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Evaluation of Nurses' Leadership Self-Efficacy in Belize

Ruth Rosalee Reina Jones
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Walden University

College of Nursing

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Ruth Jones

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Walden University
2026

Abstract

Evaluation of Nurses' Leadership Self-Efficacy in Belize

by

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BSN, State University of New York Health Science Center at Brooklyn College,

1988

MSN, College of New Rochelle, 1994

Dissertation Submitted in Partial Fulfillment

Of the Requirements for the Degree of

Doctor of Philosophy

Nursing

Walden University

February 2026

Abstract

Nursing leadership in Belize is lacking but crucial to the well-being of patients, families, and the healthcare team. The purpose of this non-experimental, descriptive, comparative study was to a) determine the difference in leadership self-efficacy for current nurse leaders with three years or less of leadership experience compared to current nurse leaders with more than three years of leadership experience in Belize, and b) examine the differences in leadership self-efficacy between nurses in a leadership position and nurses not in a leadership position in Belize. The theories supporting the study were Burns' transformational leadership theory and leadership self-efficacy, based on Bandura's health belief model. The Leadership efficacy Questionnaire was administered to 47 nurse leaders actively working in acute care, clinical or behavioral health settings in Belize then analyzed with an independent *t* test. Results indicated no statistically significant differences between current nurse leaders with 3 years or less of leadership experience and those with more than 3 years of leadership experience, or between nurses in a leadership position and those not in a leadership position. A recommendation for future research would be to obtain a larger sample while maintaining the various cultural groups and to conduct a qualitative study in which nurses and leaders can express their lived experiences. The results may be used to enhance the quality of nurse leaders' lives within their teams and may promote positive social change by informing strategies to improve leadership self-efficacy.

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Dedication

I dedicate this dissertation to my mother, Ismay Evadney Staine Whittaker, who worked tirelessly as a single parent to set me on the right path in life. As a domestic worker in Belize, she labored endlessly to ensure that I received a quality education and was grounded in Christian values. Through her unwavering love and support, she equipped me with the tools I needed to succeed in every aspect of life.

Whenever I struggled with my homework and she was unable to help, she made sure to find someone who could. She taught me to trust God in all things, to place Him at the center of my life, and to never forget to pray and give thanks—even for the smallest mercies. My mother passed away on June 18, 2025, but her lessons, faith, and sacrifices continue to guide me every day.

I also dedicate this dissertation to my sister, Patricia Reneau, who patiently helped me troubleshoot computer problems during many late nights so I could meet deadlines. I extend my heartfelt gratitude to my sisters, Beverly Whittaker and Paula Reneau, and to my niece, Kirstine Daniels, for assisting me with formatting my papers when I could not get it right.

Finally, I would like to thank all of you, as I could not have walked this journey without your love and support. May God bless each and every one of you.

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Chapter1: Introduction to the Study

The attention to effective leadership to medicine has intensified since the Institute of Medicine (IOM, 1999) report. According to the IOM (1999) nurse leaders help to ensure patients receive quality care, provide safety for the patient, and create an environment healthy for practice. Grindel (2016) asserted that leadership at the clinical point of care is central to providing quality care, especially in all areas of health care, where leaders provide ready support and innovation to trouble shoot daily challenges, and their recommendations can influence the lives of the patients they serve.

Ledlow and Coppols (2014) noted that health care leadership is essential because it enables health care workers to explore complex and changing systems. Spiva et al., (2020) suggested that nurses should continue education with determination when providing education and training for orientation programs. The existing body of research in nurse leadership has focused on first-line managers and executives, with few addressing nurse leadership efficacy (Booher et al.,2021). More research was needed to support the potential for positive social change because nursing leadership for nurses in Belize was lacking but crucial for new nurses and the well-being of patients, families, and the health care team.

In Chapter1, I present the background, purpose, research question, hypotheses and theoretical frameworks. Chapter1also included the nature of the study, the variables, definitions, assumptions, scope, delimitations, and limitations. The study's significance to

theory, practice, and social change are discussed, and the chapter concludes with a summary and transition to the next chapter.

Background

Leadership is defined as an interaction with staff to empower them and give them the enthusiasm to achieve their assigned goals (Al-Dossary,2017). Leaders in nursing provide guidance and direction for accomplishing tasks (Tomey, 2006). Leadership is a collective responsibility in whatever role one serves (Canadian Nurses Association, 2009). Nursing leadership is in crisis because of the lack of new, upcoming leaders, especially at the senior level. For example, Daly et al.,(2020) found that frontline nurses who came to the fore front during the COVID-19 pandemic needed leaders who would ensure their interests. Daly et al. noted that some nurses stated that senior leaders were often too critical of budding leaders, education, research, scholarship, and practice.

There, is also a need for support for a public policy in nursing leadership .In a systematic review of quantitative leadership studies evaluating the productivity and efficiency of health care organizations, Cummings et al.,(2010) found that leadership styles focused on people and interrelationships as contributing factors to improving care outcomes, the labor force of nurses, and the environment of care. In contrast, staff satisfaction was reduced in studies where leadership concentrated more on tasks than on interrelationships (Cummings et al., 2010).

At the level of patient care, nurses must utilize the characteristics of clinical nurse leadership. However, Grindel (2016) noted that although the clinical bedside nurse is expected to take on leadership roles, many do not possess the capability or understanding of leadership. Therefore, to accomplish effective and efficient patient care, organizations should develop leaders among nurses as an important action plan (Kim et al., 2015). Previously, nurses in formal roles identified them for leadership roles. Recently, however, a paradigm shift has occurred, prompting organizations to focus on and recognize bedside nurses as potential leaders (Al-Dossary, 2017).

The many changes in healthcare, both globally and in Belize, have given rise to challenges that nurses face in delivering safe, effective, and high-quality care at a reasonable cost (Porter-O'Grady & Mallock, 2011). These challenges seem to have overwhelmed bedside nurses, preventing them from aspiring to leadership roles. The challenge included emotional competence and skills for providing coaching to direct change in nursing and systems in a context of optimism. The leader should employ the strength for change, expedite dialogues, and learn and apply current knowledge to promote a higher quality of life for human kind (Porter-O'Grady & Malloch, 2015). Nursing staff must be recruited with the required competence level to provide the needed quality of care. Unclear job description makes it difficult for nurses to perform their jobs. Staff must know the expectations of their job (Agyeman- Prempeh et al., 2021).

Guibert-Lacas and Vasquez-Calata (2022) pointed out that essential competencies identified to promote clinical nurse leadership are cognitive, interpersonal, and intrinsic. Guibert-Lacas and Vasquez-Calata found that intellectual encouragement, affective intellect, and reflection skills were crucial. Murray and Cope (2021) concluded that leadership requires open dialogue that increases the safety of patients.

Transformational leadership is defined as leadership that provides guidance and motivation to the group to focus on tasks (Pishgooie et al.,2019).Lai et al.,(2020) described transformational leaders (TLs) as leaders using different types of actions that will inspire those who are followers of nursing staff or their task performance and helping behavior. Those inspired by TL individuals immerse themselves in their jobs and improve the performance of tasks and helping behaviors. TLs display behaviors that will enhance their follower's psychological state. In clinical areas, leadership focuses on those who receive care and the team that provides it, suggesting that nurses make exemplary leaders. (Al-Dossary,2017).

Bandura (1977) defined *self-efficacy* as believing in one's proficiency to arrange and execute a procedure to deal with a situation. Bandura's self-efficacy is derived from three sources of data (a) performance accomplishment (prior experience of their accomplishment capability to recall those moments), (b) vicarious experience (observing earning success outcome, demonstrating success), and(c) verbal persuasion achieving assistance with coaching, effective and practical corrective action). In physiological

states, assistance with the linkage in a useful manner emotion with the body. The management of one's thinking, behavior, and feeling influences self- efficacy. Self- efficacy sources use self-efficacy-associated outcomes such as motivation, behavior, and performance (Shirey,2020).

Self-efficacy in the literature referred to a linkage between advancing confidence in professionals and leadership (Van Dyk et al.,2016),encouraging professional advancement with an academic degree (Winslow et al.,2014), continuing career advancement(Cziraki et al.,2018),strengthening leadership in nursing (Murphy &Johnson,2016), and certifying a connection with the styles of leadership that encourage self-efficacy (Hao &Yazdanifard,2018) among nursing educational programs for managers to support their role and assist in instituting confidence as a professional. Retaining proficient persons can encourage self-efficacy and inculcate role models for the inspiration of future nurse leaders currently in the labor force. Winslow et al.,(2014)looked at the relationship between self-efficacy and advancing academic aspirations of RNs in the United States with in a condition of continuous learning and positive results connected with a prepared workforce. The findings suggested that nurses with a higher degree achieve a higher score compared to those who take on higher academic preparedness. Cziraki et al.,(2018) examined precursors and outcomes of leadership by testing a model of Canadian leadership in nursing. The findings were aided

by the hypothetical model that significantly relates the development of skills, short-term management roles, and an informal situation of mentoring to nursing leader self-efficacy.

Organizations should seek and implement updated information about educational policies and procedures that promote nurses taking on leadership roles to support new and inexperienced nurses to develop and excel at all levels of practice. Only with in such an environment can an individual be accountable for distinguishing challenges, planning improvements, and making the right decisions for patient care. The current study addressed the gap in knowledge, and results may improve the skills of nurse leaders for directing newer and inexperienced nurses, potentially improving quality patient care.

Problem Statement

Nurses in Belize with less than 5years of experience are unwilling to take on nursing leadership roles. Little was known about why nurses in Belize do not seek leadership positions or whether other nurses similarly resist leadership roles. Despite young nurses lacking experience, they become leaders. The suggested strategies for investigation of the problem were to consider using push-pull factors (Channel 5News Belize,2018).These nurses may not want to take on leadership because of a lack of confidence in their ability to serve as nurse leaders and there is no plan in place in Belize to prepare emerging leaders. Both younger and more experienced nurses need education and supportive mentoring to become strong leaders. Buckner et al.,(2014)identified a deficit in mentoring in areas that nurses can make a difference, such as practice,

education, and policy in healthcare. Sebelki (2017) explored the perceptions of physical therapist leaders' self-efficacy, weighing gender, age, and board certification using the Leadership Efficacy Questionnaire (LEQ). The findings suggested a moderate level of confidence in the three areas of the constructs. Brown-DeVeaux et al., (2021) wanted to determine if a structured mentorship program would affect the self-confidence and self-efficacy of ethnic minority leaders using the Leadership Institute for Black Nurses principles. Brown-DeVeaux et al used a pre-and post test using the LEQ, which showed a moderate increase in self-confidence.

Similarly, Wesley and Dabal (2009) evaluated a leadership institute developed to encourage further advancement in the careers of nurses of African origin in education, administration, and research. Phillips and Malone (2014) discussed the rise in nursing diversity and the significance of decreasing health disparities. They also discussed characteristics of prosperous staffing and keeping new minority hires and made suggestions to make a stronger development and assessed what they provided to eradicate health disparities. Gates' (2018) descriptive qualitative study explored the factors of faculty perceptions that captivated and continued a body of diverse student nurses at three universities, which consisted of a majority of minority students. The prevalent factors recognized are for faculty and students who are diverse, financial aid and provide low cost of tuition, courses on line and outreach programs in the community.

Self-confidence and self-efficacy are essential to establish for new nurse leaders. The premise is that nurses with more than 5 years of experience are more likely to serve as leaders than those with less than 5 years of work experience. Nurses with less than 5 years of experience were identified as not wanting to take on leadership (Gardiner & Sheen, 2016; Kim et al., 2015). Deficiency in self-efficacy can affect the level of self-confidence. Self-efficacy in nurse leadership can affect the factors for motivation to enhance their career. The improvement of self-efficacy needs the provision of leadership skills, experience opportunities, and mentorship in a supportive environment while preparing to replace the present leaders. In the aging nurse leader workforce, the barrier that impedes nurses' desire for leadership should be known for future leadership planning (Cziraki et al., 2017). Therefore, emerging leaders must recognize their level of confidence.

At a conference in Belize in 2018, I learned that a newer population of nurses was unwilling to assume leadership roles (Belize-Belize News, 2018). Young nurses with less than 5 years of experience lacked leadership knowledge and skills because their primary curriculum focused only on medical, surgical, and obstetrics with no professional role models of a good leader. The University of Belize (UOB), the only institution of higher learning for nurses in Belize, provides essential training and education. The current curriculum at the UOB nursing program is for Bachelor of Science in nursing, basic midwifery, and LPNs. Further, the UOB includes two introductory sections on leadership

and management: the nursing process and one clinical (University of Belize. Education. Belize, 2020).

When a country is a member of the Caribbean Community (CARICOM), (Alexander,2020),the regularity body for nurses is the National Nursing Council, which has the authority to provide nurses with a license and an exam to practice nursing. The council applies the laws of the profession, makes determinations on the scope of practice, and is involved in corrective actions. Alexander (2020) noted that a member of CARICOM is authorized to give practicing nurses either a license or registration of the completion of education and training created by CARICOM and the Ministry of Health or the nursing council. For Belize, the joint responsibility of the committee was derived from the Nurse Midwives Act of 1968 to enhance nursing education by providing exams and safe guarding the public where it is expected to have nurses sufficiently trained and educated (Nurse Midwives Act,2011), but the problem is that nurses are currently lacking the education and leadership skills. The goal of my study was to address this problem, which would support positive social change.

Purpose of the Study

The purpose of this study was to a) determine the difference in leadership self-efficacy for current nurse leaders with 3 or less years of leadership experience compared to current nurse leaders with more than3 years of leadership experience in Belize, and b)

examine the difference in leadership self-efficacy between nurses in a leadership position and nurses not in a leadership position in Belize.

I evaluated the nurses and nurse leaders' self-efficacy using the Leader-Efficacy Questionnaire, which I distributed to participants using Survey Monkey. The survey included demographic questions and questions about leadership self-efficacy and means self-efficacy. I obtained participants' consent to participate before collecting the data. I used email, social media, and flyers in public places along with snow ball sampling to recruit participants.

Research Questions and Hypotheses

There were two research questions (RQ) developed for this study:

RQ1: What is the difference in leadership self-efficacy for current nurse leaders with 3 years or less of leadership experience compared to current nurse leaders with more than 3 years of leadership experience who work in Belize?

H_01 : There is no difference in leadership self-efficacy for current nurse leaders with 3 years or less of leadership experience compared to current nurse leaders with more than 3 years of leadership experience who work in Belize.

H_a1 : There is a difference in leadership self-efficacy for current nurse leaders with 3 years or less of leadership experience compared to current nurse leaders with more than 3 years of leadership experience who work in Belize.

RQ2: What is the difference in leadership self-efficacy between nurses who are in a leadership position and nurses who are not in a leadership position in Belize?

H_0 2: There is no difference in leadership self-efficacy between nurses who are in a leadership position and nurses who are not in a leadership position in Belize.

H_a 2: There is a difference in leadership self-efficacy between nurses who are in a leadership position and nurses who are not in a leadership position in Belize.

The dependent variable was years of experience. The LEQ instrument was used to measure leadership self-efficacy, and the focus was on the three segments of self-efficacy scores, which consist of leader action-efficacy, leader means efficacy, and leader self-regulation.

Theoretical Frameworks

The self-efficacy theory supported this study. Self-efficacy theory comes from the social cognitive theory (SCT) defined by the focal attention to the way people learn (Bandura,1977). This theory addresses the relationship between what a person discerns as self-efficacy and change in behavior. The extent of self-efficacy determines the effort, energy, and amount of time a person needs to overcome a difficult situation (Bandura,1977). Two concepts support the theory of efficacy expectations and outcome expectations. In an efficacy expectation, a person has the confidence that they can achieve an accomplishment to fulfill the behavior required to generate an outcome. An outcome expectation is the person's assessment that a specific behavior will guide them

to a given outcome (Bandura,1977).Individuals with high self-efficacy levels in leadership roles provide adjustment of self by exploring situations that define the role (Fiske &Taylor,1991).However, an individual with low self-efficacy confidence in their skills will keep away from experiences or relinquish the assignment earlier than usual.

Winslow et al.,(2014) reported that general self-efficacy is perceived as greater in nurses who initiated their career at the diploma or associate's degree level and later advanced to other degrees to improve their self- efficacy. Self-efficacy is perceived as a task and specific on text (Bandura,1997). In this context, self-efficacy is leadership observed as an influential predictor of one's performance, behaviors, and accomplishment (Bandura,1997; Venskus & Craig,2017). Ducharme et al., (2017) examined the relationship between leaders' perceived influences over the professional practice environment and the engagement of clinical nurses' in essential professional practice. Nursing leaders observed more significant impact in determining resources used for patient care. Clinical nurses had more positive insight into the appropriateness of staffing on the Essentials of Magnetism based on the idea that nurse leader see themselves as more inspiring.

