor, delivery, intensive care nursery, and post partum units. She worked her way up from a staff nurse to a charge nurse, "I worked in labor and delivery as a staff or charge nurse, then I moved into a nurse manger like position but it was a shift position." She left the large urban hospital and took a position as the nurse manager in an obstetric (OB) unit for 2 years. During those two years she returned to school to earn her BSN.

She had an opportunity to move west, to Texas, to manage an OB unit at a Ft. Worth hospital and after arriving in Texas she was told her job description had been changed.

I got an opportunity to move to Ft. Worth Texas, and I packed my bags and went to become the unit manager of a labor and delivery unit in one of their facilities in Ft. Worth. When I got there they decided it would not be a nurse manager role, it would be a director role. They told me after I arrived that they had changed it to a director role. Now I not only had labor and delivery but I also had a post partum, normal nursery, GYN and GYN surgery. So I became the Director of the Women's Hospital.

Kelly remained in Texas as the Director of the Women's Hospital for 5 years.

During her time in Texas as the Director of Women's Health she returned to school to earn her masters degree, MSN. "While I was in Texas being a director that I didn't know I was going to be, I finished my masters in nursing administration with a secondary as a clinical nurse specialist in maternal child."

Shortly after completing her MSN the hospital began a downsizing process and she decided to return to the Toledo area:

I left there when they were doing downsizing and collapsing, my kids were elementary age, I was divorced and had been. They didn't want to be there and have to come back

and forth to see their father. It became harder and harder as they got a little older. So I optioned out, took a severance and returned to Ohio.

Kelly returned to Ohio and took a position as a nurse manger for an OB unit in Columbus, Ohio. She added a post-graduate certificate to her nursing education:

I finished my nurse practioners certificate (NP) and worked as a nurse manger for an OB unit in Columbus. I also worked in a physician's office; he put me through my nurse practioners program. When I finished my NP I actually went back to whole clinical practice and worked in that doctor's office for two years.

She returned to Toledo Ohio after leaving the physician's office. Kelly had a close friend who was the Director of the Nurse Midwives at a local hospital. The friend encouraged her to return to school. She returned to school and obtained her second post-graduate certificate in nurse midwifery. Kelly now had a BSN, MSN, and was certified as a clinical nurse specialist in maternal child, a women's health nurse practioner and nurse midwife.

Kelly became the Director of the Midwives and the High Risk Maternal Fetal Medicine Group when her friend retired in 1997. In 2006 the President of a small suburban hospital approached her and invited her to come and work with the OB department at his hospital.

The President of the hospital called and said, "Won't you come over here and work with our OB unit and develop some quality of care." My friend had come out of retirement and was working there as a supervisor and I thought this can be fun. So I left my directorship and my midwife practice there. It really wasn't like I was leaving for another hospital because the hospitals are under the same umbrella; so, I'm still employed by the same people. I came here and I am the Director of the LDRP and somehow I also got the

Women's Business Line development under me. I still practice one day a week as a

midwife and I take call one night per week for the midwifery group.

Kelly explained her experiences in different parts of the country and the different

hospitals have enriched her skills and abilities as a leader and manager.

I think it really opens you up to the fact that there's not just one way that's the best. And I

think that's the hardest thing for people who started in one organization and stayed in the

organization moving from nursing assistant to director of nursing and they don't know

anything but that. I think while some of these managers can be very good, and I'm not

saying that they aren't, I think they don't see all that goes on out there that could be

helpful.

Kelly's experiences and educational degrees and certifications have enriched her repository of

tools and understanding of alternative methods to achieve goals and outcomes as a nurse

manager and leader.

Dottie

Dottie became a registered nurse in 1975 after completing a hospital based nursing

diploma program from the hospital she devoted 25 years of her nursing practice to. She was

hired as a new graduate nurse in the cardiovascular intensive care unit (ICU) and in 1978 was

promoted to Assistant Nurse Manger of the cardiovascular ICU. In 1981 the manager of the unit

retired and Dottie became the unit manager. Dottie describes herself as a working manager, "I

have always worked with the patients and believe all managers should be working managers.

They should work at least two days on the unit with the staff doing patient care."

Dottie's reputation as a competent and knowledgeable cardiovascular nurse and leader

resulted in her being asked to help open a new cardiac unit at a small suburban hospital.

I had a lot of experience in the cardiovascular area and helped open the heart center at the

hospital. I got to know the docs real well and they got to know me real well. When this

hospital wanted to open a cardiac unit, one of the doctors I had worked with asked me to

give one day a week to help with that and I agreed. It was a lot of work but I really got to

know everyone and so when they advertised for a manager I applied for the role and in

2000 I began working here as the manager of the Heart Center.

This was a new experience for her as she had spent her career and education at the same

institution. She stated, "They were really surprised that I moved after working there for so long,

but I had plenty of time in there and wanted to make a change." She also shared she was

surprised that she enjoyed it because this hospital was much smaller that the other hospital.

Dottie is currently the Director Cardiac Services and manages the unit managers. The

new position has moved her away from the patient care area, "I have always worked with the

patients. Not now because I am the Director, I manage the mangers." Dottie values patient care

and wants her managers to be working mangers, just as she had been. The managers, however,

disagree with her about that.

I'll tell you the truth I would rather manager staff nurses. These managers are prima

Donnas! I want them all to be working managers, I don't know if I will be able to get that

out of them but I am trying. They need to be competent and visible to their staff. The staff

doesn't trust them.

Dottie has recently hired a new manger with the understanding the new manager would

schedule herself to work on the unit two days per week with the staff. She believes working on

the nursing unit beside the nurses will help to demonstrate competence in the nursing area.

Competence is an important leadership behavior for Dottie and she believe it will result in gaining the trust and respect of the nursing staff for the manager.

Dottie started the BSN program in the 1990's but did not complete it. "I was just too busy to go to school and run a unit." She regrets not completing her degree and believes that in today's health care environment a nurse would not have the same opportunities she has had without a BSN. She was asked about the educational preparation of the nurse managers she supervised. She explained they were primarily ADN prepared, but she believed that the education requirement for management would change.

My daughter is going to Mercy for her ADN and I told her she needs to continue on and get her bachelors. The chances of her being able to go into management without a BSN is very slim these days. I don't want her to be like me, always talking about it but never doing it.

Janet

Janet is a nurse manager for three areas: a psychiatric unit, a chemical dependency unit and an outpatient surgical department. She began her practice in 1986 as new BSN graduate in the psychiatric and chemical dependency area. "I have had my whole career in psychiatric and chemical dependency nursing." She began as a staff nurse in the psychiatric unit and after working for two and a half years in that position she was promoted to unit manager.

Janet has been in a manager or director role for 17 of her 20 years of nursing experience. She had been the unit manager of the psychiatric unit for 7 years when she was offered the opportunity to go to another, larger facility and manage the psychiatric unit there along with a second chemical dependency unit. She was ready for a change and believed it would be an opportunity for professional growth, she accepted the position. She has been at this institution for

ten years and recently was given the responsibility of opening an Outpatient Surgery Unit. That

unit has now been added onto her areas of supervision.

Janet has a BSN with a certification in psychiatric and mental health nursing and a MBA.

She earned her MBA during the last ten years while she was managing the psychiatric and

chemical dependency units at the larger institution. She held the belief that the MBA, rather than

the MSN, would provide her with the knowledge and skills she needed in her current

management position and if she were promoted the same skills and knowledge would be a

benefit in the director role. Management and leadership topics were imbedded in the BSN

program. When asked about the management content in the BSN program she stated, "Yes we

had to take a management class where we had to follow someone around for a designated period

of time and see what it was like to be a manager." The MBA program she attended provided

many more courses specific to these topics, however, than did the BSN program. A major

contributor to Janet's leadership and management knowledge and skill was provided by both of

the institutions where she has been employed. These institutions had required continuing

education courses on management and leadership for all mangers. The courses included topics

like budget preparation, staff evaluations and discipline, communication and time management.

Janet is very much like Kelly in her support of the working manger role. She proposed

that the manager gains respect from the staff when the manager demonstrate competence on the

clinical unit. She was quick to point out her staff could call her to help out and she would be able

to do so.

> I am also not afraid to get in there with my staff and do what needs to be done. I am not
>
> going to expect them to do anything I am not willing to do myself. You see there are days

when I dress like this (points to her scrubs), because I don't know what is going to

happen or what is going to go on. I am not afraid to help them.

Janet and Kelly both hold the belief that demonstrating competence in the area where they are

managing is an important leadership behavior. They are also proponents that all nurse managers

should be working managers to gain the respect and trust of the staff.

<div align="center">Expert Nurse Manager Interview Results</div>

Each of the expert nurse managers was asked a series of questions concerning behaviors

or characteristics found in leaders and the behaviors or characteristics they wanted in staff nurses

beyond the technical skills. These leadership behaviors or characteristic were analyzed and the

ones that were identified most frequently were extrapolated to develop the leadership themes.

This analysis resulted in five themes: (a) competence, (b) visibility, (c) mentor, (d) good

communication skills, and (e) caring and compassion. Results of the analysis were given to each

of the expert nurse manager participants for review to ensure accuracy and validation in

interpretation.

Competence

Competence for a nurse leader is having the experience, knowledge and skill to perform

safely and with expertise on the nursing unit (O'Grady & Malloch, 2003). O'Grady and Malloch

(2003) described the connection between skills and competence in a unique way, "Competence is

not about having skills but about using skills to achieve desired outcomes." (p. 15) Competence

was a reoccurring theme in the description of a nurse leader by the expert nurse managers. Dottie

described her vision of a competent nurse manager and the importance of the nurse manager to

demonstrate competence on the nursing unit:

I hire managers and the last manager I hired I told her I wanted a working manager. She has to schedule herself on the unit two days a week to work with patients. I want all my managers to be working managers. They need to be competent and visible to their staff or the staff won't trust them.

Valerie discussed competence as important quality as she discussed the importance of leading by example:

I see leadership as leading by example. You do not tell people what to do or how to something, with leadership you are out there with them and you gain their respect. They will follow you because you are leading them by example.

Janet also believes a leader will lead by example.

I think that anybody could probably do a management role where you are just monitoring and doing things, but I think it takes a step up to be leader. I am a very big person on leading by example not just managing and dictating and I see leading as demonstrating, showing, educating and learning right along with the staff. A good leader is somebody who leads by example. They also have the knowledge and the background to understand why they are doing something. It is not just, "well that is the way we have to do it". They have the educational reasoning behind it and the cause and affect of why we have to do it. They explain the rationale behind the change.

In order to lead by example the nurse leader must be competent. The competent nurse leader has the knowledge, experience and skill required to perform nursing duties and to role model the behaviors they want to see in their staff.

Caren and Alice discussed how a leader has a vision and demonstrates competence by being able to plan and organize the necessary steps to operationalize the vision. Alice shared that

she had two leaders she had great respect for and wanted to emulate. She explained, "They were able to set strategic goals and plan how to reach them, they were visionary." Caren's description of the leader she most respected was very similar to Alice's description.

> One of the best managers I have ever worked for, if not the best, was strategically and operationally phenomenal. She had an extremely great vision of where she thought nursing should be, of where she thought her specialty in nursing should be and how to organize people to get them there. Not only did she have the vision but also operationally she was able to bring it together. She was competent in knowing what she was doing.

> Actualizing a vision in nursing requires a solid understanding of what nursing does. The person would need to understand and have knowledge of patient care, the problems and challenges of nursing as well as the successes. The person would need to be able to navigate through the health care system and understand how even small changes can impact all areas in the hospital. It would require competence.

> Kelly was asked what made her a good leader and she said one of the traits that make her a good leader is her competence in her specialty. She has the ability to perform on the unit when the staff needs help. Kelly's description demonstrates leading by example.

> They know they can call me in the middle of the night. If they need me to get up and come in, I get up and come in. They know me as a midwife, so from a clinical standpoint it's kind of hard for them to tell me you can't do this or that. I have done it, and still do.

> Each of these expert nurse managers clearly believed that being and demonstrating competence was an important trait for leaders. Demonstrating competence in the clinical area, they proposed, aided the leader in gaining respect from the staff and it keeps the leader visibly

involved on the nursing unit. Visibility is the second important leadership behavior that was identified by the expert nurse managers.

Visibility

The expert nurse managers identified leadership visibility as an important quality for all leaders. I found this strange because visibility of a leader is such a common sense requirement for a leader. Leaders after all need to have followers in order to lead. To get people to follow a leader that person would need to develop a trusting interpersonal relationship with them. That is not a possible action if the leader is absent. O'Grady and Malloch (2003) describes the idea of a leader being present as an important part of emotional competence. They explain that leaders who are not emotionally connected to their staff will have low presence on the unit. This results in the staff feeling like the leader is not interested in what is happening on the unit or the staff. O'Grady and Malloch (2003) elucidate, "Leaders must realize that it is not only their technical skills or verbal communication that makes a difference, it is also their ability to show that there is someone at the top who cares about what is happening." (p. 197)

Sally's discussion of a leader supports the fact that a leader needs to have a following, without a following there would not be a leader; "Your people make you a leader." Caren expanded on this belief that a leader must have followers to be successful.

> One of the hardest pieces that you fill is getting the buy in of the staff that you are working with and managing the administrative needs. We must get the staffs buy in and support because I can say I am the leader of a nursing unit, but on this particular unit I can go out there and there's 60 people that belong to this unit. My math says 60 of them and 1 of me. It doesn't work very well if I don't have the support and buy in of least a

majority of them. A good leader remembers they may get the credit but they didn't do the job.

Dottie held the belief that those managers who are not visible to their staff were not leaders but were simply managers. She believed these managers had a sense of superiority to the staff and were on a "power trip". Dottie explained her view of absent leadership as she described some nurse managers in her institution.

I don't know what these managers think, they come in dressed in suits and high heels like they are too good to work with patients, they are on a power trip. They are out of touch with the staff. They need to be competent and visible to their staff. The staff doesn't trust them.

