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Lived Experiences of Nurse Leaders

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This is to certify that the doctoral dissertation by

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Walden University
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Abstract

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MPhil, Walden University, 2020

MN, University of Phoenix, 1995

BA, St. Catherine University, 1984

Dissertation Submitted in Partial Fulfillment

of the Requirements for the Degree of

Doctor of Philosophy

Public Policy and Administration

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Abstract

The National Academy of Medicine (NAM) has called for more leadership, more accountability, and increased education and training of health care leaders. The NAM has demanded that nurses participate in health care policy making, increase their knowledge of research and data collection, advise leaders across the business world, train and educate seamlessly, and practice to the full extent of their licensure. The purpose of this qualitative phenomenological study was to explore the lived experiences of 12 influential nurse leaders from the state of Arizona. Transformational leadership theory provided the framework for the study. Semi-structured interview data were transcribed, coded, and analyzed for similarities among the experiences. Six themes emerged: have and use your voice; take leadership on the "walk"; invest in yourself and others; you own the culture; development of own style; and mentoring, teaching, and coaching. Findings may be used for positive social change to transform the work environments of those providing patient care, to develop health policy, and to positively affect patient outcomes.

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Dedication

First and foremost, this doctoral dissertation is dedicated to my Lord, Jesus Christ, who has been with me every step of this journey. He has given me the strength and passion for my lifelong pursuit of studying, developing, teaching, and demonstrating leadership in all facets of my life. The next dedication goes to the love of my life, my husband Rudy Z. Mohammed. He has stood by me through every joy, challenge, and the continued rewards of our life together. This dissertation is dedicated to you as you have watched and encouraged me to pursue my dreams. Lastly, this dissertation is for all those nursing leaders who strive to better their work environments, train future leaders, and provide the culture for the best patient care possible.

Acknowledgments

This doctoral dissertation is a culmination of my career as a nurse leader. I have had many wonderful and inspirational leaders to follow and to learn from over the years. I also have had a few leaders I worked with whom I chose not to take on their characteristics. I have read many authors over the years whom I consider to be part of my personal foundation as well as the authenticity of who I am. Some of these authors include John C. Maxwell, Dr. Jim Rohn, Dr. Robert Rohm, Dr. Bernard Bass, James Kouzes and Barry Posner, Bessie Marquis, Carol Huston, Tim Porter O' Grady, Kathy Malloch, Marie Shirey, Linda Aiken, Patricia Benner, and so on. I also read many biographical books about the great founding fathers of our country including George Washington, Thomas Jefferson, John Adams, and Abraham Lincoln. There are many lessons of leadership to learn from across diverse disciplines, as well.

As for personal acknowledgements, I wish to acknowledge my current mentor, friend, and legacy leader, Dr. Pamela Fuller. She has not only been a constant encourager, she has also taken the time to read and edit my work to give me the feedback needed to push my writing to a higher level. I also wish to acknowledge my employer, Chamberlain University, as they have supported me financially, allowed me time to write, and given me the opportunities to develop my leadership to the next levels. A person is never complete in their leadership journey.

My family is next to be acknowledged in this journey. My husband and three children have watched their wife/mother over the past 11 years change her career, go back to school, work multiple jobs at one time due to the economic crisis hitting our

country, help them achieve their college and career dreams, and finally be rewarded this esteemed terminal degree. Together, we have developed a very strong family to depend on, learn from, encourage, and use our strengths to better the world around us. My father, who passed away during this doctoral journey, is never far from my mind, as well. He would have been most proud of me and would have loved to call me Dr. Catherine Mohammed.

I wish to thank Aleta Allen, my editor whose attentive, detailed eyes assisted me in writing a better dissertation and helping put my thoughts to paper. She was instrumental in the last 2 years to fine-tune and give me confidence that my study was worthwhile to influence social change.

Lastly, I wish to acknowledge Dr. Frances Goldman and Dr. Eliesh O'Neil Lane for their constant guidance and oversight of my doctoral dissertation. Thank you, Walden University, as well, for this opportunity to make social change and to live and achieve my dreams of being a doctorally prepared registered nurse who wishes to sit at the table of health policy and leadership making for this country of ours great.

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Chapter 1: Introduction to the Study

Chaos, downsizing, health care reform, Magnet versus non-Magnet, healthy work environment, constant change, and lack of leadership (American Association of Critical Care Nurses [AACN], 2006; American Nursing Credentialling Center [ANCC], 2019; Institute of Medicine [IOM], 2011, 2016; Kelly et al., 2011; Porter-O'Grady, 2009; Shirey, 2009; Smith & Buerhaus, 2007; Vaughn & Slinger, 2013) are terms that have been used to describe the state of nursing leadership in health care in recent decades. There has been a shift in the influence of the nursing leader over the past couple of decades that has positively affected the health care climate (Benner, 1999a; D. Burns, 2009a, 2009b; Curtis, Devries, & Sheerin, 2011; Curtis, Sheerin, & DeVries, 2011; Houston et al., 2012; Sherman, 2012; Scoble & Russel, 2003; Vaughn & Slinger, 2013). The leadership of nursing has never been as important in the United States as it is now. Leaders in the nursing profession understand the responsibility, the desire, the energy, and the broad view of the many complex issues in health care. In addition, nurse leaders must be ethically and morally fit to serve (Gustafsson & Stenberg, 2017). The nurse leader role has undergone much change in the past 30 years and continues to evolve. In the 1980s, the nurse leader role was that of the head nurse who managed the patient care unit and the staff. The 1990s demonstrated the need to increase the nurse leader's management skills as the complexities of health care and budgetary oversight became the norm. The present day's definition of the nurse leader is a person who leads professionals rather than manages workers. Nurse leaders are expected to be coaches and mentors, to oversee diminishing resources, to actualize quality measures and initiatives, to implement

evidence-based practices, to assist in the career development of not only themselves but their staff, and to transform their work environments to enhance the best possible patient care (Blake et al., 2012; Kelly et al., 2011; Kramer et al., 2009; National Academy of Medicine [NAM], 2011, 2021). Nurses are uniquely qualified to affect change through their vision, resourcefulness, promotion of change, and capacity to manage and endure turmoil. Nurses promote a desirable future for the nursing profession, for nursing practitioners, and for the many patients encountered in clinical, administrative, research, education, public policy environments, or any other nursing roles (Cromwell, 2016; Grossman & Valiga, 2020; Rosser et al., 2017).

The IOM in 2011 gave the nursing profession eight recommendations for increased involvement in the health policy and leadership of the United States at all levels and has continued to provide updates to measure how the profession is doing in accordance with the goals they set (Hassmiller, 2019; IOM, 2011, 2016; Lacey et al., 2012). Leaders cannot build the future alone; they must energize others to achieve the goals that are set forth. By increasing the involvement of nurses in shaping health policy, nurse leaders can promote health in many vulnerable populations (Rosser et al., 2017). The nursing profession must ensure that RNs are educated to lead and assist in the development of health care reform and other critical health policies (AACN, 2011, 2019; Grossman & Valiga, 2020; Marquis & Huston, 2020; IOM, 2011, 2016). The social implications for nurse leaders to assist in the leadership of the United States in the decision making in health care cannot be overemphasized. The Future of Nursing 2020-

2030 report indicated that little had changed in the promotion of nursing leadership and healthy work environments (NAM, 2021).

The current study addressed the experiences of nurse leaders in Arizona regarding the struggles and accomplishments were most influential in their experiences as nurse leaders. Arizona is the state where I live. I understand the practice well and have been a nurse leader for over 20 years. I sought to explore the lived experiences of the interviewed nurse leaders. Chapter 1 provides an overview of the problem addressed in the study and the rationale for exploring the lived experiences of nurse leaders. This chapter presents the social change implications, the plan for the study, and the theoretical framework for the study. The overview contains the limitations and significance of this study for the nursing profession. Researchers exploring the characteristics and meanings of nurse leadership experiences have not studied the similarities of the nurse leader in depth, but rather have focused on the relationships of perceived leadership styles and personal attributes or developing leadership through education and training (Kallis, 2011; Kelly et al., 2014; Morse & Warshawsky, 2021; Nghe et al., 2020; Pilat & Merriam, 2019). Although there was some reflection and presentation of other countries, the current study focused on the United States, specifically Arizona. This qualitative study addressed the lived experiences of nurse leaders and what the nursing profession can learn to better prepare future nurse leaders.

Background

The description of a nurse leader has evolved since the 1960s. Historically, nurses have tended to hold a narrow view of health and health care policy and have not believed

they have the power to influence. Nurses have tended to view nursing from a clinical perspective rather than an economic, political, social, or health policy perspective that can affect the health care of not only their local communities but also the nation (Graham & Jack, 2008; Robert Wood Johnson Foundation, 2015). Research has demonstrated that the healthy work environment is crucial to morale, patient safety, patient satisfaction, and nurse retention yet does not speak to the leader who leads the team (AACN, 2006; Lavoie-Tremblay et al., 2008; Lavoie-Tremblay et al., 2016; Vaughn & Slinger, 2013). Although the profession is stronger and more productive since the IOM's Nurse of the Future white paper was written in 2011, there is much more to do to increase the profession to become a catalyst for social change (IOM, 2016; NAM, 2021). Although the problem of leadership succession has been addressed in the nursing literature (Burke & Erickson, 2020; Linton & Farrell, 2009; Boutttelet Munari et al., 2019; Sherman & Saifman, 2018), insufficient empirical research has been conducted to provide insights on how to develop and train nurse leaders for the future.

Before implementing any formal or informal training to mentor and develop future leaders, the profession must identify, explore, and describe the lived experiences that are perceived by nurse leaders as important in their leadership. Even more important is examining the experience and the influences that lead a person to be a nurse leader before the development of competencies or skills needed to be a successful leader. Limited studies exist on the lived experiences of nurse leaders. Although some researchers studied the lived experiences of nurse leaders, the research reflected the perceptions of the leader's staff rather than the experiences of the leaders themselves.

Other researchers focused either on the clinical leadership models in relation to patient outcomes or on nurse satisfaction and retention (Jefferson et al., 2014; Linton & Farrell, 2009; E. Maxwell, 2015; Saleh et al., 2018; Sherman, 2010). With the focus of health care having turned to quality, improved efficiencies, better patient outcomes, and patient excellence, pressure to be successful as a leader has increased. Future focus in health care will not only be on quality and performance but may also require that effective leadership determines which organizations survive or not (Houston et al., 2012; IOM, 2011,2016).

The literature search revealed evidence that leaders tend to use transformational leadership as their leadership style in healthy work environments. Beckman (2019) and Mannella et al., (2018) posited that transformational leadership practices influence quality. According to Clavelle (2012) and Clavelle et al. (2012), the longer chief nursing officers (CNOs) are in their roles, the more inspirational they become and the more they demonstrate a stronger transformational leadership style. Positive practice environments such as the Magnet Model and the American Nurses Association (ANA) Scope and Standards of Nursing Practice for Nursing Administration described transformational leadership as necessary for open communication and the fostering of change in the working environment of shared leadership and decision making (ANA, 2019; Clavelle, 2012). The belief is that transformational leadership is vital for excellent work environments, yet it is not clear that nurse leaders are using transformational theory practices.

There is extensive literature on the four most common leadership theories used in professions including nursing. These four most common leadership theories are

transformational, transactional, authentic, and situational (Bondas, 2006; Bylone, 2010; Drenkard, 2013; Luzinski, 2011; McGuire & Kennedy, 2008; Wong & Laschinger, 2013). Some studies have been more reflective on the frontline leaders with a clinical focus rather than on the nurse leaders' transformational styles or practices (Goldblatt et al., 2008; Johansson et al., 2010). Nursing as a profession must move beyond the reliance on clinical models and develop a more clear, descriptive, and professional leadership framework (Cromwell, 2016; Grossman & Valiga, 2020). Roles and responsibilities of nurse leaders have changed from the focus on nursing alone to active participation in broader hospital and health care leadership and that of health policy. This sometimes leads to role confusion or ambiguity causing some nurse leaders to leave their leadership roles (Carvalho, 2010; Jefferson et al., 2014; Tarrant & Sabo, 2010).

Problem Statement

Despite the work that has been done on successful work environments, few researchers have addressed the lived experiences of nurse leaders regarding what they believe are influential experiences in their success or failure. In recent years, the focus of research has been on how nursing leadership may affect attrition, turnover, patient outcomes, and staff satisfaction. In addition to these outcomes, researchers have started to study leadership styles to determine the correlations between positive work environments, outcomes, and leadership style (Lewis, 2015; M. M. Pearson, 2020; Robbins & Davidhizar, 2020; Shaughnessy et al., 2018).

Nurses possess the necessary skills and capabilities to build interdisciplinary teams, promote healthy patient behaviors, change lifestyle habits, and deter chronic

diseases. Additionally, they must increase their abilities to continue to grow as a profession and contribute to their unique knowledge of nursing leadership (Marquis & Huston, 2020). Nurses know what they want but not always the pathway to success (IOM, 2011, 2016; Sherman, 2010; Sorensen et al., 2008). By studying the lived experiences of the nurse leaders, I sought to provide the profession with a clear and more concise pathway to leadership success.

There is the expectation that nurse leaders are using transformational leadership in their pursuit of excellence in nursing and in the health policies for the United States. Despite the monies spent and the focus on the development of positive work environments, there is little evidence that nurse leaders use transformational leadership much less any intentional leadership theory or style. There is less evidence that the nursing profession prepares nurse leaders for leadership roles, including the use of transformational leadership theory. Despite the assumption that transformational leadership is the ideal practice in nursing leadership, there is limited evidence that nurse leaders are using transformational theory practices. Furthermore, there is insufficient testimony regarding how nurse leaders make meaning of their leadership experience.

In other areas of nursing, public policy, and health care leadership, the goal is for excellence and quality pertaining to patient outcomes. Leadership cannot be viewed as an optional role for nurses. Leadership must occur in every health care environment that wishes to affect change (Curtis, Devries, & Sheerin, 2011). Researchers have not studied the lived experience of nurse leaders to understand the influences that guide their success. By examining the experiences of nurse leaders in their natural environments, I sought to

develop themes of leadership success based on their lived experiences. These themes may assist in the development of leadership training for nurse leaders and the promotion of transformational leadership in their practices.

Purpose of the Study

The purpose of this study was to explore the experiences and perceptions of nurse leaders in the state of Arizona. Arizona is the 14th largest state in the United States, and Phoenix is the fifth largest city in the country. With a state population of 7.28 million, the state has grown 13.6% since 2010. Maricopa County, which includes Phoenix, is the fastest growing county in the country (United States Census Bureau, 2022; World Population Review, 2019). There are 100,127 registered nurses in the state, which is 1.4% of the population (Arizona Board of Nursing, 2021). Arizona provided an excellent research setting for the current study. The use of individual interviews revealed the descriptions, concepts, and common themes deemed important by nurse leader participants. The objective was to discover the lived experience of nurse leaders to inform and prepare other nurse leaders for the future.

A review of nursing leadership studies on the experiences of leaders framed this research. Several studies have been done on leadership styles and perceptions of the nursing staff or followers. Different theories of leadership have been researched and presented in many studies. The leadership theory most representative of nursing in relation to the ideal is that of transformational leadership.

Nurse leaders know what needs to happen to achieve quality patient care and excellence in nursing education, yet there is little formal training to ensure the

transformation of work environments. The current study revealed the common themes regarding nurse leadership in health care. Once the nursing profession understands the experiences deemed necessary for success in leadership, the specialty can then develop strong professional development programs to ensure nurses' success in creating healthy work environments improving patient outcomes.

Research Questions

This study was guided by the following research questions (RQs):

RQ1: How do nurse leaders in Arizona make meaning of their leadership experience?

RQ2: How do nurse leaders prepare themselves for leadership roles in nursing?

Theoretical Framework

A theoretical framework was required to set the tone for this exploratory, phenomenological study of nurse leaders' experiences to identify the characteristics and themes around the development of nurse leaders for the future. The theoretical framework chosen for this study was transformational leadership. Transformational leadership has been entrenched in the nursing profession's pursuit of excellence (AACN, 2006, 2021).

Bass and Avolio (1994) suggested that transformational leaders have higher moral integrity because they do the right thing for the right reason. In addition, they treat their followers with compassion and care, encouraging and motivating others to be creative and innovative and keep the vision alive. Transformational leadership allows for the leader to act as a facilitator, champion, and navigator through complex change (Luzinski,

2011; Mannella et al., 2018; McIntosh & Tolson, 2009; Pearson, 2020; Robbins & Davidhizar, 2020). Avolio et al. (2009) found there continues to be many factors affecting the leader's abilities for successful relationships and influences. Avolio et al. examined contextual variables such as social and structural distance, perceived environmental uncertainty, social networks, the use of technology, and cultural orientations. In addition, Avolio et al. suggested that there are continued gaps in the research on followers and leaders and the dynamics of this relationship. Although transformational leadership qualities are desired, they must be intertwined with the day-to-day duties of the nurse leader for them to be successful (Bass & Riggio, 2014; Marquis & Huston, 2020).

Transformational leadership emphasizes how to develop vision, communication, development, trust, honesty, and collaboration. Nursing is interested in interprofessional collaboration, and an indicator of leadership is the pursuit of patient care excellence. If nurses are to become transformational leaders, they must pursue their passions, learn to communicate effectively, be willing to develop their leadership skills, and establish trusting relationships with those around them (Drenkard, 2013; Houston et al., 2012; Kramer et al., 2009; Mannella et al., 2018). These leaders must be willing to adopt change, take risks for the benefit of all, and demonstrate strong personal values (Bass, 1985; Bass & Riggio, 2014; Kouzes & Posner 2003, 2010; Marquis & Huston, 2020).

The theoretical proposition of transformational leadership is that a person transforms the culture and environment that they lead. By studying the leaders' experiences, the choices they made throughout their career, and the experiences they

deemed most influential to their success, I sought to identify the emerging themes and characteristics of successful leadership. Themes are the analytical purpose of qualitative research (Terry et al., 2017). These themes can indicate the pathway for the journey of future leaders.

Nature of the Study

The intention of this qualitative phenomenological study was to explore the lived experiences of nursing leaders regarding what they considered important and influential in their leadership. To satisfy the purpose of the study, I chose a qualitative phenomenological design to explore the lived experiences of nurses related to their leadership and nursing roles. More information on the methodology is provided in Chapter 3.

Definitions

In this study, the concepts of nursing leadership and nursing outcomes are defined to assist the reader in understanding how the concepts were used in the current study.

Nurse leader: An RN with at least 2 years of clinical experience who has been promoted to a position of leadership overseeing either clinical or professional staff. In this study, the participants had at least 2 years of experience in leadership. Nurse leaders can be found in all areas of the health care environment including the acute care setting, community or home environment, or academia (American Organization for Nursing Leadership [AONL], 2021).

Patient outcomes: The most common statistical data that are collected and analyzed by health care organizations at the national level of patient care include

infection rates, wrong site surgeries, CORE Measures, length of stay, readmission rates, C-section rates, complications, and mortality. These patient outcomes are often associated with effective nursing leadership (AACN, 2021; ANCC, 2021; Drenkard, 2010; Jones et al., 2017; Kelly et al., 2011; Lacey et al., 2012; M.M. Pearson, 2020).

Retention: The staff turnover of a health care unit, department, or organization. Retention is a major factor in determining positive leadership and better patient outcomes (Aiken, Clarke, et al., 2008; Christmas, 2008; Clavelle et al., 2012: Kelly et al., 2014; Lavoie-Tremblay et al., 2016).

Shared governance: The organizational structure of self-governance that is shared with the leadership of the organization. Shared governance is one of the healthy work environment requirements of patient care excellence (Clavelle et al., 2013; Porter-O'Grady, 2009).

Assumptions

The use of a qualitative phenomenological approach to explore the experience of being a nurse leader was deemed appropriate. This research methodology includes certain philosophical assumptions regarding how reality is defined. These three philosophical assumptions are ontology, epistemology, and axiology. Together they become a constructivist approach to understand the phenomenon of the lived experience of the nurse leader (see Denzin & Lincoln, 2017; Killam, 2013).

Ontology focuses on identifying patterns through the emergence of evidence rather than testing assumptions through controlled environments. Using this lens, I explored the words of the nurse leaders to make meaning of these findings (see Creswell,

2013; Killam, 2013). Epistemology is another aspect of the study that allowed me to explore the phenomenon through participants' perspectives. The use of epistemology helped to frame the construction of participants' realities (see Rescher, 2012). I, as the researcher, sought to understand the participants' internal perceptions of their experiences from the beginning of their leadership experiences to the current time. Participants' different perspectives allowed me to better understand their experiences and present them individually. The third aspect of this study was axiology, which focuses on the roles and values in how research is influenced. Axiology seeks to understand behavior or comprehend emerging patterns (Creswell, 2013; Killam, 2013; Rescher, 2012). Axiology was used to reveal characteristics, similarities, and themes related to participants' lived experiences as nurse leaders.

Other assumptions of this study were that the position of authority does not make a person a leader. The second assumption was that every participant would share their lived experiences as a nurse leader. Each participant had at least 2 years of experience in a leadership position at the time of the interview, per the participants' disclosure. The third assumption was all participants would describe their experiences truthfully. Participants shared their key experiences in their success regardless of their knowledge or use of any theoretical framework or concepts. Lastly, I assumed that nursing leaders were using some form of transformational leadership in their organizations' pursuit of excellence.