The health belief model (HBM) is defined as a determinant regardless of the reason people will take responsibility for prevention, unearth, or take charge of the condition of an illness (Rosenstock,1974). HBM is a theoretical model designed by social psychologists. The U.S. Public Health Services emerged in the1950s as a process to

better understand why people seek health care as an aspect of self-efficacy (Rosenstock,1974). The hypothesis is that a person's reason for behavioral change comes from assessing many constructs, such as demographic factors and personality, as evidence that these elements can affect their motivation to transform their actions (Fertman &Allenworth,2017).The HBM later included self-efficacy advanced from Bandura's (1977) SCT, which focuses on human learning, distinguishing between influence and illustration. The SCT has demonstrated how one is shaped by their behavior in a place of employment (Gibson,2004).Bandura's self-efficacy is defined as one's belief in what they can do to achieve desired outcomes based on their actions. Central to the theory is efficacy and behavioral outcome expectations. Self-efficacy expectations are strengthened when one believes they can be successful despite obstacles. Self-efficacy outcomes can affect leadership behavior if one feels that their actions will give them a desirable effect, and behavior can affect results (Dubovi & Sheu, 2022).

Self-efficacy in leadership was further defined as the level of assurance that one has in their knowledge, skills , and capabilities to provide leadership to staff or other groups (Hannah et al.,2008). The most common attribute used to define a leader was confidence in oneself. Leaders may experience limited stress when situations are changed by believing they have control of themselves and what happens (Popper &Mayscless,2007). More recently, leadership self-efficacy can transform staff nurses and leaders to institute change (Hannah et al.,2012). Leaders in nursing play an essential role

in enabling nurses to have positive relationships with their team leading to successful outcomes in the organization. Bulmer (2013) suggested that a shortage of nurse leaders is imminent due to an aging workforce and the prevailing idea that the staff nurses are not interested in taking on leadership roles.

The self-efficacy LEQ survey was established and validated using military and adult populations employed in various places (Hannah et al.,2012). Self-efficacy means that the nurse must believe that they have a natural capability and the individual measures to accept leadership as part of the professional nurses' role (Orji et al.,2012).Hannah et al.,(2012) identified the three components of leader self-efficacy: leader action, leader mean efficacy and self-regulation, which make it applicable to examine the sensitivity of nursing professionals in academics. Using the LEQ, Moran et al.,(2021) investigated the perceptions of leader self-efficacy of academic professionals in nursing to determine whether specific characteristics or involvement in particular activities could predict a leader's self-efficacy. Moran et al.,(2021) identified statistical significance between degrees and academic scores. Generally, there was a moderate to high LEQ universal score of 70 or more. The logical connections between the theoretical frameworks presented and the nature of my study included the alignment of concepts and assumptions within the HBM frameworks.

Nature of the Study

This study examined differences in leadership self-efficacy for current nurse leaders with 3 years or less of leadership experience compared to current nurse leaders with more than 3 years of leadership experience who work in Belize. Leadership self-efficacy was measured using the LEQ, which has 22 questions, which included demographics where scores are applied and a comparative analysis to evaluate the self-report of perceptions of leadership style and years of experience compared to the scores on the LEQ. The study also focused on the difference in leadership self-efficacy between nurses who currently work in a leadership position and nurses who have not worked in a leadership position in Belize. I gathered written data from the LEQ by Survey Monkey from nurses and nurse leaders who met the inclusion criteria. The validated instruments were used to organize the survey specific to leadership content. I used Statistical Package for the Social Sciences (SPSS) to analyze data including demographics, years of formal leadership training and practice, and self-report of perceptions of leadership style.

Key Study Variables

The independent variable was years of leadership self-efficacy. Newer inexperienced nurses provide the most direct care to patients and families. When nurses are unwilling to lead, it can affect patient safety and the quality-of-care criterion. Leadership in nursing is practiced at the point of care and at higher levels as unit leaders, collaborate with the interdisciplinary team to ensure patient care and give direction to the

ancillary staff and others. The independent variables were the self-reported years of practice, leadership self-efficacy as a leader, level of education, and demographics.

Inclusion criteria included bedside nurses and nurse leaders who worked in Belize with 1–5 years or more of experience.

Understanding leadership style may improve leaders' self-efficacy and enhance their self-efficacy in their relationships with bedside nurses. The American Nurses Association (ANA, 2010) defines TL as an essential element for the practice of nurse administrators. TL enhances and encourages positive change, inspires followers, and promotes eagerness and joint decision making. To create an environment of change, leaders must be open and encouraging, and workers must be eager and share in decision making (Clavelle et al., 2012; ANA, 2009).

Definitions

Attitudes: Emotional elements that call attention to something or someone where by a person methodically places information about their surroundings (Townsend, 2015).

Authentic leadership: Leadership that encourages deeper knowledge of the self, leading to self-acceptance, self-awareness, feelings, characteristics, and genuineness (Lee et al., 2019).

Beliefs: Strategies one confides in and holds to be genuine, which can have an explanation or be invalid according to the extent to support the objective (Townsend, 2015).

Inexperienced nurses: involve nurses with a clinical work experience of ≤ 5 years (Wenxia et al.,2022).

Laissez-faire leadership: Keeping away from others and not doing anything (Avolio,2011;Bass &Bass,2008; Hinkin &Schriesheim,2008; Skogstad et al.,2014).These leaders do not make decisions. They forgo their control, hold up an action, and do not use the authority of their position (Bass &Bass,2008; Hartog et al.,1997).

Leader action efficacy: The leader's ability to complete crucial action such as motivating, coaching, and identifying with an organization's goals and mission (Hannah et al.,2012).

Leader means efficacy: The leader perceive that they can learn from others when they perform their duties to improve leadership and that their sources and policies of the organization can be adjusted to effect leadership (Hannah et al.,2012).

Leader self-regulation efficacy: The leader provides meaning and motivation and brings about novel and useful solutions using effective leadership (Hannah et al.,2012).

Leadership: Interacting with staff to empower them and give them the enthusiasm to achieve their assigned goals (AI-Dossary,2017). Leadership in nursing provides guidance and direction for accomplishing tasks (Tomey, 2006). Leadership is a collective responsibility in whatever role one serves (Canadian Nurses Association,2009).

Leadership Efficacy Questionnaire (LEQ) : An instrument developed and validated by Hannah et al.,(2012) in which a military group and adults were employed

from various walks of life. This instrument measures leadership and efficacy in other disciplines. In nursing, this instrument concurs with the requirements allotted to academic professionals. Leaders should take different manifestations of efficacy when experiencing complexity and dynamic. This instrument focuses on self-efficacy and three areas of leadership (Gist & Mitchell, 1992).

Leadership practices: When nurses lead, analyze, and redo policy and patient care (Porter-O'Grady, 2003).

Online Education: A web-based program through the internet used to provide education using an electronic platform (Cojocariu et al., 2014).

Self-efficacy: The belief of an individual that they behave in ways required to bring about a particular accomplishment (Bandura, 1977, 1986, 1997).

Servant leadership: True and valid interest in others; service for one's followers is the priority (Bobbio & Manganlli, 2015).

Transactional leadership: Leadership that provides guidance and motivation to the group to focus on tasks (Pishgooie et al., 2019).

Transformational leadership: Leadership that causes the group to increase trust, show respect, and find the motivation to excel to higher levels (Bass, 1985). This leadership style is centralizing and includes a group of competencies (Fischer, 2016).

Unwilling or not willing: Disinterest in performing a task with or without providing a reason (Naskar et al., 2020).

Willingness: A factor that could result from one's socio demographic determinant (Nomura et al.,2021). The concept could also be defined as a person who has no interest or is not eager to participate in an activity (Naskar et al.,2020).

Assumptions

I assumed that the LEQ would explain the scores and the survey would provide measures of the leaders' self-efficacy (see Hannah et al.,2012). Assumptions of the meaning fullness of the study were that there would be a better understanding of the leadership style. Furthermore, because this was a voluntary survey, I assumed the nurse leaders would feel free to provide the appropriate information that the study sought to investigate. I also assumed that participants would provide an honest self-examination of their style of leadership.

The research problem was that nurses who are newly entering the profession are neither sufficiently encouraged nor motivated to pursue leadership roles at their level of practice. Although the primary nursing curriculum in Belize includes two sections on leadership and management, this limited exposure maybe insufficient to foster leadership interest or confidence. This situation likely reflects systemic factors within the health care environment in which nurses' practice , including organizational culture, limited mentorship, and a lack of clearly defined leadership pathways.

Scope and Delimitations

The study identified various elements that may affect newer bedside nurses' unwillingness to take on leadership roles at their level. The study had a limited time frame and lacked sufficient resources. The sample was purposive and included bedside nurses and nurse leaders from Belize. The nurses completed questionnaires, and the study was dependent on their feedback. The study's inclusion criteria were current nurses who were working and studying in Belize. These criteria were chosen because a lack of leadership in patient care can affect the quality of care provided by bedside nurses, their job satisfaction, and their interest in career advancement (Ducharme et al., 2017; Saleh et al., 2018). Threats to internal validity included events occurring during the study, such as participant dropouts, variations in age range, scores closer to the mean, instability of the dependent variable, and interactions from different groups. In terms of external validity, threats included the type of sampling used, since it was not a random sample (see Polit & Beck, 2017).

Participants may not have had the time or patience to complete the entire survey. Some participants may have preferred to work with paper copies rather than digital ones. Other participants may not have had the necessary computer skills or may not have had access to a computer in their homes. There may also have been limited explanation of contextual situations, inconsistencies in the reporting of results, and challenges in comparing bedside

nurses with nurse leaders who influence the clinical environment. Nurse leaders at the bedside play a critical role in shaping practice environments and motivating nurses. Developing a structured educational program focused on leadership self-efficacy would enhance nurses' understanding of self-efficacy and its meaning. Increased leadership self-efficacy can positively influence motivation, confidence, and decision-making, thereby encouraging nurses to progress to higher levels of professional and leadership functioning. This study investigated the leadership self-efficacy of nurses working in Belize who were over the age of 18 and had 1–5 years of experience. The exclusion criteria included bedside nurses and nurse leaders who were below the age of 18, were not educated in Belize, or were not currently employed.

Limitations

Administrative leaders may not have supported nurses and nurse leaders participating in interviews if they perceived and believed that nothing could change and that participating could present another challenge (see Broyles et al., 2011). The limitation of the current study's design and method was its focus on bedside nurses and nurse leaders from Belize. Participation in the study was voluntary, and no incentives were provided.

Significance

This study may be significant in that additional research can be used to determine what specific resources are required to align leadership with patient care, focusing on both the patient and the care providers based on understanding the self-efficacy and means of self-efficacy of nurses and nurse leaders. This study may also provide new information to the body of knowledge in Belize on how nurses are prepared to be leaders and advocate for their patients for advancing theory. The study's results may inform and affect positive social change from the perspective of nurses' self-efficacy to better understand the value of leadership concepts. Leadership fosters more transparent communication among various disciplines, coordinates patient care, and promotes the delivery of high-quality patient care.

Significance to Theory

The significance of theory and practice with transformational leadership (TL) is that the study could influence the quality of nurses' performance to aspire and excel in leadership roles and, as a result, enhance the quality of patient care. The nurse, as a leader, is placed in a position to provide effective and efficient leadership for a diverse demographic in an environment with complex healthcare needs. The significance of theory and research is that research supports the scientific foundation for practice. Nursing practice is grounded in theory and research and, as a result, can provide new scientific knowledge for improving quality patient care and strategies for cutting-edge education of nurses and clinical practice (Grove et al., 2017).

The current study may provide new strategies to encourage leaders to use transformational leadership behaviors. This may support an organization's mission, vision, values, and goals as applied to promoting health as an intervention for patients and staff (see Lin et al., 2015). Evidence suggests that leadership in nursing affects the patient care experience and outcomes of care, job satisfaction among nurses, and nurse retention. Morsiani et al., (2017) described the perceptions of staff nurses regarding the leadership styles employed by nurse managers. The authors noted that nurse manager behaviors may require change. The results suggested that unit nurse managers mainly used a transactional leadership style, which focused on monitoring and correcting mistakes, disciplining staff, and intervening to correct errors. This situation unfavorably

impacted the staff nurses' job satisfaction levels. In contrast, TL was used more often in connection with higher satisfaction levels, characterized by caring, respect, appreciation, and the development of the nursing profession.

Significance to Practice

Nurse managers and leaders at the unit level are responsible for ensuring the quality and continuity of 24-hour patient care within the clinical setting. Nurse managers/leaders are proficient in knowledge, skills, and administrative strength in care and link with the bedside / staff nurses and the administrative level .The current study may allow the leaders to comprehend the way their practices of leadership will affect nurses and actions correlated with care (Cheng et al., 2016). The current study may be significant to the to the advancement of the Health Belief Model (HBM) , including leadership self-efficacy focusing on self-efficacy. A health system such as Belize may identify and determine nurses leaders' preparation and practices. For nurse leaders with little experience , a plan can be designed and implemented for leadership development (Cheng et al., 2018).

Significance to Social Change

The Social Change Model (SCM) promotes fairness, social justice, self-knowledge through service, and collaboration. This framework is appropriate for programs in leadership development targeting students who do not see themselves as leaders (Read et

al., 2016). A pre-licensure program was conducted using a focus group. An instrument was pilot tested to evaluate the effect of the SCM. The results indicated that the students did not have the experience necessary to feel welcomed by change. The implications for social change in the current study entail having conversations regarding socio-cultural issues, mentorship for students / nurses, promoting giving service in the community and holding membership in other organizations. Read et al., (2016) concluded that nurse educators can organize leadership programs that promote social change. Read et al identified the need to educate nurses to become leaders because they are well placed to define and lead health care challenges. There is also a need to redesign the systems that generate leaders (IOM, 2010).

Dugan et al., (2013) suggested that leaders arise from a situation and provide interventions that may improve managerial ability and self-awareness in up-and coming young nurses. Developing governance is a continuous journey throughout life; self-reflection and experience generate good managers. Good programs may serve leadership with further opportunities for advancement while offering feedback that builds self-awareness on how to lead.

Correa and Bacon (2019) used the Press Ganey Practice Environment Survey to evaluate job enjoyment and perceptions of leadership. The results were from staff and managers and their reactions to a five-part leadership program in which items assessed by

the nurse managers were the ability, leadership, support of nurses' subscales . The first group of participants comprised of nurse managers with master's degrees in nursing who managed multiple units/population and were responsible for more than 60 full-time equivalents . The second group was staff nurses from inpatient units of five employed in their positions for one year or more who were supervised by nurse managers. The program explored the perceptions of the staff nurses after their managers involved in a program for leadership training. Correa and Bacon compared pre- and post-intervention assessments and retro review data from the National Database of Nursing Quality Indicators Press Guiney Practice Environment Survey using the servant leadership model. Correa and Bacon implemented and assessed five interventions: work done -from-home monthly, budget training, snack shack, report cards evaluating activity outcomes of the activity and developing leaders.

Competent leaders for positive social change can impact society by having nurses demonstrate a vital role in enhancing health and quality of life by exemplifying leadership. Nurses should demonstrate leadership aptitude and empowerment regarding their potential. Different empowerment programs that may affect and influence nurses according to their abilities for the eventual leaders should be initiated. Nurses who excel should be identified and used as role models to demonstrate how they make a difference in society. There should be introduction of political activities for nurses to be empowered, and enhance their exposure to the public and professions in health care

(Yi, 2018). Bard et al., (2022) reported that the COVID-19 pandemic revealed the necessity for preparing nurse leaders in whatever capacity they served. In an evaluation of the empowerment programs for nurses who provide direct care, the evidence indicated that the materials used for leadership development enhances their abilities for leadership. Those abilities can further used in the work place. These studies identified gaps and problems in practice. They provided some suggestion of how my study could contribute, to potential leadership education module for training that could contribute to positive social change.

Summary

In Chapter 1, I presented an overview of the study, including the background of the setting, and the purpose and the problem identified. The main topic of interest and the research question were introduced and discussed, and the theoretical framework was presented in relation to healthcare. The significance of the study as it relates to the limitations, practice and theory and social change was presented. In Chapter 2, I discuss the significance of studying the need for health care in leadership. The literature review supports the study.