Alice and Kelly did not specifically use the word visibility during their interviews; however, they both held strong beliefs that a good leader works to help their staff develop and grow in the profession. They believe a good leader is a coach and mentor. These activities cannot be accomplished if the leader is absent.

Janet and Valerie are proponents of leading by example. Leaders should role model the behaviors they want their staff to have. Janet provided an example of someone she thought to be a great leader.

The guy that owned the Northwest Airlines made it fun for his employees, but yet also lead by example. He would go on the flights and would show them, he was not afraid to show them what to do. He would go into the trenches and do things. Leading by example.

Visibility and competence are two of the leadership behaviors recognized as important to leaders by the expert nurse managers. The third leadership behavior valued in leaders by the expert nurse managers is that of mentoring.

Mentor/Coach

A mentor is someone who is experienced, knowledgeable and competent in a specific area who teaches, coaches, guides and advises another person who is just beginning (Bower, 2000). Mentors help to facilitate the development of those who have less experience by teaching, coaching and guiding, but also by role modeling and leading by example instead of leading by direction (Bower, 2000). The expert nurse managers recognized this special behavior as an important quality in a leader. They voiced the need for mentoring in leaders as well as the importance of leading by example and role modeling desired behaviors.

Dottie was asked what made her a good leader and she said "I'm a good mentor and I coach my managers to be better, to learn". Caren was asked to describe the behaviors in a leader she had worked with that she admired and would most like to emulate in her leadership style. "We don't have a formal mentoring program, but B.M. was a great mentor and she helped me become the manager that I am." Alice described the differences between a manager and a leader:

A manager supervises the nursing unit, they develop budgets, delegate tasks to others, ensures the unit has the supplies needed to function. A leader will do all those things as well, but they are also a mentor, a coach, a teacher and they empower their employees.

Sally also believed that the leader she most admired was a mentor and coach.

She always tried to pull the good out and develop her people even if in her heart she knew that it wasn't going to work. She went out of her way to make sure people had the chance to succeed in whatever they were doing.

Kelly discussed the leadership role as a mentoring role when asked to describe the difference between manager and leader. "I think leader, leadership is getting people to find the best in themselves and develop the best in themselves." Valerie, when discussing a staff member who

was struggling on the nursing unit described her role as the leader to "find their strengths, motivate them and develop them."

Mentoring another person who has less experience and knowledge requires many behaviors and skills such as those discussed earlier, visibility and competence. Mentoring also requires that the leader have good communication skills. The ability to communicate well was another quality the expert nurse managers identified as important in a leader.

Communication

Communication is the effective professional, oral, and written exchange of information used for the purpose of sharing information with another person or a group of people so that the message is clearly understood. Communication is a concept that has been discussed, dissected, and studied by a plethora of people. It is one of the most important tools in a leaders arsenal. Matusak (1996) describes it well in her book, *Finding Your Voice: Learning to Lead…Anywhere You Want to Make a Difference:*

> The total effectiveness of leaders rises and falls in direct proportion to their ability to communicate with meaning, their interpersonal insights and actions, their willingness to enthusiastically share their goals and vision and their willingness to be active, positive listeners. (p. 80)

All of the expert nurse managers identified communication as an important behavior in both leaders and in the nursing staff. Alice really understands and values the gift of communication that is evident in her comment about what makes her a good leader,

> I have a silver tongue. I have very strong communication skills. I have been told I am a gifted speaker and have a good command of the language. I was told by a nun in the 8th

grade to pray for the power of communication and I prayed for that all the time. I guess

my prayers were answered.

Alice also shared how a leader's communication style can cause a negative impact on staff as she

discussed the qualities of leaders she most admired; "They were able to point out my errors

without causing me to feel belittled." Sally shared that she was working on her communication

styles because it can cause a negative impact on the unit and staff:

I am a little overly outspoken and that's something I've had to work on almost every

year. Because the tone I have sometimes borders on…well it is not conducive to a good

work environment. So I have worked on that.

Sally went on to explain, "I think communication is vital in all aspects of my job."

Valerie explained how communications between departments in the hospital could result in

misunderstandings and problems,

being able to tell the person on the other end of the phone, without getting upset, what

you need and making sure that your needs are going to be met without really ticking the

other end off. Some people have a knack to do that to other people. No matter what

comes out it sounds negative, so you have to watch those types of things.

Dottie recognized the importance of listening in a leader. She described this quality in a leader

she admired; "she was very open minded and a good listener." She also shared how important it

was for staff to be effective communicators with one another for conflict resolution, "Nurses

need to approach one another when they are having problems with each other and share what the

problem is so they can work.

Janet shared that one of the reasons she was picked out to be in a leadership position was

her communication ability, or lack of fear to communicate. She proposed many people are afraid to speak out especially to people who are in a position of authority.

> I was not afraid to speak my mind when I saw things that I was not happy with, but had concerns about. I was not afraid to take those chances as a new grad with physicians and say to them "you know something is not right here and we need to try something different.

Kelly also held the belief that her ability to communicate was the skill that brought attention to her for advancement, "Communication with physicians, I'm sure, communication with the charge nurses or other leadership or manager. I am sure that there was some level of that part of me that caused somebody to go "I think she can do this". When she was asked about the behaviors she would want in a person who would be filling in for her during an extended absence she stated:

> They would need to have the ability to communicate, good clinical skills and not be afraid to speak to other managers, the director of nursing or even the president of the hospital. They need to be comfortable in communication.

Caren identified communication as one of the behaviors in the leader she admired,

> She was good at communicating, sharing her vision and the steps needed to accomplish the vision, and decision-making. The really neat thing about her is you could talk to her, you could vent to her. She was very caring, supportive and patient with the staff. You could trust her.

The expert nurse managers provided support for the theory that communication was important in all aspects of nursing with their varied discussions and examples. Caren, however, in her above statement, provided insight to the connection between communication and the last

leadership behavior identified as important by the expert nurse managers, compassion and caring.

Compassion and Caring

O'Grady and Malloch (2003) describe compassion as an integral part of emotional competence. The soft side of leadership is very important, they explain, if the outcomes that have been achieved are to last and motivation and commitment of the followers is to remain strong (O'Grady and Malloch, 2003). The expert nurse managers echo this feeling as they discussed leaders they admired. Caren's description of the leader she admired noted above incorporated the concept of caring, which she then connected to the concept of trust. She also stated, "Loyalty is extremely important, integrity and honesty are key to me in a leader as well as their ability to be compassionate." Caren discussed the leader with enthusiasm, it was obvious she cared a great deal for this leader and wanted to emulate this leaders characteristics. Alice shared a story about the leader she most admired that demonstrated the leaders caring and compassionate quality:

> One of the best leaders I ever knew was B.M. We were at a conference once and she ran
>
> into someone she knew. The person was genuinely happy to see her and came running
>
> over and gave her a hug. Later B.M. whispered she had let that person go a couple of
>
> years earlier. I laughed and said she was the only person I knew who could let someone
>
> go and they would still be happy to see her and give her a hug.

Sally's description of a nurse that was not working out well on the clinical unit demonstrated Sally's deep compassion and caring:

> I honestly don't know, she is a good nurse. I mean I cannot fault her clinically. I think it
>
> is the way they are raised. She's late for work, she's absent from work, and she's not

always honest. She just falls into that area; but, she is also probably one of the people

I've showed more favoritism to, due to her family issues.

Many of the descriptions of the leaders the expert nurse managers provided throughout

the interview and outlined in the previous sections demonstrated actions by the leaders that were

compassionate or caring. Leading by example, being present on the unit, and mentoring are

pieces of compassion and care. These behaviors demonstrate that the leaders cared for their staff,

they developed caring, trusting interpersonal relationship with their followers. They wanted their

staff to develop, to learn and to succeed in their chosen profession. They were not absent leaders,

but had high emotional competence.

Interpersonal Relationships

An important part of emotional competence is the development of trusting interpersonal

relationships by a leader. The expert nurse managers described the leaders that made a big

impact on their leadership style. Caren described the leader she most admired as, "You could talk

to her, you could vent to her, she was caring, supportive and patient with the staff. You could

trust her." Caren had a respectful, caring relationship with the leader. The leader was able to

develop this relationship with Caren because the leader demonstrated to Caren that she cared

about her professionally and personally, she cared about Caren's professional development and

growth, and that Caren could trust her.

Alice talked about two leaders she respected and admired and shared they were both

cared about her growth and development as a professional, "They were both great mentors and

taught me so much." One of the leaders Alice identified impressed her a great deal because of the

leader's ability to develop strong trusting interpersonal relationships with those who worked

under her. Alice shared a story about this leader that demonstrated her interpersonal relationships

with people who had worked for her. "The person was genuinely happy to see her and came running over and gave her a hug. Later she whispered she had let that person go a couple of years earlier." That leader had developed such a strong caring relationship with that person, whom she had fired a few years earlier, that the fired person still had a positive bond with the leader.

The leader that Sally described as the one she most respected and wanted to model behaviors after was visible on the unit. Visibility is important in developing interpersonal relationships with the staff. Sally described her as fair, honest and respectful to everyone. "She was honest, she treated people fairly." Sally also shared that the leader was someone the staff could talk to and joke with, "We sometimes would laugh at her and say, "sometimes you're too fair". Sally finished her description of this leader with the following comment: "I admired her a whole lot." There was a lot of emotion in her voice when she talked about the leader.

Visibility is an important component in developing interpersonal relationships. O'Grady and Malloch (2003) talk about the important of being visible for leaders in order to develop interpersonal relationships. Dottie shared that the leader she admired "was in touch with the staff nurses. She was always visible, walking the hallways, talking to the staff, a regular person." Dottie said the leader was approachable and a good listener. Since she demonstrated concern and caring for the staff she was able to gain their trust, admiration and respect. "She was respected by everyone because she treated everyone with respect."

Critical Thinking

Critical thinking is the ability of a nurse to reflect on the data obtained in an assessment of a situation, problem or a patient and to analyze, compare and clarify the data in order to make an appropriate decision about the interventions required (Hahn et al., 1998). Leaders use critical thinking when they assess the institution and develop strategic goals for the growth and success

of the organization. Caren described the leader she admired as having "…great vision of where she thought nursing should be…how to organize people to get them there. Her vision was phenomenal, but not only her vision but she was operationally able to bring it together." This leader assessed the nursing part of the organization and performed an analysis. She was then able to identify a way to improve nursing, her vision, and she identified the necessary interventions to realize that vision.

Alice also discussed the two leaders she admired, "They were able to set strategic goals and plan how to reach them, they were visionary." The ability to both identify areas needed for improvements and being able to identify the interventions necessary to achieve the improvements was a common theme with the ENMs when they described leaders they admired.

Janet identified critical thinking as one of the behaviors that separate managers from leaders, "I guess when I think of management I think of managers at a fast food restaurants or something like that. They don't have the critical thinking piece that a leader would." She emphasized her opinion of the importance of critical thinking when she described the behaviors she had that may have influenced her promotion to a leadership position, "I had critical thinking skills and I could problem solve very well."

Independent Decision Making

Hersey, Blanchard and Johnson, 2001, proposed that leadership is an active process; the person must accept the responsibility and accountability of being a leader. They are self-directed, independent decision makers. Leaders will seek out the opportunities to lead such as volunteering to work on committees. Valerie illustrated independent decision-making when she shared the behaviors she displayed that led to her promotion to a leadership position at the hospital.

"I guess getting jobs done, working on things, always wanting to improve things. You

know it's always been that way always trying to be involved in things that's going on in

the unit always trying to make processes better, you know we didn't have a clinical

ladder back then but it was things that we would do, amongst ourselves that wanted to

make the unit run better. … just making sure that patient's were taken care of and if there

were issues following through on those, so it was just kind of a gradual process … and

then when the charge nurse would be off somebody would need to step in and I would

step in a lot into that role."

Sally shared a similar description of her behaviors that led to her being elevated up to a

leadership position.

"I always liked to make sure things were run correctly and I took an interest in everything

around me. It was like in surgery… there wasn't ever a time that somebody couldn't say

to me "Well we need to get something from central" and I could say to them, "well that's

a special order" I mean I knew where everything came from I knew where my resources

were and I knew who my resources were."

The leadership behaviors or characteristics identified by the expert nurse managers

included, (a) competence, (b) visibility, (c) mentoring, (d) communication, (e) compassion and

caring, (f) interpersonal relationships, (g) critical thinking, and (h) independent decision-making.

These leadership behaviors are similar to those behaviors identified in the literature as required

behaviors in nurses providing care to patients. In the following section the ENMs were asked

about the behaviors they wanted in staff nurses who provide care to patients.

Behaviors Wanted in Nursing Staff

In the previous section the expert nurse managers identified the behaviors they admired and respected in leaders; in the following section the expert nurse managers discuss the behaviors they want in their staff nurses. Some of the leadership behaviors they identified as important for leaders are also behaviors they want in their staff nurses. There were five behaviors that the expert nurse managers identified as behaviors they would like to have in their staff nurses: (a) critical thinking, (b) interpersonal skills, (c) communication, (d) independent decision-making, and (f) compassion and caring. All of these behaviors are identical to the leadership behaviors the expert nurse managers admired in their leaders.

Critical Thinking

The definition for critical thinking used in this study is adapted from Hahn et al. (1998) as the ability of a nurse to reflect on the data obtained in an assessment of a problem or a patient, analyze, compare, and clarify the data in order to make an appropriate decision about the interventions required. Critical thinking is an important component in the nursing process which includes: (a) collection of data, (b) analysis of the data, (c) plan for required interventions, and (d) evaluation of the interventions. Nurses who have developed the ability to critically think are able to go one step beyond the required nursing process, they are able to predict what may occur and intervene appropriately. Caren's description of the nurse she identified as her *WOW* nurse describes the well-developed critical thinker best:

> She was not only competent in skills, clinical skills, but because she asked questions, she
>
> observed and saw the picture of the patient better. She was able to anticipate the needs of
>
> the patient. One of the advantages we have in med surg is we have time to anticipate
>
> needs. We have time to look at the labs, the diagnostics and see the change occurring;

frequently in time to abort the change and get the patient past the problem averting a

crisis. She actually takes it to the level the Ohio Board of Nursing calls assessment.