Scope and Delimitations

The purpose of this study was to explore the lived experience of nurse leaders and determine what they perceive as the most important experiences in their leadership. The goals of being able to replicate this study by other researchers were considered. A delimitation of this study was the focus on nurse leaders from the state of Arizona. In addition, only experienced nurse leaders from a professional nurse leaders' organization were sought as participants. I narrowed the scope of the study due to time constraints by limiting the number of participants to 12. The goal was to transfer the research findings to the profession of nursing and health care in general and recommend further research of the concepts and themes discovered in this study. The results may not be deemed valid or applicable to all other professional leadership groups, yet I believe that the findings are true and representative of the nurse leader experience.

Limitations

One of the limitations of this study may have been the use of the methodology of phenomenology. The sample size of 12 participants may not have been enough to reach saturation with rich descriptions for the development of concepts and themes of the lived experiences of the leaders. There were enough willing participants negating a further search for participants. This did not lengthen the study or distract me from being focused on the study. I did not need to seek further participants because concepts and themes emerged on their own from the data.

A third limitation could have been the participants were not able to elaborate or feel comfortable enough to relay their in-depth thoughts and experiences. In addition, the

interview questions may not have persuaded the participants to share their unencumbered reflections. This may have affected the identification of accurate concepts and themes during data analysis. Some of the participants gave feedback at the end of the interviews that they had not reflected on their careers in that manner and had really enjoyed the experience.

The fourth limitation of this study that may have interfered with the strength of the findings could have been my unintentional bias as the researcher. As a nursing professional with over 30 years of nursing and health care experience, I may have had internal, personal experience, educational, or philosophical biases that may have influenced my interpretations of what the participants were sharing. To ensure credible results, I sought transparency and congruency throughout all phases of the study. All data were reviewed by all participants (see Yin, 2011). The most important techniques employed were the use of careful, exact transcription of the recorded interviews, preserving and conducting the interviews using the protocol, and meticulous categorization of the concepts and thoughts. Validity was increased when the data were recorded (see Yin, 2011). Following a structured protocol for methodical preciseness promoted dependability of the research design and allowed for the transferability of findings. This protocol allowed discovery to occur naturally and allowed for unanticipated events. The orderly set of research procedures was followed to avoid bias, ensure completeness, and allow for cross-checking of data against the theoretical framework and research questions (see Miles et al., 2014; Schwandt, 2015; Yin, 2011).

Significance

The significance of this study affected three areas: the profession of nursing, the practice and public policy in health care, and the possibilities for social change. The contributions of this study toward advancing the knowledge of nursing leadership by exploring the lived experience of nurse leaders may be realized. The findings were that the experiences of the nurse leaders were similar and indicated certain themes for success. Jennings et al.'s (2007) meta-analysis of 140 articles on leadership and management indicated that there were many commonalities between leadership and management. Jennings et al. concluded that although there was a large common intersection of competencies, there was a lack of discrimination between leadership and management competencies. Concerns about adjusting work environments often need to be made quickly. The nurse leader may not be prepared or have the skills to create healthy work environments. Although it may be true that the tasks of leadership and management may be similar, the phenomena are not the same and should not be confused. Leadership may not be tied to a position of authority (Marquis & Huston, 2020; J. C. Maxwell, 2013). I aspired to discover, categorize, and develop themes around the experiences of nurse leaders. The goal was to contribute to the profession by offering suggestions for further research into nursing leadership, promote the development of intentional leadership skill acquisition, embed these concepts into the curriculum of undergraduate and graduate programs, and encourage the development of leadership/mentorship programs at health care organizations.

The results of this study may also advance knowledge in public health care policy by demonstrating that the development of nurse leaders in all areas of health care can lead to better positive patient outcomes. As the profession of nursing advances and continues to contribute to public policy, the importance of intentional development of nurse leaders for the future is imperative for the success of not only the profession but also for the health and policy development of the United States. The intentional development of nurse leaders continues to be an urgent issue requiring the attention of the leadership of health care and other influential professions (AACN, 2021; IOM, 2011, 2016; NAM, 2021). Because Magnet designated health care facilities have proven positive patient outcomes, U.S. health care leadership continues to pursue the knowledge of the characteristics of the leaders leading them to these outcomes. I found that there were similar characteristics of the nurse leader experience and gave suggestions for the possible profile in training. Because there is an initiative to increase nurses on boards across the United States, the development of nurse leaders in the public arenas is crucial (Nurses on Boards Coalition, 2021).

The results of this study may contribute to social change by positively impacting patient care and outcomes. The impact of nursing leadership in the health care environment is substantial. Leaders positively affect the working environment, which in turn affects the staff's ability to provide excellent patient care. When the focus of patient care is on the patient, the outcomes are improved. Nurses' ability to view the patient holistically and provide leadership and education to improve patients' health and

wellness will influence the health of the United States. I sought to provide a better understanding of nursing leadership to positively influence patient care environments.

Summary

Chapter 1 provided an overview of the study's purpose and research questions, a summary of leadership theory and how the transformational leadership framework was chosen, and a description of the methodology used to conduct the study. Chapter 2 provides a literature review of the theoretical foundation, the concepts studied, the research on nursing leadership, leadership experiences and development, and the studies done on transformational leadership theory to date. I also identify the research gap found in literature.

Chapter 2: Literature Review

Researchers had not studied the lived experience of nurse leaders to understand the influences that guide their success. The purpose of this study was to explore the experiences and perceptions of nurse leaders in the state of Arizona. The secondary purpose of this study was to determine whether the experiences of the nurse leaders can be used to develop nurse leader training and prepare nurse leaders of the future. Leadership theories including transactional leadership theory have been used to entice followers to work more productively or efficiently. More contemporary leadership theories indicated the importance of the motivations and behaviors of the leader. One of many challenges in the field of nursing is the need to evaluate leadership models to learn what nursing leadership interventions can improve the overall work environment, which may improve the quality of patient services and outcomes. There were several models or theories for improving nursing leadership in the literature: transactional, transformational, authentic, connective, renaissance models, situational, and emotional intelligence (Drenkard, 2013; Jones et al., 2017; Marquis & Huston, 2020; Maguire & Kennedy, 2008; Murphy, 2012; Robbins & Davidhizar, 2020; Wong & Cummings, 2009). There have been several research studies on various models or frameworks of leadership and nursing. The focus of the current literature review was an in-depth examination of the most researched nursing leadership theoretical frameworks in current health care environments and their contributions to healthy work environments. In addition, I reviewed the literature on the development of leadership skills, skill sets, and the perceptions and experiences of nurse leaders and their staff. This literature review was

not intended to be exhaustive but rather to identify key issues and the lack of research on lived experiences in nursing leadership.

Despite the work done in the areas of successful work environments, few studies had addressed the experiences of nurse leaders regarding what they believe are successful experiences. Several questions remain unanswered: What experiences have influenced the nurse leader's style of leadership? Were these experiences informed in an academic setting or a professional setting? Does the nurse leader refer to a leadership model or type of work environment as being influential, either positively or negatively? Which of these experiences have been the most influential on the nurse leader? Transformational studies in nursing leadership included evidence of the effectiveness of the style but suggested gaps in the literature regarding the experiences of nurse leaders in health care environments.

This chapter includes a review of the literature on transformational leadership and its inception, and the use of transformational leadership in relation to nursing. In addition, I discuss healthy work environments, especially the Magnet designation, and the development of leadership skills needed to lead. Finally, I explore the literature and knowledge in nursing research addressing the lived experiences of nurse leaders and the research gap.

Literature Search Strategy

The following databases were accessed to conduct the literature review for this study: Cumulative Index of Nursing and Allied Health Literature (CINAHL Plus with Full Text), Ebscohost, Health Source: Nursing/Academic Edition, MEDLINE, Books in

Print, Cochrane Library, Sage, OVID, Wiley Online, Science Direct, ProQuest Nursing and Dissertations, and the Walden Dissertation Library. A search of key terms included the following: *leadership in nursing, authentic leadership in nursing, transformational leadership, transformational leader, emotional leadership in nursing, healthy work environments, healthy work environments in nursing, Magnet work environments, Magnet and leadership, Magnet and non-Magnet research, leadership development, perception of nursing leaders by staff, perception of nursing leader's experiences, leadership skill development, leadership effectiveness, leadership quality, lived experiences of nurse leaders, Institute of Medicine reports,* and *Quality, Safety, and Education of Nurses (QSEN)*. In addition, a search for phenomenological studies pertaining to the experiences of nursing leadership was conducted. Much of the literature used to support this study came from peer-reviewed articles; classic leadership books by Covey, Maxwell, Kouzes and Posner, Bass, and Burns; and websites that were found to be relevant to the study of leadership. The key search terms were used to identify the most relevant research and gaps in the literature regarding the experiences of nurse leaders.

This literature review provided a comprehensive summary of the current professional literature related to studies of nurse leaders within and beyond the United States. The literature review begins with an overview of the most researched theoretical frameworks for nursing leadership, especially transformational leadership. In addition, I present concepts and themes that influenced nurse leaders and the theoretical frameworks

utilized for their behaviors, leadership styles, and aptitudes contributing to their success or lack of success.

Literature Review Findings

Leadership is an elusive and intriguing phenomenon. Leadership is not tangible or objective and is difficult to measure, yet it can be recognized when it is occurring (Kouzes & Posner, 2005; J. C. Maxwell, 2013, 2017). Leaders are those who are the first to take risks, volunteer, provide the vision for shared goals, motivate and inspire others into action, and share their experiences with others (J. C. Maxwell, 2011, 2013, 2017). A leader is not necessarily the person with the position of authority (J. C. Maxwell, 2011, 2013, 2017). Leaders focus on relationships, processes, constant feedback, and empowering others (Bennis, 2004; J. M. Burns, 1978; Cromwell, 2016; J. C. Maxwell, 2011, 2013, 2017; Sadri, 2012).

The scientific study of leadership did not materialize until the 20th century, and theorists' views of what is successful leadership have changed over the last 100 years (Bass & Riggio, 2014; Marquis & Huston, 2020). Most early works concentrated on general characteristics of leadership such as gender, appearance, height, and weight and led to the study of behavior and traits in the 1950s and 1960s (House & Aditya, 1997). Current research findings concentrated on the processes of influencing and developing organizational culture, and the multifaceted relationships between the followers and the leader (Jefferson et al., 2014; E. Maxwell, 2015; M. M. Pearson, 2020; Porter-O'Grady, 2009; Porter-O'Grady & Malloch, 2015).

Studies since the 1980s have focused on nurse management and leadership traits, characteristics, and their effects on work environments. The nurse leader's work and work environment have been studied from several perspectives: organizational structures, organizational cultures, staff, and coworkers. These studies have also addressed factors affecting the role of the nurse manager or the work environment: stressors, changes, power, influences, health care economics, and frequent regulatory changes (Atsalos & Greenwood, 2001; Atsalos et al., 2007; Cameron & Masterson, 2000; Carney, 2009; DeGroot, 2005; Porter-O'Grady, 2007, 2009). In most of these studies, the findings indicated that in most work environments the nurse leaders are expected to focus on management duties rather than the development of their leadership growth and skills (Drach-Zahavy & Dugan, 2002; Jefferson et al., 2014; Linton & Farrell, 2009; E. Maxwell, 2015; Sherman, 2010; Surakka, 2008; Scoble & Russel, 2003).

More recent focus has been on leadership styles (strengths based, interactive, servant, authentic, appreciative, and others) and have encouraged leaders to demonstrate support, trust, relationship building, and confidence in addition to tasks such as structure, planning, and scheduling and how a leader must be skilled in multiple areas (Blanchard, 2015; Duffield et al., 2011; Gifford et al., 2013; Morse & Warshawsky, 2021; Porter-O'Grady & Malloch, 2021; Saleh et al., 2018; Sellegren et al., 2006; Thory, 2015; Verkaaik, 2007; Yukl, 2012). Because scientists have been researching and writing about leadership for almost a century, there is only one clear conclusion: "Leadership is one of the most observed and least understood phenomena on earth" (J. M. Burns, 1978, p. 2). Leadership is more dynamic than management, and despite the long list of theorists who

have studied leadership over the years, few have explored the lived experiences of nurse leaders.

Transformational Leadership

It is important for leaders to instill and develop leadership in those they lead. This sentiment is at the heart of the paradigm of transformational leadership. The principles of this theory are fundamental to many segments of life, not just to health care environments but work, family, and community, where these principles may affect issues of social change. James MacGregor Burns (1978) conceptualized leadership as either transactional or transformational. Transactional leaders may lead through social exchange, offering rewards or transactions for increased productivity. These transactions may compromise most leaders' relationships to their followers. Transforming leadership is potent and therefore, more complex as well. Transformational leaders are those who inspire, motivate, and achieve extraordinary outcomes by helping others grow and develop. The transforming leader looks for potential motives of followers, encourages seeking higher needs, and engages the whole person's being. Often in turn, these types of leaders develop their own leadership capacity (Burns, 1978). Transformational leadership is relational, collective, and purposeful. Transforming leadership occurs when one or more persons engage with others to raise one another to higher levels of motivation and morality. This dynamic leadership has the capacity to immerse leaders into relationships with followers who assert increased motivation and elevation. These followers become more active and engaged themselves, creating new, emerging leaders (Burns, 1978).

Development of Transformational Leadership

Research based on Burn's work demonstrated over the years, that transformational leadership not only stirs followers to exceed expectations and improve performance but also leads to follower commitment and satisfaction. The use of transformational leadership has been successful in many sectors and work environments (Avolio et al., 2009; Bass & Riggio, 2014).

A crucial element of Burn's conceptual framework of transformational leadership led Bernard Bass to continue the expansion of the theory to include a pseudo-transformational component-inauthenticity. Burns held a firm belief for one to be transforming, one had to have high morals and be morally uplifting for the followers. Examples of inauthentic transformational leaders are that of Adolf Hitler or Osama Bin Laden. They were certainly transformative but not highly moral or concerned with their followers (Bass & Riggio, 2014; Burns, 1978).

To truly understand how individuals become transformational leaders, the need to start early with leadership experiences is important. These experiences may greatly affect leadership development. In Bass and Riggio's (2014) research over decades, they found that experiences early in life were of interest and correlated to the development of transformational leadership. Transformational leaders in adult life do not emerge accidentally (Bass & Avolio, 1994). These leaders were shaped by high moral standards set by their parents, parental interest in them and their academic and sports achievements, military experiences, and experiences around the time of one's first paying jobs (Bass & Riggio, 2014).

Components of Transformational Leadership

Transformational leadership deals more with colleagues and followers than pre-arranged exchanges or agreements. The continued research and development of Bass and Avolio's (1994) transformational theory into the Full Range Leadership Model is explained in the following paragraphs. These transformational leaders achieve superior results by engaging in four core components of transformational leadership. These four core components include:

Idealized Influence

Charisma that reflects high standards of ethical and moral conducts and behaviors that assist the followers to identify the leader as trusting, respected, and admired. This influence gives them a sense of vision and mission, belonging, pride, and gain respect and trust (Bass & Avolio, 1994; Bass & Riggio, 2014).

Inspirational Motivation

Reflects the leader's ability to infuse enthusiasm and optimism; to generate motivation towards common goals and communicate high expectations while being able to provide encouragement even through challenging times. Team spirit is aroused; enthusiasm and optimism are displayed (Bass & Avolio, 1994; Bass & Riggio, 2014).

Intellectual Stimulation

IS can provide methods and opportunities for open dialogue for creativity for new ideas, strategies, and approaches. Creativity is encouraged. There is no public criticism of individual's mistakes. The leader is not the one themselves being creative but allowing

for the environment and group being able to come up with new ideas (Avolio, 2010; Bass & Riggio, 2014).

Individualized Consideration

The leader's ability to accept individuals' differences by promoting two-way communication and personalized relationship considerations to help them to achieve higher levels of success or potential. In this dimension, the leader accepts responsibility to develop the uniqueness of other's potentials yet be unique themselves as leaders. The leaders delegate tasks as a means of developing the followers (Avolio, 2010; Bass & Riggio, 2014).

Other Transformational Leadership Research

Burns and Bass and their associates' work continued further research into transformational leadership theory. Two other researchers developing their leadership model around these transformational leadership principles arose: James Kouzes and Barry Posner. Their research has extended more than 40 years. Their Five Practices of Exemplary Leadership Model has been studied in more than 500 doctoral dissertations and academic research projects over the years (2003-2019).

According to Kouzes and Posner (2003), leadership is a relationship. A relationship between those who wish to lead and those who wish to follow. The Five Practices of Exemplary Leadership has five components. These are presented here:

Model the Way

Personal credibility. Leaders model the way by finding their voice and setting an example. They do what they say. They build commitment from their followers by simple,

daily acts that create progress and continue building momentum. Being there in times of chaos and uncertainty by their side (Kouzes & Posner, 2003).

Inspire a Shared Vision

The leader is driven by their clear image of the future and the possibility of what the organization could become. Enlisting others to join in this common vision. Leaders passionately believe that they can make a difference. The vision becomes our vision (Kouzes & Posner, 2003).

Challenge the Process

Leaders challenge the existing organization and/or culture by experimenting, taking risks, and learning from mistakes. The status quo is unacceptable. These leaders innovate, grow, and improve their work environments. Leaders are learners. Change can be difficult, even stressful. Leaders create the team to be hardy; to be able to handle the changes. This is accomplished through an infusion of energy, small constant steps, and the celebration of small wins. This in turn, builds the team's confidence and when that big challenge arises, the team with the leader, gets things done (Kouzes & Posner, 2003).

Enable Others to Act

Leadership is a team effort. Leaders use the word "we" instead of "I" three times more when describing their leadership experiences. Leaders foster collaboration, trust, and empowerment by strengthening others and helping them to exceed even their own expectations (Kouzes & Posner, 2003).

Encourage the Heart

Even though leaders set high standards, the best leaders celebrate and continuously recognize contributions and reward values and victories along the way. Genuine acts of caring go a long way to uplift the spirits and lead the followers forward (Kouzes & Posner, 2003).

Kouzes and Posner (2003) believe that leadership cannot be learned and is a r more powerful deterrent to its development than is the nature of the leadership process itself. Formal training and education can help the leader. Many leadership skills can be successfully learned in the classroom. Training alone is insufficient. The best learning comes from trying, failing, and learning from mistakes. Ultimately leadership development is more self-development. If there is one singular lesson learned from the work of Kouzes and Posner it is: Leadership is everyone's business.

Transformational Leadership and Nursing

Transformational theory has been studied more extensively than other theories in nursing leadership research. Transformational leadership is shown to be linked to the success of healthy work environments. (Diggins, 2016; Jones et al., 2017; Kelly et al., 2011; Mannella et al., 2018; M. Pearson, 2020; Porter-O'Grady, 2009; Robbins & Davidhizar, 2020). The theoretical framework contends that transformational leaders are committed, have a vision, able to empower others through this vision, and have a higher set of morals, compassion, and influence. Yet, the transformational leader must also have traditional management skills and continue to be focused on productivity and efficiency (Avolio et al., 2009; Cowden et al., 2011; Cromwell, 2016; Duffield, et al., 2011;

McIntosh & Tolson, 2009; Saleh et al., 2018). Transformational leadership behaviors are considered positive and have characteristics such as intellectual stimulation, inspirational motivation, individualized considerations, and a positive influence that allows for followers to identify with the leader. Transformational leadership in nursing studies have not explored the experiences or personal perceptions of transformational leaders (Kramer et al., 2009; Linton & Farrell, 2009; Upenieks, 2003a, 2003b). The collection of qualitative research in nursing has few studies that gain knowledge in the experiences of transformational leadership in nurse leaders.

Benner (1999a, 1999b) an early adopter of qualitative research in nursing studied clinical leadership in the intensive care units (ICU). She found clinical leadership tends to concentrate on monitoring quality, managing breakdowns, skilled “know how”, and coaching and mentoring of clinical staff to improve patients’ needs. The skilled know how focuses on facilitating clinical development; responding and anticipating patient needs and transitions to different levels of care; and building the many collaborative relationships needed in healthcare. The current study will explore front-line nurse leaders and their perspectives on caring for their immediate staff. Benner’s study encouraged the use of qualitative research in nursing leadership. Another qualitative study by Uhrenfeldt and Hall (2007a, 2007b) in Denmark, using a hermeneutic phenomenological approach found that Benner’s study further demonstrated characteristics coinciding with those of transformational leadership.

Transformational characteristics link ethical principles with critical analysis and moral judgement (Bass & Riggio, 2014; Rosser et al., 2017). Uhrenfeldt and Hall (2007a,

2007b, 2009) constructed thematic concepts such as: listening, empowering, conflict resolution, teamwork, trustworthiness, and communication in their study with front-line nurse leaders. These interviews also voiced dominant themes of nurse leaders being role models, motivational, instrumental in staff development, assisted in the creation of the organization's vision, worked well under stress, and expectations to manage complex changes. These concepts coincided with findings from other studies developing the theory of transformational leadership (Atsalos & Greenwood, 2001; Cummings et al., 2008; Drenkard, 2013; Graham & Jack, 2008; Sorenson et al., 2008).