Chapter2: Literature Review

The research problem is that newer bedside nurses with less than 5 years of experience are not willing to take on leadership roles in Belize. Both newer and more experienced nurses need education and supportive mentoring to become strong leaders. The purpose of this study was to a) determine the difference in leadership self-efficacy for current nurse leaders with three years or less of leadership experience compared to current nurse leaders with more than three years of leadership experience in Belize, and b) examine the difference in leadership self-efficacy between nurses in a leadership position and those not in a leadership position in Belize. The style of leadership used was also identified by the participants.

Having an operable, quality system of healthcare requires competent personnel to provide quality service in which staff are motivated and given structured learning situations that facilitate empowerment (Cassiani et al., 2020). Nurses are the basic to a healthcare system where they make up 60%–89% of the healthcare staff, provide approximately 90% of the care and service, and are the frontline providers in deprived and developed areas where they fill gaps in health resources (Pan American Health Organization–World Health Organization [PAHO-WHO], 2016). The Caribbean Cooperation in Health (2015) asked nurse educators to provide feedback on the need for human resource development, including a regional health human resource policy, an

action plan for nurses, and a public health labor force for the improvement of health and development for CARICOM members. The program would provide instruction addressing issues for nurses and midwives, including stronger leadership, because there is no organization available to develop primary healthcare resources in the area and recognize the need for stronger programs such as BSNs to become the entry-level degree for nurses (Caribbean Cooperation in Health, 2015). The major sections of the chapter are the literature strategy used to identify the literature, the theoretical foundations (TL and HBM), and the literature review.

Literature Search Strategy

I analyzed quantitative and qualitative studies from recent peer-reviewed journals published from 2015 to 2024. The recent literature established the relevance of this problem and other related areas. The databases and search engines used to search the literature included Pub Med, CINAHL, Nursing and Allied Health, EBSCO, and Pan American Health Organization (PAHO), World Health Organization (WHO), scholarly books, and the local country's informational website. I used the following search terms: *leadership, Transformational Leadership (TL), Health Belief Model, preparation, unwilling bedside nurses, and self-efficacy of leadership*. The related literature search revealed a problem currently monitored by PAHO and WHO for nurses across the world. The literature indicated there is a lack of leadership education and revealed the hurdles to

implement a state-of-the-art educational program of study to include leadership in the curriculum for those who provide nursing education (Nevenglosky et al., 2019).

Theoretical Foundation

The theories used were TL and the HBM self-efficacy of leadership as the framework and theoretical model for this study, which provided a practical foundation to support investigating how to prepare bedside nurses who are newer to the field for leadership (see Araujo & Figueiredo, 2019). According to Zhu et al., (2018), leadership is a complex interaction, and leadership theories are wide-ranging. Hospitals require nurses to take on leadership roles to make decisions, such as administrative decisions and deciding how to best care for patients (Araujo & Figueiredo, 2019).

Transformational Leadership

Initially proposed by Burns (1978). TL identifies leaders who focus on change to drive results. TL is a conscious, moral, and spiritual course which provides suggestions of ways for identical control for everyone, including managers, so all realize the same collective goal or transformation. TL is the process of developing commitment to the goals of the organization and influencing people to complete those goals, as well as encouraging and assisting staff to improve their resourcefulness and levels of

introspection (Burns, 1978). TL leaders motivate the team, support associations, and show concern for the organization. Bass (1985) further developed Burns's leadership concept, focusing on TL to the degree to which a leader can influence followers. Avolio and Bass (2002) developed a leadership model with three styles of leadership: transactional, TL, and laissez-faire.

Over the past decade, TL theory has been refined to define elements that required rearrangement of the model, where the focus is on situational occurrences in which the behavior of the leader is instilled (Bass, 1960; Yammarino & Bass, 1990). According to Kuhnert (1994), transactional is self-defining, focuses on the rules of the organization and how to apply them, and leads by external situations. In contrast, transformational leaders are internally focused and make changes according to their vision, while transactional leaders are externally focused (Howell & Avolio, 1993). Further, leaders who operationalize, TL are innovative and inspirational and encourage people to exceed their capabilities within an organization and help individuals become constructive and creative in their work. These leaders have an understanding of the employees, provide equity, and enhance the quality of employees' lives in the work environment (Zimmer, 2021). The TL style strengthens the capability of leaders to encourage and influence everyone where individuals must have self-assurance in their leadership, even causing them work for less wages; the purpose is the development of people and the leader operating as a team (Zimmer, 2021). Richter et al., (2016) reported that the source of TL is enthusiasm for the

future and belief in one's ability to achieve magnificent things by doing one's best to assist others.

Use of TL initiates positive changes in systems and at the level of the followers. Many persons with TL skills acquired them from the political arena. Additionally, TL is often encountered in religion with its capability to influence people. In the areas of religion and politics, people work in teams more often than they work alone (Zimmer, 2021). A downfall of TL is that with a charismatic leader, followers can become over dependent. This can occur when the leader becomes the soul of the organization.

A disadvantage to TL is that too much attention to the personality of the leader can sidetrack followers from their leadership development, where the aim of TL is for the leader to inspire the group to increase performance and improve their consciousness and possibilities (Cheng et al., 2016). TL inspires a group to bring their efforts together to fulfill work expectations. However, those who prefer to work independently and do not like teamwork can experience a decline in productivity when required to use the TL style (Zimmer, 2021). Transformational leadership is differentiated by its potential to reform and transfigure, to pass their limits and achieve outcomes that surpass what they anticipate (Fragonli & Tournalaki, 2020; Otair et al., 2022). The central aspect of transformational leadership is attention on values, socialization, feelings, integrity, and goals for the future, with special focus on making team members satisfied through

recognition that they are unique persons (Williams et al., 2023; Zoffman et al., 2023; Zhanbayev et al., 2023).

A Transformation leadership is differentiated by its potential to reform and transfigure, to surpass limits and achieve outcomes beyond expectations (Fragonli & Toulaki, 2020; Otair et al., 2022). The central aspect of transformational leadership is attention to values, socialization, feelings, integrity, and future goals, with a special focus on making team members satisfied through recognition that they are unique individuals (Williams et al., 2023; Zoffman et al., 2023; Zhanbayev et al., 2023). A transformative leader encourages employees to do more than what is assigned according to their functional job descriptions and progressive needs. This type of leader performs as a mentor or advisor, focusing on personal development, knowledge, and addressing the needs of the staff, while providing an understanding of the mission, broader perspectives, and respect and trust for staff. An atmosphere of confidence encourages employees to work for the organization without self-interest (Pearson, 2020).

Northouse (2022) furnishes that transformational leadership points towards the dynamics of the different ways leader can notice staff to achieve good outcomes. This style of leadership stresses the significance of how leaders discuss the needs of the staff to get them to be motivated . In that way, transformational leadership is a reinforcement and motivate to achieve personal and professional growth to achieve significant

accomplishment. The strategy of the leader is to develop change, enable effective communication, motivate staff, and integrate policy, vision, best practices, value, and future improvement (Roni, 2019).

Four components, known as the four I's, characterize TL: idealized influence, inspirational motivation, intellectual stimulation, and individualized consideration (Avolio et al., 1991). The constructs of TL are intended to encourage and influence staff to achieve extraordinary performance through transformation. This strategy is an essential element that guides organizational members towards positive change (Jufrizen & Lubis, 2020).

The leader infuses a feeling of self-respect, respect to the members, and links with everyone. The leader displays competence, awareness, and authority, characteristics that increase the respect of others and focus on the interests of others rather than individual concerns. The leader displays behaviors that are engaging during communication while attempting to make changes (Pearson, 2020). With idealized influence, the leader's role is to set the example for the team while providing assurance that there will be transformation and improvement in their performance. The element of inspirational motivation is where the staff will be educated to perform at their maximum potential (Collins et al., 2020). Inspirational motivators talk about the future and apply emphasis on essential things, plan, and provide a vision for their team. They create achievable

goals and are very deliberate about what they want to accomplish (Pearson, 2020). This example would be nurses working in teams with effective communication, such as passing on shift reports.

Intellectual stimulation refers to assessing possibilities to ensure that goals are applicable (Pearson et al., 2020). The nurse leader would have the capability to have reasoned opposition to risk-taking and would encourage the nurses to be innovative thinkers with creativity in providing patient education (Fischer, 2017). Individual consideration is providing time for educational development, while each person is respected as a person with needs and desires. The leader regards each person with needs, at their level of education, and assists them to develop their abilities (Pearson et al., 2020). The focus is on development and the mentoring process. This occurs in an empowering environment with a fruitful and innovative team (Raes et al., 2013; Renjith et al., 2015).

Poghosyan and Bernhardt (2018) investigated transformational leadership (TL) by evaluating nurse practitioners (NPs) from the perspective of primary care providers (PCPs), a context where little is known about NPs and leadership in PCP. A cross-sectional online survey design consisting of methods of NP practice and relationship was done by 279 NPs. The framework was TL with four factors to frame the responses of the NP via the reply to the leadership in the PCP organization. The survey included

evidence from extant information, qualitative meetings, and interviews with NPs about the setting of their employment, structures of the organization, and leadership making up the NPs' PCP organizational climate. The findings suggest that NPs note the existence or lack of all factors of TL; they understood their aim and function as followers to promote the mission, the future of the organization, and assist in the achievement of goals. I found variation in the response of the NPs about the factors of TL even though certain leaders show some qualities of TL, like performing to make the organization apparent. Most organizations allow the NP to perform self-reliantly, providing an opportunity for leaders to use the factors of TL and allow both NP and physicians to have the same privilege and distribution of resources. According to the responses, expressions of TL inspire the motivation to improve practice to gain and accomplish the entire purpose of PCP while enhancing and improving care (Poghosyan and Bernhardt (2018).

Essential to TL is that people require a feeling of trust, a sense of vocation, and the intention to work productively (Avolio & Bass, 2002). These qualities are specifically applicable to nurses who enter the profession with the goal of providing care for ill persons and promoting health (Weiss & Tappen, 2015). The theory of TL approach is applicable to nursing because of the mission, vision, ethical requirements, and followers values (Jambawo, 2018). The theory of TL is appropriate for this study and will help identify the gaps in nursing education and preparation in Belize. The research question is to seek to a response why these nurses do not want to assume leadership at their level.

The findings have the potential to impact social change, improve leadership education of nurses, and build on the theory which will be appropriate for Belizean nurses (See Appendix A).

Health Belief Model

The Health Belief Model (HBM), a theoretical model, developed in the 1950s by a group researching self-sustaining problems in public health as a process to better understand the reason people seek healthcare an aspect of self-efficacy (Rosenstock, 1974). In the early 1950s, public health was focused on the prevention and treatment of disease. Medical care was far from being appropriate for public health workers but there was an exception according to the history of public health that related to the compliance of patients, their symptoms, medical regimens, or doctors' communication. At the time many people did not place value on disease prevention or screening for early identification of disease characteristics, such as tuberculosis (TB), or cervical cancer.

The HBM was developed according to the premise that people are afraid of disease and healthcare, based on an association with the level of perceived fear and how to decrease fear with possible action. Healthcare practitioners and researchers were concerned that only a small number of people were being screened for TB despite mobile clinics going into neighborhoods (Glanz et al., 2015). Lately, the model has been used to

gain an understanding of people's intention to take COVID-19 vaccination (Zampetakis & Melas, 2021).

The concept of the theory includes how people become motivated and then motivate others to perform, use strategies to learn unfamiliar skills, and balance one-self. The theory clarifies how people change and affect others using the process and techniques. Thus, the Social Cognitive Theory (SCT) which started as the Social Learning Theory (SLT) in the 1960s by Bandura, developed into the SCT in 1986, and posits that learning occurs in a social context with a dynamic and reciprocal interaction of the person, environment, and behavior and has demonstrated how one is shaped by their behavior in a place of employment (Gibson, 2004).

The theoretical constructs of the HBM model based on theories in cognitive psychology where cognitive theorists maintained that reinforcements influenced expectations instead of directly influencing behaviors associated with health, the benefit is avoiding sickness (Bandura, 1993; Glanz et al., 2015; Lewin, 1951). The major HBM constructs are perceived susceptibility, perceived severity, perceived benefits, modifying variables, cues to action, and self-efficacy. Susceptibility is a self-assessment of health problems perceived as a risk to acquire (Rosenstock, 1974). Based on the model, the action of a person to change behavior comes from self-assessment of constructs from the model where HBM predicts that a person susceptible to a specific health issue will

become involved in ways that decrease their health risks. One with a low susceptibility may not acknowledge they have the risk factor to contract the problem, while others may concede they could become ill but feel it is not likely to happen (Sugg Skinner et al., 2015).

HBM included self-efficacy in 1988 to better interpret and explain for differences between individuals (Glanz et al., 2008; Rosenstock et al., 1988). Self-efficacy applies to a person's insight concerning their proficiency to favorably accomplish a behavior (Glanz et al., 2008). This construct enhanced an explanation of personal difficulties in health behaviors. Using the model authors were able to explain differences in health related behaviors, such as screening and immunization (Rosenstock, 1974). Later, HBM was employed for changes in behavior, such as diet modification, smoking cessation, and increased exercise (Rosenstock, 1974). Using the HBM authors project behaviors related to health associated with confident patterns of belief. One's motivation to take charge of health behaviors is placed in three categories: individual perception, modifying factors, and the likelihood of action. Those who believe that a health problem is serious have a high possibility of becoming involved in ways to ward off a health issue or reduce the intensity. The benefits of acting influenced health-related behaviors where people often act when they recognize the value or effectiveness of behaviors that encourage health. If a person feels that engaging in a specific action will decrease susceptibility to a health condition or decrease the severity, then that person is likely to become more involved.

The HBM construct of perceived susceptibility is that for one's actions to change, the nurse leaders must recognize that there would be a reaction for not taking on leadership roles (Rosenstock, 1974). With regard to self-efficacy and leadership, according to Bandura (1977, 1997, 2001) understanding relationships of leader self-efficacy and traits in nursing can support expansion and progress in the role (See Appendix B).

The findings of my study grounded in the HBM self-efficacy of leadership and TL theory supports the reason people choose to make their health behavior decisions and identifies the leader's self-efficacy and means self-efficacy as well as their ontological and epistemological assumptions. This model has been applied in leadership where one can identify the knowledge base of their leadership skills and education. I used the Leader Efficacy Questionnaire (LEQ), which according to Hannah et al., (2012), is the only instrument which addresses three parts of leader self-efficacy: Leader action efficacy, leader means efficacy and leader self-regulation efficacy, making it uniquely suited to explore the perceptions of the nursing professional. The LEQ was applied to evaluate the level of confidence and leadership styles. My study would benefit from the TL and HBM framework by helping Nurse Leaders design their programs with more robust strategies to reduce this population of nurses from not being willing to lead at their level. An organization with a supportive workplace is crucial to the retention and engagement of faculty. Transformational leadership had a substantial effect on the

workplace culture, job satisfaction, and an uninterrupted reverse result on burnout (Boamah, 2022).

Literature Review Related to Key Variables

The purpose of the literature review is to assist the researcher to provide and support background information of previous research, identifying the gaps in knowledge, methodologies, and areas for transformation (Maggio et al., 2016). The problem of lack of leadership from nurse managers for the nurses they support in Belize has been going on for some time and has taken various approaches. The studies discussed below consider how the problems were approached and include both the strengths and weaknesses of the studies. The research selected includes the possible variables that were explored in my study.

TL Studies in Leadership, Education, and Attitudes and Beliefs

Many research studies have been conducted using TL in different settings. Because of the increase in many studies, the focus has been on the well-being of employees (Medley & Larochelle, 1995; Nielson et al., 2008; Sofarelli & Brown, 1998; Thyer, 2003). Going back to 2013, the Institute of Medicine (IOM) (2010) report suggested that nurse leaders should come from the newer nurse to the executives. The premise was that the nurses should be able to serve as partners with other professionals and be responsible for what they give to deliver high-level quality of care while at the

same time, collaborate with other professional leaders in this high-tech ever-changing environment. According to Stanley and Sherratt (2010), leadership is important in a healthcare organization for a host of reasons, including healthcare reform, safe and effective patient care, and developing goals for the industry. The IOM (2011) reported that developing and keeping an environment of success enhances safety, need for leadership to be effective which should practice at all levels such as the patient care unit, boardroom, and the community.

Honour (2013) reported on the elevation of nurses as leaders at the bedside using the framework of Benner's novice-to-expert model to explore the organization, micro-system and at the corporate level to achieve outcomes. There was an exploration of education, mentorship, expansion of roles, and practice at the full scope and strategic planning for the future. The investigation of frontline nurse leaders found that leadership could be improved at every level in health systems so that nurses can position themselves to effect changes in transformation. The essential aspect to develop front-line leaders is having an organization with a healthy work culture (Connaughton & Hassinger, 2007; Sherman & Pross, 2010). Valued employees who support this type of culture achieve staff satisfaction, retention, professional development, and criteria for quality outcomes (Bally, 2007).