Assessment is analysis, and application. Some people can do it well on a piece of paper

and pass the exam, but when it comes to doing it on their feet on a patient minute by

minute they are not able to do it.

The ability to anticipate patient needs was also voiced by Alice as she discussed her WOW

nurse, "The nurse could think on her feet, think critically, and anticipate patient needs."

Anticipation of patient needs requires that the nurse have the ability to assess and analyze the

patient situation and identify a nursing intervention, this is the process of critical thinking.

Janet described the critical thinking process in her WOW nurse as being able to think on

her feet and ask critical questions.

The WOW nurse was able to think on her feet. She was able to understand what was

going on, able to figure things out. She would ask questions and not be afraid to ask those

questions. She had a good solid basic nursing knowledge in order to ask the questions off

of. She not only asked questions, but she asked questions like, "this is what's going on

with this patient and this is what I would like to do, what do you think?" So she was

thinking in her head and working it out in her head. It was like WOW she's got it!

Three of the expert nurse managers identified the lack of ability to critically think as a

problem with their *fizzle* nurses. The fizzle nurses were ones the expert nurse managers did not

want on the clinical unit. Valerie described her fizzle nurse, "The fizzle nurse I am thinking of,

her skills just never seemed to really get to that critical thinking point. " and Dottie described her

fizzle nurse as lacking self-direction and not being able to prioritize:

The fizzle nurse, I spent a lot of time with that one. She lacked self-direction. She had to

be told what to do and how to do it. She could not see past the task she was working on at

the time. I don't think she prioritized well. If she was giving a patient a bath, she did not

leave the room until it was done, no matter what was going on with the other patients.

She would fall apart in a crisis.

Dottie's description of her fizzle nurse is a good description of someone who is unable to

critically think. She was unable to prioritize. Prioritization requires the nurse be able to assess

and analyze patients and situations. Once the analysis is completed the nurse must make a

decision which one required immediate attention, the nurse is anticipating the needs of her

patients.

Kelly discusses her fizzle nurse as being technically competent but was unable to

advance in her thinking. "Technically she could do the skills, put in an IV, but she couldn't go

beyond that. She could not foresee what needed to be done, or plan the next step. She could not

critically think." The connection between being able to anticipate patient needs and critical

thinking was evident in all of the expert nurse mangers discussions of the WOW nurse and the

fizzle nurse. It was clear they wanted all of their nursing staff to be able to critically think like

the WOW nurses.

Interpersonal Relationships and Communication

Interpersonal relationship is defined for the purposes of this study as a professional,

trusting relationship between nurses, nurses and physicians, nurses and patients, and nurses and

patients' families. Developing relationships with others requires another behavior the expert

nurse mangers identified as wanting in their staff nurses, communication. Since you cannot

develop interpersonal relationships without the skill of communication, this section will examine

both of these behaviors together. Interpersonal relationships and communication were behaviors that were identified by all seven of the expert nurse managers as behaviors they wanted in their staff nurses.

Sally provided a good description of the importance and the connection of interpersonal relationships and communication between patients and nurses:

Patients need to feel comfortable with the nurse. They need to feel they can trust you and say things to you, and ask you things. Patients should not feel like they are putting the nurse out or that the nurse is just there to complete a task. One person once said to me "I can't believe you work in surgery where you just take your patient and put them to sleep." I said, "but you have all that time while your taking the patient and putting them to sleep to talk to them." That's how I always looked at it, because if I were on that stretcher I would want someone talking to me the whole way. Talk me to sleep if you have to. I think communication is vital in all aspects of my job.

When Sally described her WOW nurse she described how the nurse quickly interacted with all the other nurses and was a team player. The WOW nurse, in other words, developed good interpersonal relationships with the other nursing staff. Sally was also asked about the behaviors she would want in a person who would be covering for her in case of an extended leave, she quickly identified someone who could communicate well. Communication was behavior that Sally valued.

Caren also recognized the connection between of interpersonal relationships and communication. She provides a good example of the connection and the importance of both communication and interpersonal relationships in the following discussion.

Communication skills are critical. Most of the problems we have in nursing, in patient

nursing, physician nursing or whatever nursing relationship issues arise around here,

what was done, what didn't get done, whatever, falls back to communication. So having

good communication skills is very important. Skills around communication and

relationships are critical to how the patient responds, how their families respond, and how

physicians respond to you when you are trying to get their attention. Those things are

very critical, actually much more than the skills. I can have a patient that has the most

competent nurse in skills, but they don't feel they had good care because the nurse didn't

pay enough attention to them.

Kelly shared how communication could impact interpersonal relationships, "She also did

not communicate very well with the rest of the staff, and so she was never a part of the team."

When Kelly was asked about the behaviors she would want in a person who would cover for her

in case of a extended leave she quickly stated, "Ability to communicate, good clinical skills and

not afraid to speak to the other managers, the Director of Nursing or even the President of the

hospital. They need to be comfortable in communicating and in the environment."

Valerie discussed how her WOW nurse developed good interpersonal relationships with

patients that were frequently hospitalized and their expectation that the care they would receive

from her would be good because of the relationship.

Patients who come to the hospital routinely expect to be taken good care of by her. They

expect that, the nurse is going to care about them personally. The nurse is taking the time

with them, that the nurse really cares about what happens to them. The nurse is spending

time to educate them so they don't come back.

Kelly used the term customer several times during the interview and she was asked who was considered a customer. She explained who were considered customers and the importance of communication with customers when developing interpersonal relationships.

Customers are co-workers, interdisciplinary teams, and physicians, pretty much everybody. The nurse's attitude with whoever is in the lab, with the radiology person who may not be doing something quite like you think it should be done or maybe not as fast as you want it can cause problems or not. When you work in a critical care area we want a stat CT now and don't want to hear that you are going to delay us for a couple of hours. Being able to tell that other person on the other end of the phone, without getting upset, but making sure they understand what your needs are and they need to be met. All that without ticking the other end off. Some people have a knack for doing that, other people, no matter what comes out it sounds negative. You have to watch those types of communication.

Communication and interpersonal relations play an important role in the nurse's daily work. Communication occurs with other nurses, physicians, patients and their families and between departments in the hospital. Poor communication skills can result in fractured relationships with individuals.

Independent Decision Making

Independent decision making has been defined for the purposes of this study as the act of identifying something that needs to be done to improve a situation, knowledge, skill or environment and taking the required steps to meet that need without being directed to do so. A synonym for independent decision-making is being *self-directed.* The expert nurse managers identified this as a quality they wanted in their staff nurses. They did not use this term

specifically, but when they described their WOW nurses they described independent decision-making. They were asked about the terms independent decision making and self-direction and they concurred that yes that was the behavior they wanted in the their staff nurses.

Kelly viewed the nurse who demonstrated independent decision making as having passion and goals. She was very goal oriented and believed anyone who had goals would be driven to achieve these goals, doing what ever was needed without being directed to do so.

When someone tells me they are passionate I believe them. I think along with that is the desire and drive to do what it takes to be as good as whoever you see out there, whether it's me or Jane or an excellent clinician. They see them and they say they want to be like that and they do whatever they have to get there. It may be working an extra shift or scrubbing for a C-section. Take the initiative and drive to go after those things and that's the person who will probably take the next step up to be a charge nurse, supervisor, manager at some point in their life.

Valerie described a nurse who had the initiative to do a job. Valerie's description of her WOW nurse was similar to Kelly's description. Both Valerie and Kelly described nurses who took the initiative to do something. Valerie described how her WOW nurse as a person who would, "Take the initiative to learn, get in there and try things, and don't sit back. Watch other staff work and join them as team member."

Sally had described her WOW nurse as having being energetic and enjoying her work. She was asked if she would describe the nurse as being self-directed and she responded, "Oh, extremely self-directed, very self-directed."

Janet described her WOW nurse as someone who would take charge of a situation, "Getting right in there and helping the patients problem solve." The WOW nurse did not need to

be directed to help patients, but took the initiate to do it on her own. She was self-directed, she made independent decisions about what needed to be done and she did them.

Dottie described her WOW nurse as being energetic and being able to take a group of patients and provide care to them. She did not need someone to direct her actions or to help her prioritize but quickly learned how to manage the patients' care.

> The WOW nurse had a can do attitude. She could manage a group of patients and quickly became part of the team. She was not afraid to ask for help, or tell me if she made a mistake. She was energetic and pleasant.

When describing the fizzle nurse Dottie described what was lacking in her was her ability to make independent decisions. "she lacked self-direction. She had to be told what to do and how to do it." The WOW nurse, although Dottie does not use the term self-direction with her, she describes her as energetic and hard working. The fizzle nurse was not hard working and not energetic, which was the opposite of the WOW nurse, Dottie said she lacked self-direction which was a quality Dottie valued in the WOW nurse.

In Caren's comparison and contrasting of the WOW nurse and the fizzle nurse she described the concept of independent decision making.

> She had a way about her, a calm demeanor; she didn't let things bother her. She asked questions readily and wanted to grow. If she had a question or problem about something she didn't hesitate to ask. She rapidly learned to manage groups of patients. She was supportive to physicians, very responsive to physicians and families. She understood policies and knew the processes and where to go for things and stuff. If she had a job to do and didn't have the skill to do it she had the self-competence to call and ask. The fizzle nurse had problems getting up to speed in managing groups of patients; she

couldn't seem to get the focus beyond the task she was working on at that moment. She didn't ask questions appropriately and would give the excuse, "Well I didn't know we were suppose to do that" or whatever. When we asked her if she told someone it was her first time doing a skill and needed help she admitted she hadn't.

The WOW nurse had the quality of independent decision-making, she looked up policies and learned them, found where things were kept and learned to navigate the system. She would ask questions to learn. The fizzle nurse did not and the result could have been detrimental to a patient.

Alice used the term self-directed to describe her WOW nurses, "They were self-directed and confident."

Independent decision-making was an important behavior that the expert nurse managers wanted in their staff and it was an important characteristic that many of the expert nurse managers identified as the reason they were tapped for management positions. Sally shared that she believed she was promoted to a management position because,

I always liked to make sure things were run correctly and I took an interest in everything around me. It was like in surgery, there wasn't ever a time that somebody couldn't say to me "Well we need to get something from central" and I could say to them "well that's a special order" I mean I knew where everything came from. I knew where my resources were and I knew who my resources were.

Valerie was also an independent decision maker. In her illustration of the qualities she displayed that resulted in her being promoted to a management position she describes independent decision-making.

I guess getting the job done, working on things, always wanting to improve things that's

going on in the unit and always trying to make processes better. Making sure that the

patient's were taken care of and if there were issue following through on those, so it was

just kind of a gradual process. When the charge nurse would be off somebody would

need to step in and I would step in a lot into that role. It was pretty much self-appointed.

Seeing that it needed to be done and moving in and taking over. Stepping up to the plate,

not always being asked to do it.

Dottie recognized she was very self-directed and made independent decisions. She

believed that was the reason she was promoted to a management position. "I was committed,

dedicated and organized. I was very independent and self-directed. I saw what needed done and I

did it without being told. I was also pretty outspoken."

Independent decision-making is seeing what needs to be done and taking the initiative to

do it without being directed to do so. The expert nurse managers recognized this quality in them

selves and in their WOW nurses. Independent decision-making is a behavior that nurse managers

want in their staff nurses.

Compassion and Caring

The final behavior that was identified by the expert nurse managers as behaviors they

wanted in their staff nurses is compassion and caring. Compassion is defined for the purposes of

this study as the ability to empathize with others and to have a genuine desire to help them

overcome whatever obstacle the patient is facing. People who have compassion are able to place

themselves into a bad situation that another person is facing or the ability to feel the pain that

another person is experiencing. The person with compassion will do all that he or she can to help

someone. People who have compassion are the living definition of love. The bible defines love

in 1 Corinthians 4:4-8:

> Love is patient, love is kind. It is not envious, boastful or arrogant. It is not rude. It is not
>
> self seeking, it is not easily angered, it keeps no record of wrongs. Love does not delight
>
> in evil but rejoices with the truth. It bears all things, believes all things, endures all things.

Nurses see people in their worst state of being, when they are sick, injured or dying. They bath

them, clean up after them, and toilet them. A nurse who did not have compassion and caring

would not be able to do these tasks well or would avoid going into the patient's room.

Compassion and caring are critical components for nurses and nursing. The expert nurse

managers recognized this critical trait.

Caren was asked what behaviors she wanted in a staff nurse, what behaviors and skills

beyond the technical skills did she want to see in them and she responded, "the need to have a

good way of responding, and a positive attitude that makes the patient feel that the nurse cares

about them. They need to display themselves as caring and compassionate." Sally echoed

Caren's answer:

> They have to have compassion. They have to have a true dedication to their job. They
>
> have to be honest, a team player, caring. I know these all sound so glib but technical
>
> nursing is only half of nursing, the other half is the care, the compassion, doing the little
>
> things for patients that mean nothing to improving their health but makes them feel more
>
> comfortable.

Janet explained that she not only wanted nurses to be compassionate but felt that in her specialty

it was crucial. "For my field that is real important. They need to have empathy and they need to

have compassion." She demonstrated her caring and compassion for a group of nursing students who witness a frightening event in the psychiatric unit,

> We had nursing students in and we had a patient that was highly agitated. We had to do some interventions with that patient. It was a very loud, very traumatic, very scary for them and I wanted to explain what we were doing so they understood. I didn't want them to think it was an everyday occurrence but that we had rationale for everything we were doing and how this type of situation would make you feel. I think it is real important to process this type of thing with nursing students.