The Multifactor Leadership Questionnaire (MLQ) was developed from the work of Bass and Avolio (1994), Avolio et al. (2009), and Avolio (2010). There have been multiple studies adding to the context and reliability of their tool since its inception. Studies using the MLQ have focused on staff nurse perceptions of their managers looking at styles and outcomes. Conclusions from these quantitative studies were that leaders who function in a more operational capacity, being an assistant unit manager and below, are considered less transformational and rated as less satisfactory as leaders. In addition, the more discrepancy between a self-rating and the rating of the staff correlated with lower satisfaction with the leader overall (Andrews et al., 2012; Antonakis et al., 2003; Avolio, 2010; Casida & Pasher, 2011). Leadership attributes were also directly related to staff nurse satisfaction and the intent to stay on the job (Cowden et al., 2011; Lavoie-Tremblay et al., 2016; Perry et al., 2018).

Additional examination of transformational theory and nursing leadership was completed by Stanley (2006a, 2006b) who used a grounded theory approach to identify

and analyze the experience of being a clinical leader. The study ran from 2001-2004 and explored the qualities and characteristics of the clinical leaders. These findings added to the same elements and concepts of a sound clinical leader: clinical competence, clinical knowledge, effective communication, decision maker, empowerment/motivator, openness/approachable, role model, and visible. Th study did not examine how to develop the elements based on the experiences of the transformational leader.

In summary, this well researched leadership theoretical construct is viewed as important, even critical, in the development of successful nurse leaders in healthcare. There is a research gap understanding the experiences of becoming a transformational leader in nursing. The framework of transformational leadership may equip the emerging nurse leader in developing positive and successful attributes and behaviors to lead our next generations into the future. There was no conclusion on which theoretical and empirical frameworks are best for developing the nurse leader. This study will explore whether the transformational theoretical framework may enhance personal development and leadership skills through nurse leaders' journey of leadership.

Healthy Work Environment and Nursing

The definition of the Healthy Work Environment was best described by the American Association of Critical Care Nurses (AACN) publication, AACN Standards for Establishing and Sustaining Healthy Work Environments in 2005. This publication became the model for critical care work environments and the goal of the prestigious Beacon award. The Beacon Award is awarded by the AACN and demonstrates the excellence of the six standards for the development of a healthy work environment. These

standards are as follows: skilled communication, true collaboration, effective decision making, appropriate staffing, meaningful recognition, and authentic leadership. All these standards must be established together; meaning, no standard is more important than the other, although authentic leadership has been called the glue which holds together healthy work environments (Lavoie-Tremblay et al., 2008; Lavoie-Tremblay et al., 2016; Shirey, 2009; Vaughn & Slinger, 2013).

Wong and Laschinger (2013) explored leadership regarding the healthy work environment proposed by AACN (Wong & Cummings, 2009; Wong et al., 2010). Although the influence of leadership style on empowerment and job satisfaction is well documented, there are few researchers who examined the influence of the leader's experience on developing the staff nurse's empowerment and work satisfaction in these healthy work environments. What is known is that even when an organization recognizes that development of interventions enhancing the leadership of nurse leaders to create healthy work environments, there is little empirical evidence on how to do this.

Another example of a healthy work environment is the Magnet designation. The attainment of Magnet status means there is an assumed healthy work environment in the organization. The most important goals of Magnet hospitals are to create supportive, professional patient care work environments, there have been researchers concluding that even non-Magnet hospitals can create these types of work environments (Trinkoff et al., 2010). A subsequent study by Kelly et al. (2011) found that there are significant differences in Magnet hospitals: better work environments, higher education of the nursing staff, less dissatisfaction with job roles, and lower levels of nurse burnout. In this

study, researchers gathered secondary data from four states using 26, 276 nurses in 567 acute care hospitals. Their study did not specifically study nursing leadership as part of their research. This led to a belief that there must be something other than just the structures needed to create a healthy work environment. The conclusion is that there must be a nurse leader who encourages, creates, and supports the environment that fosters excellence, passion, and professionalism. Most often, these types of Magnet environments are linked to the presence of transformational leadership (Aiken, Buchan et al., 2008; ANCC, 2019; Clavelle et al., 2012; Drenkard, 2013; Houston et al., 2012; Pinkerton, 2008; Upenieks, 2003a, 2003b). Three decades of research demonstrated evidence for superior outcomes noted by the Magnet processes and credentialing (Aiken, Buchan et al., 2008; Aiken, Clarke et al., 2008; Drenkard, 2010; Kelly et al., 2011; Trinkoff et al., 2010). Despite these superior outcomes, Clavelle et al. (2012) found that even though transformational leadership remains a core component of the Magnet model, the practices of CNOs in Magnet organizations have not been widely studied. The Magnet designation requires that the Magnet CNOs must have transformational and relationship-based leadership traits, yet we know little about the lived experiences of these leaders and how they came to acquire these traits (Cromwell, 2016; Drenkard, 2013; M. M. Pearson, 2020; Pilat & Merriam, 2019; Shaughnessy et al., 2018;).

Studies have been published with the research focus on leadership aspects of healthy work environments such as Magnet. Upenieks (2003 a, 2003b) came to similar conclusions of the leadership model being consistent in Magnet work environments with a qualitative study of sixteen nurse leaders from Magnet and non-Magnet institutions.

Two topics were specifically explored: nurse leaders' perceptions of the value of their roles and how those perceptions differ between roles and organizational settings and how gender interfaces with leadership success. The findings of the study encouraged and brought about the ideas that Magnet work environments were more likely to be successful with the presence of a transformational leader.

A comprehensive systematic review of development and sustaining nursing leadership that enhances and fosters healthy work environments was published in 2007 (A. Pearson et al., 2007). This comprehensive review examined characteristics of healthy work environments such as: positive health and well-being, job and role satisfaction, desirable recruitment and retention rates, low absenteeism, low injury and illness rates, low turnover, and low involuntary overtime rates. In addition, the study focused on positive inter-staff relationships, low unresolved grievance rates, opportunities for professional development, low burn out and job strain, participation in decision making and control over one's practice and work role, evidence of strong clinical leadership, demonstrated competency, and positive perceptions of the work environment including perceptions of work-life balance. The purpose of A. Pearson et al.'s study concentrated on the findings of the qualitative inquiries that were comparable in a meta-analysis using the Joanna Briggs Institute-Qualitative Assessment and Review Instrument and the Joanna Briggs Institute-Narrative, Opinion, and Text Assessment and Review Instrument. Results and themes of the meta-analysis are as follows:

- Collaboration can increase outcomes for staff and patient and result in the creation of a healthier work environment;

- Leaders who continue to further their education and gain a “sound knowledge” of leadership principles can develop the necessary skills to improve the work environment for their staff;
- Leaders who show characteristics associated with emotional intelligence are more likely to have a positive impact on staff, patient, and organizational outcomes;
- To help improve their role in leadership, leaders should continue with their own professional development;
- An important part of the leadership role is encouraging staff to undertake professional development activities;
- Leaders who exhibit certain qualities and behaviors are likely to produce positive outcomes for staff and patients. These qualities and behaviors include being a motivator, a supporter, a listener, being honest, and being a provider of information (communicator);
- A supportive structure within an organization that can benefit people in leadership roles and assist them to provide support of their staff).

The implications of this meta-analysis supported the positive outcomes in staff and patients when a healthy work environment was created. This comprehensive review focused much on the satisfaction of staff and not on the variables such as nursing leadership, quality of care, recruitment, and retention rates that resulted in overall quality patient care.

The Institute of Medicine's 2004 report titled *Keeping Patients Safe: Transforming the Work Environment of Nurses,* determined that the following evidence-based management components were essential for effective leadership in healthcare organizations: balancing the tension between production, efficiency, and reliability; creating and sustaining trust throughout the organization; actively managing the process of change; involving workers in decision making pertaining to workplace design and work flow; using knowledge of management practices to establish learning organizations. The IOM recommended that nursing leadership was not only fundamental to patient safety but that all levels of nursing leadership participate in executive decisions and utilize evidence-base management practices. Magnet organizations are learning organizations and built with trust, managing change, and empowerment of the staff. Cromwell (2016) found that linear leadership was found not to be compatible with the Magnet paradigm of structured empowerment, self-governance, and an expectation of innovation.

In summary, the empirical evidence supports of the creation of the healthy work environment whether it is a Magnet designated facility or not. The assumption that Magnet designated environments have healthy work environments in place has been researched. There remains the continuing question: How do we develop the nurse leader and equip them with the leadership skills necessary to create these healthy work environments in which the staff nurses thrive, the patients get the best quality care, and there is a sense of trust, stability, and empowerment?

Development of Skills to Become a Leader

Nurse leaders are often ill prepared for their roles in either clinical or administrative leadership roles (Pilat & Merriam, 2019). These leaders may assume their leadership roles without any academic background and/or lack of organizational support (Carney, 2009). Studies relating to the development of nurse leaders were examined in an exploratory study by Visterinen et al. (2009) found five categories that developed into different leadership styles of thirteen nurse managers. Open-ended interviews led to the development of these leadership styles: coaching, affiliate, visionary, democratic, and commanding. This study found factors that influenced these leadership styles: earlier supervisors, values, employees, education, information, and cooperation. The main conclusion of the study was that future research could focus on how nurse managers may be educated to reflect on their leadership styles, the effect on their employee outcomes, and their work.

Other studies focused on the development of clinical leadership skills which are generally identified as the first level or step towards the higher-level leadership roles such as the clinical unit manager or director over multiple clinical units. Lacey, et al (2012) defined clinical leadership as the expert nurse who leads patients to better health care. The clinical leader is often the one who has seniority at the time of promotion not necessarily the leadership expert skills. D. Burns (2009a, 2009b, 2009c) wrote a three-part series discussing the findings from a phenomenology study in the United Kingdom using twelve one-on-ones in depth interviews. The first part of the study (2009a) presented perceived skills and attributes of clinical leaders. The focus was on the

experiences of these front-line leaders-charge nurses. The skills perceived to be needed as a first line leader were identified as: knowing the role; doing the job; clinical or knowledge expert; problem solver; effective communicator; and developer of others. The desired attributes were as follows: legitimate, recognized, and respected; dynamic and driven; and visioning, approachable, and non-judgmental. All participants in the study believed that the clinical leaders should also have a strong clinical background, be well educated, and experienced in their clinical field, thus the status of an "expert." This study discovered that having skills needed for success, were skills such as "political astuteness" and "strategic influencing". The second part of the study (2009b) concluded that there are two main categories important to the success of a front-line clinical leadership: role development, organizational structure, and culture.

Further factors influencing the role development of front-line clinical leadership emerged after discovering the following themes: training and education; increasing confidence; increasing clinical skills; increasing autonomy; increasing standards of care; being able to and wanting to lead personal drive and motivation. Organizational structure and culture factors that influenced the nurse leaders' leadership development were found to be that of workplace environment, communication, being "allowed to", and recognition by others that they are a leader. The development of the skills and knowledge necessary for success was achieved by attending educational courses. Many participants believed that people must be equipped with leadership skills. Most of the leadership courses were focused on how to manage acute or chronic diseases rather than personal or professional development courses. The third part to the study (2009c) went one step

further to define the leadership mechanisms that supported the development of the participant's leadership skills. These mechanisms were: peer support, guidelines, protocols, and frameworks, perceived clinical leaders, informal nurse mentors, local and national guidelines, and protocols to follow, and manager colleagues. Needs identified by the participants for increased organizational support were items such as identifying the clinical lead when working, a local group of peers with common interests, greater recognition of the need for leadership skills, increased access to education and training to develop those skills, and more opportunities to network and discuss for the nurse leader's development including protected time and time away from work to reduce feelings of isolation. D. Burns (2009c) summarizes that leadership development is an ongoing, interactive practice between the clinical leader and co-workers that is complex and not yet fully understood. The study overall concludes that while it is important for nurse leaders to attend leadership educational offerings, education alone may not be the only factor in a leader's success. As well, the leader may not have the ability, skills, or the experience to overcome the multiple organizational and personal barriers to be successful.

Curtis, Devries, and Sheerin (2011) concurred that the taking on of a leadership role by itself is not sufficient for success and that leadership should not be viewed as optional for nurses. Leadership development must exist in every healthcare facility attempting to effect change, quality of standards and care, and providing the best care for the patients. The purpose of the study was to explore core factors that contribute to nursing leadership development especially those of academic, specifically, undergraduate

nursing programs. The findings suggested the continued gap between education and the leadership demands of the clinical setting (AACN, 2007; Cummings et al., 2008; Heller et al., 2004;). In the second part of their study, Curtis, Sheerin, and DeVries (2011) continued to explore the role and impact of training and education on nursing leadership particularly in relation to the concept across curriculums. Their research study concluded that where leadership has been integrated into curriculum, it can have a positive and continued effect on the nurses' leadership skills and practice. For best practice, the study suggested that when a health care organization continues to develop and support leadership training, they can maintain, improve, promote, and continue the development of nurse leaders.

Carney (2009) investigated several nursing leaders' belief that academics has moved too far away from their clinical roots. Additionally, these nurse leaders perceived a current need for education in leadership skills to best prepare them for their new and future roles as nurse leaders. Leadership and interpersonal skills are required for successful healthcare organizations' futures and the outcomes of patients and their families. Furthermore, the heightened need for gathering data regarding experiences of nurse leaders may be concluded from this study. Education or training may be perceived as important experiences in the development and preparation for future nurse leader roles

Nursing Themes Discovered Through Qualitative Studies

The literature review discovered 821 studies yet only 13 that specifically used phenomenology or researched nurse leaders' experiences. Of these 13 studies, five studied the lived experience of the nurse leader. Eight more of the qualitative studies

using phenomenology studied the perceptions and experiences of the staff/followers of the nurse leaders. A few of the studies were concerned with the role transition or retention and satisfaction of the nursing staff. Three of the five studies with true lived experiences of the nurse leader themselves found in the literature took place outside of the United States.

The first of these studies presented in this next section is that of Sherman (2005). Sherman conducted a qualitative study involving focus groups with 48 nurses under the age of 40 who were not yet in formal leadership positions. The participants were asked questions using a ConCensus process that looked to identify factors that influenced their decisions to accept or reject nursing leadership positions. The nurses were from 14 different health care agencies in southern Florida. The study also wished to look at the factors influencing the younger generations i.e., Generation X and the Millennials. The study design and concurrent themes that were explored had similarities to the purpose of this study. The resulting themes were developed under seven headings. The first theme was termed major role responsibilities of nursing leader's today. These role responsibilities were ranked by priority by the focus group participants: Providing a safe environment of care for patients and staff, staffing (recruitment, retention, and scheduling), serving as a resource to staff members, motivating staff, delegation of patient care, educator, mentor, operational organizations of the unit, outside liaison to other units and departments, and the community, managing administrative issues, and managing the budget).

Sherman analyzed and put into ranking perceptions of negative feedback about the role of a leadership position: the roles are stressful, the power of the administration and the lack of power of nursing leaders, unrealistic expectations in the role, budget constraints, lots of responsibilities, too much paperwork, long hours for not much money, time consuming, no time for work-life balance, lack of support from peers, and lack of job security). Other themes that emerged were around incentives and fears about taking leadership positions. Ranking of incentives are as follows: ability to make a difference, personal growth, professional experience, money, being a mentor, status, and weekday schedule. Fears about taking a leadership position were ranked as: compensation, lack of control over decision making, too much responsibility, lack of support from administration and staff, work-life stresses, inability to please everybody, fear of failure in the role, job security, and loss of clinical skills. The ranked role of themes around nursing leadership by the focus groups: cohesive administrative staff, competent and available nursing staff, better nurse-to-patient ratios, ability to serve as a mentor to other nurses, true power delegated from administration, budget control, perks, and compensation commensurate with the role, positive staff interactions and attitudes, and less pressure in the role. The important outcome from this study is the theme ranking-the support a young nurse leader needs to move into a leadership role: mentorship, administrative support, education about being a leader, self-confidence, support of the nursing staff, family support, and elimination of barriers to move up into nursing leadership positions (Sherman, 2005).

The implications from this decade old study are that the needs have not changed for the emerging nurse leader. Though we can educate in the academic setting, the new nurse leader continues to need support, mentorship, and education in the transition to a nurse leader position. Sherman (2005, 2012) stressed that the future of nursing leadership could be in jeopardy unless we develop, promote, and mentor our young and current leaders into leadership roles.

Linton and Farrell (2009) conducted a phenomenological study on the perceptions of leadership by intensive care unit (ICU) nurses. The five themes described from the study were the experience/phenomenon of the followers of the nurse leaders not from the lived experience of the nurse leaders themselves. The themes were as follows: leading by example, communication, ability to think outside the management square, knowing your staff, and stepping up in times of crisis. Findings and suggestions for future research from this study were the importance of nursing leadership and the need to ensure current and future nurse leaders are adequately prepared for this role.

Saleh et al. (2018) was a current study using a hermeneutic phenomenology approach that was completed in Saudi Arabia. This study used semi-structured interviews with 35 staff nurses. The staff nurse participants were from across the world; a delimitation of the study was the various cultural differences in the leaders and the staff. There were 4 types of leadership styles discovered with this group of staff nurses: relational, preferential, communication chain, and ineffectual. None of these leadership styles were viewed through any specific theoretical frameworks such as transformational leadership theory. Some conclusions attributed to this study by Saleh et al. was that the

style of leadership employed by nurse managers has a major impact on nurse's satisfaction, turnover, and the quality of patient care they deliver. Further conclusions were: 1) Nurses wanted to work for managers who can display effective leadership competencies; 2) Members of the nursing management team should be cognizant of their leadership styles; 3) Leaders should develop a strong relationship with the staff nurses to earn their trust, increase job satisfaction, and decrease turnover; and 4) Open and direct lines of communication are very important.

The most recent study conducted during the timeframe of this study's research, explored the live experiences of staff nurses transitioning to the nurse manager role (Pilat & Merriam, 2019). This study focused on the pathway from staff nurse to the nurse manager role. The study explored the experiences of 10 nurse managers that had been in their role for 6 months or had a previous transition from staff nurse to a leadership position. The average tenure of the participants in their role was five years. Findings of this phenomenological study revealed five themes with subthemes. The most significant finding from this study not only as the researcher of this study, but to the author's as well, was a theme called Role Mastery not Possible. Ten of the 10 participants voiced they not only were "not at role mastery", but that they may never be able to achieve it. The primary recommendation from the study was to further explore the lived experiences of transitioning to a leadership role to gain a better understanding of why and how a developmental onboarding may support and facilitate achievement of role mastery in the nurse manager role.

Summary

In summary, the intention of this current research study was to capture the lived experience of the nurse leader. The literature presented the most researched theoretical construct for the nurse leaders is that of transformational leadership. This framework has its role in the importance of the creation of healthy work environments and the ability to empower, attain increased staff nurse engagement, and promote satisfaction in their work. One research study did not support the relationship of transformational leadership to Magnet status nor to that of the healthy work environment. This study concluded that leadership styles appear to be more related to personal attributes rather than organizational context (Anderson, 2011). The literature review demonstrated the many quantitative studies using measurement tools such as the MLQ, LPI, and the MSCEIT. One qualitative study developed themes of the new and emerging leader and suggested the need for leadership development and skills (Sherman, 2005). The latest study developed themes of transitioned nurse managers that suggest that role master may never be achieved (Pilat & Merriam, 2019). The dilemma of leadership succession was acknowledged as well (Burke & Erickson, 2020; Sherman, 2005, 2012). Even though many experts in the literature suggest there is no quick fix for developing future nurse leaders, there continues to be forward progress as the journey continues (Cummings et al., 2008; Lavoie-Tremblay et al., 2008; Lewis, 2015; Pilat & Merriam, 2019; Shaughnessy et al., 2018).

There was consensus in the literature that nursing leaders are crucial, especially those in the front-line positions. Nurse leaders are not only crucial in the creation of

healthy work environments but in the satisfaction and retention of nursing staff. The literature suggests the need for further research considering greater understanding of the experiences and influences that will not only assist the nurse leader in their role yet encourages these roles as more desirable and attractive as a career option. Qualitative methods are essential for understanding the experiences of nursing leadership. As the profession has noted for decades, nursing leadership has been an intriguing and somewhat elusive concept for researchers. There continues to be a research gap in the knowledge of leadership lived experience. This current study pursued through a phenomenological method the exploration of lived experiences of nurse leaders in Arizona to assist in filling this research gap. The next chapter discusses the research design of this study pursuing the lived experience of a nurse leader.

Chapter 3: Research Method

The purpose of this study was to explore the lived experiences of nurse leaders in the state of Arizona. This chapter presents the research plan for the use of hermeneutic phenomenology as the methodology for this study. The underlying lens of inquiry was constructivism (see Denzin & Lincoln, 2017; Merriam, 2009; Stake, 2010; Yin, 2011). Constructivism is used when the researcher wishes to investigate individuals' or a group's experiences and is interested in a holistic approach to seeing how participants interpret their experiences. The framework of constructivism was the most appropriate framework to use in this study due to my ability to seek understanding of nurse leaders' lived experience in the world of health care (see Creswell, 2013; Denzin & Lincoln, 2017; Lincoln & Guba, 2005; Moustakas, 1994).