Leadership strategies include having formal programs at all levels. Developing nurse leaders focuses on having quality nurses that are ready and prepared to lead in all settings, who will implement evidence-based care and the full scope of practice at the level of their license. Overcoming barriers is recommended by engaging the nurses in the transformation of the care environment and being responsible to improve the outcome of care (Cetin et al., 2012). The weakness is that charge nurses are provided with a little amount of continuing education and have a more organized orientation program because of the extent of the nurses' responsibilities (Eggenberger, 2012; Hendren, 2010).

On the other hand, Saleh et al. (2018) explored the nature of styles used in leadership from the perception of bedside nurses. In the background, leadership is associated with job satisfaction, retention of staff, costs, and quality of care. Styles of leadership can be critical, however, not many studies address this issue. The study used a qualitative method using semi-structured interviews with open-ended questions. Analysis was done using the phenomenological-hermeneutic methodology applied to determine various themes. Leadership style is described by the participants as relational, preferential, communication chain, and ineffectual. The strength is that the style of leadership has a considerable effect on how nurses feel about job satisfaction, the coming and going of nurses, quality of care delivered to recipients of nursing care. The weakness of the study is that the sample was 35. There is a possibility that an increase in transferability of the findings may occur which will allow investigators to determine if

the demographics and attributes of the professionals may affect the views about the kind of leadership. The gap identified is that the styles of leadership have not been explored often enough.

Further, Araujo and Figueiredo's (2017) identify the type of environment nurses should be provided by the leaders of the discipline. This allows for job satisfaction, pledge from the organization, and citizenship behavior in the organization within their expertise. The study employed a survey method among participants working in private hospitals. Factor analysis and regression were used to analyze the data the model used for the study. The results suggest that enhancing positive attitudes should be focused on effective communication with the nurse to be certain of their roles, solid working environment, and promotion of relationships according to trust. The internal climate for nurses focuses on trust and employees at a high level of involvement. The concept of internal climate used for professional nurses is concerned with the human elements such as internal quality of service, quality of life at work, shared governance, governance in nursing, and self-managing. The positive direct consequences of internal climate that comes from the literature in contemplation of job satisfaction and effective communication. However, the researcher at the time when the questionnaires were filled out was absent. The sample consists of those persons available to be involved in the study. The strength is that it contributes to exemplifying the elements that can further a favorable internal climate for the nurses and provide support to the leaders of the

organization to face the challenges of management. The gap identified is that there is a need for a trusting relationship, clear efficient and effective communication.

Lacey et al. (2017) investigated the description of the curriculum of the American Association of Critical-Care Nurses (AACN) Critical Scene Investigator (CSI) Academy, which educates the staff nurses on the leadership skills that are needed to develop a change in a unit that should influence the outcomes of patient care and included topics in leadership, communication, change method concept in quality enhancement, data and project management analysis. Final evaluation of the program effect linked to the professional growth of the nurses, anticipated patient outcomes confirmable capability, and expense evaluated by the participants. The quality improvement (QI) projects of the hospital ended in positive and fiscal outcomes of care and were normally sustained for a year post-program. The strength was that AACN CSI Academy provided the resources to support the skill acquisition for staff nurses that transpired in the first hand application of leadership skills although CSI teams for the hospitals were responsible for their own data collection for projects and lacking data for their teams. The gap is that the particular type of empowerment to guide attempts for planning that can enhance patient outcomes is not the standard in healthcare, even though it is essential for a proficient enactment.

Cziraki et al., (2017) conducted a cross-sectional survey of RNs to investigate the antecedents and outcomes of leadership in nursing, as well as self-efficacy and their desire for management positions, using structural equation modeling with Mplus. The

framework was self-efficacy by Bandura (1986, 1977) evaluating four sources of information that allow a person to make judgments regarding self-efficacy: mastery experience, vicarious experience, social persuasion, and somatic and emotional arousal. Actual performances were noted as the most persuasive existence of self-efficacy. Findings suggested that leadership self-efficacy for nurses can be influenced by providing opportunities for leadership, even though there is a lack of evidence illustrating performance accomplishment by itself brings on behavior changes that is expected.

The leadership style, TL, can transform the staff by providing efficient and effective communication and guidance in being a role model and can enhance and improve communication skills, role model, build trust, motivate staff, give positive support, and provide a safe environment of care for the practice; TL skills help nursing leaders accomplish a higher level of professional development (Bass, 1985; Bass & Riggio, 2006). Pearson (2020) influenced culture and outcomes to achieve magnet status, supporting nurses to align their values and practice for the magnet status standards. The clinical nurses requested a better and improved environment that supported them and allowed for active participation in decision making.

Chen et al.,'s (2019) cross-sectional study assessed the willingness of nurses to receive vaccination as part of the recommendation for healthcare personnel and the element connected with their willingness to be vaccinated. A self-administered survey questionnaire targeted 413 nurses. The variables were the level of knowledge regarding

the recommendations for vaccination, perception of each person risk of becoming infected, perceived severity of the infection, perceived dissemination after the onset of the disease, benefits, and barriers, cues to action for the vaccination, willingness or desire for vaccination and socioeconomic information. The researchers conducted a descriptive analysis for demographics and the constructs of HBM, t-tests, and a one-way analysis of variance (ANOVA) to examine the relationship linking the relationship with demographics and the willingness to be vaccinated using Scheffe's method, and multiple regression analysis to investigate factors connected with the willingness of nurses to be vaccinated. The results of the study indicated that nurses' willingness to be vaccinated based on the country's recommendation since Hepatitis B was increasing and included the influenza vaccine. For the Hepatitis B program, the nurse's awareness about the purpose and benefits of vaccination increased willingness to be vaccinated since they view themselves as being exposed to risks, such as needle sticks, injuries by sharp objects, and patients carrying disease. The study concluded intervention is needed that enhances and improves knowledge of immunization recommendations for healthcare personnel, the transmission perceived after a disease starts, stress on the significance of the benefits of taking vaccination and decreasing perception of barriers to help nurses become more willing to be vaccinated.

Costanzo et al.,'s (2019) longitudinal survey investigated the effects of the bedside Nurse Leadership Development Program and their involvement in inter-

professional bedside rounds led by nurses. The nurses, 26-60 years old, who participated in the development and the rounds completed The Tasks Specific Self-esteem scale. Participants were from various ethnicities, education ranged from associate, bachelor's, and master's in nursing. The Jonckheere-Terpstra test performed the analysis of the Task Specific Self-Esteem Scale bedside nurses demonstrated improvement in leadership self-efficacy, age showed statistically significant difference. The purpose of the program was to get nurses involved with other professionals using communication and the development of leader self-efficacy and skills.

Topola and Miller's (2021) mixed-method design study explored the perceptions of first and fourth-year BSN students on the role of a nurse and investigated their willingness to participate in the roles that exemplified leadership and political involvement. A survey was used to collect data on the perceptions of the role of an RN and career goals with a subset for more exploration regarding student opinions. Comparable perceptions were present among the students in the BSN programs. The students acknowledged a need for leaders, but they implied that others should lead, not them. The results suggested that strategies are needed to prepare newer nurses who show a willingness for leadership involvement, political involvement, and the transformation of healthcare.

Concepts of TL

Idealized Influences: Strategies of communication, building trust, and the role of leader (Bass,1985).These attributes are essential to the care of the patient and care outcomes.

Individualized consideration: The leader provides personalized mentorship, empathy, and support so that newer nurses can be productive members of the team, have a sense of security, and feel empowered to take on leadership at their level (Pearson, 2020).

Inspirational motivation: The role of the leader is to motivate the staff to a higher level, exceed expectations, and work with other team members to accomplish the vision and mission of the organization, not just meet the standards (IOM,2011).

Intellectual stimulation: Encourages the nurses to be critical thinkers and examine challenges to get solutions and promote creativity (Pearson, 2020).

Concepts of HBM Self-Efficacy

The concept of self-efficacy originated by Bandura (1977) and is defined as beliefs in one's credentials to arrange and carry out what is required to provide an accomplishment. Self-efficacy refers to the beliefs or faith that a person has in themselves to be successful in a specific situation as an accomplishment or achieving a goal. The main point of the SCT is the theory of learning. This theory provides an understanding of how people configure their environment, and how it affects them. This theory emphasizes

the various sources of how learnedness originates. Emphasis is on the situations which affect their self-efficacy and interprets motivation, behavior, and performance. The two concepts of SCT are established from the theory: efficacy expectation and outcome expectations (Bandura, 1977). An efficacy expectation is explained as one with the belief that a task could be an activity required to achieve an outcome. *An outcome expectation* defines as one's evaluation using a particular behavior will advance to a specific result (Bandura, 1993). Theory supports variables and provides the foundation for those connections, it provides the investigator framework to develop a hypothesis and explain the context and scope (Norman, 2007). Even though studies on the topic reflect leadership in nursing, these studies focused on the need for leadership at the staff nurse level.

Leadership

Ortega et al. (2018) evaluated development of leaders at the supervisory level where it is crucial for the nursing workforce to obtain regional healthcare coverage for everyone. This course was actualized and extended by PAHO virtually. The participants were leaders and bedside nurses where the performance of the learners was also analyzed. The learners were placed in three cohorts: English, Spanish, and Uruguay. In cohort 1, 62% were administration, 33% education, and 5% bedside nurses. Almost 80% completed their degrees 10 years before, while 2% were less than 20 years of age, 2% were 20-25 years old, 10% were 26-40 years old, and 72% were 41-55, while 14% were

age 56 with an 83% completion. In cohort 2 there were 111 participants; 4% of were bedside nurses, 59% administration, and 37% education. Cohort 3 consisted of 120 participants (111 female/ 9 male). Of those, 0.8% were between 20-25 years old, and 71.6% were administration, 16.6% education, 11.6% bedside nurses, and 89 completed the course a 74% completion rate. The pre-post course diagnostic test and status post-course satisfaction test indicated the learners improved in the leadership sector of nursing with feedback that it was appropriate for the development of leaders indicated by the increase in leadership knowledge posttest among the cohorts, the average was 90% on the final assessment test, which indicated a solid comprehension of the educational program with English-speaking cohort more informed, which may explain their performance. The largest percentage was college graduates. The gap identified is that instructing leadership is lacking.

Boamah's (2018) researched clinical leadership behaviors of staff nurses on the quality of patient care. Using survey questionnaire participants were selected from nurses who provide direct care. Authors analyzed clinical leadership from the view of the nurses using a model that examines the outcomes of clinical leadership (CL) using the standard of patient care and job satisfaction. The hypothesis was that nurses who use CL have higher standards of care, resulting in improved quality of care. A 15-point CLS was developed, which had five sub-scales for a post-series of confirmatory analysis. Using a five-point Likert scale, nurses responded to 15 elements related to job satisfaction. The

goal was to advance knowledge about informal leadership at the care level through understanding how leadership affects quality of care and job satisfaction. Clinical leadership behavior was often used and resulted in an increase in both job satisfaction and in expectations for the standard of care for patients. This is the initial study that identified a positive connection with the quality of patient care regarding CL behaviors and job satisfaction, an important finding as it demonstrates the ability and effect that efficient SN CL has on the nursing staff and patients. There is more verification of the crucial duty of the CL, illuminating the necessity for informal leadership in the context of nursing and indicating a need for front-end expenditures in leadership at the level of care, which could be a necessary strategy for improving the outcomes of patients and nurses. There was a higher level of leadership skills in the entire five dimensions of clinical practice in the representation of leadership practice. However, little is still known about the relationship between informal leaders and the positive influence on nursing practice and patient care (Downey et al., 2011).

Larsson and Sahlsten (2016) reported there are few evidence-based studies on leadership and bedside RN/Staff nurse (SN) clinical leader (CL). Larsson and Sahlsten's study defined a Clinical leader as an RN who has a BSN, has an uninterrupted connection in the provision of bedside patient care, and who has a notable ability to make an important change on assisting nurses in which no official authority was established for them. The researchers aimed to understand how RNs determine what constitutes "good"

or “appropriate” bedside leadership during patient care. This phenomenography study aimed to distinguish the different ways the phenomenon is experienced. Participants were RNs who worked on various units, worked from 2 to 15 years, had a BSN or MSN, and had no management education. The categories included RN perceptions about what is required to be a leader at the bedside for inpatient care. The findings of the study supported past studies on what constitutes appropriate or effective nursing leadership at the bedside. The findings also help illustrate the perceptions of nurses regarding the most effective or appropriate procedures and steps for bedside leadership.

Carvalho et al.,’s (2016) examined the association between authentic leadership (AL) with the personal and professional profile of nurses in a tertiary hospital. The participants worked for more than two years in the hospital. Previously a bedside nurse was defined by those who give direct care per the organization with assistance from ancillary personnel. Planning and coordination of care was based on professional profile and responses to authentic leadership questions. For this study, personal and professional profile of the variables were investigated. The sample was bedside nurses, mostly women as well as clinical nurses who were ICU/urgent care, ER CL, and coordinators; the majority of the nurses had leadership roles. Cronbach’s alpha of AL questionnaire values was 64-80 points, 32 high and low. AL compared to the knowledge reported by nurses about leadership with greater significance reported by the nurses who used TL. The means of the scores compared to baseline on the position, former accomplishment of

degree, specialization, and proficiency in leadership, and self-awareness, which was higher in BSN in comparison to clinical nurses. Nurses who held leadership positions attained an elevated sense of worth for self-awareness and ethical outlook without statistical significance and no significant relationship with the AL variables of sex and schedule of work. In conclusion, the nurses who hold leadership positions were found to attain an elevated sense of worth for self-awareness and ethical outlook without statistical significance and the nurses showed AL, self-awareness were higher than with clinical nurses, which is a vital element in the structure of AL. There was no significant relationship with other variables. The gap identified was that this type of study may support knowledge to determine the characteristics of nurses that intercede with practice.

In their study of the effect of informal leadership (IL) on nurses and patient care, Lawson et al., (2020) implemented a two-phase study with non-managerial level nurse participants at larger hospitals. The nurses who had an average number above one standard deviation greater than the system mean sample was identified as an IL. The strength of leadership on the unit was defined as the proportion of ILs on the unit. The group identified as ILs was requested to complete a follow-up questionnaire concerning the style of leadership using the Multifactor Leadership Questionnaire (MLQ), the scores provided information about their extent of transformational and transactional leadership (TL/TA) or passive-avoidant tendencies. The data was combined at the unit level for the evaluation of the connection with the satisfaction of patients. Out of 3456 nurses (from

97 units and 14 hospitals), 628 (or 18%) of all ILs had additional years of professional knowledge and a higher level of job satisfaction than those not identified as ILs. There was no significant interaction between ILs on a patient care unit average patient satisfaction. The work supported the leadership foundation done by Hollander and Hemphill (1961) who realized ILs usually come from an admixture of proficiency, trust and could include both. The findings suggest assurance of relationships that are comparable between the time essential to achieve the necessary skillful proficiency and the time it requires to develop as an IL. ILs can impact the general mood of the team where one's job satisfaction may be affected in a top-down organization. On the other hand, ILs reported higher satisfaction in their job as a result of being more engaged in their job function. The study suggests that the influence of quantitative effects on IL has not been reported in the literature.

Attitudes and Beliefs

Arkin et al., (2022) conducted study a to explore direct care nurses' attitudes, skills and beliefs pertaining to the safety of medication practice. The instruments used was Safety Concepts (NASUS) scale and the beliefs of nurse regarding the questionnaire (NBEQ). The participants were mostly females who holds a BSN. In the analysis the NASUS scale findings in attitudes mean of the median 65.5 of 100, skills 79.2 and the questions connecting to severity of errors 7.66 of 10. The conclusion was that the basis

for developing strategies for improvement requires one to comprehend the skills, attitudes, and beliefs of the direct care nurses.

Al Saber et al.,'s (2019) investigated factors of direct care nurses that affect their willingness to lead. This online survey consisted of questions about socio-demographic job characteristics and the assessment of the desires of nurses to be leaders. The perceptions staffing for nurses was measured using a single measure such as the number of patient's tasks assigned to the RN's, and for burnout. Perception of their work provided them with training for leadership and preparation, asking how well the exposure and training laid the groundwork for leadership on a Likert scale of one-to-four. The measurement of perception on financial adequacy and distinct compensation, such as benefits, with the use of self-report. With the use of a single report, outcome variables were nurses' willingness to lead on a scale from one to four. The variables were selected according to the stepwise backward choice of factors. The relationship between age and gender was quantified by using logistic regression between race, gender, education, and ethnicity. The factors that predicted nurses' willingness to lead are the number of years of experience, burnout from their job, work environment, perception, preparation of leadership, adequacy, and financial compensation. The recommendation to improve their leadership attitudes gap, the CL nurses are to be assisted in the engagement to be active participants in the concerns of the organization where they are employed. The CL nurses

should also be provided with appropriate and sufficient preparation for leadership within the environment to enhance their attitudes concerning leadership skills.