Janet was demonstrating concern and caring for the nursing students. She recognized the event was scary and could have a negative impact on the students. She wanted to soothe their fears.

The last quote is from Kelly who continues to practice midwifery once a week. I asked her how she could that with all that she was doing and she explained she needed to continue practicing because, "…you have a caring relationship with the patients and this is business. I think it's my escape." The caring and compassion that is so important for patients is also important for nurses.

Critical thinking, interpersonal skills, communication, independent decision making, compassion and caring are the common behaviors that were identified in the interviews as behaviors the expert nurse managers wanted in their staff nurses. They are also similar to the behaviors that were identified in the literature as being needed in staff nurses. The expert nurse managers identified these same behaviors as also being behaviors they valued in leaders. There are five leadership behaviors that the expert nurse managers clearly identified as both important for staff nurses to have and as behaviors that are valued in leaders. These five behaviors are (a)

interpersonal relationships, (b) communication, (c) compassion and caring (d) critical thinking and (e) independent decision-making.

Summary of Qualitative Results

Seven expert nurse mangers were interviewed to discover what behaviors they wanted in their leaders and what behaviors they wanted in their nurses. These behaviors were compared for similarities in order to discover if leadership behaviors were wanted in nurses at every level of practice. The seven expert nurse managers identified eight behaviors they wanted in their leaders, five of these behaviors were also identified as those they wanted in their staff nurses. The behaviors the expert nurse managers identified as those they wanted in both leaders and staff nurses included; a) critical thinking, b) communication, c) interpersonal relationships, d) independent decision making, and e) compassion and caring. The three behaviors the expert nurse managers identified in leaders that were not identified as behaviors they wanted in staff nurses included, competence, visibility and mentor/coach (See Table 1). The results of this strand of the study supports the hypothesis that expert nurse managers want leadership behaviors in their staff nurses.

Table 1

Comparison of Valued Behaviors in Leaders and Staff Nurses

Leader Behaviors	Staff Nurse Behaviors
Interpersonal Skills	Interpersonal Skills
Communication	Communication
Compassion and Caring	Compassion and Caring
Independent Decision Making	Independent Decision Making
Critical Thinking	Critical Thinking
Visibility	
Mentor / Coach	
Competence	

Note: There are five behaviors; critical thinking, independent decision-making, interpersonal relationships, communication, and compassion and caring that were identified as desirable behaviors by the expert nurse managers in both leaders and staff nurses.

CHAPTER V. RESULTS FROM QUANTITATIVE STRAND

The quantitative strand of the study was a nonexperimental descriptive design using a self-reported questionnaire, the Self Assessment of Leadership Instrument (SALI). In the following chapter the results of this section of study will be addressed with the statistical analyses. The chapter will conclude with a brief summary of the study results.

Participants

A total of 971 surveys were mailed to nurses who were newly licensed to practice nursing in Lucas County and Hamilton County in the State of Ohio. There were 68 surveys returned as undeliverable and 256 completed surveys were returned for a return rate of 26%. From the 256 returned surveys 111 of those were not eligible to participate: a) 57 were not eligible because they were masters prepared nurses who were newly licensed as advance practice nurses, b) 14 nurses were not eligible for the study because they did not work in a hospital, c) 11 nurses were not eligible because they were diploma graduates and d) 29 nurses were excluded from the study because they worked in critical care areas. The critical care nurses were not included because the knowledge and expert skills needed to work in these high stress critical areas predispose them to have well developed critical thinking, problem solving, and other leadership behaviors. Nurses who work in the critical care areas and do not demonstrate these behaviors generally are not kept in these areas. The resulting $N = 145$ with 88 BSN educated nurses and 57 ADN educated nurses.

The 145 participants were made up of 12 men and 133 women. The mean age of the sample participants was 30.72 years old with the youngest participant being 21 years old and the oldest being 58 years old ($SD = 8.01$). All of the participants worked in medical surgical patient care units in hospitals; however, there were 12 different specialties represented with the

majority of the nurses, 85 of them, working in general medical surgical units. The other type of units that were represented included pediatrics, gastrointestinal, cardiac, psychiatric, OB, vascular, oncology, neurology, progressive and a burn unit. There were 10 nurses who floated throughout the hospital and worked on different units.

<div align="center">Self-Reported Leadership Behaviors</div>

The first null hypothesis for this study, $H_0: \mu_{ADN} = \mu_{BSN}$, states there were no differences in the mean number of self reported leadership behaviors by ADN nurses and BSN nurses. To test the hypothesis nurses were asked to complete the SALI. The SALI has 40 items that measure leadership behaviors. They are scored on a Likert scale of 0 – 4 with 0 meaning usually not done and 4 meaning almost always done. Analysis was done on the items that had a reported score of 3 or higher, meaning the nurse did this behavior more than half the time. The mean number of leadership behaviors reported by ADN nurses with a score of 3 or higher was 31.32, meaning they did 31.32 out of the 40 leadership behaviors more than half the time. The mean number of leadership behaviors reported by the BSN nurses with a score of 3 or higher was 30.67, meaning they did 30.67 out of the 40 leadership behaviors more than half of the time.

A comparison of the means of the number of self reported leadership behaviors between the ADN and the BSN was completed using a t-test which showed there were no statistically significant differences in the means: $t(143) = 0.54$, $p = 0.29$ (see Table 2). The null hypothesis is not rejected. ADN nurses had a slightly higher mean than BSN nurses overall on the SALI items.

The ADN nurses scored the SALI items higher than the BSN nurses. The BSN nurses did not score the SALI items consistently high or consistently low but the scores were distributed across the scale. The size of the variability for the ADN and BSN scores supports this observation: standard deviation for ADN was 6.57 and for BSN was 7.28 (see Table 2)

Table 2

Summary Data for Comparison of Self- Reported Leadership Behaviors between ADN Nurses and BSN Nurses

_____

	ADN	BSN
Number	57	88
Mean	31.32	30.67
Standard Deviation	6.57	7.28

_____

A second analysis of the SALI items was completed looking at the individual SALI items and the percentage of self-reported use of each item according to the education level of the nurses (see Appendix G). This secondary analysis provided information about the items used most often and items used less often by the nurses. It also allowed for analysis of the complexity of the behaviors used by the ADN and BSN nurses.

Two leadership items were identified by 100% of ADN nurses as being done more than half the time, item 18) Assume responsibility for action taken based on your own decisions, and item 40 (Give credit when credit is due). There was one item reported by only 42% of ADN nurses as being done more than half the time, item 32 (Initiate action for new and better procedures and policies).

The BSN nurses did not have an item that 100% of the nurses reported doing more than half the time. The highest percentage was 97% for SALI item 18, which was one of the items

noted by 100% of the ADN nurses as being done more than half the time. There are three items

that were reported by the lowest percentage of BSN nurses as being done more than half the

time: items 22 (Try new ideas on a group, 45%), 32 (Initiate action for new and better procedures

and policies, 44%) and 39 (Encourage slow working members to improve their effort, 48%).

There were higher percentages of BSN nurses who reported doing SALI items that were

weighted as more complex. Complexity of the SALI items is presented in the following section

of this chapter.

<div align="center">Differences in Complexity of Leadership Behaviors</div>

The second hypothesis for the study, H_0: $\mu_{ADN} = \mu_{BSN}$, states there are no mean

differences in the number of complex leadership behaviors self reported by ADN nurses and

BSN nurses. To test the hypothesis the 40 items in the SALI was given a complexity score. The

complexity score was developed to identify the complexity of each of the leadership behavior

items in the SALI. Complexity scores were assigned according to the following definitions:

Score of 1 – The nurse was required to perform a basic assessment, analysis of one

finding, and implement two or less interventions. The entire process would take less than

5 minutes and the intervention that was needed is for one person.

Score of 2 – The nurse was required to perform an assessment, analysis of two to three

findings, and two or more interventions. The entire process would take more than 5

minutes but less than 20 minutes. The intervention may be for one person or a group of

people.

Score of 3 – The nurse was required to perform an assessment, advanced analysis of

multiple factors, and intervention(s). The entire process would take more than 20 minutes

to complete. The intervention may be for one person or a group of individuals.

A copy of the SALI and the definitions were given to two doctorally prepared nurses and one masters prepared nurse who ranked the items for complexity (see Table 3). A mean for the items with a complexity score of 3 was calculated for each group of nurses and these means were then compared with a second t-test indicating there were not statistically significant differences in the means: t (143) = 0.025, p = 0.49 (see Table 4). The null hypothesis is retained; there is not a statistically significant mean difference in the number of complex leadership behaviors completed by ADN and BSN nurses.

The mean differences do not demonstrate a significant statistical difference in the means however, analysis of the percentage of nurses who report using the SALI items does show a higher percentage of the BSN nurses who reported using items that were ranked as being more complex more than half the time. Items that had a difference of 5% or greater between the ADN and the BSN nurses were identified and compared with the complexity table to identify the complexity score of the items. The results showed that a higher percent of BSN nurses reported using items 2, ADN 87% BSN 94%; 8, ADN 80% BSN 89%; 12, ADN 85% BSN 90%; 15, ADN 83% BSN 93%; 20, ADN 85% BSN 93%; 25, ADN 60% BSN 78%; and 29, ADN 58% BSN 77% (see Appendix G). There was a greater percent of ADN nurses, 6%, compared to BSN nurses who reported using item 22 more than half the time (see Appendix G). These SALI items were all ranked with a complexity score of 3, the highest level of complexity (see Table 3). There was a greater percentage of BSN nurses who reported using these complex items more than half the time compared to the percentage of ADN nurses.

Table 3

SALI Complexity Table

_____

SALI Leadership Behavior Items	Complexity Score
1, 3, 5, 6, 9, 13, 17, 18, 19, 24, 30, 31, 34, 38, 40	1
4, 7, 10, 16, 21, 23, 26, 27, 33, 35, 36, 37, 39	2
2, 8, 11, 12, 14, 15, 20, 22, 25, 28, 29, 32	3

_____

Note: SALI Leadership Behavior statements taken from Smola's (2001) Self Assessment

Leadership Instrument in Waltz and Jenkins *Measurement of Nursing Outcomes* (2nd ed.) New

York, 10036: Springer Publisher Company, Inc. Used by permission (see Appendix F)

Past Hospital Work Experience

The third hypothesis for the study, H_0: $\mu_{experience} = \mu_{no\ experience}$ states there are no mean

differences in the number of leadership behaviors self reported by nurses with previous

experience working in the hospital and those without previous experience working in the

hospital. The nurses were asked to complete a demographic survey with the SALI that included

the number of years of experience they had working in the hospital in a position other than that

of a registered nurse. A comparison of the means of the number self reported leadership

behaviors and at least 1 year of work experience in a hospital was completed using a two-tailed *t*-

test. The result of the *t*-test showed that nurses who had worked in the hospital for more than 1

year did not report using more leadership behaviors than the nurses without previous hospital

experience: t (140) = .066, p = 0.947. The null hypothesis is supported by the data and is

accepted. There are no differences in the number of self reported leadership behaviors in nurse

who had previous work experience in a hospital and those who did not have previous experience

working in a hospital.

Table 4

Summary Data for Comparison of Self-Reported Complex Leadership Behaviors between ADN

Nurses and BSN Nurses

	ADN	BSN
Number	57	88
Mean	3.01	3.26
Standard Deviation	0.88	0.89

Note: There is not a statistical difference in the means of complexity of SALI items used by

ADN and BSN nurses.

Summary of Quantitative Results

The quantitative strand of the study was focused on three areas of leadership behavior

variables: a) relationship of educational preparation of the nurse and the use of leadership

behaviors, b) relationship of previous hospital work experience of the nurse and the use of

leadership behaviors, and c) relationship of educational preparation of the nurse and the

complexity of leadership behaviors used. The study results showed there were no significant

differences in the number of leadership behaviors self reported as being completed by ADN nurses and BSN nurses. Statistical analysis of the means of the complexity of the leadership behaviors did not show that the BSN nurses used more complex leadership behaviors more often than the ADN nurses. Additional analysis of the use of complex leadership behaviors did show, however, that a greater percentage of BSN nurses reported using SALI items that were rated as a 3 in complexity than ADN nurses.

Many of the nurses reported having experience working in the hospital as nurse's aides, unit clerks, licensed practical nurses, or other jobs for 1 year or more. A *t*-test analysis was used to discover if the hospital experience increased the use of leadership behaviors in the new registered nurses. The results were not statistically significant; the extra hospital experience did not result in the nurses using more leadership behaviors.

In conclusion, the quantitative results show that education and hospital work experience does not result in an increase in the number of leadership behaviors self-reported as being done by new graduate nurses. The education level of the nurse did not show a statistically significant difference in the number of complex leadership behaviors completed by the nurse, education was shown to have a relationship with the percentage of nurses that reported using the more complex leadership behaviors.

CHAPTER VI. RESULTS FROM MIXED METHOD STRAND

The first section of this chapter compares the leadership behaviors identified by the expert nurse managers with the leadership behaviors identified in the literature and the leadership behavioral categories established by Yura in1970. The second section of the chapter mixes the results of the qualitative strand with the results of the quantitative strand to identify if there is a difference in the leadership behavior category ADN nurses and BSN nurses use more frequently. The chapter will conclude with a summary of the findings.

Comparison of Leadership Behaviors and Categories

Based on the literature review of nursing leadership in chapter 2, there were eight leadership behaviors that were consistently identified. These eight behaviors include, (a) independent decision making, (b) critical thinking (c) interpersonal skills, (d) communication skills, (e) navigation of the health care system, (f) time management and (g) crisis management. Behaviors wanted in leaders and behaviors wanted in staff nurses were the focus of the qualitative strand of this study. Seven expert nurse managers (ENM) were interviewed about the behaviors they valued in nurse leaders and eight leadership behaviors were identified, (a) interpersonal relationships, (b) communication, (c) mentoring and coaching, (d) compassion and caring, (e) competence, (f) critical thinking, (g) independent decision-making and (h) visibility. Navigation of the health care system, time management and crisis management, three of the behaviors identified in the literature, were not behaviors identified by the ENMs as behaviors they valued in nurse leaders. A comparison of the eight leadership behaviors the ENMs identified as behaviors they wanted in their leaders with the behaviors the ENMs reported they wanted in their staff nurses revealed that five of the behaviors they wanted in their nurses matched five of the eight leadership behaviors the ENMs wanted in their leaders (see Table 5).