Qualitative research focuses on the meaning of real-life events not merely the occurrence of these events. Qualitative researchers tend to spend a lot of time in the setting of the study (Gay & Airasian, 2000; Ravitch & Carl, 2016; Yin, 2011). Qualitative research relies on human perceptions and understanding (Ravitch & Carl, 2016; Stake, 2010). The hermeneutic tradition is used to investigate the meaning and understanding of lived experience by asking complex, multi-textual questions that require inductive thinking and involve exploration and discovery (Marshall & Rossman, 2014; Moustakas, 1994; Ravitch & Carl, 2016; Silverman, 2013).

The five most common qualitative approaches were considered, and the choice was made to use phenomenology for this study. Using face-to-face interviews, I sought thick descriptions of participants' lived experiences to represent the nurse leaders'

experiences. Data were analyzed to identify themes regarding the experiences most likely to influence the nurse leader in their leadership development. The need for leadership development in the profession of nursing has been identified in the literature, as well as the need for increased social change in the lives of patients (Linton & Farrell, 2009; Pilat & Merriam, 2019; Saleh et al, 2018; Sherman 2005, 2012).

Chapter 3 presents the research procedures including participant selection and the sampling design. The study participants' profiles are presented followed by the decisions regarding the population of participants and how they were accessed, the sampling strategy, how they were recruited, the inclusion criteria, and how their confidentiality was protected. In addition, this chapter addresses prior research to provide the best and most up-to-date procedures used to develop and implement semi-structured interviews with purposeful sampling of the population of nurse leaders. The role of the researcher, which is unique in qualitative studies, is examined in detail. Any personal relationships or biases are addressed, as well as how they were handled to keep the study free from conflict of interest. Ethical components of the study, especially the use of individual interviews and observations, are discussed, including the measures used to prevent ethical violations.

Last, there is an analysis and summary of the methodology, research design, research questions, and expectations of the research process. The important constructs of validity, credibility, and dependability regarding the data are addressed, as well as the use of triangulation methods to strengthen the data and decrease the potential for personal and professional bias of the researcher (see Cho & Trent, 2006; Creswell & Miller, 2000; Denzin, 2009; Denzin & Lincoln, 2017; Flick, 2014; Lincoln & Guba, 1985; Mehra,

2002; Miles et al., 2014; Ravitch & Carl, 2016; Schwandt, 2015; Stark & Brown Trinidad, 2007; Toma 2006, 2011). Willis et al. (2008) suggested that a critically conscious researcher may challenge the confines and barriers of well-known cultural and organizational assumptions and structures to induce social change and transformation. The nursing profession is ready for such a transformation.

Research Design and Rationale

Research Questions

RQ 1: How do nurse leaders in Arizona make meaning of their leadership experience?

RQ2: How do nurse leaders prepare themselves for leadership roles in nursing?

Definitions of the Central Concepts and Phenomenon of the Study

The intention of this study was to study the experiences that influence nurses to become leaders and to determine what preparation molded the nursing leaders for their roles as leaders. In addition, I explored how participants' lived experiences were similar so findings could be used to develop leadership training. To clarify the concepts studied, I provide clear definitions of the factors related to preparation for leadership in nursing roles.

The purpose of this study was to explore the meanings of the lived experiences of nurse leaders in Arizona. I investigated the feelings, descriptions, explanations, and understanding of a natural phenomenon, in this case the experiences of the nurse leader. The purpose was also to allow certain voices to be heard. These voices are better understood by talking directly with the people involved, by observing them in their work

environments and personal lives, by listening to their stories, and by allowing them to talk unencumbered by previous literature findings or biases. Researchers cannot always separate what people have said from the place in which they said it; therefore, researchers study participants within their families, homes, schools, or work environments. Qualitative research is also used for the development of theories when either partial or inadequate theories exist for certain populations or samples. One of the reasons to use qualitative methodology is when the interactions, thoughts, and experiences are hard to capture with the use of quantitative methods. Quantitative measures and statistical analyses were not appropriate for the current research questions. In qualitative research, the participants and the investigator own the collected data (Creswell, 2014; Merriam, 2009; Miles et al., 2014; Ravitch & Carl, 2016; Yin, 2011).

Qualitative researchers perceive that there is a gap of knowledge regarding the phenomenon being studied, and they also presume that findings cannot be generalized to the general population. As the qualitative researcher reviews the literature and theoretical frameworks relevant to the phenomenon being investigated, the qualitative researcher needs to make judgments as to what is known and not known to proceed with the investigation (Chenail, 2010). Qualitative methodology is used to explore and create new research designs (Creswell et al., 2011; Stake, 2010). In the current study, the literature review indicated a gap in knowledge about the lived experience of nurse leaders.

Qualitative research is the attempt to understand human experiences, actions, practices, and values. Human actions, emotions, and thoughts are considered performances. Humans identify these actions as understanding. Their words are often

used to describe patterns of actions, feelings, and thinking. These are what some philosophers call thick concepts (Merriam, 2009; Patton, 2001; 2014; Stake, 2010). In pursuit of the meaning of the lived experiences of nurse leaders, I chose qualitative methodology to explore the perceptions of nurse leaders regarding their leadership decisions, on-the-job experiences, or educational pursuits leading to the decision to become a nurse leader. Qualitative research is not a monolithic approach to research and evaluation (Patton, 2001, 2014; Yin, 2011). Qualitative research may be suitable for exploring the phenomenon that allows researchers to understand people and their behavior in social, cultural, and economical contexts (Braun & Clarke, 2103a; Maguire & Delahunt, 2017; Hazzan & Nutov, 2014). I, as the principal researcher, sought to discover new categories of understanding and themes that describe the lived experience of nurse leaders. I explored the intersection between the personal and professional aspects of nurse leaders and how their perspectives and experiences influenced their leadership (see Braun & Clarke, 2021; Drenkard, 2013; Ravitch & Carl, 2016). Data were collected from 12 participants who were nurse leaders with at least 2 years of experience. The data collection tool was a face-to-face interview lasting between 60 and 90 minutes. The interview questions were developed by me, and I followed a protocol for consistency.

Analysis of the Methodological Approaches

After learning about the five most common qualitative approaches to research studies (narrative, ethnography, case study, phenomenology, and grounded theory), I chose the approach of phenomenology. The approaches have many things in common, one being that they all can be appropriate to answer a research question. The narrative

approach was not appropriate for the current research questions because the narrative approach is used to study only one individual's experience. The grounded theory approach involves coding and developing a theory. Grounded theory was not appropriate to employ to answer the current research questions. I did not seek to develop theory but rather sought to discover new themes and concepts through the lived experiences of nurse leaders (Braun & Clarke, 2006, 2013a, 2021; Creswell, 2007, 2013; Merriam, 2009; Patton, 2001; Ravitch & Carl, 2016).

The case studies approach was not appropriate due to the goal to interview many nurse participants versus studying one nurse leader in depth. The ethnographic approach was the closest other approach that could be utilized in this type of research study. This study is not a culture sharing group of nurse leaders because they have not yet experienced the same culture (the practice environments) or the same experiences (Creswell 2007,2013; Merriam, 2009; Patton, 2001; 2014; Ravitch & Carl, 2016). This left the phenomenological approach. After reflection on the different qualitative approaches, a phenomenological approach was appropriate for the phenomenon described, categorized, and in discovering the meanings of the experiences of these nurse leaders. Thus, the decision to use a phenomenological design and methodology approach was preferred.

In summary, the phenomenological approach is the most credible for this type of research. This research approach has the background and previous research needed to study the leadership experiences of these nurse leaders. The phenomenological approach allows the study of several individuals sharing similar experiences (see Creswell 2007,

2013; Creswell, 2009, 2014; Merriam, 2009; Moustakas, 1994; Patton, 2001; 2014; Ravitch & Carl, 2016; Yin, 2011). Phenomenology strives to be as faithful as possible to the lived experiences especially those described by the participants own words (Yin, 2011).

Role of the Researcher

The qualitative researcher is literally one of the research tools (see Braun & Clarke, 2021; Hazzan & Nutov, 2014; Yin, 2011). The researcher starts with their own experience of the study. In my role as a nurse leader and as the primary researcher, I may bring certain biases from my own experiences. The moderating of my bias was accomplished by using an objective and structured point of view when conducting my research. I did not allow my personal experience of my own nursing leadership to influence my research and focused on the participants in the study by adopting an interview protocol and questions. In my analysis of the data, I only transcribed the participants words and had the participants read over their summaries and quotes. For best results, the researcher should portray their authentic self and have a personal demeanor and rapport with the participants to encourage a free flow of thoughts (see Ravitch & Carl, 2016; Yin, 2011).

As the primary investigator, my role was to discover and explore the direct experiences of the participants by providing opportunities for these nurse leaders to reflect and discuss their personal experiences. In addition, my experience with these work environments allowed for the nurse leaders to volunteer more expert information that can teach us about the nurse leader phenomenon, and I needed to keep quiet and not offer my

opinions or own experiences (Hunt et al., 2011). There can be a special significance in the quality of qualitative research when the researcher has a personal affinity for the topics (see Braun & Clarke, 2021; Stake, 2010; Yin, 2011). As the primary researcher, I served as the means for exploring why the topic of nurse leadership and the framework of transformational leadership was important not only professionally but theoretically (see Ravitch & Carl, 2016). I served as the connection between the concepts and the core constructs of the framework and the study (Drenkard, 2013; Lofland et al., 2006; Vaughn & Slinger, 2013).

Methodology

As a qualitative inquirer, the plan for the intricate and sensitive data collection was deliberate and meticulous. The data collection plan included a protocol for the interview process, and follow up, the type of questions for inquiry, and a plan for addressing legal and ethical concerns.

The data collection technique used a focused, phenomenological approach for the identification of themes and brackets of understanding for this research study. I followed the phenomenological approach of analysis suggested by Creswell (2007, 2013) and Yin (2011), adapted from Moustakas (1994). In this approach of analysis, the researcher starts with their own experience of the study. This was accomplished to “set aside” my own biases and personal experience of the study to be able to better focus on the participants-in this case, the nurse leaders. The main forms of data collection were demographic questionnaires, interviews, recordings of the interviews, and researcher notes.

Participant Selection Logic

I was able to understand the natural settings of the participants and able to the comfort and experience with the in-depth interview process. The interviews were completed in a confidential area of their choosing. This made it meaningful for both the participants and me as the researcher. These intentional interactions increased the dialogic engagement and macro contexts of the research (see Miles & Huberman, 1994: Miles et al., 2014; Ravitch & Carl, 2016).

Miles et al. (2014) recommended that purposive sampling is appropriate when the researcher wants to study a small subset of the population when the enumeration of the entire population would be near impossible. The number of Arizona nurses is over 100,000 and the entire population of the state is 7.28 million (Unites States Census Bureau, 2022; Worldpopulationreview.com, 2019). A professional nurse leader organization was the participant pool that was approached. The Arizona Organization of Nurse Leaders (AzONL) typically has around 200 members yearly from across the state. This group of nurse leaders was chosen due to the qualifications of the members. Each member must be in a leadership position and have at least 2 years of experience in their respective leadership position. The membership is a state constituency of the national organization, The American Organization for Nursing Leadership (AONL). The members also represent nurse leaders from across the continuum of care-acute care, home care settings including community, public health nurse leaders, and academic nurse leaders.

Instrumentation

In this qualitative study, there was the commitment for a researcher developed instrument for the semi-structured interview questions. There were no research instruments available in the literature for this study. Interview questions are generally written and evaluated according to both thematic and dynamic dimensions. Thematically with concern to being able to produce the knowledge in quest, and dynamically with care to being able to enjoy the interpersonal relationship in the interview. Thematic questions relate to the how and what of the interview. These questions should advance the authentic interactions between the interviewee and interviewer by keeping the conversation flowing. All the questions were simple, easy to understand, and without difficult or academic language. In general, the "what" questions were asked prior to the "how" questions. This enabled the interviewee to be descriptive leading into the more introspective and reflective questions. "Why" questions are usually postponed towards the end of the interview. The interviewer who has a plan, knows what they're inquiring about, puts forth attempts to clarify and gave immediate feedback to the interviewee on their meanings and descriptions as the interview is occurring (see Brinkmann & Kvale, 2015).

This study's interview questions were developed from the focus of the journey from the nurse leader's first role to that of their current role. The interview questions were reviewed by an expert panel of qualitative researchers, my dissertation Chair and committee members. I chose not to have a pilot study due to time constraints.

Procedures for Recruitment, Participation, and Data Collection

Participant Pool and Sampling Size

In qualitative research, each participant is selected purposely for their contribution to the emerging theory the researcher wishes to study. The use of purposive sampling helps the emerging theory to be more complete, comprehensive, and even saturated. The use of purposive sampling also helps to allow the emerging concepts and themes to naturally occur (Chenail, 2010; Creswell, 2007, 2013). Yin (2011) suggests that purposely selecting participants that may have opposing views may decrease the bias of the researcher. Purposive selection may demonstrate that the researcher is not only interviewing participants that are confirming their preconceptions. Experiences arere categorized, sorted by experiences, or may discover new themes that can be further researched or developed. Fifteen voluntary participants from the AzONL were sought to acquire 12 participants for the study (Francis et al., 2010). These participants were recruited with the letter of inquiry through the organization's email membership list. The data collection tools that were most qualified for this type of study were the use of interviews, observations, and documents to provide for in depth inquiry of a smaller sample size (Creswell, 2007, 2013; Creswell, 2009,2014; Merriam, 2009; Yin, 2011). This study collected demographic questionnaires, and interview data with the nurse leaders who had experience from a nurse supervisor or early position of leadership with two years of experience to executive nurses with many years of practice and leadership to describe their experiences with leadership. Multiple sources of data collection increased the strength of the study (Yin, 2011).

Criteria for Inclusion

The criteria for inclusion into the participant pool was as followed: the participant must be a licensed Registered Nurse (RN) in the state of Arizona; have more than two years of experience as an RN; and be in a leadership role for at least two years. The leadership role must be that of a charge nurse or the first level of leadership in their specific healthcare or academic organization; a supervisor; clinical manager; nursing director or above; academic leadership role; or leaders in a community setting/organization, and they must be a member of the AzONL. I presented this proposal to the members of the organization at one of their quarterly meetings in the summer of 2020. Once the IRB approval was secured, I then contacted the members of AzONL through the interest letter to inquire if they would be interested in this study. The letter of inquiry to the nurse leaders is presented (see Appendix B). The participants had to be able to fill out the demographic questionnaire which was sent prior to the interview via email and be willing to sit for a 60–90-minute interview either in a confidential work setting, in their home, and by Zoom video conference call. The interviews had to be virtual due to the COVID-19 pandemic. The demographic questionnaire is presented (see Appendix G. The purpose of the demographic questionnaire was to collect the demographic data such as years of experience, level of education, position(s) held, age, gender, and other characteristics to make sure that the participant qualified for inclusion into the study and to add to the demographical statistical data about the participant pool. The participants had to be willing to be voice recorded by the researcher. The use of voice recording also assisted in the transcription and data analysis of the context of the

conversations and allowed for me to go back and relisten to the interview as many times as necessary to process and develop categories of understanding from the data collected (see Braun & Clarke, 2013a, 2021; Fonto & Frey, 2000; Janesick, 2015; Kvale & Brinkmann, 2009; Patton, 2001,2014; Richards, 2011; Yin, 2011).

Data Collection

As for the interviewing process, there was an established research protocol and exact set of interview questions that was followed for each participant to keep the structure consistent. In this research study, the interview process was followed respectively by the interview protocol (see Appendix E). The interview structure had carefully worded open-ended questions with the intention of allowing each participant to answer the same questions in the same order but allowed for flexibility in their answers. Yin (2011) suggests that the interview questions be memorized by the researcher so that it does not come across as a scripted set of questions. Yin referred to this as a "mental and private" framework from which to work. Qualitative interviews should be comparable to a conversation, as in a normal social relationship between two people. The interview was individualized to each participant. Creswell (2013) suggests the use of a team of consultants to assist in the development and review of the research tools that will be used in the study. This ensured validity was established and for the interview questions to be sufficient to answer the research questions since this was a researcher developed instrument. The participants were ensured the freedom to elaborate on their answers concerning their current lived experiences as a nurse leader (see Brinkmann & Kvale, 2015; Creswell 2013; Patton, 2001, 2014; Yin, 2011). These questions were

developed by me and reviewed by an expert panel of consultants of nurse researchers and Walden University's IRB. The list and credentials of the nurse researcher expert panel is included (see Appendix H).

The interview time with each participant was set for 60–90 minutes per session to allow for rapport to be established, a consistency in the patterns of questions, and time for the interviewee to elaborate, review, and reflect upon their answers before concluding. This kept the interviews focused and provided the framework; the participants were not expected to go into new subject matter during the interviews. In the event, they did go off topic, it was valuable information to add to the study, their responses were collected and added to the data analysis. In addition, the use of probing questions and follow up questions for each participant allowed for clarity and more in-depth exploration of the experiences (see Brinkmann & Kvale, 2015; Patton, 2001, 2014; Yin, 2011).

Another mechanism for gathering the interview data was the use of audio recording. The participants were presented a consent form for the entire process-interviewing, and the recording of the interviews so that I could gather all the information and not rely only on my field notes. The Consent to Participate Form from Walden University was presented to each individual participant with the purpose of the study and the procedures to be used in the data collection. The consent form included the protection and confidentiality of the participants and the opportunity to decline. The form included the interview and debriefing process for follow up for the participant after the study was concluded. I took notes during the interviews, but I also wanted to be able to be engaged with the participants and to encourage them and recognize their efforts. I found that the

Zoom interviews allowed for me to be able to take a lot of notes without the illusion of not being attentive to the participants. I planned to debrief with each participant individually after the study was completed to go over the findings of the research and how their experiences added to the overall thematic process (see Brinkmann & Kvale 2015; Creswell 2013). Once the interviews were transcribed, a summary of their interview was provided to the participants via email to allow them time and input to determine if anything was incorrect. In this manner, they are involved in the research as well.

Recording and Storing Data

The data collected, the interview notes, audio recordings, demographic questionnaires, and consent forms were placed on an encrypted flash drive and stored in a locked safe to protect for confidentiality. In addition, there was a checklist of the interview procedure to be completed and processed with each individual participant's interview. The text and contextual notes, demographic questionnaires, and even the audio recordings were scanned and saved via a computer and downloaded to an encrypted flash drive for further security and protection. The use of field notes to describe my experience as the researcher, observations, or personal thoughts were documented after each encounter with the participants. The interview notes and audio recordings were reviewed and transcribed to be re-reviewed and re-checked multiple times to categorize commonalities and themes for development and understandings of the experiences of these nurse leaders. These were cataloged on an encrypted flash drive. All textual and audio recordings were backed up and stored on an external hard drive. The confidentiality

and protection of each individual participant has been preserved by masking their names in the data and only initials were noted in the researcher journal (see Creswell, 2013; Stake, 2010; Toma 2006; 2011).

Data Analysis Plan

Once the 12 interviews were conducted, the data analysis plan commenced. There were demographic documents, interview notes, auditory recordings, and my field notes to transcribe, analyze, and code for concepts and brackets of similar meanings and understandings. The transcription of the interviews becomes the legitimate, concrete research. The written word from the conversations becomes the empirical data. The conversation becomes transparent and fixed and is considered "solid" (see Brinkmann & Kvale, 2015; Patton, 2001; 2014; Ponterotto, 2006; Richards, 2011; Toma, 2006, 2011). An eloquent, knowledgeable, and articulate text transcribed into the written language can be treated as repetitive and actually "boring" when sifted through time and again despite being read aloud. Nevertheless, the written transcription loses its tone of voice, emphasis, articulation, sounds, breathing, and pauses made by the participants. The written transcription can come across as empty, decontextualized translations of the once vigorous and spirited human interviewee's conversations. To assist in the deficiencies of the transcriptions, the use of audio recordings, note taking, and researcher journaling can be used to augment the data collected (see Braun & Clarke, 2013b, 2021; Brinkmann & Kvale, 2015; Patton, 2001,2014).

The data analysis was reviewed and coded manually. The data collected was reviewed and transcribed for content and thematic constructs several times by myself,

another research mentor, and my doctoral Chair and committee. The interviews were reviewed for the extent of voluntary, rich, valuable, precise, individual, and pertinent answers to the research questions. In addition, the context of the interviews was examined for the shortest and longest responses and to the degree that I needed to follow up, probe, or clarify the meanings of the interview. I also allowed for the interview to materialize into the truth, endorsing the self-reliant story from the participant and attempted not to interject any of my own intentions or biases into the translations. To make connections from the interview questions to the research questions, the detailed coding and thematic categories of the contextual and audio recordings were only used. After this process was completed, I conducted further literature review regarding any questionable findings and to determine if there had been current studies comparable to my study. The goal was to allow the data to reveal itself and to develop itself into categories of the nurse leaders' experiences and discussion of the concepts (see Braun & Clarke, 2006; 2013a, 2021; Brinkmann & Kvale, 2015; Patton, 2001, 2014; Ravitch & Carl, 2016; Stake, 2010; Toma 2006, 2011).

Issues of Trustworthiness

Trustworthiness or validity in qualitative research is both a process and a goal. The concepts of credibility, transferability, dependability, and confirmability were employed throughout the study to ensure the trustworthiness of the data collection and analysis. Attention to these issues early on and throughout the study were important to the integrity and validity of my research.