Paterson et al., (2015), survey to evaluate how nurses perceive their leadership capability and outcomes of an education program that had the goal of supporting the capabilities of recent RNs. The program included the surveys completed at the end of the third and last educational workshop and then 6 months after , and included descriptive and accounts of the activities of the program. Of the 124 participants in the educational workshop, 79 completed the first survey, 28 the next, and 31 completed the survey administered 6 months later. In each area of leadership capabilities, the mean scores were significantly better for the duration of the course. The existing tools from Scott et al., (2008) assessed individuals in their intellectual qualifications for higher instruction in a higher education program in Australia. The indicators for transformational leadership were based on Carless et al.,'s (2000) global leadership scale, evaluating the behaviors of leadership. They found there were few opportunities for nurses to receive and demonstrate leadership proficiency.

A variety of programs focusing on different leadership topics were developed to prepare nurses for formal leadership roles. Paterson et al., (2015), focused on the nurse manager, on quality, sensitive indicators which support change, human resources issues, evaluations and management, and development of clinical incidents. Gardner's (1993) theory of multiple intelligence and intrapersonal intelligence informed the first workshop

on leadership (such as the cognizance and self-assessment required for productive teams). Casida and Parker (2011) reported attributes for leadership are consistent with transformational leadership, known to be linked to an environment of trust, collaboration, effective shared governance, and job satisfaction of nurses. It is also a major characteristic of a magnet organization (ANCC, 2021). Colley, (2019) explored perceptions of BSN RN students who identify as introverts. The nurses were interviewed to determine their perceptions about scholastic experience with the inclusion of leadership preparation for positions in leadership. The framework used for the study was Heidegger's philosophical tenets which explored the lived experiences. The participants were women, ranging in age from 20 to 50; two were Hispanic and five Caucasian. The participants had various educational experiences, and a previous degree and attended two or other advanced scholastic institutions. Four dominant themes emerged from the data analysis. Such themes came out in many ways and forms during the interview. The themes' reported suggested not making them ill and that they will come to appreciate learning. The participants requested that their silence be valued and will ultimately speak. Further, their soundness to be recognized will likely heighten with self-assurance for leading while adjusting to the environment that will enhance learning. The findings imply that introverted student nurses could have physical and emotional discomfort simultaneously with the time of their experience. A minimal amount of stress can affect their learning (Vogel & Schwabe, 2016). The descriptions by the participants expand past

a low level of anxiety. Research in neuroscience holds that elevated levels of stress can interrupt the capability to remember information in the long run (Doyle & Zakrajsek, 2013; Vogel & Schwabe, 2016). The gap in leadership behavior for nursing student education is limited in understanding attitudes and beliefs needed to develop confidence and pursue leadership.

Booher et al., (2021) studied nurses and their understanding of what constitutes effective bedside treatment and improves patient outcomes. Using an open-ended interview, the interviews were analyzed by combining answers into categories to create themes on how leadership is defined. The participants defined a leader is an advocate, concerning, accessible, objective, fervent about uplifting and getting the best out of others, has integrity, inspires people to strive and achieve their goals, is considerate, modest, assertive, and a good communicator. Leadership is also viewed as an educator to new nurses/students, and identifying patient needs and coordinating care with needs assessment, accountability, and authenticity. They also noted that a leader puts others before self, is empathetic, and is a role model.

In Booher's study, 50% of the clinical nurses did not identify as leaders. For the participants, this term was associated with the manager title, but while participating in the focus group, they did come to define bedside care as a form of leadership and realize that they coordinate care, collaborate with others, advocate, certify, and provide authentic care with understanding and humbleness, and are examples to novice nurses and students.

The participants were also observed noting TL and SL as admired leadership attributes. The SL central concept is in alignment with the standards of practice for nurses set by the American Nurses Association (ANA) code of ethics (Booher et al., 2021). CL included clinical competencies, interpersonal skills (communication, collaboration, coordination of care) nurses model proficiency through advocacy and education of the patient. Further, the barriers identified regarding the effectiveness of their leadership at the bedside were increased responsibilities and workload. Overall, the concept of leadership self-perception is an area that has not been explored in the literature.

Education

Ocho (2020) explored the perspectives of nurse managers regarding their preparation for leadership positions. The participants, nurses in the Caribbean, were asked to identify the challenges faced in transitioning to leadership roles, as well as the strategies they used. The setting was in four countries: Belize, St. Vincent, the Grenadines, and Trinidad and Tobago. The cross-sectional quantitative method was used because it allowed them to do an inferential analysis of what will be investigated, identify relationships between variables, and generalize according to the findings and provided a higher level of impartiality and anonymity for the participants while not sacrificing the quality of the information (Daniel, 2016). The nurses worked in public hospitals and were given hospital promotions in leadership. The sample consisted of nurses who were promoted to a leadership position within the last five years and who

were between the ages of 30-60. The data were collected using both an open- and closed-ended questionnaire. The development of the questionnaire was done using elements of transitions so that the cultural nuances were linked with the transition into the position of leadership are included. The instrument was pre-tested to measure face and content validity with the use of senior nurses not in the study from Trinidad. Cronbach's alpha 0.718 indicated an intense inward regularity per the instrument. Inferential statistics use correlations to determine if there was a relationship between the variables, whereas the Chi-square measures the strength identified with the variables. The lack of responses at a high level from the responders in other Caribbean countries other than Trinidad and Tobago influenced the degree of the analysis in the inter-country. Of the 126 participants, there was a 63% response rate, of which 112 respondents (88.8%) were women, with an age range from 35 to 45 (54, 42.8%). employed 10 < 15 yrs., 20 years and over the group. Most of the responses 94, 74.6% from Trinidad and Tobago, HN 46% 1st level supervisor, highest level of education BSc 425, 62% diploma of AAD and most everyone works in acute care 86, 68.2% overall the participants believed that their new leadership position 68.8% (88) by agreeing or strongly agreeing with articulation. Training also helped 79 (62.7%) in preparation for a position. Overall, the majority of the participants (96, or 76.2%) were grateful for the assistance from their supervisor in their new role, and most (84, or 66.7%) were collaborative in corroborating with the staff. The person who was assigned for supervision support by 80%, opportunities by 75%, was cognizant of the

available skills to improve. Opportunities for skills improvement for 75% and 45% unaware of the skills available to improve even though their concept of their previous job holder preparing them for their new position.

The findings indicated that there was a certain level of disagreement between 51% of the participants with the position. There was an overall view that there was a lack of a framework and support within the organization to promote the transition to a new position for leadership 75 (59.5%). Overall, there was a lack of preceptors to prepare them for leadership, with the participants disagreeing or strongly disagreeing, and 17 (13.5%) un-decided. Another 99 (78.6%) were not in disagreement, strongly disagree, and not decided about having some form of coaching to support them. Participants also reported they were not sure there were enough means available to achieve success, and 88 (69.8%) were not sure or did not believe there was a human resource plan available in their organization particular question. The gap was that the curriculum was essentially technical and clinical skills with little significance on leadership, which supported the rationale for my study to evaluate leadership issues in Belize.

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Summary and Conclusions

In this literature review, I presented research studies relevant to leadership in nursing, which were the dependent, independent variables focusing on nurse leaders' self-efficacy and means self-efficacy. The major themes focused on factors that prevent

the nurses' willingness to lead in the work environment. The development of nurses at the leadership level was lacking in healthcare organizations and higher learning institutions. The research literature supported what is determined a good or appropriate leader. A leader's perceptive awareness of colleagues is an informal yet powerful leadership technique. Leaders can perceive a nurse's leadership capabilities and gauge the job satisfaction of nurses. Leadership preparation in BSN students requires a positive learning environment. Effective leaders must be proficient, A leader requires knowledge of leadership, the preparation of nurse managers for leadership requires a framework and support for the transition to leadership. Most of the studies focused on the leadership level with little focus on clinical bedside nursing. The studies tended to reflect on the influence of leadership in nursing, care of the patient, job satisfaction, education and the healthcare environment.

The IOM (2011) acknowledges that to support that, nurses are prepared to take on leadership , competency related to leadership should involve programs for professional development and be delivered through all nursing education and programs for mentorship. Nurses must be accountable for their growth and development for leadership. The American Nephrology Nurses Association's (ANNA, 2017, p. 1) core belief is that nurses should be provided with suitable circumstances to provide leadership and should capture the moment to enhance, improve, and refine their leadership skills.

The meaningful gap I addressed is nurses' willingness to lead, which extends the knowledge concerning the reason that nurses do not want to assume leadership roles in practice. Thus, it can form the baseline for preparation of program and future studies with strategic assistance from Pan American Health Organization (PAHO) and WHO. I summarized the current literature that supports my research question, to seek a response why nurses do not want to assume leadership at their level. The literature focused on leadership, education, attitudes and belief and practice, the findings have the potential to improve the education of nurses and will build on the theory which will be appropriate for Belizean nurses.

In Chapter 2, I presented my literature search strategy, theoretical foundation, conceptual framework, and the literature review to support why this study is necessary. The theoretical foundation assists in the explanation of the TL and explains the concern driving the research. The conceptual framework is the significance and applicability of the study to be completed using HBM.

Chapter3: Research Method

The purpose of this study was to a) determine the difference in leadership self-efficacy for current nurse leaders with three years or less of leadership experience compared to current nurse leaders with more than three years of leadership experience in Belize, and b) examine the difference in leadership self-efficacy between nurses in a leadership position and those not in a leadership position in Belize. Higher levels of self-efficacy may result in leaders who are more likely to serve as nurse leaders in Belize

In Chapter 3, I describe the elements of the research design, the rationale for the design, the methodology, and the target population. I describe the procedures and instruments for data collection, recruitment inclusion criteria, and my data analysis plan. Lastly, I describe external and internal threats to validity and ethical procedures that were used to protect the study's participants.

Research Design and Rationale

A non-experimental, descriptive, comparative research design was used to evaluate the relationship between bedside nurses and nurse leaders by examining years of experience and levels of leadership self-efficacy. The purpose of this study was to a) determine the difference in leadership self-efficacy for current nurse leaders with three years or less of leadership experience compared to current nurse leaders with more than three years of leadership experience in Belize, and b) examine the difference in

leadership self-efficacy between nurses in a leadership position and those not in a leadership position in Belize.

Methodology

Population

The sample population of bedside nurses and nurse leaders who met the inclusion criteria were nurses who worked in one of the health systems in Belize for at least 1 year. The target population was RN's with 1–5 years of nursing experience in Belize, received their education in Belize, and who are 18 years old and over. The healthcare system in Belize is comprised of 51.6% of nurses (Ministry of Health [MOH], 2025). Belize has 897 nurses who are registered to practice and of that 66% are RN's and the current density is 23.4 per 10,000 population which is less than the standard of 32 per 10,000 that is essential (MOH, 2025).

Sampling and Sampling Procedures

The participant sampling for this study was purposive using RN's with 1-5 years of experience working in Belize.

Procedures for Recruitment, Participation, and Data Collection (Primary Data)

The participants were recruited through word of mouth , the web-based social media site Facebook, and an email to assist in facilitating contact and providing access to a larger population appropriate for the study. The interested persons who responded to the

invitation completed a screening questionnaire to ensure that they met the inclusion criteria, including those over the age of 18, having 1–5 years of experience working in Belize, and having received their nursing education in Belize (see Rubin & Babbie, 2017). The participants were provided informed consent online or by paper. They were directed to read the informed consent before taking part in the study. The consent form provided by Walden’s IRB included risks and benefits, an explanation of the study, methods used to provide confidentiality, and a means to contact me should there be any adverse events or questions. The consent document included the procedure for respondents to discontinue their participation. I used purposive sampling due to the limited time (approximately 6 months). I had to work with the small population of nurses in Belize (Thiese, 2014). The screening question started with the following:

- Are you 18 years or older?
- Did you complete your nursing education and are currently working in Belize?
- Have you completed 1–5 years of nursing in Belize?
- Are you currently working in acute care, clinics, or behavioral health?

If the answer was no to any question, then the survey was discontinued. The survey did not ask for any type of identifying information. Prospective participants were then asked to complete the demographic information, and the LEQ questionnaire, which consisted of three components: two self-efficacy surveys and one means-efficacy survey.

The LEQ has 22 questions with a score 0 to 100 (Hannah & Avolio, 2013). The instrument was used with permission (see Appendix C). The validated LEQ was used to evaluate the nurse and the current nurse leaders (see Hannah et al., 2012; Jones et al., 2015).

Data Analysis Plan

I evaluated leader self-efficacy and means self-efficacy, which is the leaders belief in the adequacy and effectiveness of the resources and tools available to them for their role, using the LEQ developed by Hannah et al., (2012). The LEQ is a self-report questionnaire to assess perceptions of levels of confidence and capabilities. Statistical analysis was performed using SPSS version 29, and provided descriptive statistics and comparative analysis. Using SPSS, I conducted an independent t-test to determine whether there were differences in the dependent variable leader self-efficacy based on the number of years of leadership experience for nurses currently in a leadership role. I examined demographic variables of age, gender, race/ethnicity, level of education, years of nursing, and leadership experience using descriptive statistics and a comparative analysis.

The data were processed and analyzed using SPSS Version 29 as they were downloaded from Survey Monkey. I cleaned the data to ensure that all entries were complete for the analysis. I examined the data for outliers and ensured that the major assumptions for an independent were met.

All data were anonymous. No participant identifiers were obtained. The data were stored on a protected and secure, password protected computer system, and will be retained for five years per IRB requirements.

The research questions were:

RQ1: What is the difference in leadership self-efficacy for current nurse leaders with 3 years or less of leadership experience compared to nurse leaders with more than 3 years of leadership experience who work in Belize?

H_01 : There is no difference in leadership self-efficacy for current nurse leaders with 3 years or less of leadership experience compared to current nurse leaders with more than 3 years of leadership experience who work in Belize.

H_a1 : There is a difference in leadership self-efficacy for current nurse leaders with 3 years or less of leadership experience compared to current nurse leaders with more than 3 years of leadership experience who work in Belize.

RQ2: What is the difference in leadership self-efficacy between nurses who are in a leadership position and nurses who are not in a leadership position in Belize?

H_02 : There is no difference in leadership self-efficacy between nurses who are in a leadership position and nurses who are not in a leadership position in Belize.

H_a2 : There is a difference in leadership self-efficacy between nurses who are in a leadership position and nurses who are not in a leadership position in Belize.

The characteristics and demographic information obtained included education level, age, years of experience employed as a nurse, and gender. Descriptive statistics included mean, mode, frequency, and standard deviation, which is the probability of the population spread using the confidence interval of 95% as the point estimate (Salkind, 2007). Conclusions were developed based on the findings from the study (Creswell & Creswell, 2018).

Instrumentalization and Operationalization of Constructs

At the time of the development of the LEQ, the instrument was placed in three categories of leader efficacy: leader action self-efficacy, leader means self-efficacy, and leader regulation self-efficacy to ascertain their validity (Hannah et al., 2012). Hannah et al., (2012) illustrated the construct validity, testing the relationship using the conclusions from five studies using five illustrations. In the initial Leader Self and Means Efficacy (LSME) test, the focus was on predicting the performance of the leader noted by others who can affect those they supervise (Bandura, 1997). Regarding the development and validation measurement, there were outstanding theoretical and scientific gaps. Previous studies focused on leader self-efficacy but did not consider the beliefs of the leader to the extent that the resources and other expedients within their surroundings can improve or steer how they lead (Eden, 2001). Hannah et al.,'s (2008) conceptual framework was implemented to generate a multifaceted measure of leader self mean efficacy (LSME)

that encompasses and expands a group of leaders' perceptions and proficiency. The validation of the five measured samples verified the construct's design and provided evidence and confirmation supporting its convergent, discriminant, predictive, and nomological validity, ensuring that LMSE can incorporate externally appraised outcomes.

The multi-component approach to LSME was informed by the idea that the self-concept of leadership is complex and consists of many personalities (Lord et al., 2011). The self-concept of leaders constitutes many levels of knowledge about themselves, factors, and what they can do as leaders (Hannah & Woolfolk et al., 2009; Wood, 2007). This involves examining the components of LSME, self-efficacy components of LSME, leader self-regulatory efficacy, leader action self-efficacy, and LSME (Hannah et al., 2012).