The five behaviors, (a) critical thinking, (b) communication, (c) independent decision-making, (d) interpersonal skills and (e) compassion and care were used to categorize the leadership behaviors measured in the SALI.

Yura originally set six categories for the SALI, (a) self, (b) critical thinking, (c) decision making, (d) interpersonal relations, (e) group relations and (f) job relations (Smola, 2001). A comparison of Yura's original leadership categories with the five categories obtained in the ENM interviews showed that there were three of the ENM behaviors that matched Yura's original categories (see Table 4). Yura's interpersonal relation category has a much narrower interpretation than the definition of interpersonal relationships used for this study. Yura's three relations categories combined, however, does match the broader defined interpersonal relationships used for this study. Other differences between categories include a *self*-category that Yura used that does not match any of the ENM themes used for this study's categories, and this study's categories of communication and compassion and caring that do not match any of Yura's original categories (see Table 5).

The definition of interpersonal relationships for this study incorporates some aspects of Yura's three relations categories. Interpersonal relationships is defined for the purpose of this study as professional, caring, and trusting relationships between nurses and their peers, nurses and physicians, nurses and other departments or health care agencies, nurses and patients, and nurses and patients' families. Other aspects of Yura's relations categories can be found in the communication category. Communication, as it was defined in chapter 1 for this study, is the effective professional oral, written, body language or sign language used for the purpose of persuading, motivating or sharing information with another person or a group of people.

Table 5

Yura's Leadership Categories Compared to Expert Nurse Manager's Categories

_____

Yura's Categories	ENM's Categories
Critical Thinking	Critical Thinking
Decision Making	Independent Decision Making
Interpersonal Relations	Interpersonal Relationships
Group Relations	Communication
Job Relations	Compassion and Caring
Self	

_____

Note. Yura's interpersonal relations category is not the same as Bernheisel's interpersonal

relationships category.

Mixing the Data

The qualitative interviews provided behaviors that the ENMs wanted in staff nurses and

these behaviors were used to develop staff nurse behavior categories. A doctorally prepared

nurse and a master's prepared nurse placed the SALI items into the staff nurse behavior

categories. The two tables developed by these nurses assigning the SALI items into the

categories were compared for similarities and differences. The two nurses did not place four of

the SALI items into the same categories; however, after further analysis and reflection consensus

was achieved and these four items were moved into categories that the nurses believed were

appropriate (see Table 6). The ability to categorize the SALI items into the staff nurse behavior categories that were identified by the ENMs corroborates the hypothesis that the behaviors identified by the ENMs as behaviors they wanted in staff nurses are comparable to the leadership behaviors represented in the SALI.

The quantitative study showed there were no statistically significant differences in the mean number of leadership behaviors self reported as completed by ADN educated nurses and BSN educated nurses. The percentage of nurses that reported using the individual SALI items more than half the time did provide a different view of the data (see Appendix G). Categorizing these items may reveal if there are differences in the leadership categories that are reported by the nurses as being used more often compared to the education level of the nurses. The following question was addressed by the analysis: Is there a difference in the category of leadership behaviors completed more often by ADN educated nurses compared to BSN educated nurses using the leadership categories identified by the ENMs?

The data was analyzed by measuring the percent of each item reported as being used more than half the time for each category by the education level of the nurses. The results of the initial analysis were so close it was determined further analysis was not required (see Table 7). Comparison of the percentage of ADN nurses and BSN nurses who reported using the items in each category revealed that the categories used the most often and the least often were the same regardless of education level of the nurse. The category reported by the highest percentage of nurses as being used the most was compassion and caring and the category reported by the lowest percentage of nurses was communication. The percentage of use for three of the five categories was equal to or higher for the ADN nurses. A higher percentage of BSN nurses

reported using items that fell in the category of critical thinking than ADN nurses by 6.3% All

the other categories were the same or had less than a 5% difference (see Table 7).

Table 6

Comparison of Nurse Leadership Behaviors Identified by ENM and SALI Items

_____

ENM Leadership Behaviors	*SALI Items*
Critical Thinking	2, 8, 11, 20, 23, 25, 29, 33, 36
Communication	3, 4, 5, 7, 16, 21, 22, 26, 28, 30, 37, 38, 39
Independent Decision Making	1, 12, 13, 15, 18, 29, 31, 32
Interpersonal Relationships	9, 10, 14, 17, 24, 27, 40
Compassion and Caring	6, 19, 34, 35

_____

Note: SALI Leadership Behavior statements taken from Smola's (2001) Self Assessment

Leadership Instrument in Waltz and Jenkins *Measurement of Nursing Outcomes* (2nd ed.) New

York, 10036: Springer Publisher Company, Inc. Used by permission (See Appendix F)

Summary of Mixed Method Results

The themes from the ENM interviews were used to categorize the leadership items in the

SALI. The categories used was, a) communication, b) critical thinking, c) interpersonal

relationships, d) independent decision making and e) caring and compassion. Each category was

analyzed to discover if there was one category self-reported as being done more often or least

often than any of the other categories according to the education level of the nurses. The percentage of self-reported use of the leadership items by the ADN educated nurses was equal to or higher than the percentage of self-reported use by the BSN educated nurses in three of the five categories. Compassion and caring was the category that the highest percentage of nurses, regardless of education level, reported that they did more than half the time. Items that fell under the category of communication had the lowest percentage of nurses, regardless of education level, reporting they did them more than half the time (see Table 7). A higher percentage of BSN educated nurses reported using items that fell under the category of critical thinking than the percentage of ADN nurses.

Table 7

Mean Percentage of Use by Category

Leadership Category	ADN	BSN
Critical Thinking	80.3%	86.9%
Communication	73.0%	69.0%
Independent Decision Making	79.0%	80.9%
Interpersonal Relationships	82.7%	82.0%
Compassion and Caring	91.3%	87.5%

Note: Compassion and Caring was identified as being done more than half the time by more nurses regardless of education level while the category of Communication was identified as being done more than half the time by the fewest number of nurses, regardless of education level.

The category of Critical Thinking had more BSN nurses reporting they did these items more than half the time by a margin of 6.3% more than ADN nurses.

CHAPTER VII. CONCLUSIONS AND DISCUSSION

The following chapter will present the conclusions of the study with a discussion about how these findings may be used in nursing education. The first part of the chapter will present the key findings in the study with a discussion of each of these findings. The second part of the chapter will address the implications this study has for nursing education. The study's limitations will be addressed in the third section of this chapter. The chapter will conclude with suggestions for future research.

Leadership Behaviors Wanted in Leaders and Staff Nurses

This study was developed around the conviction that all nurses, regardless of where they were in their professional careers, needed to have strong leadership skills and behaviors. George et al. (2002) and Manfredi and Valiga (1990) proposed that every nurse providing care at the bedside have strong leadership skills. The leadership skills they proposed as being necessary in staff nurses included, a) act independently, b) communication skills, c) critical analysis, d) decision making skills e) problem solving, f) interpersonal skills, g) navigation of the health care system and h) time management (George et al., 2002; Manfredi & Valiga 1990). The expert nurse managers in the qualitative strand of the study were interviewed and asked about the leadership behaviors they wanted in their leaders to discover if these behaviors were the same as those identified by George et al. (2002) and Manfredi and Valiga (1990) as leadership behaviors needed in staff nurses. The behaviors that the ENM's identified as behaviors they wanted in their leaders are very similar to those espoused as behaviors needed in staff nurses by George et al. (2002) and Manfredi and Valiga (1990). The behaviors identified by the ENM's included, a) communication skills, b) critical thinking, c) competence, d) independent decision-making, e) visibility, f) mentoring and coaching, g) compassion and caring, and h) the ability to develop

strong interpersonal relationships. The ENM's had identified four leadership behaviors wanted in their leaders that were not addressed by George et al. (2002) or Manfredi and Valiga (1990). These behaviors are competence in their practice area, being visible, mentoring and coaching, and compassionate and caring about the staff. There are two behaviors that Manfredi and Valiga (1990) identified that the ENM's did not; these are time management and navigation of the health care system. Since the leadership behaviors identified by the ENM's as behaviors they wanted in their leaders correlate closely to the leadership behaviors identified in literature as those needed in staff nurses, one could conclude at this point that staff nurses need to have well developed leadership behaviors at every level of their practice. In order to discover whether the leadership behaviors that were identified by the ENM's, George et al. (2002) and Manfredi and Valiga (1990) were also behaviors wanted in staff nurses the ENMs were asked about new graduate staff nurses they thought were *WOW* nurses and what behaviors those nurses had that made them WOW. They were also asked if they would like all of their staff nurses to have these same behaviors.

The ENM's were asked about new graduate staff nurses that they respected and thought of as being WOW. They were asked to describe the behaviors of these nurses that resulted in the ENM's respect and desire to have more nurses like them. The ENM's described five of the eight leadership behaviors they had identified as wanting in their leaders as those they observed in their WOW staff nurses and that they wanted to see in all of their nurses. These five leadership behaviors included, a) critical thinking, b) independent decision-making, c) compassion and caring d) communication and e) interpersonal relationships. These five behaviors correlate positively with the leadership behaviors identified by George et al. (2002) and Manfredi and Valiga (1990) as those needed in staff nurses. The concept of compassion and caring is the only

one not identified in the literature, and time management and navigation of the health care system identified by George et al. (2002) was not addressed by the ENM's during the interviews.

One behavior that was identified by every ENM as one they wanted in their staff nurses was independent decision making. Independent decision making, which is closely related to critical thinking, was described frequently as a nurse who *takes the initiative* to do something or as the nurse was *self-directed* to do something. Nurses who do not know what to do or how to do a skill or a task and do not ask for help lack independent decision making. Nurses who see something that should to be done and they do nothing about it, lacks this important behavior. Nurses who did not have this behavior were often described as the nurse that was a *fizzle*. The fizzle nurse was the nurse ENMs did not want. They lacked the ability to motivate themselves. Fizzle nurses stand back and watch others work, but they do not take the plunge unless they are directed to do so by someone else. Nurses who do not have this important behavior walk around as if they are in a fog of uncertainty and lack direction and require constant supervision.

Independent decision making is a very important behavior for a registered nurse. The registered nurse is responsible for patient care. Registered nurses are the primary care givers of patients in the hospital. They must be able to perform assessments, diagnosis and identify interventions needed for good patient outcomes. Without the behaviors of independent-decision making and critical thinking the nurse would not be able to accomplish these basic nursing duties and the results would be poor patient outcomes.

Leadership behaviors and nursing are not two separate entities but an amalgamation of both to make a unified whole. The behaviors identified by the ENMs are also behaviors they identified as valued in nursing leaders. Two conclusions can be made from this strand of the study:

1) Leadership behaviors are wanted in staff nurses by ENMs.

2) The behaviors identified in the literature as leadership behaviors needed in staff

nurses are behaviors identified by ENMs as leadership behaviors they want in their

leaders.

George et al. (2002) and Manfredi and Valiga (1990) identified eight leadership

behaviors as behaviors needed by every nurse at every level of their practice. The ENMs that

were interviewed for this study also identified behaviors they want in every staff nurse and

these behaviors were also behaviors they identified as leadership behaviors they want in their

leaders. Many of the behaviors identified by George et al. (2002) and Manfredi and Valiga

(1990) were the same behaviors identified by the ENMs. The conclusion of this strand of the

study is that leadership behaviors in nurses are behaviors that are needed and wanted in staff

nurses providing care to patients.

The following section will present the conclusions and a discussion of the findings of

the quantitative strand of the study investigating if there is a relationship between the

development of leadership behaviors and nursing education.

Education and Self-Reported Performance of Leadership Behaviors

Chief nursing officers proposed that BSN educated nurses have stronger critical thinking

skills, are less task oriented, demonstrate more professionalism, are more focused on continuity

of care and outcomes, have a greater focus on psychosocial components are better

communicators and demonstrate more leadership skills (Goode et al., 2002). There are several

studies that support this premise. Aiken et al. (2003) showed that hospitals who have a 10%

increase in BSN educated nurses have a 5% decrease in mortality and morbidity rates. Giger and

Davidhizar's (1990) study showed that ADN educated nurses were more involved in the

technical aspects of patient care, such as the maintenance of equipment and direct nursing care. BSN educated nurses were more process oriented and had a better understanding and utilization of nursing process and demonstrated stronger leadership skills. Giger and Davidhizar (1990) however, do not identify what behaviors they are using to measure leadership skills. Another study that supports the chief nursing officers observations is found in the Reports from the New York State Education Department Survey which showed that ADN educated nurses were nine times more likely to have medication errors than BSN educated nurses (Fagin, 2001). All of these reports and observations support the idea that ADN nurses would not be using the leadership behaviors identified by the ENM's as often as BSN nurses, however, that is not what this study showed.

The quantitative section of the study was a self-reported instrument of leadership behaviors, the SALI (see Appendix F). New graduate ADN educated nurses and BSN educated nurses completed the SALI. Experience working in a hospital environment as an aide, LPN or other role was analyzed to account for factors that may enhance the development of leadership behaviors in new graduate nurses. There were no statistically significant differences between new graduate nurses with experience working in the hospital and those without experience. The results of the study showed there were no statistically significant differences in the number of leadership behaviors reported by ADN nurses and BSN nurses as being done more than half the time. The number of leadership behaviors reported by ADN nurses with a response of 3 or higher was 31.32. Interpreted this means that the ADN nurses completed 31.32 of the 40 SALI items more than half the time. BSN nurses had a mean of 30.67, interpreted they did 30.67 SALI items more than half the time. It was expected that BSN nurses would have a higher mean and would report completing more of the SALI items than ADN nurses because of the literature review in

chapter 2. ADN nurses however, had a slightly higher mean than BSN nurses overall. Further

analysis of the data provided a better understanding of the role in education and the use of

leadership behaviors.