Credibility

Credibility was established by the implementation of the strategies of triangulation, member check in during the process, presenting thick descriptions, discussion of negative cases, and having a prolonged engagement in the nurse leaders' work environments and discussions. The participants were allowed the freedom to express their experiences and the data analysis made the meaningful inferences from their voices. The participants were given a summary of their interview and encouraged to provide feedback about the accuracy of my interpretation of the essence of their interview. The interviews were recorded ensuring increased validity. In addition, I examined the perspectives for more than one vantage point to see if there is a convergence from different sources (see Creswell & Miller, 2000; Denzin, 2009; Flick, 2007, 2014; Schwandt, 2015). I chose not to use an external transcriber due to the newer technology of Zoom virtual recordings and my ability to take copious field notes. The interviews were only identified to others besides me as Participant 1, Participant 2, and so forth to ensure confidentiality.

Transferability

The goal of this study was not to necessarily produce true statements that can be generalized to other settings or leaders but rather the goal was to develop descriptive, context relevant statements. The goal for other researchers to replicate this study is to transfer aspects of the design and findings by taking into consideration the contextual factors instead (Guba & Lincoln, 2005; Lincoln & Guba, 1985; Ravitch & Carl, 2016; Toma, 2006, 2011).

Dependability

Dependability is the stability of the data. Miles et al. (2014) referred to the data being demonstrated as dependable and stable if the data answers the research questions. My plan was to increase the dependability and validity of the data by making sure there was descriptive means and factual accuracy of the data. In addition, using interpretive means by matching between the meaning attributed to the participants' behaviors and the actual participant perspective (emic). Ricoeur (2004) calls this the insider's view-how the participant views their experience. Next, using a theoretical perspective means for the ability to explain the phenomenon of nurse leadership experience. Lastly, an evaluative means being able to describe and understand data without being evaluative or judgmental. In this manner, my field notes were central to the study. I ensured that I was careful about the data and the confidentiality of the interviews by using unique codes to identify the participants, keeping the data secure, and having back-up copies of my notes and the electronic files and recordings (see J. A. Maxwell,2005; Ravitch & Carl, 2016).

Confirmability

The component of validity is to establish trust, accuracy, and genuineness of the participants' data rather than being a biased interpretation of my own. In addition to having the participants review the summaries of their interviews, there was review of the data analysis by a select group of peer colleagues in my academic organization, a research mentor, and members of my committee to ensure that the data is what it is (Toma, 2006, 2011). This data collection also included my notes from the field notes. I, as the researcher, made a conscious effort to not make inferences, interpretations, and

assumptions. I stayed as true to the facts as possible. By having multiple reviewers, the influence of the results of the field notes were minimized, and the language of the participant's perspectives were natural to them and not of my wording or thoughts (etic) (see Emerson et al., 2011).

Ethical Procedures and Confidentiality

Despite best planning and proactive initiatives, ethical issues may still occur at any phase of the research. One of the most important responsibilities of the research inquirer is to strengthen all ethical procedures early on and all during the research process. As I conducted this qualitative research to study complex, personal voices of the experiences of these nurse leaders, I protected these same voices so that their anonymity was secured. Creswell (2013) suggested that the qualitative researcher be prepared to diminish any ethical concerns throughout the many phases of the research study. These stages were: prior to the study, beginning of the study, during data collection, in data analysis, in reporting the data, and in publishing and dissemination. In the first stage, prior to the study, it was unquestionably necessary to gather the approval of the Walden University's Internal Review Board (IRB). IRB Approval: 07-27-20-0198548. The first three chapters of this research study, known as the Proposal, was submitted to Walden's IRB for review and approval to collect the interviews as data, to conduct data analysis, and disseminate the findings. After the Walden IRB approval, the professional organization of the AzONL was contacted for permission to do the study with its members. I attended one of the regularly scheduled quarterly meetings and was a featured speaker to present the study, my need for voluntary participants, and my contact

information for further follow up. As the participants will be voluntary, there should not be any power issues to overcome as the interviews will take place in their place of employment or another place at their discretion, such as their home. I performed a quick review of the American Nurses Association (ANA) Code of Ethics to make sure that there are no violations in the ethical standards (ANA, 2015). In addition, all prior work done leading up to this project was given credit with proper citations and reference sections of the research study (Brinkman & Kvale, 2005; Creswell, 2013; Denzin & Lincoln, 2017).

The second phase, the beginning of the study, was to make initial contact with all the members of AzONL. I sent the inquiry letter as viewed in Appendix B, via email to all members of the professional organization. I gave them a timeframe of one month for decision making. Once they gave permission for further contact, then they were provided a Welcome Letter (see Appendix C). This letter repeated the nature of the study and reassured their anonymity and confidentiality. Before the data collection phase of the study, the participants were sent the Consent Form which was returned to me before any data collection started. The next step was the Demographic Questionnaire (see Appendix G), which I sent to them to be completed before their scheduled interview. Once the interview was scheduled, I reviewed the research gap for the study, the interview protocol, the participants' needs for the least distractions and sensitivity, and reviewed the informed consent and answered any last questions. The participants were reminded that they may drop out of the study at any time, how they may review their interview data, and go over the transcription if requested. I attempted to build trust and avoided

leading questions or disclosing any sensitive information to diminish preconceptions or bias in the participants' data collection. I did not want them to feel exploited or ignored in their very important discussions with me. I communicated only in straightforward and clear language (see Brinkmann & Kvale, 2015; Creswell, 2013, Merriam, 2009; Ravitch & Carl, 2016; Stake, 2010; Yin, 2011).

In the last phases, that of data analysis, reporting the data, and publishing and dissemination, there were actions for me to address any possible ethical concerns. As there were multiple interviews or perspectives, I was careful on reporting all results. For example, I was careful not to share similar viewpoints with a participant or expressing negative thoughts if I disagreed. Similarly, I avoided the presentation of only the positive interviews, or the ones that agreed with my theoretical frameworks. On the other hand, if the results presented a negative or harmful picture, I was considerably careful to protect their confidentiality and privacy. These interviews were a complex picture of the central phenomenon that this study wished to pursue. I reported only honest findings, using composite themes so that individuals cannot be identified, and did not falsify any evidence, authorship, or conclusions. As part of the research community of practice, I consulted with my Dissertation Chair and Committee members, my peer panel, and peer colleagues for any other suggested action or when confronted with an issue.

Summary

In summary, this chapter presented the nature of this inquiry, that of a qualitative study using a phenomenological methodology. After the exploration of the five common approaches to qualitative studies, phenomenology was determined to be the best

qualitative approach to capture the essence of the lived experience of nurse leaders. The 12 voluntary participants were recruited from a nurse leadership organization in Arizona to assemble the registered nurse leader participants needed for this study. The process for the recruitment and participant results are presented in detail in the next chapter.

Chapter 4: Results

The purpose of this study was to explore the lived experiences of nurse leaders to determine their similarities in preparation and successful experiences. The following research questions guided the study:

RQ 1: How do nurse leaders in Arizona make meaning of their leadership experience?

RQ2: How do nurse leaders prepare themselves for leadership roles in nursing?

This chapter reports the data collection process, demographics and settings of the participants, data collected, and data analysis. The data were coded to describe the nurse leaders' lived experiences. Each participant had their own unique lived experience, which was coded to identify similarities and reveal themes among the experiences. Findings from the data analysis include direct quotations from the interviews to demonstrate the trustworthiness of the data. Each research question was answered in the data analysis with attention to the credibility, transferability, dependability, and confirmability of findings. Quotations from the participants are presented to support a category or theme. This chapter also addresses any discrepancies or non-similar experiences and how these data were represented in the study findings. The findings of the study are summarized at the end of the chapter with an analysis of the factors that may have affected the data collection or participants' experiences during the interview process.

Setting of the Interview

The setting of the interview was decided upon by the participant. Due to restrictions on face-to-face interactions due to the COVID-19 pandemic, most leaders

were working from home during this time, and the interviews, once scheduled, went smoothly. Only two interviews had to be rescheduled due to unexpected conflicts, and all were completed within an 8-week period. The original plan was to meet with the participants in their preferred location, but the pandemic reduced the need for travel and minimized interruptions and multiple rescheduling of events. There were 12 nurse leader participants who gave consent to participate in this study.

Demographics

The qualifications to participate in this study were that participants must have been an RN for at least 2 years and in a leadership position for at least 2 years. The leadership position could be the first line of leadership as a charge nurse or lead nurse. The nurse leaders were chosen by purposeful sampling. They were all members of a nurse leadership organization in Arizona and were currently in a leadership role.

The 12 nurse leaders were all women (self-selected). Three male nurses initially expressed interested in the study, but they never followed through to the interview process. The ages of the 12 participants were between 50 and 77 years. The median age was 63.25 years. The most years of experience as an RN was 50 years with the lowest being 13 years. Two participants started their nursing career as an LPN, and one had a previous career before transitioning to the nursing profession. Eight participants became RNs as early as 20 years of age. The range of leadership experience was 4 to 50 years, with the average being 30.66 years of experience in a leadership role.

All 12 participants had at least a master’s degree. Seven of the 12 participants held a doctoral degree in various disciplines, with four being in nursing. The others were

in education, public administration, and health care administration. Another interesting statistic was that 6 of the 12 (50%) had been employed by or involved deeply with a Magnet Designated facility. Each participant had been in the state of Arizona at least 12 years of their professional career.

All participants had started in the acute care arena as new graduates. Almost all had been in a charge nurse position within their first 5 years of experience, yet most stated that they did not think of this as their first leadership position. Other first-time leadership roles were as follows: course coordinator in a BSN program, manager of an operating room, clinical coordinator of 10 homecare branches, cardiac rehabilitation manager, nurse practitioner lead, director of a prelicensure BSN program, and the supervisor of an intensive care unit. Leadership roles that the participants held at the time of their participation in this study were as follows: CNO, nurse administrator, clinical professor, senior vice president of care improvement, consultant preoperative services, senior operations director of a large university, director of clinical education of a large infusion company, consultant leadership, consultant education, director of care improvement in a statewide health care consortium, senior manager consultant services, supervisor of perioperative services, and campus president of a prelicensure BSN program.

Table 1

Demographics

Participant	Years of Leadership Experience	First leadership role (*after charge RN)	Highest degree	Current role
1	50	*Course coordinator-BSN Program	PhD	clinical professor
2	41	charge RN tele unit	MBA/MHA	SVP-care improvement (state/national level)
3	55	manager-OR	MHA	consultant-OR services
4	28	supervisor/10 homecare branches	PhD	director education-professional organization
5	50	charge RN-med/surg unit	DPA	consultant-education & leadership
6	41	*Adjunct faculty	MSN	director-healthcare organization-statewide
7	26	*Cardiac rehab mgr.	PhD	Sr.mgr-consultant organization-HWE/leadership
8	28	charge RN	MBA	chief nurse officer-large hc Organization
9	38	*mgr.-rehab unit	EdD	administrator-large Magnet, academic medical center
10	33	nurse practitioner	ND/DNP	sr. ops director-large academic organization
11	31	role/pre-licensure BSN program	EdD	campus president emeritus-academia
12	4	charge RN-ICU	MSN-L	supervisor-post-op areas, Magnet, academic medical center

Data Collection

Participants were invited to participate in the study through a nursing leadership organization in Arizona. The executive director of the organization signed an agreement with me to reach out to the membership through their membership list. Email addresses were used to send the inquiry letter (see Appendix B). In all, 123 emails were sent to the membership. Of the 123, eight emails were no longer valid, and one member responded that they were not an RN and would not qualify to be a participant. There were seven immediate, positive responses from members, but then the responses diminished. Of the seven initial responses, only one followed through to participate as an interviewee. At 10 days, the inquiry letter was resent to the membership who did not respond, and there were around 15 new responses. In continuing to follow up with these positive inquiries, I sent the Consent to Participate form. The respondents had to reply to the email "I consent." There were three from this next group who completed the Consent to Participate and the Demographic Questionnaire (see Appendix G). As I worked to process these four interested participants, I emailed 12 participants once again. These individuals had expressed interest in this study after my initial presentation to the professional organization of nurse leaders. Of these, 10 responded with interest and wished to proceed with the study. Many explained that they had either found the original email in their SPAM folders, or the emails had been lost in their many daily emails.

A Zoom account was set up for the sole purpose of providing a format for the interviews as the ability to do face to face interviews was no longer possible due to the COVID-19 pandemic. The participants were given multiple time options for a 60–

90minute interview session once they had completed the Consent to Participate and the Demographic Questionnaire. The times offered were early morning prior to their workday, during the workday, late afternoon, in the evening after 6:00 p.m., or during the weekend. The first participant was set up immediately and the interview occurred within a few days. The next three were then scheduled for their audio interview via Zoom within the first 3 weeks. The next few weeks were engaged in the process of completing the steps of the participant qualification process with eight more scheduled for a total of 12 interviews. I chose to have an end date with the participants once I had secured 12 interviews.

Data Analysis

Process

The process of collecting the interview data was as consistent as possible. The advent of the COVID-19 pandemic changed the process from its original plan as conducting face-to-face interviews to those of a virtual nature. The virtual platform chosen to conduct the interviews was a separate and private account on Zoom. This account was used exclusively for the purpose of conducting these interviews. The participants were scheduled for a one-on-one Zoom conference call for 90 minutes with the researcher-me. The meeting was recorded for each participant. Each participant was labeled Participant 1, Participant, 2, and so forth. No names were revealed. The environment was consistent as well-each participant was either at home or at their place of work which was usually an office setting with no other people involved. Except for

one interview (9/22/2020), I conducted the interviews in the same place-the dining room table with nobody else in the recordings.

The interviews being virtual enabled my ability to take notes and follow the interview questions carefully. Each interview lasted between 60 and 90 minutes. Each interview was audio recorded and uploaded to an encrypted flash drive. An audio recording summary was sent to each participant for their review to add additional perspective or clarification, as well as their meaningful statements listed in the results section of this chapter. The ability to listen to each recording was enhanced by the addition of some minor equipment; the flash drive could be listened to via mobile phone multiple times for further transcription of the data. The decision was made for manual, consistent audits, readings, and transcription by one person that would serve as the data transcription for later analysis.

Manual Transcription and Coding

The individual interviews were reviewed and analyzed via listening, reviewing transcription of the interviews, and reviewing audio notes multiple times to ensure the capture of the rich, thick descriptions and open-ended answers to the set of interview questions. Thematic analysis was used for the data analysis. This approach for analyzing qualitative data was first recognized in the 1970s by Merton (1975). The approach has been expanded on and fine-tuned to that of today- thematic analysis (Braun, & Clarke, 2006,2013a, 2021; Maguire & Delahunt, 2017; Terry, et al, 2017; Trainor & Bundon, 2021). Although thematic analysis can be used in a realist/essentialist framework, I chose to use it in this constructivist framework to build the themes from the multiple codes.

This analytic method may also be used to provide a descriptive overview of semantic meanings from the codes and develop them into more sophisticated interpretative analyses (Braun & Clarke, 2013a). The six phases of the thematic analysis approach are discussed in more detail in this next section of the data analysis.

The first phase of the data analysis was to familiarize myself with the data. This included the demographic documents, interview notes, auditory recordings, and field journal notes that were later coded for concepts and brackets of similar meanings and understandings. I absorbed myself into the data and read it over and over multiple times. I highlighted with a yellow highlighter the statements that seemed important to the participants' experiences and stood out from the page. I added notes into the margins of the transcriptions and would later refer to them in my analysis.

The second phase was to generate initial codes. This was another step in the visual immersion of the words, statements, and highlighted areas of the participants' words. The words and statements were first noted in a notebook and common statements started emerging as codes and were again highlighted with a pink and then blue highlighters. The codes are what they are—there are no right or wrong codes (Braun & Clarke, 2103a, p.20).

The third phase of the thematic analysis was the searching for themes. As each code was highlighted in multiple colors, I added a title of sorts (emerging concepts/categories) to the top of the notebook pages. I identified how many statements were repeating themselves and observations of similarity in context. I focused on quality not accuracy as I read them over and over (Braun & Clarke, 2013a). The process of

reducing the statements to categories and then from these categories similarities and brackets of understanding developed. After this coding was completed, quotes and categories were further recategorized and constructed into the themes that emerged from the data, leading to the fourth phase of the analytic process. Braun & Clarke (2006, 2013a, 2021) discuss the process of the themes starting to emerge on their own –the data "is not waiting to be found" (2021).

The fourth phase of the thematic analysis is the definition of the potential themes. This is the phase where I started crossing out, moving, and even changing my mind in the sorting of the concepts altogether thinking they were more than just concepts. This led to the fifth phase: defining and naming the themes.

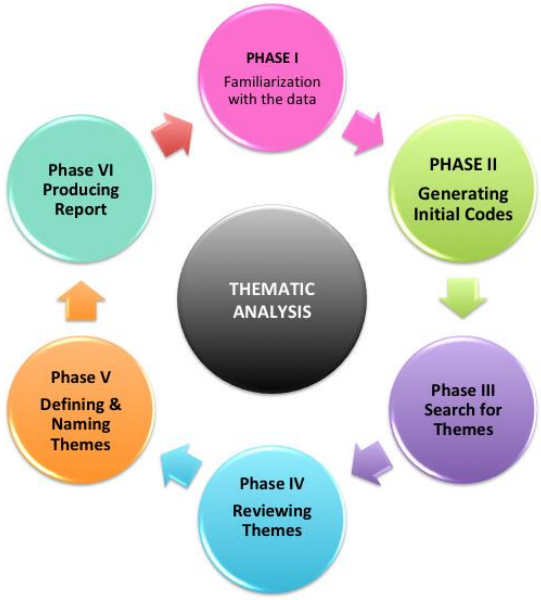
The fifth phase was the most exciting phase for me. It was a phase of further shaping, more clarifying terms, and once again moving the codes around to better fit under a category which was or was not transformed into a theme. After continued analysis, a couple of the actual quotes even became the theme name. Examples of these are: "have and use your voice," "take leadership on the "walk," and "you own the culture." As the thematic analysis is created by the researcher, that intersection of the data, my theoretical and conceptual frameworks, my professional knowledge, and learned research skills, the final names of the themes started to become clear (Braun & Clarke, 2021, p.29).

The final phase of thematic analysis is titled producing the report. This phase allows for the final adjustments to occur, the strengthening of the themes, and the final decisions of the analysis. Braun & Clarke (2103a, 2021) referred to this phase as the

quality control of the research process. A more detailed explanation of how the coding process using the participants statements and perspectives were used to analyze the data was described in the results section. A visual thematic mapping is in Figure 1 for the six-phase process. This method of qualitative analysis was also researched and expanded on by Maguire and Delahunt (2017) and Terry et al. (2017).

Figure 1

Phases of Thematic Analysis



Note. Adapted from Braun and Clarke (2103a, 2021).

Evidence of Trustworthiness

As this study's data was gathered through the usage of open-ended semi-structured interviews, the concepts of credibility, transferability, dependability, and confirmability were employed throughout the study to ensure the trustworthiness of the

data collection and analysis. This section addresses each concept of trustworthiness of this study.

Credibility

Credibility was established through the adoption of the interview protocol. Each participant was given the exact same process of triangulation, interview check in, and the amount of time to discuss at their freedom the open-ended interview questions. The participants were only identified in their audio recordings as Participant 1, Participant 2, and so forth, throughout the transcription process, and the use of their statements in the dissertation document. The participants responded to the same questions and followed through the same timelines of the interview. They were given a copy of the summary of their interview for review and the opportunity to revise any discrepancies. Due to the nature of the audio recorded interviews, I made the decision not to use an outside transcriber service. I examined the different perspectives for more than one vantage point to see if there is a convergence from different sources (see Creswell & Miller, 2000; Denzin, 2009; Flick, 2007, 2014; Schwandt, 2015).

Transferability

The ability to transfer this study to other research environments may be addressed by following the same data analysis process and the use of a similar methodology. Because qualitative research is exploratory in nature, such that the participants' thoughts, experiences, and perspectives are being explored, it may be difficult to generalize to other studies. Qualitative research depends on the transferability of the research findings, which required me, as the researcher, to be able to convey the participant data and

interpretation of the findings vividly and accurately that another researcher can follow the process. The goal for other researchers to augment this study would be to transfer the aspects of the design and findings to conduct their own study (Denzin & Lincoln, 2017; Lincoln & Guba, 1985; Ravitch & Carl, 2016; Toma, 2006 2011).

Dependability

Dependability is the stability of the data which in this study was the demographic document, the interview recordings and thick descriptions, and my journal notes as central to the study. In addition, I was able to observe the participants as they interviewed for attentiveness and any distractions during the process. I ensured the data and the confidentiality of the interviews by using unique codes to identify the participants, keeping the data secure, and having duplicate copies of my notes and the electronic files and recordings (see J. A. Maxwell, 2005; Ravitch & Carl, 2016). The interview recordings were saved on an encrypted flash drive.