The establishment of predictive validity of LSME was initiated by the evaluation of the relationship between the leader's performance, whether using transactional or transformational leadership (Bass, 1985), and the leader motivation to lead (Chan & Drasgow, 2001). The psychometric properties and construct validity of LSME were assessed using five studies with different samples (Hannah et al., 2012). Study 1 defined the steps to develop a theory based on the LSME evaluation (Hannah et al., 2012). Bandura (1997) suggested the response layout, validated by Pajares et al., (2001) was later noted to be more precise due to its predictive capability, psychometric validity than

self-efficacy scale, in minimizing response time. The measure of the scale was recalibrated to a 1-10. The score started with zero as no confidence and 100 as total confidence (Bandura, 1997).

In study 2, verified the factor structure of the Leadership Self-Management Efficacy (LSME) measure and provided additional evidence of construct validity. Confirmatory factor analysis (CFA) was used to test the proposed factors and dimensions underlying the LSME and to evaluate the overall structure and extent of the measure. Prior exploratory analyses informed the CFA model specification. Higher-order CFA models were then examined to compare one-, two-, and three-factor formulations of the LSME. The CFA also allowed for the specification of correlated error terms where theoretically justified, enabling statistical comparisons among competing models and facilitating examination of a higher-order LSME factor model. (Podsakoff et al., 2003).

In study 3, evidence showed that the LSME constructs are discriminant from the divergent conditions and attributes of person variation of the constructs along with two LSME measures that already existed. The results were disseminated over the samples of the candidates performing in other situations (Hannah et al., 2012). In study 4, the LSME was correlated with the five personality traits, where LSME was correlated with unrelated traits of extraversion, conscientiousness, agreeableness, emotional stability, and openness to experience. The learning goal orientation and meta-cognitive capability were connected to the LSME and the start of nomological validity with specified correlates of

leadership efficacy (Hannah et al., 2012). Study 5, using four samples, demonstrated that LSME predicts a leader's affective identity motivation to take on leadership, shaping their leadership style and achievements as evaluated by peers and supervisors. The findings linked LSME to the performance of the leader from two outside origins and gave the validation evidence for this distinct measure and extended research in LSE (Hannah et al., 2012). The validity of LEQ was exemplified based on the research investigation, which predicted the motivation to lead, contingent reward, performance, and style of leadership behaviors and provided support as an instrument for measuring self-efficacy.

I received permission to use the LEQ instrument from the publishers for within 3 years (see Appendix C). The populations previously used with the instrument were military personnel, working adults from various work environments (Hannah et al., 2012), nursing professionals, nurse leaders (Moran et al., 2021), physical therapists (Sebelski, 2017), correctional executive, senior leaders (Harper, 2015), teachers, and college students (Apesin & Gong, 2021). The instrument has also been used in several cultures and various organizations. Validity came from the assessments of the confidence in nursing professional style of leadership and self-efficacy (Moran et al., 2021). Harper (2015) examined a model of leadership between emotional intelligence and LSE perceptions with correctional executives and senior-level leaders. The instruments used were Wong and Law's Emotional Intelligence Scale (WLEIS) and LEQ. Data were analyzed using correlations and a Multivariate analysis of variance (MANOVA). The

study examined the leader as the independent variable, using the dependent variable of WLEIS and LEQ. The CI was 95% and there was a significant correlation, $p < .05$, of the LEQ and EI. Many of the items from the LEQ were correlated. There was a significant difference between men and women.

Apesin and Gong's (2021) pre/post data collection of the Astin's Input-Environment Outcome (I-E-O) model distinguishes the influences of experimental college variables on the LSE on the student output development despite managing the pre-college variables input. The data were collected from students and analyzed using HMR. Self-efficacy was measured using the 15-item leader self-efficacy (LSE) and rephrased the LEQ to accommodate this situation. The high school (HS) and college leadership reliability experiences, as measured using the questionnaire, exceeded the allowable baseline of 0.70 and 0.71. A relationship existed between the variables using the confirmatory analysis (CFA). The results suggested that the scale was suitable for the data ($\chi^2 = 6,597$, $df = 3$, $p = .218$, $RMSEA = .037$, $CFI = .988$, $TLI = .973$, and $SPMR = .045$). A multiple regression analysis was used to ascertain the effects of the predictors. In the correlational analysis, the college leader self-efficacy and both domains were greater than the means that correlate with the pre-college. An ANOVA was performed to determine whether the leader's beliefs and self-efficacy demonstrated improvement. The differences between high school, pre-college, and college were significant. The general leader self-efficacy $F(1,199) = 2.22$, $p = .00$, action efficacy $F(1,99) = 2,072$, $p < .001$,

and self-efficacy, $F(1.199) = 2.262$, $p < 001$. The findings suggested that leadership experiences from pre-college LSE and co-curricular significantly have an impact on the development of their LSE.

Stagg et al., (2023) surveyed members of a nurse leadership council using a pre-(before the initial council meeting) and post-survey (after the project) for the institution of the council about leader self-efficacy. The council was implemented for the evaluation of the influence of frontline nurses regarding empowerment and confidence. The setting was an acute care hospital in an integrated healthcare in California. This system consists of medical surgical and critical care nurses. The population included assistant head nurses' supervisors, department nurse managers, educators, and nursing directors for every service line with ages 30–59 years old with BSN or higher educational level. The authors used the instrument of work effective questionnaire-11 Global empowerment and LEQ leader means efficacy. The aim of the project was for improvement to establish a council for nurse leaders on the frontline and assess the influence and effectiveness of the empowerment of their perception and confidence in their performance for more than four months. The LEQ measures the confidence of the leader to perform their role and whether the current system was in support of their leadership (Hannah et al., 2012). A 22-item scale was classified from the LEQ into three for the quantification of views about their ability to implement, guide, and solve problems and their attitude awareness that they can look back and be a leader. The confidence of frontline nurse leaders using the

LEQ construct, using leader action efficacy, was measured. The analysis was the Mann-Whitney U test since the size of the sample was very small ($n = 8$ pre-post $n = 6$). There was a median non-significant decline (pre = 78.29, post 73 > 00, $p = 0.897$). The construct of leader means efficacy demonstrated a median (pre = 69.64, post 75.7, $p = 0.747$). improvement in scores. This result was used to measure participants' perceptions of their ability to utilize the assistance and resources of others to enhance their leadership performance.

Leader Efficacy Questionnaire

I used the validated Leader Efficacy Questionnaire (LEQ) to evaluate the self-efficacy of the participants (see Appendix C; Hannah et al., 2012; Jones et al., 2015). The LEQ is a validated instrument used to measure the proposed three constructs of leadership self-efficacy. In Sebelski's (2017) study the perceptions and confidence were investigated about the physical therapist using the constructs of leader self-efficacy. The reliability of LEQ was determined by their moderately elevated confidence self-rating on the constructs and t-test for the constructs. The scores did not show any dissimilarity between males and females on leader action self-efficacy (females $M = 72.83$, $SD 6.41$, males $M 72.2$, $SD 16.74$). A one-way ANOVA between the analysis of a group investigated the effects of age on leader self-efficacy scores and organized in years of 10, coming from the earlier report with the least represented were younger than 29 years, and over 60 was the smaller number represented.

Operationalization for Each Variable: The following definitions are applied using a holistic approach:

Leader self-efficacy: An individual's discernment that the individual can strongly carry out leadership by providing guidance and a rapport with the staff and earn their attentiveness to establish new goals and collaborate to remove impediments that would prevent change (Paglis & Green,2002,p.217).

Leader action efficacy: The leader's ability to complete crucial actions such as motivating, coaching, and identifying with an organization's goals and mission (Hannah et al.,2 012).

Leader means efficacy: The leader perceives that they can learn from others when they perform their duties to improve leadership and that there sources and policies of the organization can be adjusted to effect leadership (Hannah et al.,2012).

Leader-self-regulation efficacy: The leader provides meaning and motivation and brings about novel and useful solutions using effective leadership (Hannah et al.,2012).

Leadership: Interacting with staff to empower them and give them the enthusiasm to achieve their assigned goals (AI-Dossary,2017) .Leadership in nursing provides guidance and direction for accomplishing tasks (Tomey,2006) .Leadership is a collective responsibility in whatever role one serves (Canadian Nurses Association, 2009).

I used the LEQ to measure self-efficacy which contains three parts. Hannah and Avolio (2013) established the LEQ to assess a wide range of leadership styles. The way leaders are engaged in their environment could have a positive or negative effect on their staff, which can influence their ability to lead (Hannah et al., 2008). The environment could affect the leader, and the staff's self-efficacy and involve the evaluation of the leader's ability on the strategies used to influence staff (Hannah et al., 2012). This allows individuals to measure how they perceive themselves regarding specific leadership behaviors. The LEQ takes an estimated 15 minutes to complete and can be conducted for a person or a group. The instrument can be used to distinguish effective and ineffective leaders at any level of an organization and has been confirmed by several cultures and various organizations (Hannah & Avolio, 2013). The use is for the development of leaders and research. The LEQ instrument consists of a demographic section and 22 questions divided into three sections. The leader action efficacy questions 1-7 (LAE), leader means efficacy (LME) 8-14, and leader self-regulation efficacy (LSR) 15-22. Each question was valued at 100 points, each area having a value depending on the nurses' evaluation of themselves. The total score is 2200 for the entire scale.

Data Cleaning

Data cleaning for quantitative research is the procedure used to examine and prepare the data before the analysis. This procedure provides the researcher with accurate information, allows them to adjust, and pattern the data to uncover applicable data that

would give a logical summary that defends decisions (Xia & Gong, 2014). It can identify and eliminates erroneous, deficient, or extraneous information e.g., invalid zip codes or documentation errors. Data cleansing also involves refining the quality of the data by identifying, observing, and removing errors. Incomplete or inaccurate information can compromise data integrity and result in poor-quality data and unreliable findings (Ridzuan et al., 2019).

In this study, I collected data using a survey method which included the LEQ and demographic questions. The survey was administered digitally. The initial part of the procedure was to obtain the required data, such as demographics, explore the data, and then arrange the data in order, followed by cleansing. The data was assessed for errors such as missing data

Threats to Validity

Validity refers to how best the results among the participants exemplify the true findings with similar persons not involved in the study. External validity is the capability of a design to bring about an outcome that can be accurate for various persons in various times and places (Polit & Beck, 2017). For this study, threats could come from a sample not being representative of the population or out of the setting that does not meet the screening criteria since it does not use a random sample. The pre-test can influence the education model and post-test because their practices are being reviewed and may be updated using evidence-based information (Polit & Beck, 2017).

Internal validity refers to a design that can rule out other accounts for the results. Threats to internal validity in this study can be events that transpired during the time of the intervention or between or if compared with a group that was not a part of the sample. Threats can also be from the testing of the pre- and post-test. The pre-test can serve as a baseline, bringing attention to differences in the group, participants who drop out of the study, severe scores closer to the mean, instability in the way the dependent variables are measured, and when participants interact with those in different groups that can affect the outcome (Polit & Beck, 2017).

Construct validity refers to whether references can be drawn about scores related to the concept under investigation (Heale & Twycross, 2015). A confirmation has three categories that can affirm construct validity used to measure validity. Homogeneity should measure one construct. Convergence occurs because the measured concept is comparable to that of another instrument. Evidence of the theory is identified when the behavior is comparable to the theoretical premise, such as a domain of behavior (Heale & Twycross, 2015). I ensured that the instrument measuring the variable was appropriate, such as the instrument to score LEQ and the type of leadership style and the appropriate use of the theoretical and conceptual framework

Ethical Procedures

Social research follows standards related to studying human subjects. I completed an internal review board (IRB) application to obtain permission to conduct the study

(IRB I# 06-12-23-0594678). Once the IRB approval was received, I initiated the study. I invited the subjects to participate in the online survey and provided informed consent according to IRB procedures. The flyer (see Appendix D) was posted on social media, email, and word of mouth, and explained the study in detail, along with any risks and benefits and their rights as a participant. Participants were allowed to drop out should they change their mind about participating. The participants for this study were 18 years and older. Data collection was anonymous, ensuring confidentiality. The data was protected on a secure computer system where only I had access and could make the study results available. The data from this study will be kept according to the IRB standard and later destroyed after the 5-year period. The method of extinction that will be used will entirely ruin all versions and accounts of the document. The various methods require different processes for destruction. Most important is that whatever type of destruction used, the information will not be ascertained or reconstructed in any form (McNary, 2021).

Summary

This chapter outlined the research design and methodology for the study while focusing on how the study was to be conducted. It included the rationale for the design, the method used for reaching the target population, the relationship of the variables and the time factor, sampling, and how to obtain the sample using technology and recruitment of the population. The method for data collection, different instruments to score the data,

and the questionnaire for digital or written completion after IRB. In this study, I collected data using a survey method using the LEQ questionnaires digitally. The initial part of the procedure was to obtain the required data, such as demographics, explore the data, and then arrange the data in order, followed by cleansing. The data was assessed for errors such as missing data. Chapter 4 includes the data analysis, and results of the study.

Chapter 4: Results

The purpose of this study was to a) determine the difference in leadership self-efficacy for current nurse leaders with three years or less of leadership experience compared to current nurse leaders with more than three years of leadership experience in Belize, and b) examine the difference in leadership self-efficacy between nurses in a leadership position and nurses not in a leadership position in Belize. This chapter provided information about recruitment and the process of data collection, along with results which included responses to the survey, recruitment, description of the demographics of the sample and statistical analysis using tables and figures.

Research Questions and Hypotheses

Initially, I developed three research questions for my study, with the intent to examine differences in leadership self-efficacy between bedside nurses and nurses in a leadership position. Because of the small sample size, the analysis was not performed and the research questions were revised to the following:

RQ1: What is the difference in leadership self-efficacy for current nurse leaders with 3 years or less of leadership experience compared to nurse leaders with more than 3 years of leadership experience who work in Belize?

H_01 : There is no difference in leadership self-efficacy for current nurse leaders with 3 years or less of leadership experience compared to current nurse leaders with more than 3 years of leadership experience who work in Belize.

H_a1 : There is a difference in leadership self-efficacy for current nurse leaders with 3 years or less of leadership experience compared to current nurse leaders with more than 3 years of leadership experience who work in Belize.

RQ2: What is the difference in leadership self-efficacy between nurses who are in a leadership position and nurses who are not in a leadership position in Belize?

H_02 : There is no difference in leadership self-efficacy between nurses who are in a leadership position and nurses who are not in a leadership position in Belize.

H_a2 : There is a difference in leadership self-efficacy between nurses who are in a leadership position and nurses who are not in a leadership position in Belize.

Data Collection

To recruit participants, I posted flyers on Facebook and distributed them to the general public through word of mouth to identify individuals who met the participation criteria. A purposive sample was used to facilitate easy access to the target population. Data collection took approximately 3 months, which was longer than projected. Slow responses delayed the study. As a result, I had to seek other contacts to encourage and ask participants to share with their colleagues. I used the LEQ instrument to address mild,

moderate, and maximum confidence using a Likert-type scale. A total of 54 RNs started the survey, of which, 3 noted they did not work in acute care, clinic, or behavioral health, 3 did not agree to the consent, and 1 consented but did not complete the study survey questions. The final sample for the study was 47 participants. The results were reviewed for completeness, and any participant with incomplete responses were removed from the analysis. I conducted data analysis in SPSS by changing strings to numeric variables, automatic recoding of variables, and computing variables.

Demographics

The sample was nurses in Belize who worked in various settings. The sample size for my study, after removing those who did not meet the inclusion criteria, was 47. All participants were 18 or older, received their nursing education in Belize, completed 1–5 years of nursing experience in Belize, and were currently working in acute care, clinics, and behavioral health. Participants read and agreed to answer all questions to the best of their ability.

Leadership styles identified by participants were varied. Democratic, authoritative and transformational styles were the most frequent. There were more nurses with BSNs than other degrees. Many different races reside in Belize. Some citizens identify themselves as Belize Creole and live in Belize. Others are Hispanic and originate from the Cayo, Orange Walk, and Corozal districts. Others are Mayan, African American, and

White as well as from the South Dangriga and Punta Gorda district (see Table 1). Of the 47 participants, 42 reported their age, which ranged from 22 to 62 years, with a mean of 34.71 years (SD = 10). The majority of participants were female (n = 43) with four male participants (n = 4). The primary level of education was BSN (70.2%) followed by AAS degree (10%).