To follow-up on the non-significant null results, I conducted an item-by-item comparison

of the ADN and BSN responses to the SALI questions. I used a Mann-Whitney U test for these

comparisons, as the SALI questions are ordinal-level responses. Results indicated significantly

different response patterns between the two groups: items 16 ($z = -2.438$, $p = .015$), 36 ($z =$

-2.002, $p = .045$), and 37 ($z = -2.400$, $p = .016$) (note each of these was assigned a complexity

level of 2). In all three cases, the BSN nurses responded with *lower* values, indicating they spent

less time on these 3 behaviors than the ADN nurses.

The data was examined using the percentage of nurses that reported using each SALI

item according to the education level of the nurses. Items that showed a 5% difference in the

percentage of nurses reporting doing the leadership item were considered important, if not

statistically significant. The analysis showed that there were a higher percentage of BSN nurses

who reported using items that were in the Critical Thinking category than ADN nurses. ADN

nurses had a higher percentage of nurses who reported using items in the categories of

Communication and Interpersonal Relationships. These findings support the literature and past

studies by Aiken et al. (2003) and Giger and Davidhizar (1990) that provided findings that BSN

nurses use more critical thinking skills and ADN nurses are more technical skills and were more

involved in direct nursing care. Examining the individual SALI items and the percentage of BSN

nurses reporting that they do the item more than half the time and comparing this to the

percentage of ADN nurses provides a better understanding of the differences education has on

the practice of the two levels of nurses.

Five percent or more of the BSN nurses reported using items that were more complex at a score of 3 or higher (more than half the time) than ADN nurses. It is important to note that the Mann Whitney U did not show a significant difference using a score of 2 (usually half the time). The items that were rated as more complex are:

2) Fully grasp the idea of the problem, 7% more BSNS reported using this item at a 3 or higher.

8) Predict the consequences of your decisions, 9% more BSNs reported using this at a 3 or higher.

12) Recognize and locate resources in order to resolve a problem, 5% more BSNs reported using this at a 3 or higher.

15) Make decisions on a factual basis, 10% more BSNs reported using this at a 3 or higher.

20) Grasp essentials of a problem, see solutions and choose a course of action, 8% more BSNs reported using this at a 3 or higher.

25) Discriminate between relevant, irrelevant, essential and accidental data, 18% more BSNs reported using this at a 3 or higher.

29) Originate new approaches to problems, 15% more BSNs reported using this at a 3 or higher.

Each of the above SALI items is rated as a 3, the highest rating for complexity. This finding provides some insight into the differences in patient outcomes when looking at the education level of the nurse. Each of these items reflects a nurse's ability to recognize a problem and provide an intervention to prevent a crisis or worsening of the problem for the patient. Not doing these items impacts patient outcomes in a negative way. The higher percentage of BSNs

that reported using these items more than half the time supports the observations of the chief

nursing officers and the other literature presented in chapter 2 that BSN nurses used more critical

thinking skills and more complex nursing processes. It is important to remember, however, that

at the level of 2, usually half the time, the Mann-Whitley U did not show a significant difference.

ADN educated nurses perform more SALI items that are at the technical level. Giger and

Davidhizar (1990) found in their study that ADN educated nurses are more involved in direct

nursing care and the analysis of the individual SALI items support this finding. 5% or more

ADN nurses, compared to BSN nurses, reported using the following SALI items.

16) Alter your own behavior to meet a situation, 10% more ADN nurses reported using

this item at a 3 or higher.

17) Strive to understand other people, 6% more ADN nurses reported using this item at a

3 or higher.

19) Try to learn what impact you make on others, 12% more ADN nurses reported using

this item at a 3 or higher.

22) Try new ideas on a group, 6% more nurses reported using this item at a 3 or higher.

27) Encourage group members to work as a team, 9% more ADN nurses reported using

this item at a 3 or higher.

30) Have group members share in the decision-making, 7% more ADN nurses reported

using this item at a 3 or higher.

35) Stand up for the group even if it makes you unpopular 7% more ADN nurses reported

using this item at a 3 or higher.

37) Explain the reason for criticism, 8% more ADN nurses reported using this item at a 3

or higher.

38) Encourage group members to express their ideas and opinions, 11% more ADN nurses reported using this item at a 3 or higher.

39) Encourage slow-working members to improve their effort, 14% ADN nurses reported using this item at a 3 or higher.

More than half of the above SALI items are in the Communication and Interpersonal Relations categories and only one is rated at a 3 for complexity. These items are pretty focused in area of developing relationships with peers. That was not a finding that was expected. Very little of the above SALI items have a direct effect on patient's health outcomes. It also does not show the provision of direct patient care that Giger and Davidhizar (1990) proposed that ADN nurses are more involved in. The explanation for this is simple, the SALI measures leadership behaviors, the technical aspect of patient care is not being measured with this instrument and the ADN nurses are providing technical nursing care as was the original intent of Montag in 1959.

<div align="center">Complexity of Leadership Behaviors Performed</div>

Nurses provide care to acutely ill patients in an environment of complex technology, multidisciplinary interaction, cost limitations, governmental regulations, requirements by accrediting bodies and last but not least the expectations of the patient and the patient's family (Fagin, 2001). The ability to function in this environment depends on the nurses ability to critically think, problem solve, communicate, develop interpersonal relationships and to demonstrate compassion and caring. These critical leadership behaviors will have a positive effect on the patient's successful achievement of a good outcome in the shortest possible time period. Giger and Davidhizar (1990) concluded from their study that BSN educated nurses performed these activities at a higher level than did the ADN educated nurses. They found that the ADN educated nurses were more involved in direct patient care, technical nursing. There

should not be any surprise in that finding as that is what Montag (1959) had envisioned for the

ADN nurse. It has been almost 50 years since Montag established the first ADN program and

many things have changed in both education and health care. Studies are conducted to measure

the differences in nursing practice and the effect of education on nursing practice in an attempt to

show there is, or is not, a difference in the practice of nursing at the bedside. Proponents for the

ADN nursing program argue there are no differences in the care provided by ADN and BSN

nurses (American Association of Community Colleges, 1999). Other studies argue and support

that there is a difference in the complexity of nursing practice because of the differences in

education. The findings of this study support the premise that education may have an effect on

the complexity of the care provided by the nurse; further study is necessary to replicate these

results before a stronger conclusion can be drawn.

A higher percentage of BSN educated nurses reported using more complex SALI items

than ADN educated nurses. Each SALI item had been placed into a leadership behavior category

that was developed from the ENM themes. The SALI items were also ranked according to

complexity using a rubric (see Table 3). Each SALI item was then analyzed for the percent of

respondents who reported using the item more than half the time. The results showed that the

percentage of BSN educated nurses reporting they used more complex, critical thinking items

was greater than the percentage of ADN nurses.

The finding that more BSN nurses completed complex behaviors provides some support

of the nurse executive's premise that BSN educated nurses display more critical thinking,

problem solving, and communication behaviors than ADN nurses (Goode et al., 2001). The more

complex items that are done by the BSN nurses may also be why there appears to be a difference

in mortality and morbidity rates as found in Aiken et al.'s 2003 study. Aiken et al. (2003)

proposed that the BSN nurses were more observant of the subtle changes that may indicate a deteriorating condition in the patient. The SALI item 25 (Discriminate between relevant, irrelevant, and essential and accidental data) which was reported as being done by 18% more BSN nurses than ADN nurses provides support for Aiken et al.'s 2003 study.

The complexity of the leadership behaviors being done by the BSN nurses also provides support for Giger and Davidhizar's (1990) study that show that BSN nurses have better patient outcomes and commit fewer medication errors than ADN nurses. It also supports the premise by Giger and Davidhizar (1990) that ADN nurses are involved in the more technical aspects of patient care.

Overall conclusions for the quantitative strand of the study are:

1) ADN nurses report overall doing more leadership activities than BSN nurses.

2) More BSN nurses reported doing more complex, critical thinking behaviors than ADN nurses.

3) More ADN nurses reported doing more communication and relationship building activities than BSN nurses.

4) Experience working in the hospital as a nurse's aide, LPN or other role does not increase the use of leadership behaviors by new graduate nurses.

Leadership Categories

The final analysis of the study examined the themes of leadership behavior obtained during the ENM interviews. The leadership categories obtained from the interviews were analyzed for equanimity with the original categories established by Yura in1970. Further analysis was completed to explore if there was a leadership category nurses used more often, or least often, according to their level of education.

The qualitative ENM interviews provided insight into the types of staff nurse behaviors nurse managers want to have in their staff nurses. The behaviors that were identified by the ENM interviews include, a) critical thinking, b) independent decision making, c) compassion and caring, d) interpersonal relationships, and e) communication. These behaviors were a close match with the categories that Yura planned to use for grouping the items in the SALI. Yura's categories included, a) interpersonal relations, b) group relations, c) job relations, d) decision making, and e) self (Smola, 2001).

Comparison of the ENM leadership categories and Yura's original leadership categories revealed some minor differences. The first difference noted was the difference in definition of interpersonal relationships found in chapter 2 of this study and Yura's narrower definition of interpersonal relations. Yura subdivides her relationships category into interpersonal relations, group relations, and job relations (Smola, 2001). The definition for interpersonal relationships for this study incorporates each of Yura's smaller categories to make one large interpersonal relationships category that includes personal, group and job relationships.

The second difference noted was Yura's *self* category. Yura uses the self-category to measure the individual's ability for self-evaluation. The items in the SALI that would have been grouped under Yura's *self* category fit into this studies critical thinking and independent decision making categories. Hersey, Blanchard and Johnson (2001) discuss the concept of self-improvement as a means of achieving competence. Competence occurs when the person is able to gain control over the environment and "demonstrate job mastery and professional growth" (Hersey, Blanchard & Johnson, 2001, p. 48). Individuals who demonstrate competence are self-directed and they thrive on success. Self-evaluation is needed to achieve job mastery and professional growth. Identifying areas that need improvement in self would require the

individual to perform critical self-reflection, critical thinking about the strengths and weaknesses of their practice, and independent decision making to identify and take the steps needed for self improvement.

One of the categories identified by the ENM interviews was not part of Yura's original leadership categories, the category of communication. This omission by Yura was puzzling because so many of the SALI items were related to communication and communication is such an integral part of leadership and nursing. Communication is a complex, multifaceted system that involves both verbal and non-verbal skills for the purpose of sharing information between two or more individuals (Arnold & Boggs, 2003). This would include the critical communication process that occurs between nurses and other nurses, nurses and patients and nurses and physicians. These critical communications affect the outcome of patients. Heller et al. (2004) proposed that communication skills are important leadership behaviors required for all nurses and leaders.

The conclusion of this part of the analysis showed that the leadership themes obtained from the interviews have equanimity with Yura's original categories. The leadership items in the SALI correlated well with the staff nurse behavior categories developed from the ENM interviews supporting the research hypothesis: Leadership behaviors identified during the ENM interviews are comparable to the leadership behaviors measured in the SALI. Establishing this conclusion enabled the examination of a possible relationship between education level of the nurse and the ENM leadership category done more often.

Education Level of Nurse and Leadership Categories

The qualitative strand of the study provided data for the development of leadership categories that were comparable to the original leadership categories suggested by Yura. The

quantitative strand of the study provided data showing that the ADN nurses reported doing more leadership behaviors than the BSN nurses, but that the BSN nurses did more complex leadership behaviors. In the mixed analysis strand of the study the SALI items were placed into the ENM categories. The data from the quantitative strand of the study was then reevaluated to identify if there were categories that the ADN nurses did more often compared to the BSN nurses. The results showed that there were no differences between the categories done more often in relationship to the education of the nurses. ADN nurses and BSN nurses reported they completed the same category more often than the others, the category of compassion and caring. That finding is not really surprising since compassion and caring is an integral part of nursing. They also reported doing the same category the least amount of time, that category was communication.

Communication is an essential behavior for nurses and leaders. Arnold and Boggs (2003) provide four basic assumptions of communication theory:

1) It is impossible not to communicate

2) We only know about ourselves and others through communication.

3) Faulty communication results in flawed feeling and acting.

4) Feedback is the only way we know that our perceptions are valid (p. 17).

These four assumptions clarify the importance of communication when developing relationships with others. Communication is the only way we have of sharing information with one another and poor communication can result in the misinterpretation of the information that is being shared (Arnold & Boggs, 2003).

Communication is the primary tool for developing interpersonal relationships with those around us. Development of these relationships is critical in the profession of nursing. Nurses

need to be able to develop strong interpersonal relationship with one another, physicians and most importantly their patients. Communication is one of the basic tools of nursing (Arnold and Boggs, 2003). This basic tool in nursing, on which it may be argued all other skills are relying on, is the one tool that is used the least often. This finding should be troubling to nurse educators and to nurses. An examination of the nursing curriculum should be undertaken to discover if nursing communication is being taught and where, or if good nursing communication in the clinical area is being missed due to the focus of other more technical skills.

Students are nervous about being in a patient room and are very focused on doing technical skills. They count how many injections they give, medications they pass, dressings they change. They do not get excited about the time spent talking and communicating with patients or nursing staff. Communication is not seen as a skill that is learned and needs to be practiced in order for mastery to occur just as the technical nursing skills. Nurse educators need to reevaluate how and when this important skill is being taught so it can be become a skill the student nurse values as an important skill and practices it.