Confirmability

As confirmability refers to the trust, accuracy, and genuineness of the participants' data rather than being a biased interpretation of my own, the use of the audio recordings allowed me to hear the direct words and open-ended answers to the interview questions, to hear them think and retrieve memories from their past experiences, and the ability to listen to them again and again. The observations and notes taken during the interviews were written and verified as soon as they were completed and available for review. The audio recording summaries were shared with the participants so that they could revise or clarify any discrepancies-which none occurred. I made a conscious effort

to not make inferences, interpretations, and assumptions. By having more than one reviewer, the influence of the results of the field notes were minimized, and the language of the participant's perspectives was natural to them and not of my wording or thoughts (etic) (Emerson et al., 2011).

Results

As each participant shared their lived experiences in response to the various interview questions, the similarities of their experiences were revealed. The interviews commenced with the open-ended questions to gain a general understanding of their experiences and perspectives related to their roles as nurse leaders. The interview questions walked the participants through their careers from their original nursing program, their first positions as a registered nurse, to their first leadership roles, and their decisions about returning to school to further their degrees. The participants shared how they experienced encouragement to enter their first leadership role and the experiences of how they obtained their current role. The participants shared how they prepared for their leadership roles, how they modified or developed their leadership styles, whether they used any specific nursing theories in their leadership, and how they believed formal educational preparation versus on-the-job training were the most influential in their leadership development. Lastly, they were asked if they had the opportunity to speak to an emerging leader today-what would they share with them. This is presented later in the chapter after the themes and subthemes are presented. The meaningful statements were used as in vivo coding and as these codes repeated themselves and represented the

participant's experiences, most of the themes were titled using direct quotes from the participants.

Research Participants' Experiences and Perspectives

In this section, each participant was described broadly and confidentially with attention to their years of experience as an RN, years of experience in a leadership role, their experience with Magnet designation, their first leadership role, their beginning degree, and their terminal degree. Each participant will have their most meaningful statements listed that were used in the coding and categorizing of the data analysis which produced the themes and subthemes. These statements were the participants' responses to the interview questions.

Participant 1

Participant 1 was interviewed in her home, in the evening, after the workday. She has 50 years of experience as a registered nurse with 48 of those years in a leadership role. She started her nursing career as a diploma degree registered nurse. She was the only participant who had part of her career in the military—having served 22 years in the Army Nurse Corps. She was also an assistant chief nurse of an evacuation hospital for some time. Even though she had leadership responsibilities in the Army as a Lt. Colonel, she thinks of her first real leadership role when she became a course coordinator, teaching in a BSN program. She originally wanted to be a pediatric nurse practitioner upon pursuing her master's degree but found that the programs were in their infancy at that time, and she ended up in education and community health. She pursued her master's degree in Nursing (MSN) only five years into her career and has had her PhD in nursing

for over 20 years. She is currently a clinical professor in nursing at a large, state university. She does not have experience working in a Magnet facility. Some of her most meaningful statements in her interview were:

- “Never stop learning”
- “Mentorship-for your yourself and to others”
- “Don’t do it for them-” guide on the side”
- “Teaching others to be good leaders”
- “Take continuing education to better yourself”
- “Get involved in professional organizations-find one that you can really give to”
- “Passion for your profession”
- “Find your passion and keep doing it”
- “Learn the different learning styles of people”
- “Belong to professional organizations”
- “Respect others”
- “Be a role model-especially for nursing students”
- “Servant Leadership”

Participant 2

Participant 2 was interviewed during her workday from her office. She has been a RN for 44 years, including 41 years as a nurse leader. She started as a licensed practical nurse (LPN) and gained her associates degree in registered nursing soon after. Her first leadership role was as a charge nurse in a telemetry unit. As she stated, she “worked her

way" from this role to that of director. This first leadership role made her realize she needed to return to school for her Bachelor of Science in nursing degree (BSN). Due to the limited schools offering BSN degrees she instead chose to pursue a bachelor's in health science. She shared that she learned a lot of leadership skills in her baccalaureate degree, and it motivated her to go on for her master's degree. She ended up completing two programs: master's in business administration (MBA) and master's in healthcare administration (MHA). She felt ill-prepared for her first role even though she thought it was her "dream job." She realized that having just clinical skills was not enough. She did work in a Magnet facility in Arizona. Her favorite role is the one she is in currently, advising on care improvement and end-of-life initiatives across the country. Some of her most meaningful statements in her interview were:

- "Interpersonal skills are key to success"
- "Influence-both from other leaders and for herself as a leader"
- "Advanced degree assisted her in learning business kills, processes, and system"
- "Need credentials to be credible"
- She quoted "Take leadership on the walk"
- "Learn how CNOs think"
- "Invest, model, and provide others the tools needed for success"
- "Belong to a professional organization"
- "Mentorship-take someone to a national conference"

- “Be proactive, innovative, and always listen to the front lines-be part of the solution”
- “Strategic in your career-never take a position that is backwards or not challenging”
- “Not one message to all” -know your audience”
- “Be Bold, Respectful, and Kind”
- “Develop your own style”
- “Learn from your failures”
- “Encourage others to step out of their comfort zone”
- “Look for innovation”
- “Don’t accept something you don’t like or doesn’t’ sit well”
- “Be part of the solution”
- “Collaborative leadership”

Participant 3

Participant 3 was interviewed in the evening from her home office. She was the most experienced participant. She had over 40 years in nursing leadership with over 55 combined years in nursing. She had 10 years as an LPN prior to obtaining her RN licensure. She did an associate degree, which she completed on Saturdays in a more rural area of her state at that time, and it took her five years. Her first role was that of a manager of an operating room. At that first role she felt that “she had leadership qualities” but soon learned that she would need more skills. She believed that her membership in a professional organization, the American Organization of Operating

Room Nurses (AORN) was instrumental in her success. She was also one of the first in the country to gain a certification in operating room nursing and has kept it current ever since. She also believed in furthering her education to that of a master's in healthcare administration (MHA). She worked for a few years in a Magnet organization in Arizona. She stated that she took a risk and left the traditional world of clinical care and worked for big organizations like Johnson and Johnson and learned how to be a consultant. Some of her most powerful statements in her interview were:

- "Experience "got" her jobs, but education is what "kept" her jobs or moved her to the next ones"
- "Wish I would've learned more about how to deal with the politics"
- Belong to professional organizations-how I got my first certification"
- "Be good at listening"
- "Mentorship"
- "Change or get fired"
- "Learned a lot through experiences both good and not so good"
- "Other theoretical frameworks can work with healthcare as well-i.e., Six Sigma Lean"
- "Develop yourself"
- "Life-long learner of leadership"
- "Always be open to change-for new things"
- "How to make things better"
- "Look to standardize processes"

- "Be truthful; be transparent"
- Seek and receive feedback-be open to suggestions"

Participant 4

Participant 4 was interviewed during the workday from her home office. She has 32 years of experience with 28 of them in leadership roles. All but 3 years of her experience was outside of acute care. She was originally a diploma RN but went directly from that program to a BSN-MSN degree. This degree took her 5 years to complete. Upon completion, she was offered a role as a supervisor over 10 branches of a home care company. She is the youngest to finish their master's degree in this sample of participants. She has her terminal degree-PhD in Nursing. She is also a great believer in professional organizations and certifications as there is a lot of mentorships in these organizations. She had no experience in a Magnet organization. Some of her most meaningful statements in her interview were:

- "First role changed her in the ways she looked at management, leadership styles, and personalities of people"
- "Encouraged to take a leadership position"
- "Mentorship—is so important to her that she emphasized "I will still look for my own mentorship even when I am 70"
- "Still in contact with first mentor"
- "Networking-opens doors"
- "With every position I learned something new"
- "Get different perspectives not only of roles but of leadership styles"

- “Preparation: Lots of self-study; reading; continuous education”
- “Wished she’d had more formal training in her first role”
- “Learned a lot through experiences”
- “Servant leadership”
- “Develop yourself and your own style”
- “Always wanted to contribute more to the profession-give back”
- “Still looks at ways to emulate other leaders”
- “Be helpful”
- “Learn how to resolve conflict”
- “Watch others”
- “Be willing to be led by others”
- “Read and watch others”
- “Belong to professional organizations-lots of mentorship there”

Participant 5

Participant 5 was interviewed during the workday from her home office. She has 51 years as an RN with 50 of those in a leadership role. Her first leadership role was that of a charge nurse in a medical-surgical unit. She was a BSN nurse at the onset of her career and ended up with a doctorate in public administration (DPA). She is currently an entrepreneur nurse with her own consulting company for many years, providing leadership and academic consulting. She is a great believer in mentorship and attributes much of her success to her very first mentor, her “head nurse.” In addition, she asserted that kindness and mentorship can set the tone for the future of a nurse’s career. She

provided several examples of mentorships in her career. Her experience with Magnet was writing for an organization to assist in achieving the award. Some of her most meaningful statements in her interview were:

- “Mentorship-especially learn how to be a good one”
- “Success=lived experiences need both-education and on the job training”
- “My Goal: to improve the environment”
- “Always looked for positions that needed challenge; had meaning for herself and others”
- “Credentials are very important”
- “Leadership is being innovative”
- “Transformational leadership to Wholistic leadership”
- “Servant leadership-stay the same; live your values”
- “Values should align with you-does not lead to success if they do not”
- “Be patient with people”
- “Build a supportive environment”
- “Develop your own style-watch others; take the good”
- “Have a thirst for knowledge-be constantly building new skills”
- “Diversity of people”
- “Have wisdom—you may not be the person that is needed at that time”
- “Recognize organizational changes”
- “Leadership is a collaborative process”

- “Communication-key to success”
- “Use a lot of influence”
- “Attract and engage them”
- “Try to understand what they are looking for”
- “Pay attention to who you are working with”
- “Passion and energy-always remember why you wanted to be a nurse”

Participant 6

Participant 6 was interviewed during the workday from her home office. She has 41 years of RN experience with 41 of those years in leadership roles. Her first role was that of a charge nurse after only a few months of being a new graduate. She believes her first “real” leadership role to be that of when she became an adjunct faculty and had to lead a group of students. She returned to school after about 3 years as an RN for her BSN degree and what she asserts as her “thirst” for more education. She obtained her MSN and became one of the first in Arizona to become a certified nurse specialist (CNS). This role led her to discovering her passion in professional nursing standards and nursing practice. In addition to her role as a CNS in Arizona, she became one of the first nurses to become a director of professional practice. She has been in top leadership positions in the acute care setting as administrator and chief nurse office (CNO). She is in a role today utilizing her experience and skills at a state and national level. Some of her most meaningful statements in her interview were:

- “Mentor Teaching Coaching”
- “Named her mentors and still uses their “...isms” to this day”

- “Enjoy learning and seeking new challenges”
- “Clean up the messes”
- “Learn to trust other people”
- “Need your certifications”
- “Important to join professional organizations”
- “Learn from “life” lessons”
- “Look at the organization as a whole-who does your boss report to and those around them”
- “You don’t have to the subject matter expert (SME) on everything”
- “It is all about leadership”
- Be a life-long learner”
- “Networking and professional organizations”
- “Don’t be afraid to be a risk taker-there will always be another opportunity”
- “You will be laid off at some point in your career”
- “Shared governance/participative leadership”
- “Ethics are very important-don’t let yours down”
- “Be trustworthy to your people”
- “Be encouraging”
- “Assess the culture before you take a role—is it a carrot or a stick culture?”
- “Is the patient put first in the culture?”
- “So important to have and use your Voice”

- "Expand your influence-you make a difference"

Participant 7

Participant 7 was interviewed during the workday from her daughter's home. She has 39 years of experience as an RN with 26 of those in a leadership role. She has worked at 2 different Magnet designated organizations in Arizona. Her first leadership role was that of a cardiac rehabilitation manager. She pursued her BSN and MSN degrees and ended with a terminal PhD in Nursing. She is currently a leadership consultant working for a national organization that assists others in the healthy work environments. (She was in some respects the outlier of the group due to her belief that she never really had a mentor in her career or that first time encouragement to go into leadership.) Some of her most meaningful statements in her interview were:

- "A lot of hard lessons were learned along the way"
- "I never had a real mentor-I mentored myself"
- "The higher the education, the better the RNs did"
- "Many people think that they can learn all on the job without advancing their education"
- "Each degree lets you know how more there is to know"
- "Further your degree as high as you can"
- "Education did not necessarily prepare me to be a leader-one needs to prepare themselves"
- "Certifications are very important"
- "Self-learning/Life-long learning"

- "Purposively study, practice, and learn what works well"
- "Uses Posner & Kouzes' theory in her daily work"
- "Transformational leadership is my "go to" always-comes naturally have studied/used it so much"
- "Serve others"
- "Listen to others"
- "Trust and learn to lean on other people"
- "Clear the barriers away"
- "Support the work they do"
- "Prepare for meetings/projects—know what the agenda is"
- "Know when to leave a role"
- "Use your tools"

Participant 8

Participant 8 was interviewed during the workday from the living room in her home. She has 29 years of experience as an RN with 28 of those years in a leadership role. Her first leadership role was that of a charge nurse one year from being a new graduate. From there she "grew" and changed roles to the most recent role as the CNO of a large hospital in Arizona. She had not worked in an official Magnet organization but was currently leading her organization to obtain the award. She pursued her master's degree first wanting to be a nurse practitioner then changed her mind as she felt she needed more business skills. She ended up with a master's in business administration

(MBA), completing her degree by attending school in the evenings. Some of her most meaningful statements in her interview were:

- “A way to help others”
- “Professional organizations/conferences-especially out of state to gain more perspective”
- “No formal preparation- “learn from one another”
- “Lots of on-the-job training”
- “Keep everything connected to the patient”
- “Be innovative in ways to provide care for patients”
- “Always keep as priority-What’s it like on the frontline?”
- “Mentorship-still keeps in touch with hers to this day”
- “Still meets with her mentor to this day on a regular basis”
- “Personal Connections-especially from conferences, leadership trainings”
- “Build trust by fostering relationships”
- “Actively involved early on with shared leadership”
- “Shared governance—involves others”
- “Be authentic-leadership style”
- “Walk the talk”
- “Be highly visible” “Her favorite time is in scrubs”
- “Integrity
- “Remove barriers for the frontline”

- "Understand who you are"
- "Spend a lot of time on culture-especially for the patients and families"
- "Do not stay in an environment that is caustic'
- "There are individuals that will be countering your values"
- "Conflict can be healthy for increase ideas-value diversity"
- "If we only use our lens, we can shut down other's ideas"
- "Not everyone is going to think like you"

Participant 9

Participant 9 was interviewed from her office, early in the morning, before her workday started. She has 44 years of experience as an RN with 38 of these years in leadership roles. Her first position was in a charge nurse role, yet she stressed that her first formal role was as a manager in a rehabilitation unit. In addition to the oversight of patient care staff, she also oversaw patient care coordinators. She started her career as a diploma RN. She had the early belief that you did not have a voice unless you were in a leadership role. Her early nursing experience was in a very hierarchical organization. She also found an early passion for nursing practice, and this is what started her nursing leadership journey. It took her 25 years to learn that she needed to go back to school to further her education- "that life experience was not going to get you certain jobs." She continued her education journey to the completion of her doctorate in education (EdD). She has assisted an organization to obtain their Magnet designation in Arizona. She is currently in an administrator role in a large, academic, Magnet designated organization. Some of her most meaningful statements in her interview were:

- “Early on-learned lessons the hard way”
- “She learned that she needed to be politically astute”
- “Learn to listen’
- “Seek to understand”
- “Little to no preparation for her first roles”
- “Did a lot of reading on her own”
- “Learned early on-don’t push too hard”
- “Knew at the core who I wanted to be as a leader; didn’t know how to get there”
- “Left leadership a couple of times—found herself right back”
- “We’re nurses-we’re about healing; solving a problem”
- “Understand the culture/organizational structure”
- “Learn to create/secure your own data”
- “Education is needed to further your career”
- “Looking ahead-how shall I end my career-what kind of a role do I want?”
- “Important to build credentials for end of career”
- “Important to publish/present nationally’
- “Maybe if I’d had the education earlier in my career, I might have not made some missteps”
- “We still don’t onboard our nurse leaders well enough”
- “Must have clinical knowledge”

- “Help other RNs navigate into leadership roles”
- “Know what your role is at any level of leadership”
- “Always be looking for emerging talent”
- “Never coast—be in a position that is challenging”
- “Transactional leadership in early roles of leadership-lots of negotiation”
- “Learned transformational and servant leadership-believes that one needs to be a servant leader before one can be a transformational one”
- “You don’t know good leadership until you see it”
- “Seek to understand how things were before you came”
- “Feedback: learn to accept and move past criticism and change what needs to change”
- “Reflect and take 24 hours before you respond; make a decision based on facts, not emotion”
- “Wants RNs to be great leaders”
- “Quiet, steady, steadfast work”
- “Look beyond the obvious”

Participant 10

Participant 10 was interviewed during the workday from her home office. She has been an RN for 40 years. She has been in leadership roles for 33 years. Her first leadership role in nursing was as a nurse practitioner lead role. This role was leading as a nurse practitioner without the advanced practice degree as is minimum requirements today. She was able to pursue this leadership position due to the rural areas of the state

she was living in at the time. She returned for both her BSN and MSN within 10 years of becoming a RN. She eventually furthered her education to a doctoral degree and completed two nursing doctorate degrees. She loves learning; “unpacking things.” She has not worked for a Magnet organization during her career. She currently works for a large university system and assists leaders in leading others. Some of her most meaningful statements in her interview were:

- “Always be open to opportunities”
- “Mentorship-seek it out.” She drove 2 ½ hours “just to have a peer”
- “Still meets regularly with an early mentor”
- “No preparation for the first nurse practitioner role/no map to follow”
- “Completely learned “trial by fire”
- “Believes that success is a combination of lived experiences”
- “Devours books”
- “Formal and informal professional development
- “We can always learn more/avid reader”
- “Executive coaching has been a huge influence in her life”
- “Be open to learning from others”
- “The importance of authenticity” she realized later in her experiences
- “Be true to yourself”
- “Never sees herself as the big boss person”
- “Be friendly but not their friend”

- “Of high functioning leaders-everyone has a job they were fired from”
- “You don’t have to be so “stiff”-let them do it themselves; nothing is a wasted experience”
- “Join peer groups/professional organizations early on”
- No real theory followed- “takes pieces from several—emotional intelligence, servant leadership, Lewin’s change theory”
- “Be confident enough to make mistakes”
- “Be able to talk about it-be open and take correction”
- “Learn how to accept where you are and manage up”
- “Know when to call it when”
- “What have you done to help your boss be successful?”
- “Set expectations”
- “You own the culture”
- “Learn to listen”
- “We don’t arrive at great leadership-you just get better over time”
- “Some people get enamored-It’s just hard, tough work!”
- “Rewarding and worthwhile”
- “An investment in humility”

Participant 11

Participant 11 interviewed from her home office; recently retired from academia. She has 44 years of experience as an RN with 31 of those years in academic leadership.

She started as a staff RN, went into staffing development in the acute care setting and after pursuing her MSN was offered a position in a pre-licensure nursing program. She moved through different leadership positions to that of the top executive nurse, the dean of nursing. Her last position right before retiring was a campus presidency of another large university of nursing. She worked in a Magnet designated faculty before leaving to academia. She pursued a terminal degree with an EdD in educational leadership. Some of her most meaningful statements in her interview were:

- "Encouraged to take a leadership role"
- "Mentorship-silent and non-judgmental;" "Ask for a mentor is you do not have one;" "You need a sounding board"
- "Keeps in touch with all of her early mentors"
- Develop your inner self/professional self"
- "Thought of being in leadership role-didn't know how to go about it"
- "Completely changed her whole way of thinking"
- "Completely changed her trajectory"
- "You never stop thinking about your work"
- "Learn how to make better decisions—in all aspects of your life-stick to the facts, policy, and be non-biased"
- "Never forget who you are serving"
- "Preparation-reading, watching, listening, mentorship, conferences, networking"
- "Educational preparation as well'

- “You need the credentials to have the recognition and respect of your peers”
- “Understand and study the role”
- “Leading from the gut”
- “Apologize when you make a mistake”
- “Influence on others”
- “Have the nerve and the guts”
- “Trust in people”
- “Hire good people”
- “Live by your strong values”
- “Stick up for your people/program. Students. Patients”
- “Networking: Develop relationships with staff, leadership, accomplished people in the profession”
- “Reach out to knowledgeable people”
- “Learn to massage the relationships up and down”
- “Pulled from multiple theories-Knowles, Orem, transformational, and finally servant leadership”
- “Develop others;” “My responsibility and honor to develop others, mentor others even if it means they leave”
- “Be authentic”
- “Put yourself out there-let your virtues get stronger”
- “Never back down when the going gets tough”

- "Communication so important in writing- "check before you send three times"
- "Careful of your communication in person to avoid misunderstandings-be thoughtful and watch your tone"
- "Listen and watch what's not said"
- "Be politically aware, watch the body language"
- "Meet with them first if needed; try not to be blindsided"
- "Leadership takes a lot of strength"
- "You put your whole soul into it!"
- "Exciting—never boring!"
- "Learned so much about how to handle life from being a leader"
- "Appreciative of the journey"
- "Just never enough time…"

Participant 12

Participant 12 was interviewed from her work office towards the end of the workday. This participant had the least years of experience as an RN (13 years) and in leadership, only 4 years. She has experienced her entire career in two different Magnet organizations in Arizona. Nursing is a second career for her, entering nursing school in her mid-30s. She pursued her master's degree soon after starting work as a RN, choosing a master's in nursing leadership (MSN-L). Some of her most meaningful statements in her interview were:

- "She was mentored early in her career;" "continues to look for mentorship
- "Her first role in nursing leadership changed the course of her career"

- “Increased her confidence”
- “Still friends” with first mentor
- “Grew at first through clinical committees”
- “Education a must—increased communication skills, nursing theories, and the use of evidence-based practice”
- Theoretical framework: complexity leadership theory
- Needs of the patient come first- “We are the gateway to keeping patients safe”
- “Learned how to talk to people in a way I never thought I could”
- “Leadership is hard work”
- “Be positive”
- “Need to earn their trust”
- “Need to be empathetic”
- “Be an advocate for the nurses”
- “Always learning”

Emerging Themes

During the process of transcribing the audio recordings and capturing the participants’ statements, the data repeated itself. I highlighted these statements under each participant’s notes. After these statements were all coded, I categorized them into similar concepts which led to similar topics. I then placed certain concepts onto their own pages of a notebook. As I transferred a statement under a concept, I would cross it out so it could not be used again-thus eliminating all the statements one by one. I listened to the audio recordings three times to make sure that I captured the participants’ statements to

each of the interview questions. I labeled the statements that would later be used to develop a theme or subtheme a "powerful" statement. Each theme and subtheme will be presented in detail. Here is a preview of the six themes with subthemes that emerged from the data analysis:

Table 2

Themes and Subthemes

Theme	Subtheme
Have and use your voice	Communication
	Listen
	Feedback
Take leadership on the "walk"	Live by your values
	"Walk the walk"
	Be politically astute
Invest in yourself and others	Continuous learning
	Formal versus informal education
	Learn business skills
You own the culture	Understand the culture
	Building trust
	Building people
	Passion
Development of own style	Preparation
	Influence
	Learning from mistakes
	Changed themselves
Mentoring, teaching, and coaching	Encouragement
	Life lessons
	"Still in Touch"

Have and Use Your Voice

This theme of having and using your voice was spoken about many times in the interviews. Interpersonal skills such as listening, direct and multiple modes of communication, giving and receiving crucial feedback, and advocating for the staff, team

members, nursing students, or patients and families all contributed to the development of this theme. The theme emerged from the qualified statements during the participants' interviews and is further broken down into three subthemes: Several participants articulated *"I didn't have a voice until in a leadership role,"* (Participant 9), or *"I thought I needed to be in leadership to have a voice,"* (Participant 3, 4, 6), or *"I always wanted to be a leader but didn't know how"* (Participant 3,11).