Table 1*Frequencies and Percentages of Demographic Variables*

Variable	Category	<i>f</i>	%
Gender	Male	4	8.5
	Female	43	91.50
Education	Trade/technicalschool	1	2.10
	Associate'sdegree	10	21.3
	Bachelor'sdegree	33	70.20
	Master'sdegree	2	4.30
	Professionaldegree	1	2.10
Primary cultural background	AfricanAmerican	4	8.5
	BelizeanCreole	24	51.1
	Caucasian	1	2.1
	EastIndian	2	4.3
	Hispanic/Latino	12	25.5
	Garifuna	3	6.4
	Mayan	1	2.1
Leadership style practiced	Authoritative	3	6.40

Variable	Category	<i>f</i>	%
	Delegative	3	6.40
	Democratic	32	68.1
	Laissez-faireservant	3	6.40
	Situational	1	2.10
	Transformational	3	6.40
	Transactional	1	2.10
	Not answered	1	2.10
Currently in a leadership position	Notaleader	23	48.90
	Leader	24	51.10
Length of leadership experience	Leader with less than 3 years experience	33	70.2
	Leader with more than 3 years experience	14	29.8

Note. *f* denotes frequency, % denotes the percentage of the total the frequency represents.

Results

To analyze the data, I used SPSS Version 29. RQ1 was: What is the difference in leadership self-efficacy for current nurse leaders with 3 years or less of leadership experience compared to current nurse leaders with more than 3 years of leadership experience who work in Belize?

I used the independent samples t-test to determine whether there was a statistically significant difference between the means of two independent (unrelated) groups on a continuous dependent variable. The independent samples t-test compares leadership efficacy scores between participants (Kim & Park, 2019) who were current nurse leaders with 3 or less years of experience compared to current nurse leaders with more than 3 years of experience.

There are four assumptions for the independent samples t-test. The assumptions include the following: The assumptions include the following: (a) the dependent variable is continuous, (b) there are independent groups, (c) no significant outliers, (d) normality within each group, and (e) homogeneity of variances.

Assumption one was met because the dependent variable was measured continuously. The outcome must be measured on an interval or ratio scale, allowing calculation of means and meaningful differences. Leadership efficacy, as measured by the Leadership Efficacy Questionnaire, meets this assumption because the scale measures from zero to a hundred (0-100) and produces continuous scores that can be treated as

interval-level data. Each item contributes to a composite score where the distances between values are consistent and interpretable, allowing for the calculation of means, standard deviations, and meaningful comparisons across participants (Kim & Park, 2019).

Assumption 2 was met because I had two independent groups of participants. One group were current nurse leaders with 3 years or less of leadership experience and the other group were current nurse leaders more than 3 years of leadership experience. Therefore, there were different participants in each group. Assumption 3 examined the data for any significant outliers. There were no extreme outliers in the data, which was assessed using the box plot for values greater than 3 box-lengths from the edge of the box.

Assumption 4 of normality was assessed with the Shapiro-Wilk test. The LEQ score was normally distributed for the group of current nurse leaders with greater than 3 years of leadership experience ($p > .05$), however, for the group of current nurse leaders with 3 or less years of leadership experience the data was not normally distributed ($p < .05$).

Since the independent t-test is robust to deviations from normality and the sample sizes of the groups were nearly equal, I proceeded with the independent t-test.

In order to answer RQ1 the study participants who were currently a leader were included. A total of 24 participants met this criterion. An independent samples t-test was performed to examine differences in leadership self-efficacy based on years of leadership

experience. There were 13 current nurse leaders with 3 years or less of leadership experience (M = 77.21, SD = 14.20), and 11 current nurse leaders with more than 3 years of leadership experience (M = 79.84, SD = 11.76). An independent t-test was performed to determine if there were differences in leadership self-efficacy between current nurse leaders with 3 or less years of experience and current nurse leaders with more than 3 years of leadership experience. Leadership self-efficacy was not statistically different for current nurse leaders based on their years of leadership experience, 3 or less years or more than 3 years. $t(22) = .496, p = .625, 95\% \text{ CI } [13.62, 8.36]$ (Table 2).

Table 2

Independent Samples Test for Current Nurse Leaders

Mean	ig.	<i>f</i>	ne-	wo-	ean	<i>S</i>	9	9		
LEQ			sided <i>p</i>	sided <i>p</i>	difference	<i>E</i>	5% CI lower	5% CI upper		
Mean Equal					-	5	-	8		
variances	123	729	.488	2	315	630	2.62905	.38604	13.79902	.54092
assumed										
Equal variances							-	5	-	8
not assumed			.496	1.995	312	625	2.62905	.29908	13.61880	.36069

The second research question for my study was: What is the difference in leadership self-efficacy between nurses who are in a leadership position and nurses who are not in a leadership position in Belize? In order to answer RQ2 all (n=47) study

participants were included. An independent samples t-test was performed to examine differences in leadership self-efficacy based on whether participants in a leadership position or not. There were 24 nurses in a leadership position ($M = 75.47$, $SD = 7.19$), and 23 nurses who were not in a leadership position ($M = 78.41$, $SD = 12.93$).

All assumptions were evaluated for the independent t test. The dependent variable, leadership self-efficacy, was measured continuously on a scale from 0-100, which were interval level data. There were two independent groups of participants. One group had participants who were in a leadership position and the other group had participants who were not in a leadership position. There were no significant outliers, which was verified by examining the box plots for the LEQ variable for each group. The LEQ score was not normally distributed for the group of nurses who are in a leadership position ($p < 0.19$), however, for the group of nurses not in a leadership position the data was normally distributed ($p < .05$). I proceeded with the independent t-test since the independent t-test is robust to deviations from normality and the sample sizes of the groups were nearly equal.

An independent t-test was performed to determine if there were differences in leadership self-efficacy between nurses who are in a leadership position and nurses not currently working in a leadership position. Leadership self-efficacy was not statistically different for nurses based on whether they were currently working in a leadership position or not, $t(36) = .972$, $p = .338$, 95% CI [9.10, 3.20] (Table 3).

Table 3*Independent Samples Test for Leadership Experience*

Mean						M	S	9	9	
LEQ	ig.	<i>f</i>	ne-	wo-	ean	<i>E</i>	5% CI	5% CI		
			sided <i>p</i>	sided <i>p</i>	difference	difference	lower	upper		
Mean Equal						-	3	-	3	
variances	.392	.072	.960	.5	.171	.342	2.94837	.06967	9.13101	.23427
assumed										
Equal variances							-	3	-	3
not assumed		.972	6.281	.169	.338	2.94837	.03464	9.10125	.20451	

Summary

In Chapter 4, the data analysis addressed two research questions using an independent t-test. The first research question examined whether there was a difference in leadership self-efficacy between current nurse leaders with three years or less of leadership experience and those with more than three years of leadership experience in Belize. The second research question examined whether there was a difference in leadership self-efficacy between nurses who were in leadership positions and nurses who were not in leadership positions in Belize. All statistical analyses were conducted using SPSS version 29.

Data were collected using a quantitative survey method, including the Leadership Efficacy Questionnaire (LEQ) and additional questionnaires administered digitally. The data collection procedure began with obtaining demographic information, followed by

data exploration, organization, and data cleansing. The dataset was assessed for errors, including missing data. Appropriate measures were applied to the variables, and variables were recoded and assigned values as needed to ensure accuracy and consistency.

The results for Research Question 1 indicated that there was no statistically significant difference in leadership self-efficacy among current nurse leaders based on leadership experience of three years or less compared to more than three years. Similarly, the results for Research Question 2 revealed no statistically significant difference in leadership self-efficacy between nurses who were working in leadership positions and those who were not working in leadership positions. Thus, the null hypothesis was accepted. However, the model was not statistically significant, and the small sample size represented a limitation of the study. An unusually small sample provides insufficient statistical power to adequately address the primary research questions, which likely contributed to the statistically non-significant results (Andrade, 2020).

The analysis also reported the standard deviation for nurses with three years or less of leadership experience was 14.2, compared to 11.7 for those with more than three years of leadership experience. The observed effect size of 13.14 suggests a meaningful difference between the groups; however, the relatively large standard deviations indicate considerable variability within each group. Similarly, participants in leadership positions had a standard deviation of 7.12, whereas those not in leadership positions had a standard deviation of 12.93. Although the effect size of 10.52 indicates a notable difference

between these groups, the variability in scores, particularly among nurses not in leadership roles, suggests that leadership self-efficacy differed substantially across participants.

In chapter 5, I present the interpretation of the findings, limitations of my study, and recommendations will be presented with the implications for social change.

Chapter 5: Discussion, Conclusions, and Recommendations

The objective of this quantitative comparative analysis descriptive study, influenced by leader self-efficacy, social cognitive theory (SCT) regarding human learning, transformational leadership (TL), and health belief model (HBM), was to assess if nurses who worked in Belize and underwent leadership training or those with 1–5 years of nursing experience exhibited higher levels of self-efficacy and were more inclined to assume roles as nurse leaders. A key aspect of the study is whether the leadership training has equipped nurses with the skill necessary to become transformational leaders. The results of research question one there was not a statistically significant difference in leadership self-efficacy between current nurse leaders with 3 or less years of experience and current nurse leaders with more than 3 years of leadership experience. In research question two, leadership self-efficacy was also not statistically different for nurses based on whether they had leadership experience or not.

This research was crucial and relevant because nursing leadership must take place at every level and position within nursing. Nurses must possess the confidence and abilities to take on leadership roles in patient education, advocacy, education, and administration. The organization that hires them must be prepared to support and promote nurse leadership. This group of participants established the basis for additional leadership research (see Singh & Spadaro, 2022).

Interpretation of Findings

The findings of this study contribute to an understanding of how nurses with and without leadership experience rated themselves on the Leadership Efficacy Questionnaire (LEQ). Nurses who demonstrate higher levels of self-efficacy may be more inclined to assume leadership roles. The essence of leadership involves interacting with staff to empower them and provide enthusiasm to achieve assigned goals (Al-Dossary, 2017). Leadership in nursing provides guidance and direction for accomplishing tasks (Tomey, 2006). Self-efficacy is defined as an individual's belief in their capability to behave in ways required to achieve a particular accomplishment (Bandura, 1977, 1986, 1997). Leadership self-efficacy in nursing is closely associated with job satisfaction, staff retention, cost efficiency, and quality of care (Saleh, 2018). Clinical leadership specifically involves coordinating patient care, collaborating effectively with interdisciplinary team members, and using strong communication skills to promote patient wellness (Booher et al., 2021). When examined through the constructs of the LEQ, the results of this study align with the existing literature. The data indicate that nursing experience influences readiness to assume leadership roles, as reflected in the responses of nurses with more than years of experience. The LEQ provided insight into the strengths and weaknesses of participants' self-confidence levels, as measured by the constructs of Leadership Action Self-Efficacy (LAS), Leadership Motivation Efficacy (LME), and Leadership Self-Regulation (LSR).

Saleh (2018) provided insight into leadership styles, which participants described as relational, preferential, and communication-focused. Leadership style plays a significant role in job satisfaction, staff retention, and the delivery of high-quality patient care. It can also influence the overall success or failure of an organization; however, only a limited number of studies have examined leadership styles in depth. In my study, participants were asked to identify the leadership style practiced in their work environment. Several styles were reported, with the democratic leadership style being the most commonly cited followed by autocratic and TL.

Asfar and Umarani (2020) provided insight into the mediating effect of trust in leaders and the moderating effect of this trust on the relationship between transformational leadership (TL) and the creative work behavior of nurses. Their findings demonstrated that TL fosters trust in leadership, which strengthens leader–staff relationships and promotes innovative behavior among nurses. Trust in leaders also influences the overall work environment and the quality of care delivered. In my study, TL similarly provided guidance that enhanced nurses' performance and contributed positively to their overall well-being and leadership self-efficacy.

Al Saber et al., (2019) reported that the factors that predicted nursing willingness to lead are the number of years of experience, burnout from employment, environment of care, preparation of leadership, and perception. The results of Najafi and Nasiri (2023) study suggested that many novice nurses meet a turbulent work environment,

uncomfortable situations, and deficient knowledge that influenced their self-confidence. While there was a few feedback that some nurse liked the questions from the study, because it points out to them how leaders are expected to perform. The result also demonstrated the areas that the nurses struggled answering the question according to the scores.

Najafit and Nasiri (2023) reported that novice nurses do not have the level of appropriate self-confidence, leaving them unprepared to work at the bedside. Kovner et al., (2014) noted that 80% of the population of nurses are novices. Research revealed that most of the nurses at the start of their job demonstrate being inadequately prepared to assume a new responsibility (Gardiner & Sheen, 2016; Kim et al., 2015). Studies indicated that courses for undergraduate nursing are not sufficient and new inexperienced nurses do not have the required instruction for providing care in the real environment of care (Lee et al., 2013; Maria et al., 2020).

In comparison, the findings from this study, indicated that the predicting variables did not support the research questions, as no statistically significant differences were found between the groups. Specifically, the results did not demonstrate a statistically significant difference in leadership self-efficacy between current nurse leaders with 3 years or less of leadership experience and those with more than 3 years of leadership experience in Belize. Additionally, the study examined differences in leadership self-efficacy between nurses in leadership positions in Belize, providing insight into novice

nurses' willingness to lead, their confidence levels, and the influence of years of experience. In contrast, existing literature suggests that years of experience can predict nurses' willingness to assume leadership roles, which is often reflected in the higher levels of leadership self-efficacy. Bush et al., (2020) reported that the primary style of leadership is aligned with TL with the highest average rating which includes coaching, people development and building communication and a low self-efficacy. The functioning of the nursing profession is associated with how a successful healthcare system operates (WHO, 2020; The Lancet, 2021). Living in the post-COVID era required a need for confident leadership. Campbell and Koca (2021) reported that the portrayal of nurses and nursing has changed globally. The global focus had been that hospitals were overcrowded, did not have enough equipment to protect the employees, and were concerned regarding commitment and compassion.

Nurses promote health and well-being and provide care for patients. Clinical skills of nurses include the delivery of health services and public health promotion of health, primary, acute, mental health, and emergency services in disaster settings and humanitarian (Hetland et al., 2020; WHO, 2020). Countries such as Belize require substantial financial resources to make radical changes to improve nursing leadership (Lancet, 2021; WHO, 2020). The essential findings of my study include topics on leadership, style of leadership practiced, leader self-efficacy, preparation of nurses, years of experience, and years of leadership. The data analyzed did not identify a difference in

years of leadership and leader self-efficacy in intentionally developing nurse leaders at the novice stage, early in their professional careers.

The HBM and TL theory include the way people are motivated and motivate others to excel in their tasks, using different techniques to learn new skills and balance themselves. SCT proposes that learning occurs in a social situation and in an environment that is effective with people who provide the context in their work environment (Gibson, 2004). According to the HBM, personal change comes from an assessment of self from the constructs of the model (Sugg Skinner et al., 2015). Self-efficacy was included in the HBM in 1988, when the model used leadership to identify how nurses' knowledge base develops. LEQ is the only instrument that evaluates nurses' and nurse leaders' confidence levels (Hannah et al., 2012). The theory provided the supporting framework for the study.

Cziraki et al.,'s (2017) cross-sectional survey of RNs investigated antecedents, outcomes of leadership, nursing self-efficacy, and the desired position in management. The framework used comprised four sources of information, allowing one to make judgments about their self-efficacy. The findings suggested that leader self-efficacy can be affected when an opportunity for leadership is provided. The LEQ consists of attitudes, values, beliefs, skills and education embedded within the questions which give rise to the level of confidence by the score when answering the questionnaire. A lack of confidence was noted in the scores across the various areas and could have negatively affected the retention of this group of nurses, the attraction of new employees, and the

nurses' dedication to the organization they serve (see Arasanmi & Krishna, 2019).

Although some nurses reported appreciating the study questions because they highlighted expectations for leadership performance, the results also identified areas in which nurses struggled to respond, as reflected in lower scores. These findings suggest that further research with this population is warranted to deepen the understanding of leadership self-efficacy. This study confirmed that newer nurses could benefit from targeted information and strategies designed to strengthen self-confidence, support leadership development, and promote both professional and personal growth.

Limitations

A limitation of this study was the relatively small sample size. The sample was convenience-based, and the work environment was not examined as part of the study. Additionally, the study focused exclusively on nurses who were educated in Belize and currently employed within the country. As a result, the generalizability of the findings is limited. Most participants reported residing in Belize City, with only a small number representing the other five districts, further restricting the applicability of the results to the broader nursing population (Polit & Beck, 2017).

Internal validity could have occurred with the use of the instrument. This instrument had been used in areas such as education, nursing, and other healthcare

personnel for leadership purposes. The LEQ was used to evaluate the LAE, LME, and LSR to assess nurses' confidence and leadership ability (Mind Garden, 2019).