The themes from the ENM interviews were used to categorize the leadership items in the SALI. The categories used were, a) communication, b) critical thinking, c) interpersonal relationships, d) independent decision making and e) caring and compassion. Each category was analyzed to discover if there was one category self-reported as being done more often or least often than any of the other categories according to the education level of the nurses. Compassion and caring was the category self-reported as being done more often than the other four categories by both ADN educated nurses, 89%, and the BSN educated nurses, 84%. Communication was the category self-reported as being done the least often than the other four categories by both ADN educated nurses, 70%, and BSN educated nurses, 71%.

Implications for Nursing Education

The results of this study are somewhat ambiguous and as such the implications for nursing education and health care facilities should be taken cautiously. The statistical data failed to reject the null hypothesis and the frequency percentages are not really reliable as a tool to over ride the statistical conclusions. As such the implications that I present in this chapter should be taken with caution and understanding that this study was an exploratory study which did provide new avenues for study but does not clearly support changes.

In 1984 the National League of Nursing instituted new accreditation criteria for nursing schools. This criterion was a mandate that management and leadership concepts be included in the curriculum (Manfredi & Valiga, 1990). Like most accreditation criteria, this one was somewhat vague in how it should be implemented or what the content should include. It could be a course on management and leadership or these concepts could be intertwined throughout the nursing curriculum. Most schools of nursing developed courses of nursing management and leadership to meet this criterion. The development of the new management and leadership courses may have had an unintended secondary action, the discontinuation by many nursing schools of the nursing communication and interpersonal relationship courses. An internet search of 20 nursing schools and their curriculums showed only two of the 20 schools around the country had courses in therapeutic communications. In the 1970's and 1980's when I attended three different nursing schools in two different states, therapeutic communication courses were required courses in all three schools. This change may be the reason communication is the least used leadership behavior category by new graduate nurses, regardless of their education level.

Communication includes the written aspect as well as the verbal aspect of communicating with others. College students, including those in the nursing major, take courses in English

composition. English composition courses help students develop the ability to communicate with the written word, however, it does not help nursing students master therapeutic communication skills that are needed for patient care. Arnold and Boggs (2003) identify communication as the foundation for developing therapeutic interpersonal relationships with patients. Communication is an integral part of nursing and since the lack of these types of courses appears to have had a negative affect on new graduates using the leadership behavior of communication these courses should be reevaluated by schools of nursing as an integral part of the nursing curriculum.

Manfredi and Valiga (1990) completed a study of nursing schools to discover if management and leadership concepts were being taught as one, meaning management and leadership are the synonyms, or if they are each taught as separate concepts. They found that nursing management and leadership courses were taught during the last semester of the curriculum. They also discovered that if the terms were not used as synonyms management concepts constituted the majority of the courses with minimal information about leadership characteristics or development (Manfredi & Valiga, 1990).

Chandler (2005) and Heller et al. (2004) also investigated how and if leadership behaviors were being developed in nursing students. Heller et al. (2004) did not believe these concepts were being addressed adequately in the ADN programs and proposed these concepts should be strengthened in the basic, pre licensure level of nursing education. Chandler (2005) also recognized this but she proposed that the problem was with the placement of the management and leadership courses in most nursing curriculums. These courses are found, in most schools of nursing, in the final semester of the curriculum (Chandler, 2005). Other nursing skills are not introduced at the end of the course of study, so why are the leadership skills, which

may the more difficult skills to develop, introduced at the end of the curriculum? The answer may be found in the approach to education.

Schools of nursing have historically trained nurses to perform nursing skills. The change that has occurred in healthcare requires a different approach to nursing education. Nurses must be educated, not trained. The difference between these two concepts is the idea that learning is a life long requirement for nurses. The term *training* indicates there is an end but the term *educating* leaves the door of learning open, because there is no end in educating (Watson, 2001). Many schools of nurses use a behaviorist type of theory for educating nurses. Behaviorist learning theory is appropriate for training and is great for teaching skills, but it is not for the nursing professional (Watson, 2001). ENMs want to have nurses who are educated practioners, whose imagination and creativity take them beyond the realm of basic nursing skills. One of the ENMs expressed this in her discussion of behaviors she wanted in staff nurses, "I can teach them the skills, but I can not teach them to critically think and communicate."

Leadership behaviors that have been identified by the ENMs as behaviors they want in their staff nurses are behaviors that cannot be developed the last semester of nursing school. These are behaviors that are developed throughout the curriculum and the lateness of the management and leadership course in most nursing curriculums inhibit the student from mastering these behaviors (Chandler, 2005). Nursing schools may argue that critical thinking, communication, and problem solving are addressed in every clinical course with the patient care plans. What I have found in my 13 years of teaching, however, is that the students do not develop these important behaviors adequately. It is time to move beyond the nursing care plan that has been in place since I began nursing school in 1971, as this teaching tool does not appear to be a successful tool for developing leadership behaviors.

Chandler (2005) suggests using a teaching assistant program at the BSN level to help with the development of leadership behaviors. The BSN teaching assistant role would begin with the first clinical course and continue throughout the nursing curriculum. Each semester the student would have increased responsibility in the student teaching assistant role. This educational plan would take the leadership concept and put it into practice early in the curriculum. Whether nursing schools implement Chandler's idea, or some other idea, what is important is that nursing schools recognize the importance of developing these critical leadership behaviors in their nursing students to ensure safe, holistic patient care that results in optimal patient outcomes.

Nurses are leaders in every aspect of the profession. The behaviors identified by the ENM interviews support this premise. They are the same behaviors that were identified by these experts as valued behaviors in their leaders. Developing these behaviors in young nurses is critical for the safe and effective care of patients. Schools of nursing need to reevaluate their curriculums to ensure leadership development activities and communication courses are incorporated into nursing curriculums.

Implications for Health Care Facilities

Hospitals have a financial and patient safety benefit in increasing the number of BSN nurses that are working in their institutions. The nursing shortage has resulted in nurses working many hours of overtime and being required to be on call on their days off. Nurses essentially do not get a day off since they are on call. This causes dissatisfaction and job burn out. Nurses who are dissatisfied will resign and go to another hospital to work until they discover it is the same at every hospital and that results in them leaving the nursing profession. Orientation of new nurses

to replace those lost is very costly for hospitals and today there is a hemorrhage of nurses leaving the profession.

Young, Lehrer and White (1991) found that BSN nurses have an investment of time in their profession. This finding is particularly important for society, and hospitals in particular that need registered nurses. The nursing shortage that the world is currently experiencing is expected to continue and to worsen as a large number of nurses are leaving the profession or are preparing to retire (Young, Lehrer & White, 1991). BSNs who have invested their time and money into their education are less likely to leave nursing and go into a different profession (Young, Lehrer & White, 1991). Decreasing the loss of young nurses is an important step to ending the shortage and the financial drain of orientation on the hospitals.

BSN nurses use more critical thinking and complex behaviors than ADN nurses. The current practice of treating each nurse equally without deference to the education level of the nurse needs to be reevaluated for the safety of the patient. Aiken et al. (2003) study, as well as the studies completed by the New York State Education Department, shows patients are at a higher risk for medication errors and mortality and morbidity when there is a higher ratio of ADN nurses to BSN nurses. Increasing the number of BSN nurses would improve patient outcomes and that has an added financial benefit. Hospitals have an important role to play in motivating nurses to earn their BSN.

Montag (1959) established the ADN technical nurse with the idea these nurses would work under a professional nurse, the BSN educated nurses. It was not instituted by hospitals when the ADN program was instituted, however today's environment makes it more critical to reevaluate how acute care hospitals are staffed. Currently there is no external motivating force for nurses to earn a BSN instead of an ADN. There is no differentiation of practice, pay, or job

opportunity. Changing these elements by establishing guidelines for ADN practice in the hospitals, increased pay for BSN educated nurses, and increased opportunities for BSN nurses will make earning the higher degree more desirable for many nurses.

Nurse executives have recognized the practice differences in these two different levels of nurses and have decided the educational level of the nurses should be at the BSN level (Goode et al., 2001). This idea may not be practical nor may it be feasible at this time. ADN nurses make up the majority of nurses working in health care today and they play a crucial role in direct patient care. They should not be eliminated as they are valuable assets to health care, but there does need to be differentiation of practice between ADN and BSN nurses. Differentiation should include the clinical areas where ADN's may practice and identification of a maximum patient acuity level that the ADN nurse can safely care for. ADNs are technical nurses and should be expected to practice beyond their technical training. ADNs should also work under the supervision of BSN nurses.

<center>Limitations and Indications for Future Research</center>

Research studies that are developed around the use of self-reports have an inherent problem with selection bias and this study is no different. Selection bias will have an affect on the study's results and any results obtained from self-reports should be analyzed with this knowledge and understanding. Selection bias is the tendency of people to rate their behavior or actions higher than they may be (Creswell, 1998). This may have been the case in the ADN data set particularly. ADN educated nurses are aware of the current discussion and bias toward the BSN degree for entry into the practice of nursing. To neutralize this type of study limitation the investigator may want to use a combined self-report and observation to validate the self-report.

This study was an exploratory study and was focused more on context; however, it would be beneficial to discover the factors that may influence students to attend a two year college or a four year college. There are several factors that may affect a person's decision to attend a two year college instead of a four year college such as financial, environmental, social, or familiar. Understanding the personal factors that affect this decision may provide greater understanding of differences in the personalities and nursing practice of the ADN and the BSN nurse.

The study results showed that there is a problem with nurses and communication. A study investigating how communication is covered in the nursing curriculum would be an important study to do. Communication is an important tool for nurses and we need to discover why new graduate nurses are not utilizing it more. Comparing new graduate nurses from schools that continue to require a course on communication and interpersonal relationships with new graduate nurses from schools who do not have this type of a course would provide insight whether the course does increase the use of communication behaviors in new graduate nurses.

A second area of importance to study would be in the area of developing the leadership behaviors noted in this study in student nurses. Will implementing a student assistant or student charge nurse type of role throughout the curriculum help to develop these behaviors?

The qualitative strand of the study should also be repeated using expert nurse managers across the country instead of in one relatively small area. It would be a large study, and would require the collaboration of several researchers, however, it would provide a clearer picture of what is wanted and needed in new graduate nurses. This type of information aids nursing schools in making curriculum decisions. A suggestion, however, is to add an education criteria for the ENM. The BSN should be the minimum degree established for the ENM.

In conclusion, the study has provided valuable information about the leadership behaviors wanted in staff nurses. The area of communication was recognized by the ENMs as an important behavior, but it was self-reported as being used the least of all the leadership categories by both the ADN and the BSN nurses. Schools of nursing should reevaluate the implementation of communication courses in the nursing curriculum to increase new graduates use of this important behavior. Caring and compassion, although thought of as being pushed back due to technology and high demands on nurses, was the behavior identified by both ADN nurses and BSN nurses as being used the most often. That finding, as a nurse, was good to see.

Leadership behaviors are both wanted and needed at every level of nursing practice. Nurse educators should reflect on how they are educating nursing students to ensure they are educating and not training. An unknown author stated, "A trained person knows where to go to get the answers, but an educated person knows the right questions to ask."

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APPENDIX A

Letter to Nurse Administrators

[Date]

Dear Nurse Administrator,

My name is Susan Bernheisel. I am a registered nurse and a doctoral student in the Leadership Studies Program at Bowling Green State University. I am currently in the process of recruiting expert nurse managers for my study examining leadership behaviors in staff nurses. The research study will fulfill a partial requirement for the doctorate in leadership studies at Bowling Green State University.

The research study is a mixed methods study and the qualitative part of the study involves interviews with a minimum of 7 expert nurse managers at a variety of hospitals around the Toledo, Ohio area. An expert nurse manager is defined as a manager who has a minimum of 5 years experience in the nursing management position, has a history of achieving unit and institutional goals, and has a low personnel turn over rate compared to other managers in the institution.

I am writing to you to ask for names and recommendations of nurse mangers in your institution that qualify for the study using my definition of expert nurse manager noted above. The individuals you recommend will receive an e-mail of invitation to participate in the study and an explanation of who I am, what I am doing and why, what will be done with the results, any risks that may occur from participating in the study, a promise of confidentiality and a description of the time commitment required to participate in the study.

I look forward to hearing from you. If you have any questions or concerns you may reach me by phone at: (419) 450-5466 or by e-mail at Susanb7mac.com. You may also contact my Dissertation Advisor, Dr. Mark Earley at earleym@bgnet.bgsu.edu. If you have any questions please do not hesitate to contact Dr. Earley or me by either of the above methods.

Thank you,

Susan Bernheisel R.N., M.S.N.
Doctoral Student
Bowling Green State University

APPENDIX B

Nurse Manager Consent

INFORMED CONSENT FORM

[Date]

Dear Nurse Manager,

My name is Susan Bernheisel. I am a registered nurse and a doctoral student in the Leadership Studies Program at Bowling Green State University. I am writing to invite you to participate in a research study on leadership behaviors in staff RN's. This study will fulfill a partial requirement for the doctorate in leadership studies at Bowling Green State University. The information will help health care institutions make important decisions concerning the best staffing matrix for patient care units. The research study will also provide valuable information to nurse educators and will aid in curriculum development for educating future nurses.

The purpose of the study is to explore the use of critical leadership behaviors identified in the literature. Leadership behaviors are not technical skills but the behavioral conduct of identified leadership behaviors in staff RN's.

This study involves audio taped interviews with a minimum of 7 expert nurse managers at a variety of hospitals around the Toledo, Ohio area. An expert nurse manager is defined as a manager who has a minimum of 5 years experience in the nursing management position, has a history of achieving unit and institutional goals, and has a low personnel turn over rate compared to other managers in the institution. The study involves a minimum of two interviews and an evaluation of the accuracy of my interpretation of the information you provided. I estimate that your initial participation interview will take approximately 1.5 - 2 hours. I estimate the subsequent participation interviews will be approximately 30 minutes to 1.5 hours in length and I estimate the final evaluation of my interpretation should take approximately 30 minutes. The estimated total maximum amount of time for your participation is approximately 4 hours.