Subtheme: Communication. Communication was a subtheme of use your voice with participant comments such as "*Not only one way to message, "Know your audience,"* and *"Communication in both your face to face and in your writing."* Participant 11 stated, *"Read the email 3 times before sending," and "Be thoughtful, kind, and aware of your tone."*

Subtheme: Listen. Listening emerged as a subtheme under use your voice as important for the nurse leader to listen to the concerns of the staff, patients, and families and to be able to speak up/advocate for them. Examples of this included: "Especially to the frontlines." Several participants stated, *"learned to listen," "listen to both sides of the story."* In addition to listening to the staff, *"listen to the voices of the patients and families" and "listen to the voices of the nursing students." "Always advocate for the staff/units/patients/students."*

Subtheme: Feedback. A third subtheme that emerged under use your voice was related to the leader feedback to those around the leader. Participant 3, 6, 9, and 11 verbalized these statements; *"Crucial conversations with others"* yet *"not giving one*

message to all;" and *"the message must be individualized."* Participants agreed *"give constant feedback to others"* and *"be receptive to feedback given to you."*

Take Leadership on the "Walk"

Taking leadership on the walk was the theme of being a role model, living by one's values and principles, standing up for yourself and your team, and being politically astute to learn the nuances of the organizational power structures and relationships to gain the resources needed for your team. The theme emerged from these qualified statements during the participants' interviews and is further broken down into three subthemes:

Subtheme: Live by Your Values. The subtheme of live by your values, was placed as a subtheme under the theme of take leadership on the "walk," can be discerned by the participants' responses such as *"Be bold, respectful, and kind."* All participants experienced "poor" leadership at some point in their careers. Participant 6 stated *"You don't know good leadership until you see it."* Other participants, 2, 4, 7, 8, and 10 discussed *"being highly visible and accessible,"* and *"being authentic"* with the staff. In addition, participants 2, and 8 discussed to not *"accept something that doesn't feel right."* As much as you are living your values, *"there will always be someone that will be "countering" your values."*

Subtheme: "Walk the Walk." In addition to living by one's values, participants spoke to another subtheme under the theme of take leadership on the "walk" such as *"Model the way," "promote the tools,"* and *"lead the change."* Participant 2 used this direct quote *"Walk the walk,"* and others, 2, 3, 7, 8, 9, and 10 used phrases such *as "set*

expectations," "be proactive, not reactive," "be innovative-always looking for new ways," and *"be part of the solution."* By walking the walk, the leaders demonstrated integrity and follow through*: "follow through with whatever you say you're going to do," show "integrity,"* and *"be true to yourself."*

Subtheme: Be Politically Astute. A third subtheme under the theme of take leadership on the "walk" was spoken to by participants 6, 7, 9, 10, 11: *"Understand the organizational structure,"* and *"understand the whole organization."* Understanding the organizational structure and be politically astute by knowing *"who is your boss's boss?" "Who are the informal power brokers?" "Look ahead"* with comments from the participants such *as "do your homework," "ask for and know the agenda ahead of time," "meet with them ahead of time,"* and *"try not to be blindsided."* In addition, participants further responded with statements *as "watch and observe body language"* and *"what was not said."* There is a *"need to massage the relationships "up and down." "You may get fired."* Participant 6 voiced, *"You're going to get laid off or fired at least once."* Another (P10) stated that in one study she read, *"good leaders get fired at least once."*

Invest in Yourself and Others

This theme encompassed all about the continuous learning, improving oneself, the decisions to return to school, being an avid reader, and introducing others to leadership. Every one of the participants discussed their decisions to return to school, many of them several times. The participants spoke to the need for more business acumen. The participants also discussed their on-the-job training and experiences as important in their

success as well. The theme emerged from these qualified statements during the participants' interviews and is further broken down into three subthemes:

Subtheme: Continuous Learning. Continuous learning emerged as a subtheme under invest in yourself and others as the participants explored probing questions around their own success influences such as *"Leadership is having a thirst for knowledge," "I love learning," "learn by reading/studying on one's own," "read, read, read…,"* and *"constantly building/learning new skills such as: technology; Zoom; teaching online; meetings online."* (Participants 2, 4. 5, 6, 7, 9, 10, 11, 12)

Subtheme: Formal Versus Informal Education. Another subtheme under invest in yourself and others was demonstrated in the responses: *"I knew I wanted to be a leader, I just didn't know how to get there…"* (Participants 5, 9,11). The need for formal and informal education was expressed through these statements: *"Conferences, certifications, Continuing education units/credits (CEUs), credibility"; "Need more credentials to be credible;" "To have the recognition of your peers."* (Participants 1-12). Participants 2, 3, 4, 6, 7, 9, 10, and 11 stated *"Further your degree" "as far as you can."* Participant 10 stated that it was a *"Combination of both lived experiences."* Being an *"avid reader"* and *"keeping up with the newest information in our field by using newsletters and list-serves."* Participant 9 stated that *"Must have clinical knowledge and be up-to-date."* Another participant stated she wished *"she had kept up even more with the clinical knowledge necessary to be an expert."*

Subtheme: Learn Business Skills. This subtheme under invest in yourself and others pertained to not only learning more about nursing education and leadership, yet a

leader must also learn business skills to be successful in their role. Skills identified as important included: *"Systems processes and business tools."* and *"how to use and find resources"* (Participants 2, 4, 6, 7, 10, 11). These skills helped the nurse leaders to *"increase confidence."*

You Own the Culture

The theme of owning the culture is development of a supportive, authentic, transparent, trusting environment is of utmost importance in these leaders' priorities. The importance of understanding the current organizational culture, building a new culture, and ultimately creating the culture that build people are experienced. The importance of finding and keeping one's passion was critical as well especially in the culture of caring for the patients, families, and nursing students. The theme emerged from these qualified statements during the participants' interviews and is further broken down into four subthemes:

Subtheme: Understand the Culture. The first subtheme under you own the culture is assessing the culture before one takes a new role according to participants 6, 10, 11: *"Really assess the culture before you take a new role."* Seek to understand the culture as participant 6 stated, *"Is it a carrot or stick culture?"* Participant 9 stated *"What was the culture before you showed up?"* Participant 5 emphasized the importance of the patient being at the center of the culture *"Is the patient at the center/first in the culture?"* Once assessed and understood, *"Spend a lot of time building the culture," "create a supportive environment,"* and *"create a culture of diversity of people and thoughts."* Participant 7 said *"Not everyone is going to think like you do. Seeing things through our*

lens only can shut us down to other ideas." In summary, *"leaders understand organizational structure/culture"* (Participants 1-12).

Subtheme: Building Trust. Another subtheme that merged under the you own the culture theme was building trust to change the culture. Participants 1, 2, 6, 8, and 9 stated to do this successfully *"show them your strong clinical skills," "be transparent,"* and *"be authentic."* Participant 7 stated that *"you don't have to be the subject matter expert on everything."*

Subtheme: Building People. Another subtheme under you own the culture is about building people in the culture. Participants all supported the need for *"healthy conflict,"* and build people by *"hiring good people," "surround yourself with the team you are building,"* and *"always be looking for emerging talent."* In addition, *"encourage nurses to step out of their comfort zone"* and *"help RNs navigate into leadership positions."*

Subtheme: Passion. Encouraging and displaying passion in what you are doing develops into another subtheme under you own the culture. Participants 2, 6, and 11 state *"Always remember why you wanted to be a nurse."* Other statements were: *"keep your passion and energy," "passion for the patients, families, or students," "find your passion and create the culture around that"* for example: professional practice, long-term care, the operating room, the critical environment, and academia.

Development of Own Style

The theme of developing your own leadership style composes of the preparation of each nurse leader for their first leadership roles, the next role, taking certain roles,

influence of other leaders, and learning from mistakes. The participants shared how they changed and developed their own leadership over the years. The theme emerged from these qualified statements during the participants' interviews and is further broken down into four subthemes:

Subtheme: Preparation. As most participants *"did not feel prepared for what their first roles needed,"* the subtheme of preparation emerged. Participants shared *"I wish I had returned to school earlier," "I was so young, I wished I had more formalized training."* Another (P6) stated it as *"prepare for the next role."* Participant 2 stated to *"never take a role that took you backwards—always move forward to a new/bigger role."*

Subtheme: Influence. Another subtheme under development of own style of leadership was around the concept of influence and how important it is in leadership. Participant 2, 4, 5, 10, 11 stated *"Watch others,"* and *"allow yourself to be led by others."* Participant 5 stated to *"be the 1st one to raise your hand"* when opportunities arise.

Subtheme: Learning From Mistakes. Learning from mistakes was spoken about by all participants. Statements included *"Learned from "mistakes, error, trials," and "I learned the hard way."* Participants emphasized that *"every position learned something new."* Participants 2, 3, 4, 5, 6, 8, 9, 10, 11 spoke about being harsher with followers in the beginning*, "Wish I had been less intense," "I pushed too hard,"* and *"be patient with others."* Of importance though is the environment in which they as a leader needed to grow and develop their own style *"where I can grow or support the work that I do."*

Subtheme: Changed Themselves. In the development of own style, the participants discovered that they changed not only their styles but their perspectives as well. This subtheme speaks to how *"These leadership roles 'changed their whole way of thinking,"* (Participants 1-12). Other comments were *"learn the good and the not so good of others' styles," "learned different perspectives,"* and *"learned how to make better decisions."* Participant 11 stated *"I learned better how to handle life."* In addition to changing themselves some found that they started looking for certain types of leadership roles. Look for positions that *"challenge"* as Participant 6 stated, *"I found I liked to clean up messes."* Others learned to *"Look for roles that were meaningful to themselves or others"* (Participants 1, 2, 3, 6, 8, 10, 11, 12). Participants also emphasized that *"keeping your values and principles intact"* was of utmost importance in developing your leadership style.

Mentoring, Teaching, and Coaching

This last theme emerged throughout the participants' interviews and stories of their experiences of being encouraged by another leader to pursue their first leadership role. These early mentors led to other mentors, many of whom are still in "touch" with the participant leaders. These mentors were instrumental in their successes as leaders and in turn, they became mentors themselves teaching and coaching new and future leaders. The theme emerged from these qualified statements during the participants' interviews and is further broken down into three subthemes:

Subtheme: Encouragement. Eleven of the twelve participants were encouraged to take their first leadership role from another leader. As the participants discussed their

experiences getting into leadership roles, they found that encouragement from other leaders/mentors was crucial to their success. Statements were *"take someone to a national conference," "my first few years I was mentored by kind and caring nurses,"* and *"my director, head nurse, first supervisor…were amazing."* The encouragement to others was just as important as well.

Subtheme: Life Lessons. Learning from their mentor or coach was realized in the participants' conversations as well. Participants all discussed how learning about their mentor's past experiences helped them in their success as nurse leaders. Statements such as these*: "Learned from the mentor's life lessons," "be open to learning others' experiences,"* and *"what would so and so do?"* Participant 6 even referred to this as *"xxxisms-what would so and so do/have done…"* (name changed to protect the confidentiality of this mentor).

Subtheme: "Still in touch." Long-term, even life-long relationships with their mentors/coaches were evident amongst the participants. Statements such as *"Absolutely still in touch," "Still in communication with them today," "For over a decade now," "Meet with them regularly"* In addition, the mentors continue to help them grow.

Theoretical Inferences

An additional part of this study was to explore the theoretical framework or leadership theory that the participants learned about, experienced, utilized in their practice, or believed were influential in their leadership journey. Each participant was asked the following during their interview this question: How have any of the leadership theories influenced your success as a leader? Servant leadership and transformational

theory were spoken to most frequently in participant responses to the question: How have any of the leadership theories influenced your success as a leader? For example, Participants 1 and 4 spoke about the use of servant leadership, and Participant 4 added thoughts about the development of other people. Two of the participants suggested that transformational leadership was a higher theory encompassing some of the others such as emotional intelligence and servant leadership. For example, Participant 5 also spoke about *"servant leadership as a step towards transformational"*, and now uses what she referred to as wholistic leadership, which is a body perspective and has more engagement from the followers. Participant 7 also spoke to *"transformational leadership as her go to theory"* and currently uses in her consultant work, Kouzes and Posner (2006) as an extension of that theory. Like Participant 5, Participant 9-spoke to a change in her career, starting with the use of transactional theory in her early years then learning about transformational and more currently servant leadership, noting *"you need to be a servant leader to be a transformational leader."* Participant 2 spoke about collaborative leadership, situational leadership, and the use of crucial conversations. Participant 6 also spoke about participative and situational leadership for leadership theories and the nursing theorist Jean Watson for a model of caring, and shared governance.

Interesting to note, many of the participants had not formally learned any leadership theories in their masters' programs; one participant (7) had been in a fellowship program with the AONL and had not been presented any formal theory in this program. For example, Participant 3 spoke about quality management and six sigma lean yet did not intentionally use any leadership theory in her practice. Participant 8 spoke to

the use of Duffy's nursing, caring model, and shared governance. Like Participants 3 and 8, Participant 10 spoke to the environments she worked in rather than specific theory and that she *"learned from everyone-no real theory,"* but if she had to choose a couple, she would say she uses servant leadership and Lewin's change theory. Participant 11 spoke about several theorists, such as Knowles (adult learning), nursing theorist Dorothy Orem, and transformational leadership when dealing with people. Finally, Participant 12, who was the most recently in school, spoke about complexity leadership theory which promotes *"buy-in"* of others to solve issues.

All seven participants who completed their doctorates stated that there was some leadership in these academic programs, yet it did not greatly affect their leadership styles. The conversations discussed how transformational leadership theory was *"very organizational"* whereas servant, wholistic, and the use of nursing theorists were used more for serving people versus managing people. Most of the participants voiced how they were *"life-long learners"* of leadership and studied it by several measures: self-study, continuing education, networking, and conversations with their mentors and other leaders. As one participant (10) stated, *"the theories don't have all of the pieces needed."*

Reflection of Their Leadership Journeys

An unexpected finding during this study was the similar and heartfelt responses to the very last question of the interview. The question was "Tell me anything else that you believe would be important to tell me that I may have forgotten." The participants' used this question as an opportunity to pause, contemplate, and then share their "reflections" on their career/experiences overall. Multiple participants shared with me that they had

never reflected on their experiences as they had with the questions of the study. One participant (11) told me that *"they were excellent questions,"* and another stated that she was *"grateful to have had the opportunity to reflect on her journey,"* another stated, *"thank you for letting me tell my story."* These are some of the collective compelling statements that were common:

- "I had always wanted to give back," "Contribute more…" "Help others"
- "Continue still to emulate other leaders"
- "Leadership is a collaborative process"
- "I loved the reflection," "It helped me to move forward,"
- "You never stop thinking about your work"
- "It's all about leadership"
- "Purposely study and practice what works well"
- "Listen to others"
- "Rewarding," "worthwhile," "you put your whole soul into it," "plain, hard work!"
- "Seek assistance from knowledgeable people," "Lean on others."
- "Wish I had been more involved in…organizations, local or national leadership, publishing."
- "Know when to leave," "know when to call it quits."

Summary

The purpose of this qualitative phenomenological study was to explore the lived experiences of nurse leaders in Arizona. The data was collected from 12 voluntary

participants through 20 open-ended interview questions. The same data collection process was followed with each participant. The trustworthiness of the data was thoroughly scrutinized to minimize researcher bias and maintain the integrity of the participants' discussions and maintain confidentiality. Each participant shared what most referred to as a "reflection" of their "leadership journey." Through these reflections, participants provided some clarity, purpose, and deep thoughts about their lifelong careers and experiences as a nurse leader.

Each participant shared their experiences with their preparation for a leadership role, ranging from no preparation to self-preparation to returning to formal schooling, to obtaining and keeping a mentor throughout their careers as they moved through various leadership roles and responsibilities. Two themes that emerged across all participants were that formal education gave them significant preparation, but that lived experiences were also valuable in their preparation for leadership roles.

Finally, the participants shared similarities of the nurse leaders' lived experiences were categorized and constructed into six themes with three to four subthemes each. This concludes the findings of the study. Chapter 5 provides discussion on the interpretations, limitation, implication, and further recommendations for this study on the lived experience of nurse leaders.

Chapter 5: Discussion, Conclusions, and Recommendations

The primary purpose of this study was to explore the lived experiences of nurse leaders. A phenomenological approach was used to understand how nurse leaders make meaning of their leadership experiences. This study addressed the experiences of nurse leaders in Arizona with the goal of discovering what meaning these leaders ascribe to their lived experiences during the development of their careers. In conjunction with the meaning of their experiences, I searched for similar experiences among the leaders regarding how they prepared themselves for their roles. I also wished to address the gaps in the literature about leader preparation and success. Literature findings indicated the need for leadership programs, yet there were only a few studies addressing the lived experiences of leaders regarding their successful experiences. In addition, researchers had studied the followers of nurse leaders but not the experiences of leaders themselves for insight into what similar experiences leaders might have had.

A secondary goal of this study was to examine the purposeful adoption of a theoretical framework by the leaders that may have influenced their leadership style. Transformation leadership theory is the most familiar leadership theory in nursing due to the Magnet movement across the United States as the best practice, evidence-based, and award-winning approach. Although most of the participants mentioned transformational leadership as one of the theories they learned about or pursued early in their careers, many believed that it was not encompassing all that was needed to be a successful leader.

I interviewed 12 nurse leaders from across the state of Arizona who were in a leadership position for at least 2 years. Data were collected and analyzed with the goal of

answering the research questions. The participants shared their experiences by answering 20 open-ended, semi-structured questions. I explored their leadership progression from their first role to their current role and what practices were considered influential in their success. These leaders also reflected on their wisdom gained over the years, their struggles, and the achievements that they would use to coach a new leader. Two research questions guided the study:

RQ 1: How do nurse leaders in Arizona make meaning of their leadership experience?

RQ2: How do nurse leaders prepare themselves for leadership roles in nursing?

Findings revealed many similarities and shared experiences. In addition to the similarities discovered, the data analysis revealed concepts, categories, subthemes, and themes. The nurse leaders' stories provided thick descriptions about their lifelong experiences, and these were interpreted without bias. The findings were used to answer the research questions. The interpretation of these findings is provided in this chapter along with limitations of the study and recommendations for further research. Finally, I provide a summary and conclusion to this study.

Interpretation of the Findings

I conducted 12 face-to-face virtual interviews that lasted between 60 and 90 minutes. The participants were self-selected and voluntary. The participants were assigned a confidential number (Participant 1 through Participant 12). Participants were all women with ages ranging between 50 and 77 years. The fewest years of experience was 13, and the most was 50 years (three participants). The 20 open-ended questions

elicited participants' experiences throughout their careers and allowed for reflection and sharing of the challenges, accomplishments, and the acumen essential for successful leadership.