Generalizability to cultures other than those of the participants may be limited. The participants were Creole, Hispanic, African Americans and very limited from the Mayan, White and from Belize. The cultures can have an influence on how the participants responded to the question. This is an indication where the evidence can enhance the management of patient care with a limitation of the culture (Kamper, 2020). There was a lack of evidence-based studies on leadership self-efficacy and the length of leadership experience in nurses who received their education and work in Belize.

In a review of demographics, the nurses with 1–3 years of experience fell in the category of novice to expert, as demonstrated by Benner (1982). Benner's stages are novice, advanced beginner, competent leader, proficient leader, and expert nurse. In Benner's (1982) seminal work on clinical competency, she noted what it means to be an expert nurse.

Recommendations

There is a need for evidence-based research involving nurses at all levels in Belize to address leadership self-efficacy and to actively engage beginning nurses in leadership at their respective levels. Future studies should employ qualitative methodologies to allow nurses to express their lived experiences related to leadership. Participation in leadership training was generally low; therefore, efforts should be made

to implement annual leadership development programs in which nurses can present individually or in groups about their experiences as bedside leaders. Leadership in nursing should be fostered at all levels and across all positions. At a time when the nursing workforce is experiencing an aging cohort of nurse leaders, it is essential to understand the factors that influence nurses' desire to lead and the determinants that contribute to effective leadership. The work environment should include managers who provide coaching, guidance, encouragement, and support to enhance nurses' leadership abilities. Opportunities that promote leadership development can positively influence nurses' self-efficacy and inform future educational programs for nurses who are inspired to lead and assume nursing management roles (Cziraki et al., 2017). Additional research focusing on Belizean nurses is warranted to further explore leadership self-efficacy within this population.

The essential strength of the study is the response of nurses with 1-5 years of experience in Belize and that the questionnaire was completed anonymously. There is a possibility that the participants perceived the questions differently. The findings of this study did not exemplify that years of experience is associated with leadership self-efficacy and leadership experience. Applying strength to self-efficacy in various ways is essential in public health and is crucial to research in the future. Strengthening self-efficacy provides a positive effect with a favorable time for putting into practice interventions that will promote health (Morton & Montgomery, 2013). Since leadership

experience is scarce in nurses with 1-5 years of experience future research should include an interventional study using a pre- and post-test to identify whether there would be any improvement before and after the questions from the LEQ or leadership training.

To gain knowledge and investigate self-confidence, researchers should focus on nurses' interconnection with their experience (Squires & Dorsen, 2021). Nurses are the best source to explain their self-confidence. Most of the nurses from the study reported that their self-confidence is enhanced with positive actions from their superiors by assigning them to work alongside of them, enhancing their skill and power to make decisions. Challenges can be identified for novice nurses with weak self-confidence in their clinical duties to assist in identifying the root cause of the issue and take action to find solutions for the challenges (Najafit & Nasiri, 2023).

Implications

This study provided a framework for understanding leadership self-efficacy in relation to leadership experience among nurses and nurse leaders in Belize. It examined leadership self-efficacy and years of leadership experience within these two groups and compared outcomes between them. Prior research has explored leadership styles among nurses, job satisfaction, nursing education, leadership development, and self-efficacy; however, limited studies have focused specifically on leadership self-efficacy across varying levels of nursing leadership experience in Belize. The findings of this study may be used to enhance learning, increase motivation and self-efficacy, and inform revisions

to nursing curricula. Nurses with higher levels of self-efficacy are better able to demonstrate critical thinking skills and independently assume leadership challenges. Furthermore, these findings are valuable and have the potential to promote positive social change by strengthening leadership self-efficacy from the start of nursing education, ensuring that nurses enter the workforce with a strong foundation for effective leadership.

The Institute of Medicine (IOM, 2011) called for nurses to assume leadership roles in the implementation, evaluation, and design of healthcare systems. Meeting this mandate requires strong and sustained leadership from nurses at all levels, including those in clinical practice, to influence health policy development. To support this goal and promote positive social change, nursing education programs, from undergraduate through graduate levels, have increasingly integrated leadership principles across a wide range of learning experiences for nursing students (Moran & Sebelski, 2020). As healthcare continues to undergo rapid change and transformation, the roles of nurses will continue to evolve. Consequently, nurse leaders must develop innovative strategies and solutions to actively engage nurses in leadership roles at every level of practice. The enhancement of the level of self-confidence in this group of nurses to achieve social change could be done by providing situations that would provide motivation for them to become change agents. These types of situations can be of assistance to nurse educators and leaders in nursing to provide organized situations for learning.

Nurses can reflect on past situations and make their own changes. The nurse can learn new skills in leadership, research, political action, and sensitivity to other cultures, which can be done as continuing education or in a curriculum (Johanson et al., 2022). At an individual level, to bring about positive social change from the results of this study, a preceptor program should be developed with nurses who could have a positive relationship with novice nurses and function as good role models. A leadership development program should be initiated where nurses can view monthly presentations on complex care patients. A robust orientation program for nurses and nurse leaders would also be appropriate where nurses can have control over their learning and prepare appropriately for the real environment of care. A further needed development is a quality improvement program managed by the nurses.

Implications for practice to improve leadership self-efficacy using the Social Change Model (SCM) include encouraging impartiality, fairness, self-awareness, and collaboration, while providing ongoing support to both nurses and nurse leaders. The SCM offers a framework that can be integrated into the nursing curriculum to intentionally develop leadership skills, particularly among individuals who may not initially perceive themselves as leaders (Reid et al., 2016). Dugan (2013) extensively tested the effectiveness of educational programs grounded in the SCM and demonstrated positive outcomes in developing students' leadership abilities, skills, and sense of accountability at the collegiate level.

Leadership development activities within the SCM are organized into four categories: (a) socio-cultural conversations that promote awareness of language and culture; (b) formal mentoring with faculty and informal mentoring with peers; (c) community service experiences; and (d) participation in local and non-local groups outside the academic setting. When applied in practice, the selected leadership framework should be inclusive and implemented across all levels of an organization. Additionally, leadership programs should identify distinct, measurable outcomes that clearly describe expected behaviors and competencies. These outcomes should directly align with the activities implemented to ensure meaningful evaluation of leadership development efforts (Reid et al., 2016).

Conclusions

The primary purpose of this study was to identify, using empirical evidence, factors contributing to the reluctance of nurses with one to five years of nursing experience assume leadership roles. The findings did not demonstrate a significant difference in leadership self-efficacy between current nurse leaders with 3 years or less of leadership experience and those with more than 3 years of leadership experience. Additionally, no significant difference in leadership self-efficacy was found between nurses in leadership roles and nurses not in leadership roles in Belize using the current predictors. These findings suggest that other predictors may be more influential and warrant exploration in future studies with larger sample sizes.

In contrast, Alilyyani et al., (2024) reported that years of experience and length of employment were significant predictors of leadership skills among nurses and intern nursing students, resulting in significant differences between groups. Self-confidence has consistently emerged as a key attribute of effective nursing leadership and is closely linked to the ability of nurses to provide high-quality care. The experiences of new graduate nurses, often described as novice nurses, are particularly important for identifying factors that are associated with low self-confidence and reduced leadership self-efficacy (Najafi & Nasiri, 2023). Early recognition of these factors can support the development of targeted interventions aimed at strengthening leadership development among early-career nurses.

These findings align with broader concerns identified in Belize regarding nursing education and leadership preparation. During a conference held in Belize from December 2–4, 2015, under the auspices of PAHO and WHO, gaps were identified in Domain One related to the development of competencies for nurse educators. Key issues included inadequate preparation for frontline practice, wide variation in educational levels and training, non-standardized quality of nursing education across institutions, and limited faculty involvement in curriculum design. As a result, nurse educators were expected to function at a higher level and ensure alignment with curricula that support the development of nurse leaders. The outcomes of that conference reflect the early state of nursing leadership in Belize and anticipated the challenges identified in this study.

Together, these findings underscore the need for structured, standardized leadership development beginning at the novice level and continuing throughout a nurse's career to enhance self-efficacy and strengthen nursing leaders across all levels of practice.

The Health Belief Model (HBM) self-efficacy construct and transformational leadership (TL) models have been used in recent research to identify nurses' baseline knowledge and leadership confidence. The Leadership Efficacy Questionnaire (LEQ) is used to assess nurses' perceived confidence in their leadership abilities. Leaders with elevated levels of self-efficacy are more likely to demonstrate effective performance and professional practice, and their engagement with staff may be perceived as more credible. Credible leadership is grounded in ethical values toward both staff and the organization (Hattke & Hattke, 2019). Leaders who possess a strong belief in their capabilities are associated with increased staff engagement across diverse contexts and exemplify transformational leadership behaviors (Hannah & Luthans, 2008; Yildiz & Simsek, 2016). Furthermore, self-efficacy has been shown to enhance the confidence of professional nurses, contributing to improved leadership development and practice (Van Dyk et al., 2016).

Therefore, this study contributed to the existing body of knowledge on nursing leadership in Belize by providing new insights into leadership self-efficacy among nurses and nurse leaders. The findings help bridge the gap between performance, education, and leadership training by emphasizing the need to explicitly include leadership roles and

expectations within nursing job descriptions. Greater attention should be given to the content and structure of leadership education to prepare nurses to become transformational leaders and to establish a sustainable pipeline of nurse leaders.

Ultimately, strengthening leadership self-efficacy among nurses can foster positive social change and has the potential to improve the overall quality of patient care.

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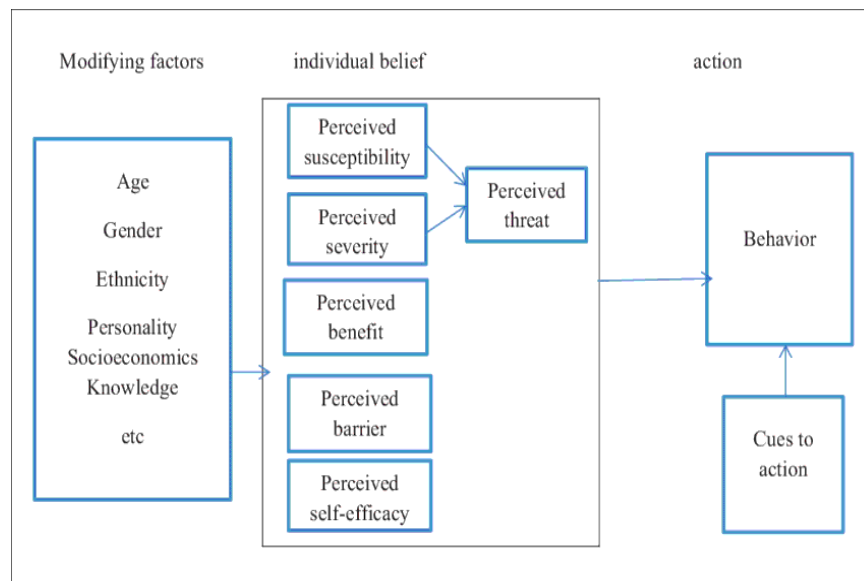
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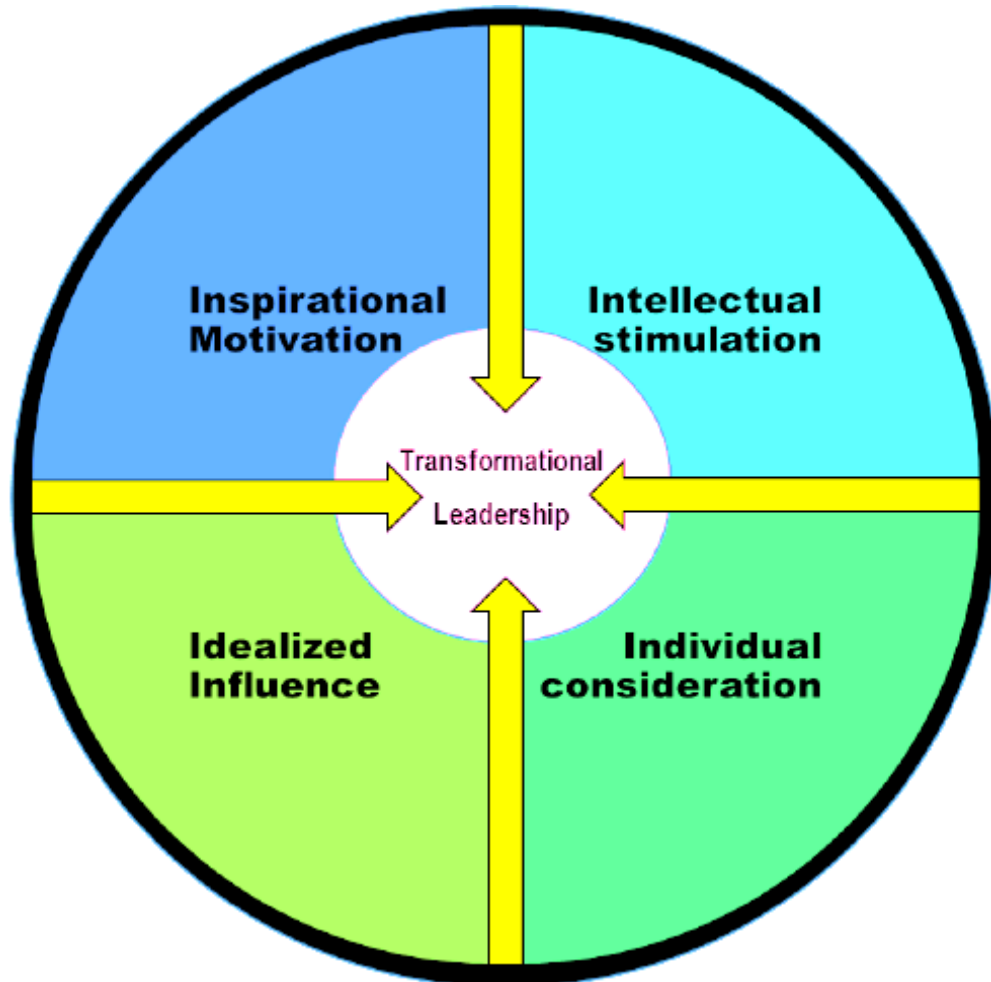
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Appendix A:Health Belief Model



Note. This model suggests the capability to make predictions about the attitudes and beliefs of nurse leaders (Zewdie et al.,2022).

Appendix B: Transformational Leadership Model



Note. This module of leadership focuses on the engagement of staff and provides the opportunity for the best performance (Renjith et al.,2015).

Appendix C: Permission Letter

PermissionLetterAugust30,2022

Walden University

Dear Sir/Madam

Re: Research Paper-Transformational Leadership

My name is Ruth Jones, and I am a student of Walden University, enrolled in the Ph.D. program in Nursing. To achieve partial fulfillment and meet requirements, a research study is required that will benefit the Nursing discipline, bringing about positive social change.

I am asking for permission to use the LEQ. A copy of this study will be available should you need it. I await your response. Should you have any concerns, please contact me via email:

ruth.jones3@waldenu.edu.

Sincerely yours

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Leader Efficacy Questionnaire
Self and Rater Forms plus Scoring Guide

By Sean T.Hannah & Bruce J.Avolio

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Ruth Jones

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I will remove this online survey at the conclusion of my data collection and I will

personally confirm that it cannot be accessed.

I agree to this condition.

I agree to abide by each of the conditions stated above

Your name (as electronic signature):	Ruth jones
Date:	7/19/2023

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Appendix D:Flyer

My name is Ruth Jones am a student at WaldenUniversity pursuing a doctoral degree in nursing .I am currently writing a dissertation to complete the program.To complete the requirement ,I am seeking for participants in my study.Therefore,I am looking for nurses with arrange of 1-5years' experience as staff nurses or bedside and nurse leaders to evaluate leader self-efficacy.

Participants Should Be:

- 18 years or older
- Received their nursing education in Belize
- Have1–5 years of nursing experience working in Belize
- Currently working in acute care, clinics and Behavioral health

If appropriate the participants will complete a consent form. The participants will later complete a questionnaire online or on paper. The process should take about 60 minutes for the nurses and 75 minutes for the nurse leaders. Interested nurse sand leaders should click on the link and follow the directions to answer the questionnaire. For questions about the study and completing a paper questionnaire you may contact me @ruth.jones3@waldenu.edu or call 646 670 6086 WhatsApp.

For further information, you may contact my chair, Dr. Carolyn Sipes.

Carolyn.sipes@mail.walden.edu

Please click on this link to participate in the survey

<https://www.surveymonkey.com/r/nurseleadbze>