The anticipated risks to you are no greater than those normally encountered in daily life. This study may benefit patients, staff nurses and health care institutions by helping healthcare institutions determine the ideal staffing mix for patient acuity and successful outcome achievement.

I am writing to invite you to participate in the study as you have been recommended to me as a nurse manager who meets the definition of an expert nurse manager. I will protect the confidentiality of you as a respondent and your responses throughout the study and publication of study results. Only members of the dissertation committee will have access to the data and information you provide. Your identity will not be revealed in any published results unless you specifically request identification. The information you provide for the study will be kept confidential. To protect each participant's confidentiality each participant will be assigned an identification number. The identification numbers with the corresponding names will be kept on

a secure computer flash drive that requires a password for access. All tape recordings will be completely erased after the successful completion of the study.

Your participation in this study is completely voluntary, and you can refrain from answering any questions without penalty or explanation. You are free to withdraw consent and to discontinue participation in the project at any time. If you decide to participate and change your mind later, you may withdraw your consent and stop your participation at any time without penalty or explanation.

I will contact you by phone in one week to confirm your willingness to participate in the study and to set up a time and place to meet. If you have any questions or comments about this study or your rights as a study participant, you may contact any of the people below:

Susan Bernheisel   Chair of BGSU   Dr. Mark Earley
(O) 419.251.1299   Human Subjects Review   Dissertation Chair
(H) 419.875.5554   Ph: 419.372.7716   Ph: 419.372.0247
E-mail: Susanb71@mac.com   E-mail: hsrb@bgsu.edu   E-mail: earleym@bgnet.bgsu.edu

I look forward to meeting with you.

Susan Bernheisel R.N., M.S.N.
Doctoral Student
Bowling Green State University

By signing this consent the participant indicates he/she has read the consent form, had all of his/her questions answered and is agreeing to participate in the study. A signed copy of the consent will be provided to the participant.

Participant Signature: _____ Date: _____

APPENDIX C

Nurse Consent

[Date]

[Address]

Dear Nurse,

My name is Susan Bernheisel. I am a registered nurse and a doctoral student in the Leadership Studies Program at Bowling Green State University. I am writing to invite you to participate in a research study on leadership behaviors in staff RN's. This study will fulfill a partial requirement for the doctorate in leadership studies at Bowling Green State University. The information will help health care institutions make important decisions concerning the best staffing matrix for patient care units. The research study will also provide valuable information to nurse educators and will aid in curriculum development for educating future nurses.

The purpose of the study is to explore the use of critical leadership behaviors identified in the literature. Leadership behaviors are not technical skills but the behavioral conduct of identified leadership behaviors in staff RN's.

This study will ask you to complete the attached demographic information and the 40-item Self Assessment Leadership Instrument. The Self Assessment Leadership Instrument measures nursing behaviors that are not normally viewed by nurse experts as technical nursing skills but are considered as behavior. Completing the demographic information and survey will take approximately 30 to 45 minutes of your time. A stamped self-addressed envelope is included for the return the completed demographic information and survey.

The anticipated risks to you are no greater than those normally encountered in daily life. This study may benefit patients, staff nurses and health care institutions by helping healthcare institutions determine the ideal staffing mix for patient acuity and successful outcome achievement.

I am writing to invite you to participate in the study as you have been identified by the State of Ohio as a nurse who meets the study participant criteria. The criteria to participate in the study is that the nurse must have received a license to practice registered nursing for the first time between December 2004 and July 2006.

The information you provide for the study will be kept confidential and your identity will not be revealed I will protect the anonymity of you as a respondent and your responses throughout the study and publication of study results. Only members of the dissertation committee will have access to the data you provide. Your identify will be protected by not requiring your name or other identifying elements on the demographic information, the completed survey or the return envelope. These steps will ensure that neither I nor any other individuals will know who responded to the survey.

Participation in the study is completely voluntary and you may refrain from completing the demographic information and the Self Assessment Leadership Instrument without penalty or explanation. By completing and returning the questionnaire and demographic information you are indicating your consent to participate in the study.

If you have any questions or comments about this study, you can contact any of the individuals noted below.

Susan Bernheisel	Chair of BGSU	Dr. Mark Earley
(O) 419.251.1299	Human Subjects Review	Project Advisor
(H) 419.875.5554	Ph: 419.372.7716	Ph: 419.372.0247
E-mail: Susanb71@mac.com	E-mail: hsrb@bgsu.edu	E-mail: earleym@bgnet.bgsu.edu

Please return the completed forms in the self addressed stamped envelope by November 3, 2006.

Thank You,

Susan Bernheisel R.N., M.S.N.
Doctoral Student
Bowling Green State University

APPENDIX D

Interview Protocol

Project: Leadership Behaviors in Staff Nurses

Time of Interview:

Date:

Place:

Interviewer: Susan Bernheisel

Interviewee:

Position of Interviewee: Nurse Manager

Description of Study:

This qualitative study will explore the concept of leadership and leadership behaviors identified by expert nurse managers. The study will also explore behaviors of staff nurses that expert nurse mangers value in their nurses.

Interview Questions:

1. How long have you been in nursing?

2. Tell me about your work experience in the profession of nursing.

3. Share with me your nursing educational background?

    a. Have you had continuing education in the area of leadership development?

4. In your basic nursing education program did you have a course in leadership and management?

    a. If yes, were the terms leadership and management used interchangeably or was there specific content addressing leadership and specific content addressing management?

       b.   Were leadership and management concepts incorporated into your other courses?

5. Do you believe there is a difference between manager and leader? (if yes) Please describe what you believe the differences are between leadership and management.

6. Think of a leader that you have worked with whom you admire and respect, the best leader you have ever worked with or known, what were the leader's behaviors that impressed you in such a way as to see this person as a great leader?

7. What behaviors do you think you demonstrated that impressed your supervisors?

       a.   What behaviors do you currently model that make you a good leader?

8. Think of two new graduate nurses you have hired at some time in your managerial career. Think of one that was just a WOW, and one that was a bit of a fizzle. What were the specific differences between them? What made the WOW a WOW and the fizzle, well a fizzle?

9. Now think of one of your staff nurses that you believe is one of your best nurses, someone you would trust to leave in charge during your absence. Describe the behaviors that the nurse displays that have resulted in you having respect and value for that nurse.

10. What behaviors, outside of technical skills, do you think are important for all staff nurses to have? Explain.

Thank you for participating in this interview. Your information will remain confidential. I will provide you a copy of the results of our interview for confirmation of my findings.

APPENDIX E

Demographic Background

Part I: Your Demographic background:
Directions: Complete the following questions using the most appropriate answer. Place a check mark in the box that best represents you in Part I.

1. Male _____ Female _____

2. Your current age: _____ years.

3. Identify any non-nursing degree earned:

    a. None: _____
    b. Associate Degree: _____
        Please identify the area degree is in: _____
    c. Bachelors Degree: _____
        Please identify the area degree is in: _____
    d. Masters Degree: _____
        Please identify the area degree is in: _____
    e. Other: _____

4. Check each nursing degree you have earned:

    a. Diploma Nurse: _____
    b. Associate Degree in Nursing: _____
    c. Bachelors Degree in Nursing: _____
    d. Masters Degree in Nursing: _____
    e. Other: _____

5. Number of months or years you have worked in a hospital in any position.

    a. Never: _____
    b. Less than 6 months: _____
    c. 6 months – 1 year: _____
    d. 1 – 2 years: _____
    e. 2 – 3 years: _____
    f. Greater than 3 years: _____

6. Do you currently work in a hospital? No _____ Yes_____ (If no please stop here. If yes please continue with questions 7 and 8 and the remainder of survey.)

7. How long have you worked in a hospital as a registered nurse?
    a. Never: _____
    b. Less than 6 months: _____
    c. 6 months – 1 year: _____
    d. 1 – 2 years: _____
    e. 2 – 3 years: _____
    f. Greater than 3 years: _____

8. What department do you currently work in? _____

APPENDIX F

SELF-ASSESSMENT LEADERSHIP INSTRUMENT

About the Questionnaire:
　　　　Please consider the following behaviors as they relate to your leadership. You should consider your reaction to each behavior and mark the rating accordingly.
　　　　A 5-point numerical scale (4 . . . 3 . . . 2 . . .1 . . .0) is used to indicate the rating. The interpretation of the points on the continuum ranges from:

　　　　　　　　4 – Almost always behave in this manner
　　　　　　　　3 – More than ½ the time
　　　　　　　　2 – About ½ the time
　　　　　　　　1 – Less than ½ the time
　　　　　　　　0 – Usually do not behave in this manner

Directions:
　　　　1.　Read each statement of behavior.
　　　　2.　Indicate your judgment of how often you use this behavior.
　　　　3.　Circle the number that most closely indicates your estimate (i.e., 4 or 3 or 2 or 1 or 0)
　　　　4.　Respond to *every* statement.

Statement of leadership Behavior   Rating

1. Evaluate your own needs	4	3	2	1	0
2. Fully grasp the ideas of the problem	4	3	2	1	0
3. Are aware of how you communicate with others	4	3	2	1	0
4. Are able to persuade groups to agree on specific issues	4	3	2	1	0
5. Organize your thoughts clearly and logically	4	3	2	1	0
6. Listen attentively for meaning and feelings	4	3	2	1	0
7. Get others to work together effectively	4	3	2	1	0
8. Predict the consequences of your decisions	4	3	2	1	0
9. Aware of the perceptions of others	4	3	2	1	0
10. Encourage the understanding of point of view of other group members	4	3	2	1	0

11. Plan ahead for what should be done	4	3	2	1	0
12. Recognize and locate resources in order to resolve a problem	4	3	2	1	0
13. Show a willingness to make changes	4	3	2	1	0
14. Influence a group in goal setting	4	3	2	1	0
15. Make decisions on a factual basis	4	3	2	1	0
16. Alter your own behavior to meet a situation	4	3	2	1	0
17. Strive to understand other people	4	3	2	1	0
18. Assume responsibility for action taken based on your own decisions	4	3	2	1	0
19. Try to learn what impact you make on others	4	3	2	1	0
20. Grasp essentials of a problem, see solutions, and choose a course of action	4	3	2	1	0
21. Hold the attention of others while presenting pertinent ideas	4	3	2	1	0
22. Try new ideas on a group	4	3	2	1	0
23. Delegate responsibility appropriately	4	3	2	1	0
24. Feel good about face-to-face exchanges of ideas	4	3	2	1	0
25. Discriminate between relevant, irrelevant, essential, and accidental data	4	3	2	1	0
26. Get others to follow your advice and direction	4	3	2	1	0
27. Encourage group members to work as a team	4	3	2	1	0
28. Direct group members or instruct them on what to do	4	3	2	1	0
29. Originate new approaches to problems	4	3	2	1	0

30. Have group members share in the decision making	4	3	2	1	0
31. Look for ways to improve yourself	4	3	2	1	0
32. Initiate action for new and better procedures and policies	4	3	2	1	0
33. Know how to proceed to get something done	4	3	2	1	0
34. Are friendly and approachable	4	3	2	1	0
35. Stand up for a group even if it makes you unpopular	4	3	2	1	0
36. Can define your role in a situation	4	3	2	1	0
37. Explain the reason for criticism	4	3	2	1	0
38. Encourage group members to express their ideas and opinions	4	3	2	1	0
39. Encourage slow-working members to improve their effort	4	3	2	1	0
40. Give credit when credit is due	4	3	2	1	0

APPENDIX G

Percentage of Respondents Who Indicate They Perform Each SALI Item More than Half the

Time

_____

SALI Item	ADN	BSN
1. Evaluate your own needs.	64	68
2. Fully grasp the ideas of the problem.	87	94
3. Are aware of how you communicate with others.	92	88
4. Are able to persuade groups to agree on specific issues.	57	56
5. Organize your thoughts clearly and logically.	92	96
6. Listen attentively for meaning and feelings.	94	96
7. Get others to work together effectively.	73	72
8. Predict the consequences of your decisions.	80	89
9. Aware of the perceptions of others.	78	82
10. Encourage the understanding of point of view of other group members.	82	88
11. Plan ahead for what should be done.	94	94
12. Recognize and locate resources in order to resolve a problem.	85	90
13. Show a willingness to make changes.	85	81
14. Influence a group in goal setting.	58	60
15. Make decisions on a factual basis.	83	93

Table Continues

SALI Item	ADN	BSN
16. Alter your own behavior to meet a situation.	87	77
17. Strive to understand other people.	98	92
18. Assume responsibility for action taken based on your own decisions.	100	97
19. Try to learn what impact you make on others.	92	80
20. Grasp essentials of a problem, see solutions, and choose a course of action.	85	93
21. Hold the attention of others while presenting pertinent ideas.	69	81
22. Try new ideas on a group.	51	45
23. Delegate responsibility appropriately.	80	78
24. Feel good about face-to-face exchanges of ideas.	78	80
25. Discriminate between relevant, irrelevant, essential and accidental data.	60	78
26. Get others to follow your advice and direction.	62	61
27. Encourage group members to work as a team.	85	76
28. Direct group members or instruct them on what to do.	57	52
29. Originate new approaches to problems.	58	77
30. Have group members share in the decision-making.	80	73
31. Look for ways to improve yourself.	94	93

Table Continues

SALI Item	ADN	BSN
32. Initiate action for new and better procedures and policies.	42	44
33. Know how to proceed to get something done.	85	84
34. Are friendly and approachable.	98	94
35. Stand up for a group even if it makes you unpopular.	76	69
36.Can define your role in a situation.	94	90
37. Explain the reason for criticism.	80	72
38. Encourage group members to express their ideas and opinions.	87	76
39. Encourage slow-working members to improve their effort.	62	48
40. Give credit when credit is due.	100	96

Note: SALI Leadership Behavior statements taken from Smola's (2001) Self Assessment Leadership Instrument in Waltz and Jenkins *Measurement of Nursing Outcomes* (2nd ed.) New York, 10036: Springer Publisher Company, Inc. Used by permission (see Appendix F)