The first seven interview questions focused on participants' first role, how it came about, the person who encouraged them to take this role, and how they prepared for this first role. Because the literature addressed the need for mentorship, leadership competencies, training, and transition to the role of a nurse leader, the current participants spoke about the important influence of their first mentors and current mentors (see Burke & Erickson, 2020; Nghe et al., 2020; Pilat & Merriam, 2019). These questions led to the development of the concepts and themes of continuous learning because most participants did not feel prepared for their first roles. Participants reported a desire for a mentor to model the way, and they acknowledged the need to invest in themselves by returning to school for advanced degrees, business skills, and enhanced credentials to develop their leadership style. The literature demonstrated that even in the best work environments with well-designed leadership programs, the new nurse leader may feel that role mastery, confidence, and satisfaction may suffer (Pilat & Merriam, 2019). The current participants also confirmed the demand and urgency for graduate education for aspiring nurse leaders. Many reported that they did not have the business acumen, understanding of health care systems, and human resource management skills needed to be successful (see AONL, 2021; Morse & Warshawsky, 2021; Munari et al., 2019; Nghe et al., 2020; Pilat & Merrimore, 2019; Sherman & Saifman, 2018). Fennimore and Warshawsky (2019) suggested that graduate education should be the minimum standard

for nurse managers. Lastly, the training and success planning of future or aspiring nurse leaders had been investigated in the literature, which indicated that nursing educational training and planning are needed to prepare the future leaders more intentionally (Bognar et al., 2021; Burke & Erickson, 2020). The current participants shared how they not only developed their own leadership skills, but they also intentionally looked for other nurses to develop their leadership roles (P2, P6, P8, P9, P10, P11).

This study addressed the experiences of nurse leaders in their preparation for their roles. All had masters' degrees, most of which were obtained early in their careers, and 7 of the 12 had terminal degrees. The themes that emerged from these first interview questions were the following: (a) invest in yourself and others and (b) mentoring, teaching, and coaching.

The next six interview questions addressed how participants' experiences shaped their careers, leadership styles, and missteps or lessons learned. These reflections revealed the concepts of how to move to different leadership roles; how to take on challenging roles intentionally to grow; and how to use their voice for change, advocacy for the staff, and development of other leaders. Rebounding from leadership failure was revealed in many of the participants' responses, but there was little in the literature to provide a clear description of how this experience is portrayed (see Bellack & Dickow, 2019). P6 and P10 note that *"you will get laid off"* or *"you will get fired"* at least once in your career. P5 stated that nurse leaders need to know when to move on: *"you may not be the one."*

The participants' experiences led to the construction of another theme: leadership on the "walk." This theme emerged among the participants as their leadership values developed. P6 referred to these values as "be bold, be respectful, and be kind." Mentorship was revealed as a theme as the leaders advanced in their career experiences. The similar experience was that a person must role model mentorship and learn to be a good mentor to other developing leaders.

The last seven questions elicited the reflections of the participants' journeys over the years. The participants were asked about how they would have changed their leadership preparation, their use of leadership theories, how they developed or changed their styles, and what most and least valuable experiences they would share with an emerging leader today. The sharing of these experiences led to the development of the concepts and themes around investing in yourself and others; continuous learning to improve and be constantly keeping up with changing clinical knowledge, technology, and health care policy and politics; and the importance of leading and owning the work environment culture. The theme of you own the culture emerged from participants' insistence on the leader as most influential person in the workplace culture. Much had been written about the positive outcomes of the Magnet environments and culture (ANCC, 2021; Prado-Inzerilla et al., 2018) but not in relation to the leaders' experiences in building, transforming, or owning the culture. M.M. Pearson (2020) considered the use of transformational leadership as the means for a nurse leader to shift the nursing culture. Current nurse leader participants shared the importance of developing the culture so that it is trustworthy, authentic, and develops other leaders. The concepts of building trust,

developing others, finding their passion (all participants found a certain passion in nursing), and using their influence to develop and prepare others for leadership were revealed through these interview questions. Many of the participants thanked me for the opportunity to reflect on their careers and leadership development through these interview questions.

Lastly, the probing question around leadership theory use and development allowed for the participants' exploration into their own style and whether they believed they intentionally used a theoretical framework or not. Some of the participants' use of theory developed around their role i.e., quality improvement tended to steer toward Demings, TQM theories, or six sigma lean, or some in academia discussed nursing theorists such as Jean Watson or Dorothy Orem. All participants except for one (P10) agreed that they used several theories to guide their leadership style. Seven participants had the similar experience that they were "life-long" learners of leadership. Four participants shared that they used servant leadership, but many others shared that one must be a servant leader to be a transformational leader. Although many knew of and used transformational leadership, some referred to this theory as either "organizational" or "not complete" or "it is not wholistic." One participant (P5) even stated, *"it is my go-to always"* yet taught Posner and Kouzes in her consulting work. The other theories mentioned were situational leadership, participative, shared governance, and even Lewin's change theory. Interestingly, the participants who pursued business degrees (MBA) did not learn any leadership theories.

Transformational leadership has been investigated in the literature in many facets: patient outcomes, staff satisfaction and retention, the Magnet model, staff empowerment, followership, and healthy work environments (ANCC, 2021; Clavelle et al., 2012; Diggins, 2016; Kelly et al. 2014; Pearson, 2020; Prado-Inverell et al., 2018; Robbins & Davidhizar, 2020; Shaughnessy et al., 2018). One author even suggested that the nursing workforce should demand transformational leadership (Lewis, 2015). My conclusion was that each participant was familiar with leadership theories and took principles from one or more in their leadership styles, but none found one theory to be complete and encompassing all that is needed in leading people. One participant even suggested that transformational leadership was more of an organizational leadership theory and was not comprehensive to lead people in all work environments.

Limitations of the Study

The limitations to this study of the lived experience of nursing leadership are presented in this section. There was the original intention of conducting the interviews in a face-to-face manner with the ability to enter their work environments to experience their work worlds. With the advent of the COVID-19 pandemic, it was not possible, yet I believe that the virtual interviews lead to a more focused interview with less distractions and interruptions that the pre-COVID-19 work environment might have allowed. The Zoom environment lessened the personal contact or even intimacy with further exploration with the interview questions that a face-to-ace might have supported. The virtual interviews allowed for a faster collection of data than I had anticipated due to the little travel and setting up of appointments in their places of work.

The self-selection of the participants may have affected the trustworthiness of the data as they were willing participants and available to consent and serve in the study during the time of the study. The participants were from one state and may have limited lived experience collectively. The participants were a good sampling from across the care continuum and represented many aspects of nurse leadership in healthcare. I continued to follow the interview protocol, open-ended questions, took field notes, and recordings as planned. The participants were credible, knowledgeable, and had the required lived experiences needed for not only adequate responses to the interview questions but they were seasoned, thoughtful, and reflective responses. The ability to listen to the recordings multiple times allowed for greater confidence in the concepts and categories that developed through the participant data.

The most notable limitation to the study was my lack of experience especially in the coding of concepts, categories, and themes. The sample size of 12 participants may not be large enough to transfer to other studies or the development of leadership programs. Lastly, as a nurse leader for over 30 years, I was able to keep my personal biases and own lived experiences separated from the participants' voices as I conducted the interviews and data analysis. I kept a reflexive journal to document my thoughts and ideas about the interviews and processes during the data collection period. In this way, I separated my personal thoughts from the participants' voices (Braun & Clarke, 2021; Shaw, 2010). The next section discusses the recommendation for further research.

Recommendations

In the review of the most recent literature before the conclusion of this study, there continued to be the gap in the research regarding the lived experiences of nurse leaders and their perceived needs for success. One recent article, Morse and Warshawsky (2021) advocates for the need of nurse leader competencies for nurse leaders. In this study, the competencies deemed necessary for success are learned "on the job experience," and may take up to 7 years to become a proficient leader in their role. This study recommended that leaders would benefit from structure competency development and graduate education. Other research concluded that although succession planning and attendance in a planned didactic/mentorship program, aspiring nurse leaders continued to require an ongoing and more comprehensive leadership competencies for optimal results (Bognar et al., 2021). Another article discussed an east coast health care organization which developed their own leadership program for "midlevel" nurse leaders (Nghe et al., 2020). Another article published during the time this study was conducted, presented the lived experience of the staff nurse transitioning to a nurse manager role. In this study, the common themes gathered from these novice, midlevel nurse leaders were as follows: unclear expectations, inadequate onboarding, the lack of skills in finance, balance, and emotional intelligence, the need for graduate education, and the need to reach out for support and mentoring from colleagues. Unfortunately, many of the participants in this study did not feel that "role mastery" was possible (Pilat & Merriam, 2019). Sanford and Janney (2019) proposed stronger updates to leader competencies: strategic thinking, executive presence, innovation governance, business skills, and the use of big data.

Lastly, as nurse leaders may experience a failure or what some refer to as a "derailment," Bellack and Dickow (2019) even proposed a framework that focuses on: Vision + Relationship + Execution.

The themes developed from the lived experiences of this qualitative study restate the importance of the beginning demands and continuing obligations throughout a leader's career. Participants discussed their needs for increased success in leadership by influences as coaching, mentoring, and ongoing training, and education. The participants discussed their first leadership roles as *"learning on the job," "as I went,"* or *"trial and errors or even failures."* Investing in yourself and others developed into another theme as the participants discussed their needs for continuous learning not only for themselves but in the potential and development of others. Ever-changing healthcare trends and technology will require the application of new learning and skills and the need for continuous change in the competencies needed for leadership success (Fennimore & Warshawsky, 2019).

In reference to the practice of transformational leadership, the nursing profession continues to provide the desire for leaders to adopt these principles for shifting culture and patient satisfaction. Nurse leaders' encouragement and support for staff is crucial for the development of harmony and enhanced focus on patient care. The transformational leader is key to the empowerment of nursing staff, which may transform the healthy environment for the entire health care organization and thus the patients (Pearson, 2020; Robbins & Davidhizar, 2020).

One of my recommendations are to continue the research into the lived experiences of the nurse leaders to add and clarify the theme construction of this study. The repetition of a similar study may add to the themes and the lived experience of the nurse leader. In addition, further development of these themes may benefit the development of leadership competencies. These competencies can then be further developed into undergraduate nursing programs, leadership trainings for transition to leadership roles, and focus on the development of the graduate leadership degrees. The profession of nursing continues to believe in the principles of transformational leadership which may be embedded into leadership competencies (Morse & Warshawsky, 2021; Pearson, 2020; Robbins & Davidhizar, 2020).

Implications

The implications of the influences and experiences of nurse leadership for the profession is considerable. There are predictions of nurse shortages soon, yet there are also numerous needs for effective nurse leaders (Pilat & Merriam, 2019; Titzer et al.,2013). The National Academies of Medicine updated the vision for the profession of nursing in 2020 to meet the anticipated leadership and social needs of our country (NAM, 2021). The report calls for strengthening areas of nursing in the workforce, leadership, education, well-being, and emergency preparedness/response (Raso, 2021). In fact, leadership was mentioned more than 100 times in the report.

As more social determinants continue to be identified, changes in health care policy and finances, quality improvement initiatives, and innovative delivery models are rapidly challenging the health care leadership, the positive affect that nurse leaders can

have on these systems may be immense. The development of nurse leaders to be highly skilled in the acute care setting is desired, but the ability to affect the health care of the United States through public policy by addressing equity of health and health care may be greater. Nurse leaders work in all areas of the continuum of health: the community, public health, acute care, rehabilitation care, policy makers, research, academia, and even political roles. Nursing can create a culture of health, reduce disparities, and improve the health and well-being of the United States in this next decade (Buerhaus et al., 2013; NAM, 2021; Smith, 2019). By identifying the characteristics of successful nurse leaders, future nurse leaders can better prepare to contribute to the transformation of the healthy work environments across the continuum needed for our future. It has been demonstrated that healthy work environments produce better patient outcomes.

The implications for continuing qualitative research, especially that of phenomenology and the use of thematic analysis is essential. Even in the few years of conducting this study, qualitative research has continued to grow, develop, and the study of lived experiences has become a valued and credible methodology. This study may be able to add to that research knowledge base.

Lastly, as the practice of nursing leadership continues to learn not only from its own members, it also contributed to the research of leadership in general. Transformational leadership and its antecedents have been studied in the profession of nursing extensively, yet the participants in this study ask for further development of the theory and more leadership models in which to learn and to teach and develop others. As one voice said, *"it doesn't cover everything."*

Conclusion

This qualitative, phenomenological study was conducted to provide a piece to the research gap into the lived experiences of nurse leaders. There has been documentation throughout the literature that leadership competencies continue to be needed for the emerging nurse leader (Bellack & Dickow, 2019; Bognar et al., 2021; Morse & Warshawsky, 2021; Nghe et al., 2020). There has been recent documented research into the lived experience of the transition to a new nurse manager position that shares similar needs as the themes revealed through this study-mentorship, needing education and training for business, policy, and leadership skills, and how to build a positive work culture leading to superior patient outcomes (Pearson, 2020; Pilat & Merriam, 2019; Shaughnessy et al., 2018). Nursing continues to desire the pursuit of the esteemed Magnet designation and the positive leadership and work environments that stem from the award (Burke & Erickson, 2020; Diggins, 2016; Lewis, 2015; Shaughnessy et al., 2018).

This study analyzed the interview data from 12, experienced nurse leaders who spent 60–90 minutes with me and discussed using semi-structured interview questions, their careers from the beginning of their first leadership role to that of their current roles. The data led to the development of six themes with subthemes for each that may be adopted for the further development of leadership competencies, curriculum, and/or leadership training programs for transitioning nurse leaders. These themes were: have and use your voice, take leadership on the “walk,” invest in yourself and others, you own the culture, development of own style, and mentor, teaching, & coaching.

There is confidence this study kept the participants' confidentiality yet was able to construct valuable data from their individual interviews. I thanked them all for their willingness to share their lived experiences with me. They added to the body of research and assisted in the development of improved and futuristic leadership competencies and skills. The importance of continuous learning, developing, and improving leadership success is imperative to the health of the United States and beyond. America is a leader in health care delivery, leadership, and innovation and research. It is my hope that this research study will be used in future studies to advance the profession of nursing and increase our involvement in the health policy of our country.

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Appendix A: Participant Selection

1.) Send all participants in the Arizona Organization of Nurse Leaders (AzONL) an inquiry letter describing the study and the need for voluntary, purposive participants.

2.) Of the respondents from AzONL to become a participant, if there are any more than 12, randomly select 12 participants to participate in the interviewing process.

3.) Of the greater than 12 participants, keep them in the process in case the participant level drops to less than 12.

4.) The minimum required participants to develop this study is 10.

5.) The participants selected for the participant pool will be notified of the intent to interview within 30 days of the selection by the primary researcher.

6.) The participants will be sent a Welcome Letter by the primary researcher with the Walden University consent form, interview guidelines, and interview questions for review.

7.) The participants will have the choice to opt out of the study at any time.

Appendix B: Participant Inquiry Letter

Dear fellow member of the Arizona Organization of Nurse Leaders (AzONL):

I am Catherine Mohammed PhD(c), MN, RN, currently a PhD candidate at Walden University pursuing my doctorate in Public Policy and Administration with specialization in Health Services. I am conducting a qualitative study, exploring the phenomenology around leadership, nursing leadership to be exact. I am looking to explore and better understand how nurse leaders make meaning of their experiences. In addition, what, if any, training or preparation in their role was deemed important to the nurse leader? Lastly, are the nurse leaders' experiences similar to each other?

The importance of this study is to answer the question: How do nurse leaders in Arizona make meaning of their leadership experiences?

The importance of this study is also to further the research in the science of nursing leadership.

My study is a qualitative study using purposive participants who wish to allow me to interview them in the convenience of their work place or another place of their convenience. The study requires 10-12 participants that are a member of AzONL, a nurse leader with at least two years of experience, and the ability to spend 90 minutes with me

as the researcher. In addition, if interested, the participant can be involved in the transcription and be informed of the study process and outcomes.

If you are willing to be a participant in my study, please respond to my email or at the cell phone number below. I am excited and eager to meet with you all and hear your personal story of nursing leadership.

Catherine J. Mohammed PhD(c), MN, RN

Appendix C: Participant Welcome Letter

Dear Study Participant:

Thank you so much for being willing to participate in the research project titled:

Developing Leadership in Nursing through their Lived Experiences

The purpose of this study is to learn and be able to share the lived experiences of the nurse leader, one such as yourself. There has been limited research using phenomenology to capture and learn from the experiences of nurse leaders. How can we best prepare the Nurse Leader of the Future if we don't start with understanding their experiences? Your interview and observational data will be the keys to the outcome of the research questions of this study. The goal is to participate in an approximate 90 minute interview with the primary researcher, Catherine Mohammed. This will involve spending the time sharing your story through a set of pre-determined interview questions. These questions will guide us through your experiences from a novice nurse leader to who you are today.

The participant process will be explained in the Consent to Participate Form included in the Welcome Packet with this letter. Please feel free to contact me at any time during the research process so that I can answer your questions.

Thank you again for investing in the profession and the future of your profession,

Catherine J. Mohammed PhD(c), MN, RN

Appendix D: Participant Interview Guidelines

1. After contacting the interview participant, decide on the interview environment.
2. Make the appointment with the participant and follow up with an email and Outlook invite.
3. Send the participant the demographic questionnaire to fill out prior to the interview.
4. Arrive 15-20 minutes early to settle the environment and make sure that the participant can still follow through with a 90 minute interview.
5. Test interview equipment prior to starting the interview/recording.
6. 6. Have a back-up recorder in case the current recorder/equipment fails. Develop rapport and allow the participant to become comfortable with the setting and timeframe.
7. Allow occasional silence to be comfortable; allow the participant to have time to think, bring forth their ideas, and to ask questions if needed. Pause and wait.
8. If the participant goes off track or even may become aggressive, remain in control and lead them to the next question. Do not embarrass or intimidate the participant.
9. Take time to ask for explanations to anything you do not understand. Do not speak when they are speaking. Use encouraging words to move them along or let them know you are listening.
10. Do not fidget, yawn, roll eyes, or seem disinterested in their answers. If the theme/question seems exhausted, move them on to the next question.

11. Be cautious if you believe you have entered a sensitive topic. Probe gently but stop if they are uncomfortable or unwilling to continue.
12. Provide a debriefing when finished. Ask if they would like a transcript sent to them to check on any corrections.
13. Close with thank you and gratitude for their participation.
14. Reflect on the interview, review the recordings several times to make sure nothing is missed in the transcription of the interview.
15. Provide complete confidentiality with all interviews and the participants' identities.

Appendix E: Interview Protocol

I. Welcome the study participant.

II. Make sure that the interview environment is free from distractions and is where the study participant wishes to do the interview.

III. Review the study participant consent form with the participant. Have them sign the consent form prior to the beginning of the interview.

IV. Review the interview procedure with the study participant.

V. Let the participant know that the interview will be recorded so that the researcher can review and capture any missed conversations.

VI. Allow the participant time to review or go back on any questions.

VII. Keep as close to 90 minutes for the interview as possible.

VIII. Allow for flexibility in the interview process.

IX. At the completion of the interview thank them for their time and participation.

X. Keep all recordings confidential and secured throughout the research process.

Appendix F: Interview Questions

1. Tell me your name, title, furthest degree, and role in your current organization.
2. How many years have you been in this role?
3. How does this leadership role fit into the organization as a whole?
4. Are you a current member of the Arizona Organization of Nurse Leaders?
5. Now that I have established the correct qualifying criteria for you to be a participant in this study, we can procced with the interview. Tell me about your very 1st leadership role…
6. Why do you believe you took this first role?
7. Tell me about how this role changed you?
8. Tell me about the person who first encouraged you to take a leadership position?
9. Were you prepared for this role?
10. Tell me about the experiences that you feel prepared you for this first role?
11. What experiences do you believe were more important for your leadership preparation: your education or the on the job training?
12. Tell me more about that…
13. How have you continued to prepare yourself for your career up to the role you have now?
14. What do you know now that you wished you had known then when you were starting your leadership journey?
15. Tell me about your leadership journey…

16. Tell me how you would have changed your leadership preparation knowing what you know now?
17. How have any of the leadership theories influenced your success as a leader?
18. How have you developed your leadership style?
19. Tell me more about that…
20. Tell me anything else you believe would be important to tell me that I may have forgotten?

Appendix G: Participant Demographic Inquiry

Name:_____Male_____Female_____

Age:_____

Highest level of education:_____

Years of experience as a RN:_____

Years of experience total as a nurse leader (starting with your first position as a charge RN or first level supervisor):_____

Your first position as a nurse leader:_____

Current position as a nurse leader:_____

How many years in this current position:_____

Magnet organization:_____

Experience working in a Magnet organization(s):_____

Any other pertinent information that I need to know about you:_____

_____

Best email to contact you at:_____

Best phone number or text to contact you:_____

Appendix H: Expert Research Panel

Dr. Judy Hightower

Qualitative Study Expert

Dr. Ellen Poole

Research/Dissertation Mentor

Dr. Pamela Fuller

Qualitative Study Expert

Chair, Dissertation Committee (until March 2021)

Dr. Frances Goldman

Walden University

Current Chair, Dissertation Committee

Dr. Eliesh O'Neil Lane

Walden University

Committee Member, Methodologist

Dr. Barrett Mincey

Walden University